S. HRG. 108–664

# MEDICAID IN CRISIS: COULD LONG TERM CARE PARTNERSHIPS BE PART OF THE SOLUTION?

## HEARING

BEFORE THE

## SPECIAL COMMITTEE ON AGING
## UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

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# MEDICAID IN CRISIS: COULD LONG TERM CARE PARTNERSHIPS BE PART OF THE SOLUTION?

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**TUESDAY, JUNE 22, 2004**

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

The committee met, pursuant to notice, at 10 a.m., in room SD–628, Dirksen Senate Office Building, Hon. Larry Craig (chairman of the committee) presiding.

Present: Senators Craig, Bayh, and Kohl.

## OPENING STATEMENT OF SENATOR LARRY CRAIG, CHAIRMAN

The CHAIRMAN. Well, good morning, everyone. We are actually going to be a few minutes ahead of schedule this morning. That is rare in the U.S. Senate, but there are going to be a couple of votes at 10:45, so I thought we could get started and get through most of our testimony.

Let me welcome you all to the U.S. Senate Special Committee on Aging. I would venture to say that Senator Bayh and I have a particular interest in today's hearing, as it deals directly with legislation that we have co-sponsored, and Senator Bayh will be joining us for the balance of the hearing, hopefully within a few moments.

As you know, this hearing is on what we call the Medicaid crisis: could long-term care partnerships be part of a solution to that problem? For the past several years, Medicare has commanded most of Congress' health care attention. This is understandable but it is also to some degree—has obscured the equally important issue of long-term care. Experts estimate that four out of 10 people who reach the age of 65 will need long-term care at some point. The average cost of a 1-year stay in a nursing home today is about $66,000, and the average length of stay is about two and a half years.

This often ruinous expense comes as a surprise to many seniors who mistakenly believe that nursing home care is covered under Medicare. As a result, many seniors find themselves in the tragic position of having to spend down their lifetime savings until they reach the poverty level to qualify for Medicaid. The Government, either State or Federal, now currently pays more than 60 percent of long-term care costs, but with the baby boom generation quickly aging, long-term care costs are expected to double by the year 2025 and nearly quadruple by 2050.

Given these sobering demographics and the continuing budget pressures facing State governments, the present Medicaid documented funding approach to long-term care is simply unsustainable. To help address this difficult challenge, Senator Bayh and I have reintroduced the Long-Term Care Insurance Partnership Program Act of 2004. This legislation would allow Americans to purchase State-approved private long-term care insurance policies and, in return, the State would guarantee that should the policy benefits be exhausted, the Government would cover the cost of their continuing care through Medicaid without first requiring a beneficiary to become impoverished.

This legislation builds on partnership programs currently operated in four States: California, Connecticut, Indiana and New York. We are lucky enough to have representatives from Indiana here with us today to share their experiences. The bill would lift current Federal restrictions and make such programs available nationwide.

Like over 15 other States, my own State of Idaho recently passed a joint memorial asking Congress to amend Federal law to allow States to enter into these innovative partnerships. I am extremely pleased that President Bush has also recognized the value of this approach and that the President has included it in his 1904 budget request to Congress.

Enrollment in these policies is growing, and out of 150 partnership policies currently in force in these four States, only about 86 policy holders to date have exhausted their long-term care insurance benefits and been forced to return to Medicaid. Such long-term care partnership programs truly represent a win-win for all concerned, something rarely encountered in health care policy.

For the individual, such partnership policies allows the person to feel secure that the money they saved for their golden years will not be quickly wiped out on their way to poverty. For States, such policies offer a way to relieve pressure on skyrocketing Medicaid expenditures. Long-term care partnership programs alone will not completely resolve the Medicaid crisis so many States face, but it is one innovative option that States can consider, and I certainly look forward to the testimony that we are about to receive.

Senator Craig. Now, let me turn to those who have come to be with us this morning to testify. Our first panel is made up of Michael O'Grady, assistant secretary of Planning and Evaluation, Health and Human Services, here in Washington and Raymond Scheppach, executive director, National Governors Association here in Washington, DC also.

So with that, Michael, let me turn to you first.

**STATEMENT OF MICHAEL O'GRADY, ASSISTANT SECRETARY OF PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Mr. O' GRADY. Good morning, Mr. Chairman.

It is a pleasure to be here to discuss long-term care insurance, particularly the partnership program. There are at least three key benefits for individuals who purchase long-term care insurance: flexibility, the flexibility to stay in their own home, to go to an assisted living center or to go to a nursing home; choice, the choice of which providers they would like to use for their long-term care services; and control, control over how much and what kind of services they use.

There are also clear benefits for the society as a whole. With the aging of the baby boom, Medicaid will be placed under significant financial pressure in the future. In 2004, total spending on long-term care for the elderly was $135 billion, and roughly a third of that was financed by the Medicaid program. By the year 2025, total spending is predicted to almost double to $260 billion, and by 2050, the population over age 65 is expected to double.

There will be a compelling need to focus scarce Medicaid dollars on those who need it the most. Any measures that can increase the baby boomers' prefunding of their own long-term care will improve the situation significantly. Whether you are a proponent of using the public sector, the private sector or a combination of the two, policies that result in the boomers funding their own needs will greatly reduce the possibility of a crushing financial burden on their children and grandchildren.

The administration has a number of initiatives to encourage purchase of long-term care insurance, including making long-term care expenses deductible, an upcoming consumer awareness campaign. Long-term care, although the demographics underlining it are the same forces as we see in the Medicare crisis and in the Social Security crisis, it is, in effect, sort of a quiet stepchild. But the same forces are in effect; the same finances will be upcoming.

The partnership program, we are certainly encouraging. What are partnerships? It is a program by which States can change their own Medicaid eligibility rules, their, quote, spend-down rules, and long-term care insurance does not count toward those calculations. Participants buy insurance that covers the cost of their own care. If they exhaust their long-term care insurance and need to go on Medicaid, they are allowed to keep additional assets equal to the value of their long-term care policy.

This additional protection of assets increases the value of long-term care insurances for Americans, especially those of moderate income. Legislation is needed to give States the flexibility to introduce partnerships if they wish. Many States are anxious to do it; initially, 12 States passed legislation, but they are prevented by Federal Medicaid law from doing so. Only four of the 12, as you mentioned in your opening statement, California, Connecticut, Indiana and New York, moved quickly enough when partnerships were allowed to get their programs operational before the cutoff.

OBRA 1993 prohibited the other States from moving ahead and cutoff the possibility of additional States starting programs. The four programs underway have continued, but the other States can-

not start any new programs. The OBRA 1993 prohibitions reflect a concern that partnerships would be used to game the Medicaid program. A decade later, the data is in, and those concerns seem unwarranted. One hundred eighty thousand policies have been purchased in the four partnership States. Only 86 individuals, or 0.05 percent, or five one-hundredth of a percent have actually gone on Medicaid.

To summarize: long-term care insurance is an important tool in providing Americans with choice, flexibility and control during their last few years. It is an important tool in helping older Americans to stay in their own homes as long as possible. Partnership programs increase the value of long-term care insurance and make it more attractive to more people. The concerns about partnerships reflected in OBRA 1993 have not come to pass. Finally, anything that encourages the baby boomers to prefund their own long-term care reduces the financial burden on future generations and allows scarce Medicaid dollars to be focused on those with the greatest need.

Thank you for your time.

[The prepared statement of Mr. O'Grady follows:]

TESTIMONY OF MICHAEL O'GRADY

ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning, Mr. Chairman and Members of the Committee.

It is a pleasure to appear before you today to discuss long-term care insurance, and particularly the Partnership program. We are pleased that you are holding this hearing to focus on this issue, which is so important to all Americans, especially to us aging baby boomers. We may not be ready to admit it, but in increasing numbers we will require long-term care.

People want to stay in their own homes as long as possible. Giving people more choice and more control over the long-term care services they receive leads to higher quality care and greater satisfaction. The Medicaid program is currently the largest public payer of long-term care services. Data from the U.S. Census Bureau and CMS makes it abundantly clear that Medicaid – the "last house on the block" for financing long-term care-- is not going to be able to rise to the demographic challenge. Nor is it fair to expect it to. Furthermore, the basic structure of Medicaid, which dictates who receives services and how they receive them, is unlikely to work for the baby boomers, who are used to controlling their own destinies to the greatest extent possible.

With long-term care insurance, people can choose to stay in their own home or to go into a nursing home or another care setting, depending on their needs and condition. They are not restricted by the limitations of what public money will cover. As it becomes increasingly difficult to sustain public financing of long-term care, private pre-funding becomes more important. Long-term care insurance is critical to allow people to pre-fund their long-term care needs. The Administration supports measures to encourage people who can afford it to pre-fund their own long-term care by purchasing long-term care insurance. Encouraging baby boomers to pre-fund their own long-term care needs will reduce the financial burden on their children's generation and target Medicaid dollars to those who need them the most. The Administration continues to support passage of legislation providing an above the line tax deduction. This kind of deduction would be available to all taxpayers whether or not they have medical expenses above 7.5% of their adjusted gross income. The legislation that this committee is discussing today is an important step in encouraging people to take responsibility to protect their own independence with long-term care insurance.

The Partnership legislation would give states more flexibility under Medicaid to encourage the purchase of long-term care insurance. It would permit them to exclude from the estate recovery process the amount paid by qualifying long-term care insurance. The Omnibus Reconciliation Act of 1993 allowed programs that had already been approved by the Health Care Financing Administration to operate as approved, but prevented the expansion of Partnership programs by instituting a set of new requirements that states had to observe in order to offer a Partnership program. The requirements are

contained in the estate recovery sections of Medicaid law (Section 1917 (b)). Several states attempted Partnership programs under the requirements and found them unworkable for the state and for consumers.

The Partnership legislation you are considering would reverse these provisions. This change is needed. It is good for states, who tell us that long-term care is the most expensive part of their Medicaid budgets. It is good for consumers who value choices and maintaining their independence. And, ultimately, it is good policy for our country.

**The Need for Long-Term Care**

The Congressional Budget Office estimates that spending on long-term care for the elderly in 2004 will total about $135 billion. While families and other informal caregivers provide the bulk of unpaid services, Medicaid is responsible for the largest share of the cost of paid services. Medicaid currently pays for approximately 35 percent of formal long-term care services with self-pay payments representing 33 percent and Medicare representing 25 percent. Private insurance and Other Sources together make up only 7 percent. In 2002, Medicaid accounted for more than 20 percent of total state spending. Furthermore, state Medicaid budgets continue to grow at a faster pace than other types of state spending.

The U.S. Census Bureau estimates that the number of elderly people in the United States will double between 2000 and 2030. By 2050, 21.5 percent of the population will be

over 65. My office estimates that total spending for long-term care for the elderly will increase from $102 billion in 2000 to $260 billion by 2025. Medicaid's share of long-term care costs in 2025 is projected to be roughly $83 billion. There is little question that the increase in demand for publicly supported long-term care far exceeds our current financing system's capacity.

## THE PARTNERSHIPS PROGRAM WORKS

Four states are now operating successful Partnerships programs—California, New York, Indiana, and Connecticut. They are able to do so because their programs were in place prior to the enactment of OBRA '93, which stopped the growth of this popular program. (One additional state, Iowa, was approved by HCFA to operate a program, but unable to get the a successful program up and running.)

We have learned a great deal from these states' experiences. They demonstrate that states can engage consumers in planning ahead for their potential long-term care needs, and that private and public resources can be combined in a way that benefits consumers, states and the federal government.

**REASONS FOR ACTION**

Why is it critical that we make this option available again? First, the Partnership expands the market for long-term care insurance to those who otherwise might not be able to participate by offering products that provide coverage for as little as one year, then allow the purchaser to retain some assets and go onto Medicaid. In general, private long-term care insurers rarely offer one-year products because consumers don't want a product that covers only a portion of the anticipated risk. With Medicaid as a backup to private insurance, these shorter-duration, comprehensive policies become a viable alternative. Premiums for private long-term care insurance have been rising due to falling lapse rates and other factors. This trend threatens to make private insurance affordable only to those with significant income or assets. The population able to afford the higher premiums is less likely to require Medicaid and is of less concern for public policy. Partnership policies expand the market to those with less income and assets by offering a shorter term, comprehensive policy that is backed by Medicaid. Such a policy is not available without the Partnership. The Medicaid back-up makes the purchase of such a policy affordable because of its short duration and desirable because of Medicaid's coverage beyond insurance. The availability of Partnership products makes participation in an insurance pool possible for a broader population, especially those likely to eventually need Medicaid.

My office was able to obtain insurance industry data that allowed comparison of long-term care insurance sales in states with Partnership to those without. The data suggest

that sales of long-term care insurance in states with Partnership programs were increasing faster than those without Partnership programs.

Second, the Partnership provides an alternative to transfer of assets. Consumers have an increasing number of ways to avoid "spending down" to Medicaid eligibility. We all know that this type of "estate planning" is big business. The Department is currently assessing the impact of products being marketed as "Medicaid Friendly Annuities." The Connecticut Partnership surveyed its participants and found that roughly one-third of respondents said they would have transferred their assets to become Medicaid eligible if they had not purchased a Partnership policy. Partnership insurance policies represent a real alternative to "gaming" Medicaid eligibility.

Finally, but most importantly, the Partnership program offers a way for consumers to finance their own care and to control how and where they obtain the long-term care services they may need. It empowers them to purchase long-term care insurance, which gives them cash with which to buy long-term care services. With this money they can continue to stay at home for as long as possible, if that is their choice.

## PARTNERSHIP COST ESTIMATES

The Partnership was designed as a budget neutral program. The participating states hoped that they could offset state losses associated with the limited Medicaid eligibility

asset disregard by having fewer people need long-term care under Medicaid. Cost estimates conducted by the researchers at the University of Maryland[1] confirmed the program design and showed budget neutral or small savings for the program. Recently, the CMS Office of The Actuary also estimated that the Partnership would have a budget neutral impact on Medicaid.

The average age of Partnership policy purchasers, at the time they buy the policy, is roughly 60. Most of these buyers will not be using long-term care services for at least twenty years. After that they must first exhaust their insurance benefits, then spend down any assets in excess of their Partnership protected assets, and finally, qualify for Medicaid. In the twelve years since the inception of the four state Partnership programs approximately 180,000 policies have been sold, just over 2,000 policyholders have received insurance payments, yet only 86 people have gone on Medicaid.

There have been a number of other estimates of the long-range impact of Partnership on Medicaid including a simulation modeling approach conducted by the University of Wisconsin, and several individual state program estimates based on actual program data. Each of these has found either small savings or budget neutrality.

[1] Cost effectiveness conducted by Mark Meiners at the University of Maryland in 1993 using the using the *Lewin Long-Term Care Simulation Model*
Testimony Of Michael O'Grady
U.S. Senate Special Committee on Aging
June 22, 2004

**PARTNERSHIP IN CONTEXT**

The Partnership alone is not the answer to the Nation's long-term care financing problem, but is an important component of an overall effort to reform how we pay for long-term care. The larger picture of long-term care financing reform includes the following major policy initiatives:

First, consumers remain largely unaware of their risk for needing long-term care and the things they can do to plan ahead. New financing alternatives have little hope of succeeding unless baby boomers become aware of their risk and believe they need to act. The Department is planning to conduct pilot long-term care educational campaigns in four states early in 2005. Our hope is that these campaigns will help make planning for long-term care an integral part of planning for retirement.

Second, the baby boom generation will demand a wide array of options. Attitudes about long-term care are widely divergent. Financing alternatives need to address not only differing attitudes but also the differing financial circumstances. Not everyone will buy long-term care insurance. In addition to supporting the Partnership, the Department is exploring other financing alternatives such as home equity conversion, and long-term care annuities. Home equity conversion provides funds to the homeowner that can be used for any purpose, including long-term care costs. A long-term care annuity combines income support with long-term care insurance coverage into a single product that

addresses both needs and avoids the need for consumers to choose the risk against which they want to insure.

Finally, Medicaid's coverage of long-term care is a critical component of our safety net for older persons. It was intended to serve those who could not provide for their own needs. The Department continues to work with states to improve Medicaid's coverage of long-term care services. Though our Real Choice Systems Change grants, Cash and Counseling demonstrations, the New Freedom Initiative and numerous other programs, state Medicaid programs continually improve the delivery of long-term care services.

## CONCLUSION

It has been more than a decade since the passage of Omnibus Budget Reconciliation Act of 1993, the law that constrains expansion of the Partnership program. At that time twelve states had passed legislation enabling state Partnership programs, but only five had been approved for operation of a Partnership program without meeting the new requirements specified of OBRA'93. Some of those states attempted Partnership programs under the requirements set in OBRA and failed while others saw that the requirements in OBRA made it impossible and simply stopped all program activity. No new programs have emerged to challenge the conventional financing route of private pay until impoverishment and then Medicaid.

Currently several states are seeking authority to change Medicaid eligibility policy to increase look-back periods, reduce spousal allowances, expand their definitions of estate, and increase estate recovery activities. These efforts have only limited potential to contribute to long-term care financing. States cannot hope to finance the long-term care needs of the baby boomers through closing "loopholes" in Medicaid eligibility.

Mr. Chairman, incremental reform is not easy. The Partnership initiative is important because it provides a practical approach to financing long-term care. It is not the only answer or the only approach. It is one part of our strategy to address the demographic challenge we face.

I applaud the Committee's efforts to highlight this issue and your efforts, Mr. Chairman, to pass legislation so that states can get moving. We must continue to develop new ideas for financing long-term care to enable our senior citizens to have more choice in how they obtain supportive services and to enhance the quality of their lives.

I am happy to answer questions.

The CHAIRMAN. Michael, thank you very much.

Now, let me turn to Raymond Scheppach, executive director, National Governors Association. Welcome to the Committee.

**STATEMENT OF RAYMOND SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS ASSOCIATION, WASHINGTON, DC**

Mr. SCHEPPACH. Thank you, Mr. Chairman. I appreciate the opportunity to appear before you today on behalf of the nation's Governors to discuss the critical issue of long-term care.

This morning, I would like to briefly cover three issues: first, the State fiscal challenges for Medicaid; second, the importance of your legislation, S. 2077; and also Governor Kempthorne's leadership on long-term care as NGA Chairman.

After 3 years of the worst fiscal crisis in the last 60 years, States are now witnessing relatively robust revenue growth. Regardless of the length and bullishness of the economic recovery, however, States will continue to confront very difficult long run budget decisions. Over 50 percent of a State's budget goes to education and Medicaid. Medicaid is a mandatory Federal entitlement whose growth rate is driven by rapidly changing demographics and rising costs, while education is primarily discretionary.

Medicaid's growth is biasing State budget decisions and is winning the contest for State dollars. This will limit the States' ability to adequately fund education over the next decade. Medicaid currently represents about 21 percent of State budgets. It has grown over 11 percent per year over the last 25 years. We were fortunate over the last 10 years, because during the boom period of 1995 to the year 2000, it went down considerably, but even there, the growth rate over the last 10 years was over 8 percent. Unfortunately, over the last 3 years, it rebounded again to over 11 percent per year. This is in spite of the fact that every State cut reimbursement rates, cut eligible populations, cut benefits and instituted formularies.

Elementary and secondary education represents 21 percent of State budgets and higher education another 11 percent. Over the last 3 years, when Medicaid growth again exploded, secondary education growth rate fell to 2.7 percent per year, and higher education fell to 1.5 percent. Unfortunately, over the next decade, it looks like a continuation of these recent growth rates.

That means Medicaid rates continuing probably in the 8 to 10 percent range and education probably in the 2 to 4 percent range. This is going to cause us a major problem, I suspect, now that we have an open economy. We need to compete on the international marketplace. To do that, we need to invest in the education and training of the work force.

The bottom line, Mr. Chairman, is that Medicaid is trumping education in State budgets. With respect to long-term care insurance, in recent years, there has been growth in the availability of private long-term care insurance. Although the growth in this market has been slow, for those that have access and can afford such coverage, it is a reasonable alternative to public financing such as Medicaid.

The insurance industry estimates that for every individual on long-term care insurance, the potential savings is about $5,000 for Medicaid. As indicated previously, there are four States that have partnerships, California, Connecticut, Indiana and New York. Currently about 140,000 of these remain in force. The four States that operate these programs are very pleased with their success, but Federal legislation currently restricts any further expansion.

We strongly endorse your legislation, S. 2077. This is a win for older citizens who can stay in the community as well as a win for States in saving money and a win for the Federal Government in terms of saving money. As indicated previously, Governor Kempthorne chose as his Chairman's Initiative this year long-term care. In May, we brought together teams from 30 States, teams of four to five State policy individuals for 2 days in Chicago to talk about what innovations can take place to provide more long-term care. At the NGA annual meeting, we will be releasing in Seattle this summer a CD ROM related to four issue areas: promoting wellness and disease management, encouraging personal and financial planning, promoting community-based living and supporting family givers and in-home workers.

We have also been working with the Department of Health and Human Services, who is funding an academy with us. This is where we bring together eight States for intensive technical assistance where they are supposed to develop their programs, go back, work with their legislatures and get them enacted. So I think States are taking a fair amount of leadership in this area.

Your bill is obviously not a panacea. It is not a silver bullet, but it is a win-win situation. It is something that Congress should enact. I thank you, Mr. Chairman.

[The prepared statement of Mr. Scheppach follows:]

NATIONAL GOVERNORS ASSOCIATION

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*Raymond C. Scheppach*
Executive Director

**Statement of**

**RAY SCHEPPACH, EXECUTIVE DIRECTOR**
**NATIONAL GOVERNORS ASSOCIATION**

before the

**SENATE SPECIAL COMMITTEE ON AGING**

on

**LONG TERM CARE INSURANCE PARTNERSHIPS**

June 22, 2004

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Mr. Chairman and members of the committee, my name is Ray Scheppach, and I am the Executive Director of the National Governors Association. I appreciate the opportunity to appear before you today on behalf of the nation's Governors to discuss the critical issue of long-term care and to endorse S. 2077, the Long Term Care Insurance Partnership Program Act of 2004.

**Long Term Care**

Increases in life expectancy and the aging of the baby boom generation are contributing to unprecedented growth in the population older than sixty-five. Similarly, improvements in medical technology are contributing to an increasing number of individuals with physical and other disabilities that are living longer, healthier lives. These growing populations are fueling an increasing demand for primary, acute, and long-term health care services. At the same time demographic and cultural changes are decreasing the availability of informal care. These factors will place a significant strain on our nation's current long-term care system, on beneficiaries and their families, and on current sources of public and private funding for these services.

One of the most important responsibilities of state and federal government is to protect and improve the health of our nation's citizens. The federal government, through Medicare and Social Security has been enormously successful in reducing the number of seniors living in poverty and in providing for some of the most basic health care needs of seniors and individuals with disabilities.

**Medicare and Medicaid**

There have always been significant gaps in the coverage of Medicare. The most important gaps are for preventive care, prescription drugs, and long-term care. Additionally, there are significant beneficiary cost-sharing responsibilities. As a result, Medicare covers on average only about one-half of beneficiaries' health care costs. Medicare's coverage of long term care is even more limited. Following a hospital stay, Medicare covers skilled nursing care for up to 100 days. Following a hospital stay, home health care is available under Medicare on a part-time or intermittent basis—and must include skilled nursing care. Furthermore, because of the "homebound rule", the ability of Medicare to provide home health services is limited to those who essentially are disabled enough such that they cannot leave the house at all.

Because Medicare does not fully address the long-term care needs of the nation, states (through Medicaid and state-financed programs) are facing an expanding range of long-term care challenges. According to a long term care report prepared by the Aging Committee in June of 2002, Medicaid is the only major source of financing for long-term care in this country, accounting for 45 percent of all paid long term care services, which is almost twice as much as Medicare and private insurance combined.

Furthermore, Medicaid is the financial sponsor for approximately 70 percent of the nation's nursing facility residents, and this care is extremely expensive. Nursing home care costs average $57,700 annually. Assisted living costs average $28,700 annually.

Two visits a day by a home health aide to help with activities of daily living (bathing, dressing, chores) can cost $2,500 a month.

Currently, Medicaid spends approximately 42 percent of its $300 billion annual budget delivering services to individuals who are already Medicare beneficiaries. These dual eligibles are a relatively small portion of the Medicaid program (6 million of a total of 50 million beneficiaries) and enjoy the full range of Medicare benefits. But it is primarily Medicare's gaps in long-term care coverage that drive state Medicaid spending in this area.

Due to financial pressures in state and federal governments, individuals and families, who already play a significant role in financing and delivering long-term care services, are under pressure to provide more assistance to their aging spouses and parents. There is a growing demand to increase the supply of long-term care providers and to develop new alternatives, services, and settings in long-term care. Moreover, there is an increasing need for government to integrate and streamline fragmented programs to be more client-friendly, cost-effective, and to assure quality service delivery.

**Long Term Care Insurance**

In recent years, there has been growth in the availability of private long-term care (LTC) insurance. Although the growth of this market has been slow, for those who have access to and can afford such coverage, it is a reasonable alternative to public financing, such as Medicaid. Although long-term care insurance will be helpful, private long-term care insurance is not a complete solution for all the nation's long-term care problems. We recognize that a solution is not easily achievable and that a multitude of intermediate solutions must be considered.

This is important to states, because for every individual with a privately held LTC insurance policy, the insurance industry estimates that Medicaid would save $5,000 in annual spending for nursing home care. Policies typically cover 70 percent of nursing home costs, 90 percent of assisted living costs, and 100 percent of home care costs.

But, unless sales of LTC insurance policies increase dramatically, the share of the market financed by private insurance is expected to be only slightly higher in 2025 than it is now. Although it will never be the entire solution, it is nonetheless important to look to long-term care insurance as a component of the growing long-term care dilemma.

**The Partnerships**

Four states – **California, Connecticut, Indiana and New York** - offer LTC Private/Public Partnership programs. These programs combine private insurance with Medicaid. When individuals with Partnership policies need to access Medicaid, they receive more favorable treatment under Medicaid's asset or resource rules than non-policy holders.

From 2002 to 2004, approximately 174,000 applications for coverage were received, 140,000 policies were purchased, and just over 115,000 policies remain in force. As of December 2003, of about 167,000 Partnership policies sold, approximately 138,000

remain in force. Only 1,700 policyholders have received payments, and approximately 50 policyholders have accessed Medicaid. Detailed information about these state programs follows:

- **California's** Partnership Program offers policies to individuals through individual polices and to state government employees as a benefit option via the California Public Employee Retirement System (CalPERS). The California Partnership for LTC provides a variety of tools to assist both consumers and agents, including a video, LTC planning summits, and Web-based resources. Cumulative applications received since the inception of the program in 1994 have exceeded 40,000.

- **Connecticut's** program has a LTC Planning Committee, composed of state agencies and key legislative committee members. Its Partnership program is the main statewide vehicle, not only for LTC insurance, but also for education about the range of LTC needs. Every LTC insurance policy offered by Connecticut to its state government employees is a Partnership policy. The state also has a mandatory training program for all insurance agents selling policies in Connecticut. More than 31,000 policies have been purchased since the program began.

- **Indiana** maintains a state LTC task force that issues extensive quarterly reports on number and types of policies purchased, purchaser demographics, asset protection earned, service utilization, participating insurers, information and referral service telephone and website usage, and presentations. Indiana also requires life insurance agents to be certified to sell Partnership policies and to participate in continuing education programs. Over 24,000 policies have been purchased. As of the end of 2003, only 174 policyholders have accessed benefits and eleven policyholders have accessed Medicaid after having exhausted their Partnership policy benefits.

- **Connecticut's and Indiana's** LTC partnership programs have had reciprocity since 2001. Policyholders in either state can receive dollar-for-dollar Medicaid protection if they relocate to the other state. To date, no individuals have relocated to either states and become eligible for Medicaid. However, the reciprocity agreement is the first of its kind in the country and represents a model for portability of the Medicaid Asset Protection benefit.

- **New York's** Partnership program includes a total asset protection for purposes of Medicaid eligibility. Over 40,000 policies have been purchased since the program began in 1993.

The four states that operate these programs have been very pleased with their success, but federal legislation currently restricts any further expansion to other states. We strongly endorse S. 2077 as well as any other efforts to lift these restrictions and allow all interested states to pursue meaningful partnerships between public programs and the private long term care insurance industry.

**Other State efforts to reduce reliance on Medicaid Long Term Care**

- ***LTC Insurance Marketing Campaigns:*** In addition to the Partnership states, there are a total of 25 states currently offering long term care insurance for their state employees and retirees. Three of these states have begun conducting marketing campaigns at these individuals in order to encourage them to enroll. In 2002, The State of Michigan and Met Life ran a $2.7 million multi-media campaign to increase public awareness of LTC costs for state employees. While the average participation rate in group LTC plans is between 5-8 percent, State of Michigan employees/retirees achieved a participation rate of 16 percent.

- ***Income Tax Deduction for LTC Insurance Premiums:*** Under current law, LTC premiums and expenses, along with all other kinds of health related expenses, must exceed 7.5% of annual income before they can be deducted from federal income taxes. States have moved to supplement this and currently 13 states offer a state income tax deduction or credit that is equal to the federal deduction and 24 states offer higher deductions or credits higher than the federal deduction.

- ***Reverse Mortgages (Home Equity Conversions):*** These loans allow homeowners, age 62 and over, to "cash in" on the equity in their homes without any income qualifications and with limited credit qualifications. The borrower can receive the money as a lump sum distribution, through monthly payments over a period of years, lifetime, or through a line of credit. This tax-free money can be used without restriction and does not count as income toward Social Security, Medicare or Medicaid benefits. The full loan amount, including principal and interest, is repaid when the borrower sells the home, moves or dies. The borrower retains ownership of the home and is responsible for taxes, repairs and any maintenance to the residence. The funds from the reverse mortgage can also be used to purchase LTC insurance or pay for LTC needs

- ***Life Insurance Policies Providing for Accelerated Death Benefits (ADB):*** These life insurance policies provide cash advances against the death benefit while the policyholder is still alive. A 1998 study by the American Council of Life Insurance (ACLI) found that nearly 90 percent of ADB policies specify one type of condition (terminal illness) that will accelerate benefits. About 7 percent of life insurance policies make an ADB provision specifically available for chronically ill people who are likely to need long term care. Most pay for permanent confinement in a nursing home. A very small proportion pay for home and community care. For a majority of policies the accelerated benefit payment amount is capped at 50 percent of the death benefit. Payments are usually made in a lump-sum. Access to ADBs is usually provided via riders to life insurance policies. Additional premiums are not usually required for terminal illness, but are the norm for features that accelerate solely in the case of long-term care, dread disease and permanent confinement to a nursing home. In 1998, 245 companies were selling polices with ADBs and nearly 40 million policies were in force.

- ***Annuities:*** An annuity is an insurance product that pays out a periodic amount of income for the life of an individual or the lives of a couple in exchange for a premium charge. Annuity payments may be either guaranteed (fixed or increasing) or variable, depending on the contract structure and underlying investments. Life annuities frequently offer a guaranteed period over which benefits will be paid even if the annuitant does not survive. A life annuity can be offered through an employer-sponsored retirement plan or an individual product, funded either on a pre-tax or after tax basis. For example, an annuity is the form of payment received from the U.S. social security system.

- ***Proposed Life Care Annuity Product:*** This potentially new product has been conceptualized by Mark Warshawsky at the U.S. Department of the Treasury, Brenda Spillman at the Urban Institute and Christopher Murtaugh at the Center for Home Care Policy and Research. Its purpose is to further the development of private insurance as a means for financing long-term care for most retired households, while simultaneously encouraging the use of voluntary life annuities as a distribution mechanism for retirement funds. An insurance product innovation, the life care ("TLC") annuity, would integrate the life annuity and the "disability" form of long-term care insurance. Insurance companies would make steady periodic income payments to a retired household, and increase them when a member of the household is disabled to an extent that would typically cause expenses for long-term care to be incurred. The product could be offered to people in relatively poor health now precluded from purchasing long-term care insurance. TLC annuity would not require that decisions about long-term care insurance be made early in the life cycle. The potential scope for the product is large, including households with all types of retirement financial assets, including tax-favored forms, and owner-occupied housing (reverse mortgages). Potentially, the product could improve the economic security of many retired households, reduce dependence on Medicaid, and be designed to fit into state Medicaid partnership programs.

**Governor Kempthorne's Initiative**

As Chairman of the NGA, Governor Kempthorne chose as his Chairman's Initiative *A Lifetime of Health and Dignity: Confronting Long-Term Care Challenges in America.* Over the past year, ten of the nation's Governors have joined Governor Kempthorne in focusing on long-term care (LTC) issues as part of the *A Lifetime of Health and Dignity* Task Force. The Task Force's goals are to:

- encourage community-based care;
- support family caregivers and in-home workers;
- promote wellness and disease management;
- encourage personal financial planning for health care costs; and

- explore how technology can provided improved and cost-effective community care.

In the fall of 2003, Governor Kempthorne conducted a series of site visits related to the Task Force's work. These site visits included trips to:

- **Detroit, Michigan.** In Detroit, the Governor visited the elderly and disabled division of General Motors.

- **Austin, Texas.** In Austin, Governors Kempthone and Perry participated in a two mile "Texercise" walk. Texercise is a senior health and wellness initiative.

- **Atlanta, Georgia.** In Atlanta, Governors Kempthorne and Perdue visited the U.S. Centers for Disease Control and Prevention and toured the Aware Home – a high technology home designed to assist seniors with activities of daily living; and

- **Boston, Massachusetts.** In Boston, Governor Kempthorne, visited the MIT Age Lab and experienced a telemedicine consultation at Mass General Hospital with a patient on Nantucket Island.

In support of the Initiative's goals, the Task Force has undertaken the following activities to discuss and identify innovative solutions to long-term care challenges:

- **A Lifetime of Health and Dignity Kick-off (December 10, 2003, Washington, DC).**

  Taping of PBS Broadcast: Living Better: A National Conversation on Aging Task Force Governors and invited guests engaged in a lively discussion about the initiative's major issue areas. The conversation was broadcast in forty-four markets nationally – including six major metropolitan areas.

- **NGA Winter Meeting (February 21-24, 2004, Washington, DC).**

  A Lifetime of Health and Dignity Plenary Session. Governors discussed health and aging issues with Kenneth Cooper, MD, CEO of the Cooper Aerobics Center, Bill Novelli, CEO of AARP, and Joe Coughlin, PhD, Director of the MIT Age Lab. Broadcast live on C-Span.

- **May Policy Forum (May 20-21, 2004, Chicago, IL).**

  Thirty states sent senior executive level staff teams of up to four officials. The opening session included a roundtable discussion with Governor Kempthorne, Former Ambassador and Senator Carol Moseley Braun, Former Speaker of the U.S. House Newt Gingrich, and Chicago media personalities. At the meeting national experts assisted state officials in states seeking to foster long-term care innovations that they could apply in their states.

- **NGA Annual Meeting (July 17- 20, 2004, Seattle, WA).**

*A Lifetime of Health and Dignity* plenary session will focus on the role of technology in promoting elder-ready homes and communities. A second special session, held in conjunction with the PBS Broadcast series *Thou Shalt Honor,* will focus on care giving.

At the Annual meeting, four publications will be released on CD-ROM related to:

- Promoting Wellness and Disease Management;
- Encouraging Personal/ Financial Planning;
- Promoting Community-Based Living; and
- Supporting Family Caregivers and In-Home Workers.

Support for *A Lifetime of Health and Dignity* has been provided by The Robert Wood Johnson Foundation, the U.S. Department of Health and Human Services, AARP and The Commonwealth Fund.

***Related NGA Long Term Care Activity:***

With support from the U.S. Department of Health and Human Services, The NGA Center for Best Practices will hold a Policy Academy on *Rebalancing Long Term Care Systems Toward Quality Community Living and Healthy Aging.* The goal of the Academy is to help states develop customized strategies to rebalance their long term care systems away from institutional care and toward community-based living. Strategies will include enhancing community infrastructure by:

- Developing and organizing community care service systems;
- Addressing the mental health and substance abuse needs of older persons; and
- Promoting healthy aging.

Up to eight states/territories will participate in the academy. The Academy will be held in Denver in August.

After participating in the Policy Academy selected states will be eligible for a year of follow-up technical assistance and a $48,000 implementation grant.

**Conclusion**

I thank the committee for this opportunity to speak about state activities with respect to long term care. Helping to ensure that a full spectrum of long term care services is available to citizens in need is a critical goal of state and federal governments. Although we recognize that it will never be the full solution to this coming crisis, developing the long term care insurance infrastructure is an important piece of the solution, and one that can be accomplished relatively easily. S. 2077 will provide a common-sense tool for states to use and we hope that we can work together to ensure its passage this year.

The CHAIRMAN. Raymond, I thank you very much. I was extremely pleased that Governor Kempthorne would take that as his initiative. It kind of coincided. He is my Governor and also, of course, Chairman of the National Governors Association, and so, we see this as a team effort, as, of course, dealing with Medicaid and those who are eligible for it has always been at a State and Federal level.

Before we go to questions, let me turn to my colleague, Senator Kohl, who has joined us.

Herb, any opening comment?

Senator KOHL. No.

The CHAIRMAN. All right; well, then, let me start with questions.

Mike, you mentioned some savings in budget neutrality. In your best estimate, how much could be saved with long-term care partnerships if we had them nationwide?

Mr. O' GRADY. It is a little hard to put a firm number exactly what it would do. What we do know is that by moving through partnerships, you are encouraging people to buy the long-term care insurance. As Ray pointed out, it is sort of one of the tools in the toolbox to help people prefund their own care.

As I said before, we do have this demographic trend that is underlying where really the more you can get the baby boomers to use their own money rather than relying on future taxes or their own children's spending. So is there a firm number on exactly how many more there will be? I do not know of one. We can certainly look into it to try and find it. But it is certainly—this is an attempt to move in the right direction and to again, as was pointed out, to add one more tool that will allow people to prefund their own care.

The CHAIRMAN. Ray, a similar question to you: you mentioned a $5,000 figure. Would you break that out? That is annualized per patient?

Mr. SCHEPPACH. I think that it is a total number for Medicaid.

The CHAIRMAN. Total?

Mr. SCHEPPACH. That is right. That is from the insurance industry. I do know that the State people think that they are saving money on all four of the particular programs right now.

The CHAIRMAN. But the States involved have not done an analysis as to what their average savings per individual is under their current policy?

Mr. SCHEPPACH. I do not think they have good numbers. The individual from Indiana is here later. She may want to address that. I know they have done a number of surveys, however. So, I mean, I think they have a sense of it.

The other point I would like to make, though, is that this is an insurance that is not widely available in most places.

The CHAIRMAN. Exactly.

Mr. SCHEPPACH. So I think by expanding it, it will probably become more efficient, and perhaps the cost savings will be even larger.

The CHAIRMAN. Well, that was going to be my next question, and I can ask it of both of you: if long-term care partnership legislation of the type that Evan and I have here passes, will the insurance industry from your experience be willing to work with the States to offer suitable policies, and how can we assure that these policies

offer enough coverage? A combination of will they offer it, and do you think the industry will step up if this opportunity exists, and will there be enough coverage?

Mr. O' GRADY. I would say that in terms of will they step up, yes. I think that they will. What we have seen in other forums where we have moved into offering and allowing new insurance products to be offered, and there is a demand for them, they certainly move up. Their competitive instinct is to make sure that they move up before one of their competitors moves up and takes that market share.

Is there still work to do for them to try and think about how to be as innovation as possible, to make this as attractive to people? I think so. There is still room for improvement there, and how you might make it so that it really does fit the needs of particular subpopulations of the elderly.

The CHAIRMAN. Sure.

Ray.

Mr. SCHEPPACH. I also think they will step up. The other thing, of course, that is going on in States, that a lot of States are requiring now that this be an option for state employees in terms of their health care benefits, and I think the Federal Government has recently done that as well. So I think some of these other things will get the spotlight more on it. It will increase the awareness of individuals and develop a more sophisticated insurance market at lower costs.

The CHAIRMAN. Mike, you mentioned that of course, the legislation or the partnerships in long-term care are only a part of the solution. What else needs to be done?

Mr. O' GRADY. Well, there are a number of other things that, you know, this falls into a general category of trying to increase the savings rate, especially among the boomers who are now at their peak earning period. So you want them to be able to save, and we look at international comparisons of American savings rates to others; there is certainly an indication from the pension world, certainly from other aspects of retiree health insurance that there is a need to save at higher rates than we currently do.

So part of the other tools you might bring to bear are certainly how long-term care expenses are treated in terms of tax deductibility, how they are treated there to encourage. Are there other things that could be done? Certainly. There are other forms of annuities; there are other forms of savings, and Congress may consider whether—how tax advantaged or otherwise. That is certainly as we have done certain other areas. Like, I used to work for Senator Roth in the Finance Committee. Certainly, when we saw the Roth IRA come in, and you see that attempt to get new savings, not just people shifting from something with a little more tax advantage than they had before but really getting people to save more, and that is the general area that we are talking about.

Some of the other tools that might be brought to bear are—we are looking at home conversion. People hold an awful lot of equity in their homes. If they spend down to Medicaid, some of that equity will be eventually taken by the State after they die.

Are there other ways that they could use their home equity to stay in their own home longer and be able to do that in a way that

both meets all the concerns of Congress and the Administration but at the same time keeps elderly Americans in their homes as long as they possibly want to?

The CHAIRMAN. Ray, any comment in that area?

Mr. SCHEPPACH. Yes, a lot of it is public awareness, I think, and that is one of the areas where I think States are beginning to step up more, and also private sector financial counseling; it needs to be part of that. I do think tax treatment, whether it is tax credits or deductibility is a possibility. Including it with other types of insurance, whether it is life insurance, annuities, other health insurance so that people get used to it being part of a general insurance package.

The CHAIRMAN. We have just been joined by my partner in this legislation, the Senator from Indiana, Evan Bayh, and Evan, do you have any opening comment you would like to make? Then, we will go back to Herb for questions if he has any and return to you? We are running up against a 10:45 two-stacked votes, so I thought we would run into that vote until we are right at the tail end of it, and then, we will probably recess and jog over and make the first and the last vote and get back here for our second panel.

Please proceed.

Senator BAYH. That being the case, Mr. Chairman, I would defer to the panel. I would just say thank you for your leadership in holding this hearing. It is a pleasure to work with you and Senator Kohl on this issue. It is good to see Mr. Scheppach again. As a matter of fact, our State began this—we are one of the four States, as you know, that is fortunate to have been able to experiment with this effort and began it in 1991 in a previous incarnation of mine when I was Governor of our State.

The CHAIRMAN. I was going to say, this was done on your watch, was it not, or did it start before——

Senator BAYH. The enabling legislation was enacted in 1987. The program was instituted in 1991, when I was Governor of our State, Larry.

So I just thank you for your leadership and our panelists. We have two——

The CHAIRMAN. Yes.

Senator BAYH [continuing]. Panelists coming up who are from Indiana, so obviously, I look forward to introducing them. I thank Senator Kohl for his forbearance.

The CHAIRMAN. Herb? Senator Kohl?

Senator KOHL. I thank you, Mr. Chairman, and I am pleased that you are holding this hearing today.

With the retirement of the baby boom generation within sight, it is past time that Congress and the administration take a serious look at the holes in our long-term care system. More and more Americans will need care in nursing homes, assisted living facilities and home health care. Yet, too few Americans have planned for these costs, and Government programs alone, as we know, cannot be the answer.

So we need to look at a variety of ways to encourage people to plan for their future health care needs. This hearing focuses on long-term care partnerships as one potential solution, and it seems clear that they could be of some help to people. It is a good idea

and one worth considering. However, as this legislation moves forward, I think we need to take a careful look at total asset policies and make sure that they do not allow wealthier people to use partnerships to inappropriately shield their assets to qualify for Medicaid.

Medicaid, as we all know already, faces huge financial challenges, and I think we would all agree that we need to be very careful not to add unnecessarily to that strain. It is clear that partnerships could be one part of the solution for long-term care, and I commend the Chairman and Senator Bayh for bringing this proposal before the Committee.

We all know that partnerships alone cannot solve our nation's long-term care challenges. At best, this would be just one small part of trying to address the problem. I appreciate the fact that both of you have suggested that there are other ways in which we need to move if we indeed are going to take a comprehensive look at the problems of long-term care, and so, I was going to ask you to talk about some of those other ways, and you have mentioned some already, but I just want to emphasize, and I am sure that Senator Craig and Senator Bayh would agree that long-term care partnerships in and of themselves, while good, certainly do not fully address the needs of long-term care in our society today.

Would you agree with that, Mr. O'Grady?

Mr. O' GRADY. Yes, I would, and when we think about this population, and we think about how to help them prepare as much as possible, I think that one of the things about partnerships is they help you focus on those moderate income folks, the kind of person who maybe made $40,000 or $50,000 a year when they were working; now, they are making maybe $20,000 in retirement, and if they are hit with one of these $60,000 a year nursing home bills, they are going to fairly quickly spend down into Medicaid.

Lower-income folks, they are not holding these kind of assets. They are Medicaid, and in the thinking of how you target Medicaid dollars, those are the folks that Medicaid is really designed for, to give them the sort of safety net and protections. Higher-income folks who have a lot of assets, they are probably, you know, they are going to in effect self-fund.

Now, if they would like to buy insurance to cover that, that is great, and you want them to have the opportunity. But when we think about these different measures, kind of the key target population to a certain degree is that moderate income guy who, when we think of Medicaid and who they serve, long-term care is the one sort of spike where the program really spends up into the moderate income group when we think about the, you know, TANF population or other people like that who are linked with Medicaid.

So this is the one area where we are really moving into moderate income folks, and as I said before, there is this demographics of the baby boom going on so that if there is any way to get that generation to do some prefunding, it is just going to make things so much better than whatever their children and grandchildren face, either through public programs or private funding that they might have to pay.

So you want to figure out any way you can get any tool in the toolbox to get this generation to finance their own, not put it on their children and grandchildren.

Senator KOHL. I think that is good.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you.

Ray, one last question of you, and then, we will get to our second panel, and I think we can gain testimony from them before we need to break to vote. Reports suggest that estate recovery programs in the States are not the most cost-effective way of offsetting the cost of Medicaid. Why are States not more aggressive in their estate recovery efforts?

Mr. SCHEPPACH. Well, first, you have a whole, large sophisticated industry out there that is working to shelter individuals' income, and so, that is the first problem. The other problem is that the politics around this issue are tough, so even if a Governor oftentimes wants to introduce legislation in his legislature, it is very difficult to get it passed. So you are up against some pretty serious obstacles.

The CHAIRMAN. Well, gentlemen, thank you very much.

Senator BAYH. Mr. Chairman, can I just ask——

The CHAIRMAN. Please.

Senator BAYH [continuing.] Just a quick question of Mr. O'Grady.

The CHAIRMAN. Of course.

Senator BAYH. I understand the issue of cost has been raised, and we are working with the different scoring agencies to try to get them to take a more global view. My colleague, Senator Kohl, did raise the issue of the potential for wealthy individuals perhaps shielding assets and getting on Medicaid, which initially has some intuitive sense to it.

I would like your opinion, though, about the possibility of wealthy individuals seeking their health care from Medicaid providers. At least in my experience, it is unfortunate; many providers do not opt into the Medicaid system, but it is a fact; and most wealthy individuals, at least in my experience, those are not the providers they go to. So it seems while it is a risk that I think we need to protect against, I think that it is unlikely that Bill Gates or someone like that is going to be going to an urban hospital to get health care.

Mr. O' GRADY. Right, and when we think of that side of the physicians that they might go to, the specialists they might go to, most of these folks are going to be covered by Medicare, and that will be their aside. When we are thinking about where a wealthier individual might be in a position to spend down is more in a nursing home setting, where nursing homes do have a mix of Medicaid and private pay. If they have too many Medicaid, they are in financial difficulty and how you sort of blend that.

The one sort of real advantage that you have got here in moving forward on your bill, though, is that we are always, as we face these new challenges, we are always sort of stuck with, well, how do we think this is going to really work? You know, is it time for a demo or a pilot? Well, in effect, you have got 10 years.

The CHAIRMAN. You have done it.

Mr. O' GRADY. You have done it. You have got four States. They are diverse States. You have got it. We see—I think it was 86 or 89 people actually over a decade have actually spent down and triggered Medicaid.

Senator BAYH. Governors have been arguing for this kind of flexibility for years.

Mr. O' GRADY. Right, and you have got the reassurance of a track record here. So, you know, we are always looking to be breakthrough and innovative, but then, you know, the CBOs of the world say show me the data. It is little hard to be innovative and have an experience to show, but you have a win-win here in terms of it has got a proven track record.

Senator BAYH. Two other quick things.

Mr. O' GRADY. Sure.

Senator BAYH. Just one on the cost front. I think one of our Indiana experts is going to offer her assessment of our experience, but as Mr. Scheppach was mentioning, Mr. Chairman, there is a whole industry that has arisen about asset transfers so that rather than—people engage in all sorts of financial machinations to qualify for Medicaid by transferring their assets here and there, and I believe that she may testify that it has been up to 15 percent has been our experience, that these kinds of policies will avoid that kind of behavior and thereby save Medicaid money, because individuals will be taking responsibility for themselves as opposed to engaging in this sort of financial engineering to qualify for Medicaid.

Just one other point that I think needs to be—as we assess the cost, that needs to be factored in as well, and I think she is also going to testify about the savings per year that accrue from every year delayed, which certainly ought to be taken into account.

My last question, and then, let us get on to the next panel: do you have an opinion, either one of you, about the dollar-for-dollar coverage versus total asset coverage? Do you have an opinion about the advisability of one versus the other?

Mr. O' GRADY. The data that we have seen on that, I mean, it seems to me that there were certain concerns when New York first went to sort of a larger——

Senator BAYH. I think this gets to Senator Kohl's concern.

Mr. O' GRADY. Yes, I mean, we have not seen the sort of concerns come out that this somehow is going to mean, in that State anyway, higher income people really sheltering large amounts of assets.

Senator BAYH. Congressman Waxman had concerns about this back in 1993.

Mr. O' GRADY. Right.

Senator BAYH. Which is one of the reasons the program was just limited to only four.

The CHAIRMAN. Right.

Mr. O' GRADY. Right, and that is the idea of you look at the design, and you have concerns, the advantage again that you have is that we have 10 years of experience, and those concerns have not proven out. So you have got some confidence there you can move forward without it blowing up on you later.

Senator BAYH. Thank you, Mr. Chairman.

The CHAIRMAN. Gentlemen, thank you very much for being with us this morning and offering your testimony. We appreciate it. We appreciate the partnership that we have got going here on this legislation. We will continue to with you. We need your Governors out there tromping the turf to convince our colleagues here that this is the right direction to go in, Ray.

Mr. SCHEPPACH. Right, we will be there.

The CHAIRMAN. All right; thank you very much.

The CHAIRMAN. Now, let me ask our second panel to come forward this morning if they would, please.

Evan, if you would, I will let you start and introduce your two home State folks who are here, and then, I will introduce the balance of the panel, and then, we will start with the testimony.

Senator BAYH. Thank you very much, Mr. Chairman.

I am honored and pleased to have two Hoosiers with us today who I can introduce. I want to welcome them both. Why do I not start with Melanie Bella, who is the director of our State Medicaid program with an annual operating budget, Mr. Chairman, of over $4.2 billion, and it serves over 800,000 low-income and disabled Hoosiers. That is about one out of every seven citizens in our State.

During my years as Governor, Mr. Chairman, I spent as much time in the Medicaid program as anything else trying to strike the right balance between what the taxpayers could afford and quality, affordable health care for the indigent and disabled who needed it, and Ms. Bella has done an outstanding job of striking that right balance.

She has a number of honors and awards from national organizations. I will not go through them all but just touch briefly upon the Visionary Award that she received from the Robert Wood Johnson Foundation's Office of Improving Chronic Illness Care. She has also been selected to join the National Academy of State Health Policy and was elected to the Executive Committee of the National Association of State Medicaid Directors as the Midwest regional representative.

Before serving as the Medicaid director, Ms. Bella was a senior vice-president for Netgov.com, director of operations and strategy for the Indiana University School of Medicine, one of the largest schools of medicine in the country, Mr. Chairman, and director of health policy for the Health and Hospital Corporation of Marion County, IN, which deals with a very significant Medicaid population.

She received her undergraduate degree from DePauw University and her master's of business administration from an institution in Boston, Harvard University. So we welcome Ms. Bella today, and Melanie, I want to thank you today for the wonderful job you are doing on behalf of the people of our State. We look forward to hearing your testimony today.

Also with us today is Bob Bishop from Carmel, IN. Bob, I cannot tell you how often people from other States tell me they have friends in Carmel, IN, but as you and I both know, it is Carmel. So I welcome you.

Bob is 70 years old, married with five grown children and nine grandchildren. What a blessing. He purchased plans for himself and his wife. He purchased dollar-for-dollar coverage for himself

and total asset protection for his wife. I believe he is going to refer to the partnership as a blessing and believes it would be devastating for someone to work their entire life, successfully raise a family, then retire only to have all of their assets placed in jeopardy because of health care circumstances beyond their control.

So, Bob, you are going to put a human face on this today with your personal experience, and I want to thank you for taking the time and trouble to journey here to the nation's capital. So I welcome both you and Melanie and look forward to hearing from you both.

Mr. Chairman.

The CHAIRMAN. Evan, thank you very much, and I must say, Melanie, we are glad to have an expert, if you will, assisting us as we work this legislation.

Let me introduce the balance of our panelists: Mark Meiners, national program director, University of Maryland Center on Aging in College Park. Mark, we appreciate your presence here. Kevin Corcoran, National Association of Health Underwriters in Arlington; and Steve Chies?

Mr. CHIES. Chies.

The CHAIRMAN. Chies, chair of the American Health Care Association in Cambridge.

Now, Mark, we will start with you and move through our panelists. Please proceed.

## STATEMENT OF MARK MEINERS, PH.D., NATIONAL PROGRAM DIRECTOR, UNIVERSITY OF MARYLAND CENTER ON AGING, COLLEGE PARK, MD

Mr. MEINERS. Mr. Chairman, Senator Bayh, it is a pleasure to be here. My history with long-term care insurance goes quite a ways back, 1979, I was a young researcher with the Department of Health and Human Services and begun——

The CHAIRMAN. Pull that microphone just a bit closer.

Mr. MEINERS. Sorry. I began a research agenda on long-term care insurance, because there was none. So we explored whether there was market failure and why there was market failure and discovered some ways that we could develop products. So, by the mid eighties, some of this research had really led to the insurance industry taking it seriously, looking at getting products to the market. My next phase in this was to try to figure out a way to really make sure that the product was there for the middle and modest income people that we have talked about already this morning so that we could really help people avoid spend-down.

That is what led to the partnership program. The Robert Wood Johnson Foundation supported us at Maryland to do a multistate initiative that ultimately ended up in these four States that we are now talking about today having existing programs, and Senator Bayh, I remember when we kicked the program off, the press conference, we were there, and it was a great time.

I am now here to——

Senator BAYH. Seems like ancient history.

Mr. MEINERS. It does; well, it was 1991, so it has been awhile back.

But now, it is the time to take that next step. We need your help, and I really appreciate this legislation to overturn the OBRA restrictions. I said in my testimony to really kind of close it off is saying that this is really a no-brainer. I do not mean to offend anybody by that, but in a sense, we have struggled with this issue, and I think the partnership is a way to balance sort of the countervailing points of view on long-term care insurance. It really gives States a way to step up and provide middle and modest income people an opportunity to avoid impoverishment and to avoid the temptation to game the Medicaid system.

So it does the things that we really want long-term care insurance to do but does it for the right people, and I think that is very important. It also, I think, one of the things that we sometimes lose sight of is that it will help create an atmosphere where agents in the communities can really step up and expose a broad spectrum of their citizens to this insurance risk with the idea that there is actually something to be done about it, and that cannot be emphasized enough.

Right now, I think long-term care insurance is often viewed as a niche product for the well-to-do. This is a way to make sure that any time an agent walks through the door with their portfolio of insurance, they can expose people to long-term care insurance as well, because they have a way to help people think about it even though they may not have a lot of income and assets; they have enough to afford something. That is very important. It changes the mindset.

In terms of arguments for the partnership, I think research are a couple of things that really speak to why I think it is a no-brainer. First of all, in the scheme of how you might subsidize this insurance, we talk about pre-tax benefits, and I certainly would support those. But I also think that when you budget those out in times of budget deficits, it is very difficult to not think about the costs of those pre-tax dollars in supporting such a market.

This is a very efficient subsidy. It only kicks in once somebody has on their own purchased the product and then gone through that product, and it is only at that point that Medicaid is at all at risk of having to pay some of the benefit. It is an incentive to get more people to enter the market.

We have used that mindset to do some simulations in launching this program, so in answer to the questions that you have about cost-effectiveness, our simulations suggest that by the year when we reach a steady State in the year of 2020 that one could expect as much as a 7 percent savings in Medicaid budget. Even though we were really going for a budget-neutral kind of world, that potential does exist, for the reasons I said: it brings more people into the market who otherwise would not be there, and in fact, it creates a situation where people who might game the system do not game the system.

The other side of it is where I would argue it is a no-brainer is because I think it really helps mitigate some of the concerns Congressman Waxman had about erosion of support for Medicaid. I think we need to support Medicaid. There are many people whom Medicaid must serve, but it should not be the middle class. This is a way to create a situation where even though we are encour-

aging people not to use Medicaid, we are supporting Medicaid in the sense that you have a constituency out there that should their circumstances change that they would want Medicaid to be as good as it can be at the time they need it.

For them, can be supported by the fact that they would have assets to help support their care in addition to the support from Medicaid. So I think it really balances a number of very strong countervailing interests and does so in a way that supports middle and modest income to really be a part of this market.

We have had, I think, a lot of success getting these products off the ground. I think there is much more success to come once more States are on board. That is the key of overturning OBRA. We need to make this not just a niche market, which it will remain if it is only in these four States.

I will be happy to answer the kinds of questions you were asking the other panelists before.

[The prepared statement of Mr. Meiners follows:]

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Statement of
**Mark R. Meiners, Ph.D.**

University of Maryland Center on Aging

Testimony before the Senate Special Committee on Aging
Hearing titled:

"Medicaid Crisis: Could Long Term Care Partnerships Be Part of the Solutions?"
June 22, 2004

Mr. Chairman and members of the Special Committee on Aging, my name is Mark Meiners. I am a professor at the University of Maryland where I specialize in the economics of aging and health as it relates to public policy. As part of my duties I have helped the Robert Wood Johnson Foundation develop and direct several state programs designed to improve our Nation's long-term care financing and delivery systems. This is fascinating yet frustrating work and we need your help to succeed.

Today I want to focus on a program I have been working on for many years - the Partnership for Long-Term Care. This work began over 17 years ago when I was a Federal employee with the U.S. Department of Health and Human Services. It is the second major phase of my research and program development efforts on LTC insurance. Earlier (1980) I had developed the research support for the idea that long-term care was an insurable event which subsequently helped launch the current long-term care insurance industry and put this topic onto the National health policy agenda. The Partnership Program follows on this work and is intended to help assure that long-term care insurance is an option available to people with middle and modest income and assets. Only then can we feel comfortable that long-term care insurance is reaching its potential as an effective piece of the long-term care financing puzzle and an efficient strategy for dealing with the crisis in Medicaid.

The Partnership for Long-Term Care is an excellent case study of the creativity and perseverance states have demonstrated in carrying out their long-term care responsibilities in the face of great barriers. It is the barriers with which we need your help. Today I will serve as a historian in addition to providing an academic and advocates perspective to justify that support.

Formal Statement:

Over the past few years the health policy debate has focused on Medicare and how to handle prescription drugs; especially how to deal with the fact that many state Medicaid programs already pay significant drug costs for those who are eligible for both programs. The importance of insurance covering prescription drugs aside, states are desperate for fiscal relief and programmatic help in dealing with the growing burden of long-term care on Medicaid. As we go forward in preparing for an aging population's health care financing needs we must now ask --- what about long-term care (LTC)?

LTC has long been the stepchild in our periodic flirtations with health care reform, playing a weak "third fiddle" to concerns about the uninsured and catastrophic expenditures on prescription drugs. The states have been left to struggle with the issue of long-term financing as part of their responsibilities in funding and administering the means-tested Medicaid program.

LTC is a major cause of catastrophic expenditures for seniors and it involves many of the same challenges faced in the Medicare reform / prescription drug benefit debate. Means testing vs. universal coverage. Private market insurance vs. government run insurance. Federal vs. state responsibilities. Uninsured vs. underinsured. Fortunately with LTC there is a model insurance program working in four states (CA, CN, IN, and NY) that has already begun to successfully take on these challenges. It is fiscally conservative, helps middle-income people avoid impoverishment, serves as an alternative to Medicaid estate planning, promotes better quality insurance products, supports consumer protection efforts, enhances public awareness regarding long-term care needs and options, and helps maintain public support for the Medicaid program.

The Partnership for Long-Term Care is collaboration between state governments and private insurers designed to provide a unique incentive that allows people to purchase a state-certified private LTC insurance policy to get help from Medicaid without first having to be impoverished. It achieves several objectives. Medicaid dollars are saved because LTC needs will increasingly be met by the private sector as people better prepare for this risk. It promotes greater self-reliance rather than relying on a government entitlement. It assists expansion of the LTC insurance market, something obviously needed in anticipation of the pending demographic shift.

Normally when a long-term care insurance policy runs out, policyholders risk having to spend virtually all their savings before qualifying for Medicaid. In contrast, when a Partnership policy is exhausted, the policyholder is eligible for coverage under Medicaid without having to deplete all their savings. The basic message of the Partnership emphasizes product quality -- everyone should have some coverage, if necessary, trading lifetime less comprehensive coverage for shorter high quality benefits -- and then be able to access Medicaid's benefits without being impoverished if those benefits are not enough.

It is an important message. A new index recently released indicates that 85 percent of Americans over age 45 (82 million people) have neither public nor private insurance coverage for LTC. There is clearly much to be done. The same index research suggests that 16 percent of those 65 and older who are at suitable income levels now have private LTC insurance. We should seek to at least double this rate of coverage over the next ten years. To do this it is especially important for middle income families to have affordable insurance since they represent the largest segment of the population and are

most at risk of ending up impoverished and on Medicaid if they need LTC and have not prepared financially for that risk.

The special strength of the Partnership LTC insurance is that it makes purchases of insurance covering the equivalent of 1 to 3 years of benefits (e.g., anywhere from about $50,000 to $300,000 depending on the location) more meaningful by those in the middle to modest income group. Without the special asset protection, shorter, more affordable, coverage (when it exits at all) can still leave the purchaser at risk of impoverishment from catastrophic expenses. Faced with this possibility, people too often go without long-term care insurance, even though they need and could afford some protection.

Each of the four Partnership states have somewhat different nuances to their programs which makes for more work than the private insurance industry prefers but the major barrier to expanding this program to more states has been restrictive legislative language introduced by Congress in 1993 that limits the extent of the asset protection incentive. As many as 14 states had passed enabling legislation to create programs modeled on the Partnership but all these efforts were effectively stifled after "OBRA '93." Under this legislation new Partnership states are required to recover any remaining protected assets from the beneficiary's estate upon death, thereby negating family protection considerations as one of the key reasons for buying this type of insurance. To remedy this situation Congressman Peterson (PA) and Congressman Pomery (ND) have recently introduced H.R. 1406 to remove the restrictive legislative language so additional states can enter into LTC Partnerships. The Long-Term Care Partnership Act (S. 2077) introduced by Senator Craig (ID) and Senator Bayh (IN) supports this same effort to give

the states the right to develop LTC Partnership Programs like those already in existence for more than 10 years in other states.

The Partnership is designed to balance the public interest with the need for a strong private market. It has weathered initial opposition from social insurance advocates like AARP but there is insurance industry hesitance about a program that is only operating in a few states. This creates a classic "catch 22" situation. Without insurers helping to push Congress for the repeal of the OBRA '93 restrictions, it may be difficult to stimulate the multi-state interest necessary to justify the commitment of resources by insurers to help the Partnership expand to meet its potential. Recognizing this problem the National Governor's Association (NGA) has called for elimination of federal barriers to public/private insurance partnerships. The NGA understands that states need and want the opportunity to explore options like the Partnership because they are faced with significant budget concerns about their Medicaid long-term care responsibilities. The National Association of Health Underwriters has also been a strong advocate for the removal of the OBRA restrictions. Insurance agents understand that long-term care is a issue of great important to their local communities and a critical piece of any solid approach to retirement planning for people of all walks of life.

The Partnership is now at the stage where refinements are being made to increase its market impact. Revisions of the Partnership and non-Partnership policies to make them more compatible have already helped broaden the market. Continuing such efforts will be important as new generations of insurance products emerge on the market. Because state by state development is costly, the idea of a uniform national partnership has also prompted discussions among the states and the insurers who have been most

active in the current Partnership effort. There remains a large untapped market of middle- and modest-income people who need help in preparing to pay for LTC. The Partnership for Long-Term Care offers real world experience upon which to build an affordable way for states to offer this needed help.

The Partnership for Long-Term Care has enjoyed more than ten years of persistent, patient, support from states, insurers, agents, consumers, and the Robert Wood Johnson Foundation – the kind of support that comes when there is agreement that the problem needs to be solved, the program is promising, and everyone's collaboration is needed. The Partnership is now at the stage where refinements are being made to increase its market impact. Continuing such efforts will be important as new generations of insurance products emerge on the market. Overturning the OBRA '93 restrictions should be a no-brainer for Congress.

The CHAIRMAN. Mark, thank you very much.
Melanie, please?

**STATEMENT OF MELANIE M. BELLA, ASSISTANT SECRETARY, INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, INDIANAPOLIS, IN**

Ms. BELLA. Mr. Chairman, thank you for the chance to be here today. Special thank you to Senator Bayh, because without his leadership, we would not be here.

On behalf of Governor Kernan, I feel fortunate to represent Indiana as one of the four partnership States and share with you a little bit about our experience. Just to give you context, in Indiana Medicaid, we are spending close to $788 million to $800 million on nursing home care alone. In any given year, it ranges from 18 to 20 percent of our budget.

As we look at the aging of our population and project, that demand is going to increase. It is not sustainable for our State Medicaid program, as we are paying for two out of every three Nursing home beds today as it is. So we are very much in favor of expanding the long-term care partnership program to help promote the market as a whole.

For Indiana, it allows us to provide important incentives for purchasing long-term care insurance. It allows us to reward Hoosiers who plan ahead, and it provides us with critical assistance to manage the Medicaid budget. In Indiana, we have sold over 30,000 policies. We have about 26,000 actively in force today, and I will talk to you a little bit about who those folks are in just a minute.

I want to talk about three key features that the partnership program has. One is asset protection. Indiana is the only State to have both total asset protection and dollar-for-dollar asset protection. So policy holders can choose if they want to purchase a policy that allows them to protect all of their assets or if they would like to purchase a policy that protects dollar-for-dollar.

Again, that gives our policy holders an important choice where they can figure out what preplanning is best for their situation. Seventy-five percent of our policyholders have the total asset protection, so that is an attractive incentive for them. The asset protection is most important, from my perspective in running the Medicaid program, because it gives us a very viable alternative to the Medicaid estate planning and asset sheltering that has been referred to.

There is a growing market of attorneys and financial planners who manage to find very creative ways to shelter assets and create loopholes to get on Medicaid early. We like to joke it is kind of like the whack a mole game. As soon as we close a loophole, another one pops up. We are constantly chasing ourselves to keep closing those loopholes. There are creative people out there. By having the partnership program, we are able to say to legislators and the Governor and others who take quite a bit of pressure for some of these initiatives we are trying to do that we have a viable alternative that allows people to shelter their assets from Medicaid in a way that benefits them as well as the State. So it is a very powerful tool to help us get the legislative support that we need to close more and more of those loopholes.

The second feature that I want to talk about is the reciprocity feature. Within the partnership program, Indiana and Connecticut have reciprocity, meaning that with the asset protection feature, someone who purchases in Indiana can have their assets protected from Medicaid in Connecticut.

The bill that we are talking about today would really help us, because we do not have very many people retiring between Indiana and Connecticut, and so, the more States that are part of this program, the more attractive it is, especially as we try to get younger policyholders to purchase, because they do not know where they are going to retire. So giving them the opportunity to know that the reciprocity is going to exist in more than two States would be very valuable to continue to assist us.

The third feature that we have been asked about is there a tax benefit for this? There is a State tax deduction in Indiana. Also, as you know, there are Federal tax deductions for the federally qualified policies.

I want to spend just a minute talking to you about who the people are on our program and get to the question of is this a good incentive, is this really good for Medicaid programs? Of the 26,000 people that I told you about who have an active policy in force, we have 187 people who are in their benefit period or who have used a benefit at any given time. Fifty-two of those people have passed away. So of those who are remaining, 13 people, that is 0.004 percent, have actually exhausted their benefits and are in an asset sheltering period.

So when you look at the average length of time for a policy translates into about 4 years when people are purchasing their coverage period. The average length of time in a nursing home is about 2½ years. Generally, people are not exhausting their benefit before they would go into the asset shelter period. So from our perspective, it does strengthen the Medicaid program and does not end up costing more than it would by offering that asset protection.

So in closing, just to reiterate, Medicaid cannot be the payer of last resort for the lower and upper middle class. We have got to offer them viable alternatives to plan, and this is a tremendous tool for States, and we would very much encourage your expansion.

Thank you.

[The prepared statement of Ms. Bella follows:]


Joseph E. Kernan, Governor
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**Testimony of**
**Melanie M. Bella, Assistant Secretary**
**Indiana Family and Social Services Administration**

**Before the Senate Special Committee on Aging**

**"Medicaid Crisis: Could Long Term Care Partnerships Be Part of the Solution?"**

**United States Senate**
**Washington, D.C.**

**June 22, 2004**

**INTRODUCTION**

Mr. Chairman, thank you for inviting me to testify today on behalf of Governor Joe Kernan and the State of Indiana on our Long Term Care Insurance Program. This opportunity is even more of an honor and privilege given that the Indiana Long Term Care Insurance Program would not be where it is today were it not for the vision of Senator, then Governor, Evan Bayh who understood the importance of implementing a program to encourage individual responsibility for long term care and reduce the growing burden on our Medicaid program and taxpayers.

Thank you also for demonstrating your leadership on this issue by joining with Senator Bayh in introducing legislation to expand the Partnership for Long Term Care, which the Robert Wood Johnson Foundation helped to develop, beyond the four pilot states – Indiana, Connecticut, New York, and California – to every state interested in promoting self-responsibility and Medicaid asset protection. Based on our experience in Indiana, we believe this legislation will spur the growth of the long term care insurance market, thereby providing Hoosiers with more affordable insurance options.

**BACKGROUND**

The Indiana Long Term Care Insurance Program (ILTCIP) is a public-private partnership between the State of Indiana and private insurance companies to make high quality long term care (LTC) insurance policies available to Indiana residents.

In 1987, the Indiana General Assembly passed enabling legislation to create the ILTCIP. This bipartisan legislation was the first of its kind in the country. Indiana received federal approval for the ILTCIP program in December 1991. Under the leadership of then Governor Evan Bayh, the first ILTCIP policies were available in May 1993.

The ILTCIP was created to address the following concerns:

- Rapidly increasing Medicaid expenditures for nursing home care;

- A rapidly growing elderly population in the state, especially in the number of persons age 85+, the heaviest users of long term care services;
- The limited extent to which people were using private insurance to protect against the high cost of long term care;
- The variability in the quality of long term care insurance policies and benefits provided under these policies; and
- The only public program providing significant financial relief to seniors was Medicaid, which required seniors to become impoverished in order to qualify.

The purpose of the ILTCIP is to provide incentives for the purchase of private long term care (LTC) insurance through a partnership between the Medicaid program and private LTC insurance companies. The ILTCIP helps Hoosiers plan for their LTC needs without fear of impoverishment and helps the State contain the growth of Medicaid LTC expenditures by encouraging persons to purchase private insurance. The goals of the ILTCIP are to:

- Foster and encourage the development of high quality, affordable LTC insurance;
- Provide a means by which Hoosiers can plan to finance their own long term care needs, without the fear of impoverishment;
- Increase the number of Hoosiers purchasing LTC insurance policies;
- Contain the growth of Medicaid expenditures for long term care, by encouraging buying of private insurance; and
- Improve public understanding of long term care financing and provide counseling services to persons in planning for their long term care needs.

The ILTCIP has been modified over the years to make changes designed to increase the purchase of Partnership policies. Such modifications include:

- Amending the statute to allow for the development of an ILTCIP facility-only policy;

- Moving the program into the Office of Medicaid Policy and Planning (OMPP) and providing state funding for the program;
- Expanding the expanding the asset protection feature to include both dollar-for-dollar and total asset protection;
- Establishing reciprocity with other states' partnership for long term care programs; and
- Passing tax legislation to provide a state tax deduction for premiums paid for ILTCIP policies beginning with tax year 2000.

The most significant change for the ILTCIP occurred in 1998 when the Indiana General Assembly added total asset protection as an option in ILTCIP policies. Indiana is the only state with a Partnership program that offers both dollar-for-dollar and total asset protection. This is a significant benefit for Indiana citizens.

**MEDICAID ASSET PROTECTION**

A key feature of Indiana LTC partnership policies is Medicaid asset protection. Medicaid asset protection allows policyholders to keep more assets than is normally allowed when, and if, the policyholder needs help with long term care from the Indiana Medicaid program. There are two types of asset protection - total and dollar-for-dollar.

- "Total asset protection" means all assets will be disregarded during the Indiana Medicaid eligibility process, should the policyholder choose to apply for help from Indiana Medicaid.
- "Dollar-for-dollar asset protection" means that the policyholder will be allowed to retain one dollar of assets for every one dollar of benefits used in the Partnership policy. However, any remaining assets will be considered (unless otherwise protected by law) during the Indiana Medicaid eligibility process.

Whether the policyholder receives total or dollar-for-dollar asset protection depends on the amount of LTC insurance initially purchased and the amount of benefits used under their ILTCIP policy. If, at the time of purchase, the maximum benefit (total amount of dollars the policy will

pay out) when the policy was first purchased equals or exceeds the State-set dollar amount for the calendar year of the policy's effective date, the policyholder may earn **total asset protection.** If the maximum benefit initially purchased is less than the State-set dollar amount for the calendar year of a policy's effective date, the policyholder will earn **dollar-for-dollar asset protection.** For example:

- If the original effective date of a policy is 2004, the State-set dollar amount is $187,613. A policyholder who purchases coverage equal to, or greater than, $187,613 will earn total asset protection once the policy benefits are exhausted.
- A policyholder who purchases coverage of $100,000, which is less than the State-set dollar amount, will earn dollar-for-dollar asset protection. In other words, once the policy benefits are exhausted, the policyholder will be able to disregard $100,000 when determining Medicaid eligibility.

Cumulatively, 75% of all ILTCIP policies qualify for total asset protection.

The ability to provide legitimate asset protection is critical to state Medicaid program's efforts to eliminate asset shelters and close eligibility loopholes. A market has been created by some attorneys, consultants, and financial planners to offer "Medicaid planning" services. Medicaid planners help individuals with substantial assets qualify for Medicaid and avoid using their assets to pay for nursing home care. This is accomplished by converting available, non-exempt assets to unavailable or exempt assets, or by transferring assets to family members. Another goal of Medicaid planning is avoiding Medicaid estate recovery in order to preserve assets for heirs.

States across the county are grappling with this issue and looking for ways to close loopholes and ensure limited Medicaid funds are being used to pay for services for those who truly need them and rightly meet the Medicaid financial requirements. The Medicaid asset protection offered through Partnership policies is a vital tool for states to be able to offer as a reasonable alternative to the asset sheltering techniques being promoted today.

**RECIPROCITY**

As a result of state legislation in Indiana and Connecticut and the approval of the Health Care Financing Administration (now Centers for Medicare and Medicaid Services), reciprocity exists between the Indiana Medicaid and Connecticut Medicaid program. Beginning January 1, 2001, under a reciprocity agreement between Indiana and Connecticut Medicaid programs, each state's Medicaid program can honor the asset protection earned under the other state's Partnership policies.

The reciprocity between the Indiana and Connecticut Partnership programs is the first in the country and demonstrates the potential for establishing widespread portability of Medicaid asset protection. Although the LTC insurance benefit was always portable, this is the first time the Medicaid asset protection feature is able to transfer with the policyholder if the policyholder relocates.

This means that if an Indiana resident purchases a Partnership policy and then later moves to Connecticut and has to apply for Medicaid assistance, he/she can receive Medicaid asset protection from Connecticut Medicaid. The same is true for a Connecticut resident who initially purchased a Partnership policy in Connecticut and relocates to Indiana and needs Medicaid assistance. At this time, the reciprocity offers dollar-for-dollar asset protection and not full asset protection, yet this is an important first step.

The next step is allowing all states to establish LTC Partnership programs. All states should have the same opportunity that Indiana, Connecticut, New York and California have to offer LTC Partnership policies to their residents. Once that is achieved, the final step is promoting reciprocity amongst all participating states. The more portable the asset protection feature is, the more attractive it is to potential purchasers—especially younger purchasers who may not know at the time of policy purchase where they plan to retire. Expansion to all states will improve the overall LTC insurance market and make policies more affordable for everyone.

**TAX BENEFITS**

Beginning with tax year 2000, Indiana residents who pay premiums for Indiana Partnership LTC insurance policies can receive a state tax deduction. The full amount of the premium paid by a taxpayer for a Partnership policy for the taxpayer or his/her spouse may be deducted.

Premiums paid for LTC policies that meet certain federal standards may also be deducted, up to a limit, as a medical expense on the federal tax return. The types of policies that qualify are better known as "tax-qualified" (TQ) policies.

In other words, all Partnership policies quality for an Indiana state tax deduction. And, if the policy is a TQ Partnership policy, it qualifies for the federal deduction as well. This is yet another incentive the State of Indiana uses to encourage Hoosiers to purchase LTC insurance.

**ILTCIP STATISTICS (as of March 31, 2004)**

As of March 31, 2004, there are 13 insurance companies approved to participate in the ILTCIP. A snapshot of ILTCIP data is listed below that summarizes sales, purchasers, policy features and benefits used to date. Through March 2004, 31,042 policies have been purchased. A priority for Governor Kernan and the Family and Social Services Administration in the 2004-2005 biennium is to increase the number of Partnership policies purchased by 15,000 by June 2005, to reach over 42,000 policyholders. The passage of the Long-Term Care Partnership Act (S. 2077) would really help in our efforts to increase enrollment by raising the knowledge, interest and importance of LTC insurance at the national level.

**Sales**

- 36,474 applications received
- 31,042 policies purchased
- 25,998 policies in force

**Purchasers**

- 57% female
- 77% married
- Average age: 62
- Age range: 19 – 90 53% of all policyholders were age 65 or under at the time of purchase 97% all policies purchased have been by first time purchasers

**Policy Features**

- 86% of policies are comprehensive policies (nursing home plus home health care)
- 75% of policies qualify for total asset protection
- Common daily benefits chosen: $120 nursing home; $120 home health
- Common elimination periods chosen: 30, 90, or 100 days

**Benefits Used**

- 187 policyholders have used benefits, thus earning $7.3 million of asset protection (all have been dollar-for-dollar; this amount represents the amount of benefits paid out)
- 68% of benefits used have been for nursing home care
- 13 policyholders have exhausted their policy benefits and are receiving Medicaid assistance (asset protection totaled $646,000 cumulatively)

**Impact on Medicaid**

- In a survey of ILTCIP policyholders, 15% responded they would have transferred assets in order to qualify for Medicaid had they not purchased a LTC Partnership policy.
- The average length of stay in a nursing facility is 2-2.5 years.
- ILTCIP policies with total asset protection have a maximum benefit equal to approximately 4.5 years of nursing facility care.
- Actuarial estimates indicate the benefits derived from preventing or delaying Medicaid eligibility more than exceed the costs of asset protection if and when a policyholder exhausts his/her benefits.

- Every year that Medicaid eligibility is delayed or prevented saves Indiana Medicaid and the federal government approximately $35,000 in nursing home, prescription drug and other medical services costs.

**CLOSING**

The budget challenges facing all states in the Medicaid and long term care arena are only going to worsen unless significant changes are made to the way these services are financed. As the nation's population ages and people live longer thanks to advances in technology and medicine, the demand for long term care services is only going to grow. Today, 750,000 people older than 65 years of age live in Indiana, or one in every eight Hoosiers. More than 90,000 Hoosiers are older than 85. Over the next two decade, the number of people over age 85 is expected to grow by 55 percent.

States cannot afford to continue to be the primary payers of nursing home and other long term care services. State Medicaid programs are now paying for two out of every three nursing home beds. In Indiana, this represents $788 million in state fiscal year (SFY) 2004, or 18% of total Medicaid expenditures. These costs are not sustainable. The more attractive the Partnership policies are, the more people who will purchase the insurance. The more people who purchase, the less reliance there will be on state Medicaid programs to fund long term care.

As Medicare begins to take more responsibility for providing the services seniors need through the Part D pharmacy benefit, the Bush Administration and Congress should also give serious consideration to how long term care services are being financed. Since, at least in the short term, states are likely to continue to bear those costs, including for individuals dually eligible for Medicare and Medicaid, states need more tools to address these growing long term care costs. To that end, the Administration's support for expansion of the LTC Partnerships is much appreciated and we are hopeful that Congress will pass the Long-Term Care Partnership Act, introduced by Senator Craig (ID) and Senator Bayh (IN).

Everyone deserves the chance to plan for his or her LTC needs and receive Medicaid asset protection. All states should have the chance to reward their residents for taking responsibility for planning ahead and purchasing a high quality LTC insurance product before turning to Medicaid and the state for assistance.

Additional Information on the Indiana Long Term Care Insurance Program can be found online atwww.longtermcareinsurance.IN.gov

**Indiana Long Term Care Insurance Program:**
**Cumulative Program Statistics Through March 2004**

**Cumulative as of 03/31/04**

| | |
|---|---|
| Applications Received | 36,474 |
| Applications Denied | 5,142 (14%) |
| Total Policies Purchased | 31,042 |
| Total Policies Dropped * | 6,153 (20%)<br>377 Died (6%)<br>1,670 Voluntarily (27%)<br>1,587 Unknown (26%)<br>135 Converted (2%) |
| Policies Not Taken Up During 30 Day Free Look | 2,384 Not Taken Up (39%) |
| **Policies in Force** | 25,998 |

**Does not include exhausted or recissions.*

**Policies in Force as of 3/31/04**

| | |
|---|---|
| Nursing Home and Home Care Policies | 22,447 (86%) |
| Nursing Home Only Policies | 3,551 (14%) |
| First Time Purchasers | 24,357 (94%) |
| Upgrades or Replacements | 1,641 (6%) |
| Individual | 24,902 (96%) |
| Group Certificates | 318 (1%) |
| Organization Sponsored | 778 (3%) |
| Male | 11,133 (43%) |
| Female | 14,865 (57%) |
| Married | 19,990 (77%) |
| Not Married | 5,633 (22%) |
| Unknown | 375 (1%) |

The CHAIRMAN. Thank you very much for that very enlightening testimony.

Bob, now, let us turn to you and find out why.

**STATEMENT OF ROBERT BISHOP, LONG TERM CARE PARTNERSHIP INSURANCE CONSUMER, CARMEL, IN**

Mr. BISHOP. Thank you, Mr. Chairman and thank you, Senator Bayh, for your words of introduction.

The CHAIRMAN. Please pull your mike a little closer if you would, please.

Mr. BISHOP. Sure.

My name is Robert Bishop. I reside with my wife in Carmel, IN, and except for 2 years while on rotational assignment have always lived in Indiana. My wife and I have five grown children, all of whom are gainfully employed. We have nine grandchildren, and both my wife and I are 70 years old.

Until my retirement in early 1991, I was employed for 39 years by the Indiana Bell Telephone Company, which was, at that time, part of Ameritech. Most of my career, I was involved in network planning, where we planned and conducted economic comparison studies dealing in large part with the timing and economic feasibility of introducing new technologies into the telephone network. Long-term care insurance was not a priority item with me until I attended a broker-client meeting in, I believe, the year 2000, where Indiana's partnership program was explained.

The meeting awakened me to the substantial risk I was exposing my estate to and to the potential hardship, both economic and emotional, I was placing in the path of my family by not owning long-term care insurance. This realization, along with the knowledge that I could permanently protect some of my assets under the partnership plan caused me to purchase a limited amount of insurance and to take advantage of this protection.

Anticipating my wife would outlive me and probably live well into her eighties as her mother and grandmother did, I chose to buy a larger amount of insurance for her which qualified for the 100 percent plan. Due to cash-flow constraints, I purchased a lesser amount of insurance for myself, qualifying me for dollar-for-dollar asset protection.

Insurance premiums for long-term care are not insignificant, particularly when you wait as long as I did to purchase it. Consequently, I feel that I am somewhat underinsured. However, whenever a major purchase is being considered, one must weigh many factors, including present and future cash-flow constraints, probable future inflation rates, and in this case, the stability and long-term prospects of the insurance company itself.

When on a fixed income, these considerations become even more critical. On the other hand, had I moved ahead years earlier while still working, I would not have been able to benefit from the partnership plan. This is because Indiana's program did not go into effect until, I believe, 1993.

While the existence of the partnership plan was not in and of itself the reason I purchased the insurance, it certainly was a very significant motivator. The partnership plan is indeed a blessing. To me, it would be devastating and shattering for a person to work his

entire life, successfully raise a family, then retire with the notion that he can live out his days using the proceeds from an accumulated nest egg only to die in poverty because of circumstances brought about by situations completely beyond his control.

I do not want that to happen to me or my wife. I do not want to lose that sense of pride and accomplishment that one has when he has run a good race.

Thank you for the opportunity of appearing before you this morning. I would be happy to take any questions you may have.

[The prepared statement of Mr. Bishop follows:]

# Testimony of Robert Bishop

*Consumer Witness*

June 22, 2004

Good Morning. Thank you Senator Bayh for your words of introduction.

My name is Robert Bishop. I reside with my wife in Carmel, Indiana and except for two years while on rotational assignment have always lived in Indiana. My wife and I have five grown children all of whom are married and gainfully employed. We have nine grandchildren. I am 70 years old.

Until my retirement in early 1991 I was employed for 39 years by the Indiana Bell Telephone Company which was at that time part of Ameritech. Most of my career I was involved in network planning where we planned and conducted economic comparison studies dealing in large part with the timing and economic feasibility of introducing new technologies into the telephone network.

Long Term Care Insurance was not a priority item with me until I attended a broker/client meeting in, I believe, the year 2000 where Indiana's Partnership Program was explained. The meeting awakened me to the substantial risk I was exposing my estate to and to the potential hardship, both economic and emotional, I was placing in the path of my family by not owning Long Term Care Insurance. This realization along with the knowledge that I could permanently protect some of my assets under the Partnership plan caused me to purchase a limited amount of insurance and to take advantage of the Partnership protection.

Anticipating my wife would outlive me and probably live well into her eighties as her Mother and Grandmother did, I chose to buy a larger amount of insurance for her which qualified for 100% protection of her assets. Due to cash flow constraints I purchased a lesser amount of insurance for myself qualifying me for dollar-for-dollar Partnership asset protection.

Premiums for long term care insurance are not insignificant, particularly when you wait as late in life as I did to purchase it. Consequently, I feel that I am somewhat underinsured. However, whenever a major purchase is considered, one must weigh many factors including present and future cash flow constraints, probable inflation rates, and in this case the stability and long term prospects of the insurance company. When on a fixed income, these considerations become even more critical. On the other hand, had I moved ahead years earlier while still working, I would not have been able to benefit from the Partnership plan.

While the existence of the Partnership Program was not in and of itself the reason I purchased the insurance, it was certainly a very significant motivator. The Partnership plan is indeed a blessing. To me, it would be devastating and shattering for a person to

work his entire life, successfully raise a family, then retire with the notion that he can live out his days using the proceeds from an accumulated nest egg only to die in poverty because of circumstances brought about by something completely beyond his control. I don't want that to happen to me or my wife. I don't want to lose that sense of pride and accomplishment that one has when he's run a good race.

Thank you for the opportunity to appear before you this morning. I'll be happy to take any questions you may have.

The CHAIRMAN. Well, Bob, thank you very much for that testimony and that kind of presentation of reality. We appreciate that.

Kevin, now we will turn to you. Please proceed.

**STATEMENT OF KEVIN CORCORAN, EXECUTIVE VICE PRESIDENT, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS, ARLINGTON, VA**

Mr. CORCORAN. Good morning, Mr. Chairman, Senator Bayh.

My name is Kevin Corcoran. I am the executive vice-president of the National Association of Health Underwriters. NAHU is an association of almost 20,000 health insurance professionals involved in the sale and service of health insurance, long-term care insurance and related products, serving the insurance needs of over 100 million Americans.

We believe long-term care partnership programs can serve an important role in encouraging Americans to plan for their long-term care needs by addressing affordability, which is the most basic component of access to any type of health care.

As Chairman Craig addressed in his opening remarks, the challenges facing Medicare are significant. In the year 2020, one in six Americans will be 65 years or older; the number of people in nursing homes will begin to mushroom as the baby boomers reach age 75. Nursing home costs currently run over $66,000 annually, and this will continue to increase. Eight out of 10 people in America are not insured for this type of catastrophic expense, and as a result, Medicaid has become the primary payer for long-term care expenses.

Medicaid now pays an amazing 60 percent of long-term care expenses for people nationwide, either for people who are poor or for those who have spent down their assets in order to qualify for Medicaid.

As we all know, most States are experiencing significant budgetary problems, and Medicaid is one of their biggest expense items. Currently, costs for long-term care consume almost two-thirds of most State Medicaid budgets. It is imperative that we do something now to encourage consumers to plan for this expense, as they do other expenses, and that we create reasonable incentives for them to do so.

Long-term care partnership programs can do just that. Under a partnership policy, if a policy holder exhausts the benefits provided by their long-term care insurance, Medicaid will pay for their long-term care expenses. But rather than being required to spend down all of their assets to qualify, the policy holder can keep personal assets equal to the benefits paid by the policy.

States with partnership programs are projected to realize savings, since their treasuries will be the last payer for care and the not the first. The success of the existing partnership programs, as we have heard, are outstanding, and most of the people who purchase coverage through them find that their benefits are more than adequate for their needs, and these programs also offer care options that are not always available through the Medicaid program.

Preliminary studies suggest that the asset protection provided in a long-term care partnership program would not result in increased State expenditures but would generate savings for the States, and

in fact, as we have heard, of the nearly 150,000 long-term care partnership policies in force, only 86 nationwide have ever accessed the Medicaid safety net.

Unfortunately, because of OBRA 1993, there is an impediment that prevents the development of additional partnership programs and is interfering with the fact that 16 States have passed legislation, resolutions or studies indicating their desires to enact such programs. OBRA 1993 was written when the partnership programs were new and had not had a chance to prove their effectiveness. The concern at that point was that asset protection would favor only more affluent Americans, but this could not be further from the truth.

A dollar for dollar model, which is used in most of the States, protects assets equal only to the amount of the benefits used, and even in New York, where the total asset model is tilted toward higher-income citizens, nearly 42,000 partnership policies are in force, and in the 12 years since they have been enacted, only 38 people have accessed Medicaid.

The folks in New York have seen that there were significant problems with or issues with folks looking to spend down their assets, but as we have said before, that has not yet come to fruition.

But the real benefit for partnership programs is that they allow persons with moderate income to buy affordable basic coverage, with the assurance of a Medicaid safety net if their need for care exceeds the benefits available through their policy. NAHU believes that the language in OBRA 1993 discriminates against the residents of the 46 States that cannot establish partnership programs, preventing individuals with moderate income from having the option to affordable private insurance for long-term care expenses.

We applaud your actions, Senator Craig and Senator Bayh, for your work in sponsoring S. 2027 to move this process forward. We also applaud Congressman John Peterson of Pennsylvania and Earl Pomeroy of North Dakota for introducing H.R. 1406 in the House. We believe this legislation would save Medicaid millions of dollars, since long-term care needs would be met by the private sector rather than through public expenditure.

Every dollar paid by a private long-term care insurance policy is potentially one less dollar paid by a State Medicaid program, and in addition, as we have heard, it would encourage greater self-reliance in people to meet their own care needs rather than relying on an already overburdened Government program.

In short, now that we know that partnership programs work, it is time to extend them to all Americans. Consumers will have a choice of care options only available with private insurance coverage. Medicaid can provide an appropriate safety net as it was intended to do, and both Federal and State Government will reduce their Medicaid long-term care expenses. This is a win-win situation for both the consumer and the Government.

I thank you for your time today, and I look forward to answering your questions.

[The prepared statement of Mr. Corcoran follows:]


*Testimony for*

# THE UNITED STATES SENATE

## SPECIAL COMMITTEE ON AGING

**June 22, 2004**

***By***

**Kevin P. Corcoran, CAE, Executive Vice-President**
**THE NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS**
**2000 North 14th Street, Suite 450**
**Arlington, VA 22201**
**(703) 276-3806**
**www.nahu.org**

Good morning. My name is Kevin Corcoran, and I am the Executive Vice President of the National Association of Health Underwriters. Thank you for inviting us to this hearing today. The National Association of Health Underwriters is an association of insurance professionals involved in the sale and service of health insurance, long-term care insurance and related products, serving the insurance needs of over 100 million Americans. We have almost 20,000 members across the country.

NAHU has been working on a variety of incentives to increase access to long-term care insurance for many years, and we are pleased to have this opportunity to discuss the practical application of long-term care partnership programs with the members of this committee. We believe long-term care partnership programs can serve an important role in encouraging Americans to plan for their long-term care needs by addressing affordability – the most basic component of access to any type of health care.

The issue of long-term care, and the financing of that care, is growing in importance daily, as our population ages. In the year 2020, one in six Americans will be 65 or older, and the number of people in nursing homes will mushroom as the baby boomers begin to reach age 75.

Nursing home care currently costs more than $57,000 annually[1], and will only increase with time. Eight out of ten people aren't insured for this type of catastrophic expense; as a result, Medicaid has become the primary payer for long-term care expenses. Medicaid now pays a staggering 54% of long-term care expenses nationwide, either for people who are poor, or for those who have spent down their assets in order to qualify for Medicaid.

As we all know, most states are experiencing significant budgetary problems, and Medicaid is one of their biggest expense items. Currently, costs for long-term care consume almost two-thirds of most state Medicaid budgets[2]. It is imperative that we do something now to encourage

[1] 2003 MetLife Mature Market Institute Annual Survey
[2] National Governor's Association, Health and Human Services Committee

consumers to plan for this expense as they do other expenses, and that we create reasonable incentives for them to do so.

Long-term care partnership programs do just that. In general, with a partnership policy, if a policyholder exhausts the benefits provided by their long-term care insurance partnership policy, Medicaid will become the payer for their long-term care expenses, but rather than being required to spend down all assets to qualify for Medicaid, the policyholder is able to keep personal assets equal to the benefits paid by the policy. Presently, four states offer long-term care partnership programs, and they are projected to realize Medicaid savings since their treasuries are the last payer for long-term care, not the first.

There are two models currently being used in partnership programs, the dollar-for-dollar model and the total asset protection model. Three of the states -- California, Indiana and Connecticut -- offer the dollar-for-dollar model while New York uses the total asset model.[3] In the dollar-for-dollar model, for every dollar of benefit used, a dollar in asset protection is earned. This model is conceptually easy to understand and attracts people of limited means to purchase a partnership policy. Besides providing them with choices in their care, it preserves the dignity to make financial choices in the disposition of their assets.

The total asset model requires the purchase of a policy with a specified benefit duration, three years in the case of New York, with fairly rich benefits, including lengthy benefits for home health care and broad inflation protection. The state believes that this type of policy makes it less likely that a person would need to access the Medicaid program. All of an individual's assets are protected under this model once they exhaust benefits under their policy and if they decide to use Medicaid for their additional long-term care needs.

The success of the existing partnership programs has been outstanding, and most people who purchase coverage through them find the benefits of the insurance they purchase adequate for their needs, as well as offering them additional care choices not always available through the Medicaid program. In fact, of the nearly 150,000 thousand long-term care partnership policies in

[3] Indiana has a hybrid model combining dollar-for-dollar with total asset in an effort to appeal to all income strata

force, only 86 nationwide have ever accessed the Medicaid safety net[4]. Indications from preliminary studies undertaken by the states so far offer strong evidence that suggests asset protection provided in a long-term care partnership program would not result in increased state expenditures but generate savings.

Unfortunately, there is an impediment that prevents the development of additional partnership programs, despite the fact that 16 states have passed legislation, resolutions or studies indicating their desire to enact programs[5]. A provision of federal law was written into OBRA '93 when partnership programs were new and hadn't had a chance to prove their effectiveness. The concern at that time was that asset protection would favor only more affluent Americans. This could not be further from the truth because the dollar-for-dollar model only protects assets equal to the policy benefit. Wise financial planning may ultimately result in the purchase of long-term care insurance coverage, given the increasing cost of nursing home care, whether through a partnership program or otherwise. Even in New York, where the state's total asset model is tilted toward higher-income citizens, there are nearly 42,000 policies in-force and only 38 people have accessed Medicaid - a testament to the success of the partnership program.

The real benefit of partnership programs, however, is for individuals of moderate income. They can buy affordable basic coverage with the assurance of a Medicaid safety net if their need for care extends longer than the benefits available through their policy. NAHU believes that the language in OBRA '93 discriminates against residents of states that do not provide asset protection to residents through partnership programs, discouraging individuals of moderate income from purchasing private insurance for long-term care expenses.

We applaud Chairman Craig and Senator Bayh for their important work in sponsoring S. 2077 to address this inequity. We also applaud Congressmen John Peterson of Pennsylvania and Earl Pomeroy of North Dakota for introducing H.R. 1406 in the House. We believe this legislation would save Medicaid millions of dollars since long-term care needs would be met by the private sector rather than through public expenditure. Every dollar paid by a private long-term care

[4] See attachment #2, NAHU, LTC Partnership Statistics
[5] See attachment #1, NAHU, Partnership for Long Term Care State Legislative Activity

insurance policy is potentially one less paid by a state Medicaid program. In addition, it would promote greater self-reliance to meet one's own long-term care needs rather than relying on an already overburdened government program. Finally, it would expand the long-term care insurance market, something badly needed in anticipation of a dramatic increase in the number of elderly requiring long-term care.

In short, now that we know partnership programs work, it's time to remove impediments to their implementation. Consumers need the care options only available with private insurance coverage. Medicaid can provide an appropriate safety net as it was intended to do, and both federal and state governments will reduce their Medicaid long-term care expenses. This is a win-win situation for both the consumer and government.

Thank you for your time today; I would be pleased to answer any questions you may have.

Attachment 1

**National Association**
**Of Health Underwriters**

*America's Benefits Specialists*

# Partnership for Long Term Care State Legislative Activity

A number of states have passed enabling legislation to create partnerships while a few are studying the issue. Table 1 displays current operational partnership states along with what it costs to operate the partnership in the respective states. Table 2 displays those states that have attempted to create partnership programs along with any available updates. Table 3 displays those states that are studying partnerships.

*Table 1*

Active Partnerships

| *State* | *Notes* | *State Appropriation* | *FTEs* | *Notes* |
|---|---|---|---|---|
| CA | RWJF Grantee | $500,000 | 10 | Charges carriers $10,000/yr. for marketing |
| CT | RWJF Grantee | $200-300,000 | 3 | $75,000 allocated for operational expenses |
| IN | RWJF Grantee | $200-300,000 | 3.5 | $87,500 allocated for operational expenses |
| NY | RWJF Grantee | $500,000 | 5 | Includes operational costs, salaries and fringe benefits |

*Table 2*

States That Attempted to Create Partnerships

| *State* | *Type* | *Bill #* | *Year* | *Notes* | *Update* |
|---|---|---|---|---|---|
| CO | Enabling | SB93-163 | 1993 | Enables Partnership program, and provides protection from estate recovery as prohibited in OBRA'93. OBRA also states that this provision cannot be waived. Law requires state to seek a waiver of OBRA'93 partnership provisions. | Additional legislation passed in 2001 authorizes implementation "when feasible" and directs state to seek waivers from OBRA provisions. Directs CO insurance division to implement statutory changes to accomplish the development of the Partnership. Authorizes the state dept. to pay the premium to reinstate a lapsed Partnership policy. Encourages CO state dept. to conduct a public education campaign and conduct an evaluation (if funds are available). |
| HI | Enabling (5 yr demo) | SB-1369 | | Enables Partnership demonstration and provides protection from estate recovery as prohibited in OBRA'93. OBRA also states that this provision cannot be waived. | Establishes a LTC financing program commission to design a program based on the New York State Partnership. Requires commission to report findings to 2003 House session. |
| IA | Enabling | S63 | 1993 | Enables Partnership program, and provides protection from estate recovery as prohibited in OBRA'93. State Plan Amendment Approved one day before OBRA'93 cutoff. | |

| State | Type | Bill # | Year | Notes | Update |
|---|---|---|---|---|---|
| D | Enabling and Resolution | HB 658<br>HJM 17 | 2004 | Enables Partnership program and provides protection from estate recovery as prohibited in OBRA '93.<br><br>Urges Congress to act and remove current impediment to state long-term care partnership programs. | Signed into law 3/23/04<br><br>Adopted 3/15/04 |
| IL | Enabling<br>(5 yr demo) | HB 2471 | 1991 | Partnership launched complying with OBRA'93 estate recovery provisions; four insurers participated. Insurers stopped selling policies because potential buyers scared by estate recovery provisions. | Program made permanent in 1997. Changed Partnership from a "pilot" to a "program". |
| MA | Enabling | CHAP 138 | 1992 | Law authorized a modified version of Partnership that only provides protection from Medicaid estate recovery. State Plan Amendment approved before OBRA '93 deadline. | Several attempts have been made to convert the program to models similar to that of CT, In and CA. |
| MD | Enabling | DEL971 | 1992 | Law requires states to seek waiver of OBRA '93 partnership provisions. Attempted Post OBRA Partnership, program never implemented. | State seeking to adjust State Plan Amendment to incorporate full partnership features. House and Senate resolution urging US Congress to allow assets exempted under Partnership to be excluded from Medicaid estate recoveries (amend Title XIX of Sect. 1917 of Social Security Act). |
| MI | Enabling | H4328 | 1995 | Law conditions enactment of the program on: 1) CMS approval and 2) availability of federal exemption from estate recovery (requires repeal of OBRA '93 partnership provisions). | |
| MO | Enabling | H998 | 1990 | Enables Partnership program, and provides protection from estate recovery as prohibited in OBRA'93. OBRA also states that this provision cannot be waived. Law requires state to seek a waiver of OBRA'93 partnership provisions. | Subsequent legislation modified the definitions of income that can be counted. |
| MT | Enabling | SB69 | 1997 | Enables Partnership program, and provides protection from estate recovery as prohibited in OBRA'93. OBRA also states that this provision cannot be waived. Law requires state to seek a waiver of OBRA'93 partnership provisions. | |

| *State* | *Type* | *Bill #* | *Year* | *Notes* | *Update* |
|---|---|---|---|---|---|
| ND | Enabling | HB1415 | 1993 | Legislation passed in 1/93 but never implemented "because Congress passed the Omnibus Budget Reconciliation Act of 1993, which contained previsions precluding the pursuit of the Program". Final Report Insurance and Health Care Committee 1997 | Program repealed SB 2046 - 1997 |
| OH | Enabling | SB39 | 1993 | Provides protection from estate recovery as prohibited in OBRA 93. OBRA also states that this provision cannot be waived. Law prohibits program from being in violation of federal requirements. | |
| OK | Enabling<br><br>And memorializing | S. 1547<br>HB 2565<br><br>Senate Resolution #49 | 2004 | Provides protection from estate recovery as prohibited in OBRA 93 using a dollar for dollar model.<br><br>Adopted May 2004 | |
| PA | Enabling | HB52 | 2003 | Enabling legislation for LTC partnerships once OBRA '93 impediment is removed. Provides for a 1 for 1 offset program with a $150,000 benefit structure in 2003 and a 5% inflation protection. | |
| PA | Enabling | PA SB253 | 2003 | Enabling legislation for LTC partnerships once OBRA '93 impediment is removed. | |
| RI | Enabling | H5705 | 1993 | Enables Partnership demonstration and provides protection from estate recovery as prohibited in OBRA'93. OBRA also states that this provision cannot be waived. | |
| WA | Enabling | HB 1908 | 1995 | Legislation passed and some form of partnership program currently exists. | Has a partnership operation in place, however, no insurers have filed. |

*Table 3*

Other State Activity

| *State* | *Type* | *Bill Number* | *Year* |
|---|---|---|---|
| MN | Study | | |
| TN | Study | SJR 330 | 1992 |
| VA | Study | SJR | 1994 |

Attachment 2

**National Association**
**Of Health Underwriters**

*America's Benefits Specialists*

# LTC Partnership Statistics

Compiled June 10, 2004

Note: The numbers shown below cumulative figures unless otherwise specified, and are complied and reported by the individual states on a quarterly basis.

**California (as of December 31, 2003)**

*Policy Information*

Number of applications received: 77,423
Number of policies purchased: 63,984
Number of applications denied: 13,439
Number policies not taken up (dropped within 30 days of purchase): 3,316
Number of applications pending & withdrawn: 0
Voluntarily dropped & for unknown reasons: 6,000
Number of applications in force: 54,632
Number of policyholders to date, who have received service payments: 743

Male: 21,692 (41%)
Female: 30,923 (59%)
Median age: 61

*Aggregate Information on Asset Protection*
**Total asset protection earned by all policyholders who have received benefits: $15,177,911**

Asset protection earned by policyholders who have exhausted their policy benefits and accessed Medicaid as of 4th quarter, 12/31/2003: $1,076,353

Total asset protection earned to date by policyholders that have exhausted benefits: $3,363,133

Total asset protection earned to date that will NOT be accessed due to death of policyholder that passed away while in benefit: $9,728,850

*Information on Policy Benefit Eligibility*
Number of policyholders, this quarter, who have qualified to receive benefit payments: 74
Cumulative number of policyholders, to date, who have qualified to receive benefit payments: 838
Number of policyholders currently eligible for benefit/payments made (this qtr): 183
Number of policyholders that have exhausted benefits: 63
Number of policyholders that have died while in benefit: 254
**Number of policyholders that have exhausted their policies and accessed Medicaid: 21**

For a complete report: http://www.dhs.ca.gov/cpltc/HTML/Agent_Pages/quarterly_report_library.htm

**Connecticut (as of December 31, 2003)**

*Policy Information*
Number of applications received: 40,167
Number of policies purchased: 33,068

Policies in force (Active): 26,938
Number of applications pending (includes withdrawals): 2,282
Policies not taken up (dropped within the 30 day free look period): 2,496
Policies denied: 4,817
Policyholders who received service payments: 244
Female: 56%
Male: 44%
Age range: 19-89

*Claim Profile*
Average age at time of purchase: 69
Average age at time of claim: 75
Average policy benefit purchased: $212,601
Average policy benefit at time of claim: $182,287
Average time elapsed between purchase date and eligibility date: 58 months (4.8 years)
*Policy Benefit Eligibility and Utilization Counts*
Number of policyholders who have qualified to receive benefits - to date: 279
Number of policyholders who received services this quarter: 95
**Number of policyholders who have exhausted their policy benefits and accessed Connecticut's Medicaid or have applications pending: 16**

*Aggregate Information on Earned Medicaid Asset Protection*
**Total Medicaid asset protection earned by currently active policyholders: $6,674,240**
Total Medicaid asset protection earned by policyholders who have accessed Medicaid or have applications pending: $1,108,669
Total Medicaid asset protection earned by persons who have voluntarily dropped their policies: $88,539
Total Medicaid asset protection earned to date by persons who have exhausted their policy benefits but have not applied to Medicaid: $858,451 υ
Total Medicaid asset protection earned to date that will not be accessed (policyholders who have died): $2,343,734
**Total Medicaid Asset Protection earned - to date: $11,182,979**

Claimants who exhaust their benefits and choose to live out-of-state, or have income or unprotected assets exceeding Medicaid eligibility levels, are unlikely to apply to Connecticut's' Medicaid program.

For a complete report: http://www.opm.state.ct.us/pdpd4/ltc/consumer/stats.htm

**Indiana (As of December 31, 2003)**

*Policy Information*
Applications received: 35,243
Policies purchased: 29,950
Total policies denied: 4,885
Total policies in force: 25,103
Total policies not taken up (dropped within the 30 day free look period): 2,332
Total policies dropped to date: 5,910
- Died: 343
- Unknown: 1,505
- Converted: 133
- Male: 10,709
- Female: 14,394
- Age range is 19 to 90.

Average time elapsed between purchased date and claim date was 43.92 months (3.66 years)

*Aggregate Information on Asset Protection*
Cumulative number of policyholders, to date, which have received benefit payments from their policy: 174
Number of policyholders, this quarter, that have received benefit payments from their policy: 73

**Number of policyholders that have exhausted their policy benefits and accessed Medicaid: 11**
Number of policyholders that received benefits and have died: 40
**Asset protection earned by policyholders to date: $6,183,281.19**

*Claims Profile*
Female: 70%
Male: 30%
Average age at time of policy purchase: 62
Average age at time of claim: 78
For a complete report: http://www.in.gov/fssa/iltcp/2diltcp7.html

**New York (as of September 30, 2003)**

*Policy Information*
Applications received: 71,949
Number of applications approved (purchased): 53,529
Applications pending & withdrawn: 6,204
Number of policies dropped voluntarily & for unknown reasons: 5,286*
Number of applications denied: 11,701
Total number of policies In Force (active): 41,732
Policyholders who received service payments: 896
**Does not include drops reported as deaths, rescissions or exhausted benefits*

Average age: 60 with a range between 27 and 87
Male: 16,936 (41%)
Female: 24,796 (59%)
First Time: 39,655 (95%)
Policies dropped: 11,908:
Not taken (dropped within 30 day free look period): 5,359
Died: 1,173
Other: 5,286

*Aggregate Information on Asset Protection*
**38 policyholders are presently receiving Medicaid benefits**

For a complete report: http://www.nyspltc.org/library/qrt_upd.pdf

The statistics are provided by the states through quarterly reporting. The statistics presented are of key indicators. Contact John Greene, Director of Federal Affairs (703) 276-3807 for additional information.

The CHAIRMAN. Kevin, thank you very much.

Now, let us turn to you, Steve. I said Cambridge. I did not say Cambridge, MN.

Mr. CHIES. That is correct, Senator.

The CHAIRMAN. Thank you.

**STATEMENT OF STEVE CHIES, CHAIR, THE AMERICAN HEALTH CARE ASSOCIATION, CAMBRIDGE, MN**

Mr. CHIES. I would like to thank Senator Craig and Bayh and every member of the Senate Aging Committee for providing us this opportunity to appear today. We certainly admire and respect the dedication and the effort that you have gone through in order to provide for America's citizens to try to meet their long-term care needs.

My testimony today is given on behalf of the American Health Care Association and the National Center for Assisted Living. We represent over 10,000 members across the country, and our 1.5 million caregivers are providing quality care and services to about 1.7 million Americans who are in our care.

As America will soon confront its greatest unfunded liability, the public cost of its long-term care needs, Congress certainly needs to investigate a variety of approaches that utilize the tax code and other incentives to more effectively meet the needs. In that regard, AHCA and NCAL strongly supports the Long-Term Care Insurance Partnership Program Act of 2000, legislation introduced by Senators Craig and Bayh, that expands the ability of citizens to purchase State-approved long-term care insurance policies and take control of how and where their long-term care needs are met.

Should the need for care exhaust the benefit of the policy, the partnership program provides asset protection, thus allowing individuals to qualify for Medicaid without spending down their lifetime savings.

Mr. Chairman, expansion of the long-term care insurance market is especially important. It is important for patients because it allows them to choose where and from whom their care is provided. It can empower them and their families to receive home or community-based care services if the extensive care needs of a nursing facility are not necessary.

Expanding the long-term care insurance market will bring about funding stability for this important health care sector, which will result in the provision of higher quality care. For States and for taxpayers, the inherent benefit of expanding the long-term care insurance market is reduced financial and budgetary pressure on Medicaid-financed long-term care.

The partnership is a good idea that must be pursued, but there are other issues as well. An expansion of long-term care insurance that incorporates the efficiency of the marketplace with the safety net guarantees associated with Government involvement has the potential to merit strong bipartisan support in Congress.

Specifically, through tax incentives, tax deductions and credits, the nation's health care system becomes more efficient, more responsive to patient needs and individual choices and sustainability for the long term. With diligent development and implementation of a public-private hybrid, we could make it possible for the major-

ity of future Medicaid-eligible retirees to pay privately for the care they receive.

This can only be accomplished by fundamentally shifting the role of Government from Government simply paying for services to Government helping individuals save for their own long-term care retirement needs. Enactment of the Long-Term Care Insurance Partnership Act is a critical but important step toward achieving that goal.

Another initiative now serving as a bipartisan legislative precursor to a broader effort in the above-the-line tax deduction, this legislation has strong support in the House and the Senate. In an effort to see it move forward this session, this measure was included in the Ronald Reagan Alzheimer's Breakthrough Act of 2004, introduced just last week.

In order to help establish the legitimacy and necessary citizen awareness of public-private programs, there must be a national informational effort designed to help individuals and their families understand their options and the consequences of inaction. The fact that 85 percent of Americans believe their long-term care insurance needs will be met by Medicare, Medicaid or their existing health insurance is alarming and underscores the need for government to help educate and inform its citizens to understand how to prepare for their retirement and financing their long-term care and health needs.

When individuals understand the risks they face, the costs of care and the options before them, we as a nation should be confident that the vast majority of Americans will choose to act responsibly and plan for their own future needs and the needs of their families. This fundamental premise reflects Americans' values. Americans want to control their destiny, and every individual must and should take some level of responsibility for their future and that of their family.

Through the Craig-Bayh legislation and tax incentive concepts we have outlined and through other vehicles, we believe that the capacity to fend off the inevitable collapse of Medicaid and perfect our nation's ability to ensure the long-term care needs of its citizens are met in a way of their choosing, but no matter how much wishful thinking Medicaid supporters can muster, the demographic realities require a change in policy and a transformation in our thinking.

We thank you for this opportunity to testify before you today, and we look forward with you and this Committee to try and productively develop a strategy for providing long-term care needs that will meet every American citizen.

Thank you.

[The prepared statement of Mr. Chies follows:]

ahca
American Health Care Association

ncal
National Center for Assisted Living

# WRITTEN TESTIMONY
OF
## *Steven Chies*
Chair
American Health Care Association
For the U.S. Senate Special Committee on Aging Hearing:
**Medicaid Crisis:**
***Could Long Term Care Partnerships Be Part of the Solution?***
**June 22, 2004**

My name is Steve Chies, and I am Chair of the American Health Care Association (AHCA) – the nation's largest association of long term care providers. In this capacity, I also serve on the Board of Directors and Executive Committee of the National Center for Assisted Living (NCAL), which is the assisted living voice of AHCA.

I would like to thank Senators Craig and Breaux – and every member of the Senate Special Committee on Aging – for providing us the opportunity to appear today. We admire and respect your genuine dedication and hard work on behalf of caregivers and the frail, elderly and disabled throughout America.

My testimony today is given on behalf of AHCA/NCAL and more than 10,000 member long term care facilities, including not-for-profit and proprietary skilled nursing facilities, assisted living residences, and facilities for the mentally retarded and developmentally disabled.

We represent over 1.5 million caregivers, and approximately 1.7 million residents and patients.

I also serve as Senior Vice President of Benedictine Health Systems in Cambridge, Minnesota, a not-for-profit company representing 60 facilities in the Great Lakes region, responsible for the care of 5,000 frail and infirmed individuals in both acute and long term care campuses.

I am also an independent owner -- taking an active part in two family-owned and operated facilities that have been in our family for three generations.

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I have appeared before this Committee in the past to testify on long term care financing issues similar to those before us today, and we thank you for your consistent, diligent attention to the many challenges facing long term care.

A thoughtful discussion regarding Medicaid's chronic solvency problems -- and the extent to which the expansion of long term care insurance and partnerships can improve the financial stability of this key federal program -- is timely and necessary.

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

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

In that regard, AHCA and NCAL strongly support the Long Term Care Insurance Partnership Program Act of 2004 – legislation introduced by Senators Craig and Bayh that expands the ability of citizens to purchase state-approved long term care insurance policies and take control of how and where their own long term care needs are met. Should the need for care exhaust the benefit of the policy, the Partnership program provides asset protection, allowing individuals to qualify for Medicaid, without "spending down" their total life savings.

The many benefits to this legislation are significant:

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

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

AHCA/NCAL have long advocated that individuals ought to receive care in the most appropriate long term care setting. The insurance model does just that. It promotes more individual choice -- and can help keep patients out of facilities if their care needs can be met in a less restrictive setting. It is a fact that most individuals would prefer to receive their care at home. This is a demand that will continue, and having one's own insurance provides more choices and more freedom.

With the roller coaster ride of funding instability produced by endless budget cuts, funding restorations, eligibility and benefit changes, more cuts and the general cycle of uncertainty that best characterizes federal long term care funding over the past decade – regardless of who controls Congress and the White House – our profession is acutely aware of the linkage between Medicaid and Medicare funding instability and our ability to maximize patients' care quality. You cannot have both.

In this context, it is noteworthy that the Medicare Payment Advisory Commission's (MedPAC) March 2004 report to Congress specifically stated:

*"Many efforts are currently underway to improve quality in Skilled Nursing Facilities (SNF's) and nursing homes, but these efforts are grafted onto a payment system that is largely neutral or even negative with respect to quality."*

Ongoing efforts to improve quality, therefore, will be enhanced by the continued expansion of the long term care insurance market.

The Partnership bill introduced by Senators Craig and Bayh is one good idea that must be pursued – but there are others as well.

An expansion of long term care insurance that incorporates the efficiency of the marketplace with the safety net guarantees associated with government involvement has the potential to merit strong bipartisan support.

Specifically, through tax incentives; deductions and credits, the nation's health care system can become more efficient, more responsive to patient needs and individual choices, and sustainable for the long term.

With diligent development and implementation, a public-private hybrid could make it possible for a majority of future Medicaid-eligible retirees to pay privately for the care they receive.

This can only be accomplished by fundamentally shifting the role of government – from government simply paying for services to government helping individuals save for their own long term care needs. Enactment of the Long Term Care Insurance Partnership Act is a critically important step toward achieving that goal.

Another initiative now serving as a bipartisan legislative precursor to a broader effort is the "above-the-line" tax deduction supported by President Bush and by U.S. Representatives Nancy Johnson (R-CT) and Earl Pomeroy (D-ND) and by Senators Charles Grassley (R-IA) and Bob Graham (D-FL). This proposal received additional support just last week with its inclusion in *The Ronald Reagan Alzheimer's Breakthrough Act of 2004* introduced by Senators Barbara Mikulski (D-MD) and Kit Bond (R-MO).

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

But to encourage broader based public participation, there would also be a need for a refundable tax credit targeted toward low- to moderate-income Americans – who will have the greatest need for government-paid long term care services currently provided by Medicaid.

For low- to moderate-income individuals, the refundable tax credit would fully or partially pay the premium cost of a long-term care insurance policy offered by the private sector, or by the federal government. Such a credit could be utilized in purchasing state partnership program policies.

Such a tax credit also makes insurance coverage more affordable to this segment of our population than simply providing a pure 'above-the-line' tax deduction.

Once tax incentives enable greater numbers of Americans to responsibly provide for their long term care insurance needs, there is a second logical step.

With an established insurance market it may become more feasible to look at shifting the government's role in the coverage of long-term care to the federal level – thereby relieving states of the increasingly onerous budgetary burden that is the focus of current debate in Washington and state capitols nationwide.

A fundamental consolidation of this nature would allow for the coordination of both acute and long-term care for the elderly and long term care for the disabled.

Most important, the coordination of care at the federal level will eliminate today's failed patchwork financing system, and create a more efficient, seamless system of care.

Every long term care stakeholder – patients, government, providers, advocates and others – would benefit from this consolidation process.

In order to help establish the legitimacy and necessary citizen awareness of a public-private program, there must be a national informational effort designed to help individuals understand their options – and the consequences of inaction.

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

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

This fundamental premise reflects American values: Americans want to control their destiny, and every individual must – and should – take some level of responsibility for their future, and that of their family.

If armed with the facts and the means, people will do what is right to protect their health, their family, and their economic interests.

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

Through the Craig/Bayh legislation and tax incentive concepts I have outlined, through other vehicles like reverse mortgages and health savings accounts, and by addressing issues such as eliminating the 3-day-hospital-stay requirements for skilled nursing care under Medicare, we will have the capacity to fend off the inevitable collapse of Medicaid and perfect our nation's ability to ensure that the long term care needs of citizens are met in a way of their choosing.

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

But no matter how much wishful thinking Medicaid supporters can muster, demographic realities require a change in policy and a transformation in thinking.

Two recent, significant events in Washington can help us focus our attention on the course we must now pursue:

The dedication of the World War II Memorial helps us realize the commitment we have to our frail, elderly and disabled – and those who yesterday and today are fighting to preserve, protect and defend freedom.

And just two weeks ago, we watched in wonder as hundreds of thousands of Americans from all walks of life came to honor a former President, Ronald Reagan, who understood the value and importance of freedom as we pursue our lives and our dreams.

At stake in the debate we are engaging in here today is indeed freedom – and how we as a nation can empower every American to preserve their independence, and that of their family.

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

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The CHAIRMAN. Steve, thank you very much for your testimony.

Let us see if we can get—we have been reprieved a bit. The vote has been shoved forward on us, so maybe we can get through our rounds of questioning prior to that vote.

Mark, let me turn to you. If this is such a good deal for Medicaid, private insurers and long-term care policy holders, and you call it a win-win; someone else referred to it as a win-win; who is the loser? Is there a loser?

Mr. MEINERS. I do not think there is a loser. I think this is one of those unique strategies that sort of balances different opinions and different perspectives and does so in a way that people can win. I think that people need to adjust their thinking a little bit differently. For example, the insurance industry is more comfortable or most comfortable probably with lifetime protection, maybe a little less so today.

Marketing products that are one to 2 years or maybe 3 years is less common, so there needs to be some adjustment there. Agents will not make quite as much money on a one, two or 3-year product as they would on a lifetime product, but if they sell more of them, they are still going to do well and also do what I said before: have more of a way to enter someone's home with a full portfolio of insurance interests for them, so I do not see them losing.

States, well, I think that States, this gives them an opportunity to really provide a broad spectrum of options for their consumers as opposed to sort of being hesitant about that. In fact, with respect to the carrot and the stick, there has always been this sort of stick we have talked about, asset recovery. But States, as somebody said earlier, are hesitant to do that, because it is a political hot potato.

But when you give people good options, it is a little easier to sort of speak in terms of carrot and stick, and so, I think that States can come out well with that. So and I think the consumers, the ones we can really help, are people—sorry Senator Kohl had to leave, but people like my mother, who I now next week will be helping to move into assisted living, people who are middle income—teachers, which she was—who could afford insurance and therefore help protect some of their resources.

I think it is a win for them, whereas, otherwise, I think they look at the situation where they are faced with having to end up on Medicaid; they will either game the system, or they will just go bare and take the risk. I think those things put them in much less of an acceptable situation.

So after many years of looking at this and thinking about it, I think it has a lot of positives, and when you ask about sort of the array of options out there of what to do about long-term care, I think this one fits very much even, in my opinion, a little more prominently than people were talking about. It is not the silver bullet; it is not the only option, but I think it is something that goes down to the middle class, who are really at risk of becoming impoverished because of long-term care. Many of the options we talk about do not get there, and that is very important.

The CHAIRMAN. Thank you.

Melanie, you have been out on the front line of this laboratory of experimentation that Evan knows better than most of us is State government. If you can work it well at the State level, and we have

talked about now having programs out there on the market for a period of time and therefore clearly being able to assess it here, understanding it better, we are not very good at making intelligent guess estimates at what these programs will cost us when we get involved in them.

But here, we may well be able to do so. Have you been able to estimate the cost savings to the State of Indiana since initiating your long-term care partnerships?

Ms. BELLA. We are getting closer at that. It is difficult. Now that we have had more experience, and we have had people who are actually getting into the period where they are exhausting their benefit, it allows us to begin to quantify that.

Prior to anyone exhausting their benefit, we would just have to make a set of assumptions. So we do have some pieces that we are putting together to help us do that. For example, as Senator Bayh referenced, we survey a sample size of all new policies each quarter, and one of the questions we ask is how would you have funded your long-term care absent having one of these policies?

Right now, we range 15 to 20 percent who respond that they would have sheltered their assets in order to get on Medicaid early. So our first step in trying to quantify this will be looking at our base of policy holders, estimating how many might make a claim each year and assuming 15 percent of those would have sheltered their assets.

Where it gets a little more difficult is knowing how long they would have needed care, because, as I said, the average person would not exhaust their benefit before they would need to turn to Medicaid. So the short answer is we are working on it, but we do know the State spends a minimum of $35,000 a year on someone on Medicaid in a nursing home. So at a rough guess, every year that we can delay or prevent each person going onto Medicaid, know we are saving actually the State and the Federal Government at least that amount of money.

Senator BAYH. Can I interject, Mr. Chairman?

The CHAIRMAN. You certainly may, and I am going to turn to you, because my time is up on the first round, so I will let you take this over.

Senator BAYH. Melanie, is it fair to say that you are getting closer to quantifying the savings, but it is savings we are talking about here?

Ms. BELLA. It is more than fair to say that. It is definitely savings we are talking about when we look at the benefit that has been exhausted and then look at the number of people who have actually gone onto Medicaid, which, as I mentioned, is only 13 people out of our pool.

So we are working with our actuary and actually the other three States as well so that we can come up with a standard methodology to do this, but we definitely believe that the numbers show that the savings exceed any possible cost due to asset protection.

Senator BAYH. So from the taxpayer's standpoint, it is unquestionably a good thing. It is just a question of how much of a good thing.

Ms. BELLA. Exactly.

Senator BAYH. Bob, I would like to build upon that. We focused here on the financial considerations. In your testimony, you spoke about, I think very eloquently about having run a good race and the emotional and psychological costs and strains that come with having to wonder whether that is all going to go for naught because of a health event beyond your control.

I would like to get your reaction to the notion: even if it is a break even deal for the Government, that does not cost the Government; does not save the Government; does not cost the Government, is it not a real benefit to average citizens to take that worry off of your shoulders? So from a societal standpoint, putting the finances aside, the evidence suggests it is a good thing financially for the Government, but even putting that aside, from a citizen's standpoint,. is there not a real benefit here that, all else being equal, is important to society, too?

Mr. BISHOP. I certainly think so. The emotional aspect of it is tremendously important. The fact you know you have taken steps to handle a situation that has a reasonable chance of occurring is in itself, comforting. If the situation does develop, it is important, particularly for the spouse that remains at home, to know the assets that person is relying on to provide the income that will enable them to continue their lives as normally as possible, remains in place.

They do not have to worry about where funds will come from to pay the mortgage, or purchase food and other necessities.. So yes, the emotional aspect of having long-term care insurance with the protection plan or the partnership plan is very important.

Senator BAYH. It sounds like one of the lessons that we should take away from your testimony is that you probably would advise your children or your grandchildren to buy these policies a little bit earlier in life; is that correct?

Mr. BISHOP. I think that is clear. I waited until I was 67 years old, and that was too late. That is not to say I should have not purchased it, but had I purchased it earlier, it would have been a much less important segment of my monthly expenditures.

In fact, we have five children, the oldest is 50 and the youngest is 42. The one that is 50 and I have talked about long term care insurance with him. He was very pleased that I made the decision I did in 2001, but he is not really enthusiastic about doing so himself.

However, to be perfectly fair with him, he is putting two children through college right now, so he is a little preoccupied.

Senator BAYH. We can all relate to that. You might be interested to know we have another piece of legislation that would make several thousand dollars of the premiums for these policies tax deductible to incent people. That might get your son's attention.

The CHAIRMAN. I was going to say, Evan, he may be preoccupied, but his money is really preoccupied if he has got kids in college.

Mr. BISHOP. Absolutely right.

What you just spoke of is important. As you know, Indiana has that feature, and the premiums for a partnership plan are deductible from the State gross tax. That is an incentive. The partnership is an incentive. Then, if the Federal tax code was modified, as you

suggest, that would be another push toward furthering this program.

Senator BAYH. Thank you, Bob. By the way, you are correct. We did start—the 1991 figure I referred to is when the Federal Government gave us approval to go forward, 1993 is when the first policies were made available. So thank you for bringing that to all of our attention today.

Mark and Melanie, let me ask both of you: from your testimony, it sounds like both of you, really, everybody we have heard from today, there really is no evidence that wealthy people are using this as a way to access Medicaid. Is that a fair statement?

Mr. MEINERS. Yes, I think that is a fair statement. I mean, it is something that we were confronted with early on and thought a lot about it. I will give you——

Senator BAYH. It is a theoretical concern, but in fact, it does not sound as if it has been borne out.

Mr. MEINERS. Right; I mean, there are several ways to look at it. First of all, wealthy people; this protects assets, not income, OK? So if someone has a lot of assets out there, it is going to be generating the kind of income that is going to have to be used to pay for the claim. So that is one protection.

Another thing is, you know, none of us truthfully aspires to get our long-term care through Medicaid. I mean, it is just a fact. We want it to be as good as it can be, but it is not as good as if you can buy it on your own. Then, the other part of why I think the States have opted to, you know, not exclude high end people is because it is nice to have folks like that as part of the risk pool, frankly, because they are very, very unlikely to ever need Medicaid, and yet, their premiums are contributing to the pooling that you need to share the risk.

So there are a lot of reasons to not, I think, worry about that particular concern and make this sort of a more or less a one size fits all. I personally favor the dollar for dollar approach, because it really gets to the middle and modest income people, but I was a fan of what Indiana did with the hybrid of the two models.

Senator BAYH. Melanie, our experience has not been one where the more well to do are accessing Medicaid through this mechanism; is that correct?

Ms. BELLA. That is correct. We do not have any reason to believe that it is not appealing to our target group, which is the middle, low-upper middle income group, who is really going to be caught with having just enough assets that they could be in a position where they would be spending those down to get on Medicaid yet not enough to never have to worry about it, which it is that group that they really do not need this protection as much, because they have the means there to pay for their nursing home care and still be able to preserve their assets, because they are at such a high level.

But it really does appeal to that group right in the middle who really have a need to protect those assets.

Senator BAYH. The final thing I would say, Mr. Chairman: I was asking one of my very able assistants about the 16 States that have applied.

This deals with reciprocity, Melanie. Florida has not yet applied, so maybe we need to get the word to the people in the great State of Florida. There may not be many folks retiring between Connecticut and Indiana, Melanie. I suspect if we conducted a marketing campaign in Connecticut about the lower tax rates in Indiana, maybe we could promote some of that, but it has not happened to date, but that is something that a nationwide system would clearly enable people to move and retire and still access this kind of protection, so that is a good point.

Mr. Chairman, I thank you for your leadership, and it is a pleasure working with you, and Bob, Melanie, all of you, I want to thank you for your expert testimony here today. It really does help shine a light on this, and hopefully, we will get some momentum behind what I think all of you have just described as a win-win idea.

The CHAIRMAN. Evan, thank you very much.

Kevin, let me turn to you: what is the motivation for insurers to offer State-approved long-term care plans over their current long-term care plans?

Mr. CORCORAN. Well, what we are seeing is that as Mark had said, long-term care is in a lot of cases still seen as a niche market. The opportunity to access a broader marketplace by having programs in all the States, by having a program of reciprocity that will allow them to aggregate their risk and aggregate the participants in the program is appealing to them.

There is obviously a lot of interest in long-term care, and anything that can be done to expand the size of the marketplace is going to be appealing to them. The partnership program is something of a built-in marketing program for them, because the State will be explaining the benefits of it, and if they are participating in the program, that gives them an opportunity to address those consumers, to be able to get in front of them and sell their products that they are trying to sell now, but it gives them another step in the door.

The CHAIRMAN. Well, what is the greatest reservation, then, for carriers to participate in long-term care partnerships?

Mr. CORCORAN. At the outset, we had some carriers that were concerned about some of the issues as far as the administrative expense, making sure that there is uniformity and administrative efficiencies across all of the different lines, and they are concerned that they may end up with a lot of fragmented products.

But that has pretty much evaporated. Those issues have been addressed. They have worked them out for themselves, so we are not seeing that as an issue anymore. I do not believe there really are any.

The CHAIRMAN. We have heard talk of two models here: the total asset model and the dollar for dollar model. Which model is best for the consumer from your point of view?

Mr. CORCORAN. I am not sure that there is a best. I think that the different models have different pros and cons, and for different individuals, they are going to serve folks in a different way. I think Indiana's approach of offering both programs is an innovative way to be able to address all aspects of your marketplace. In fact, Governor Pataki in New York has put forward a proposal in his budget

to create a dollar-for-dollar model to complement the total asset model that New York currently has.

NAHU has prepared language and model language for States to use, and we do typically represent or present to them the dollar-for-dollar model as the model of choice, but again, it is one that each State and each individual will need to see what options work best for them.

The CHAIRMAN. Thank you.

Steve, what is the strongest motivation for providers to support State-approved long-term care plans over current long-term care plans?

Mr. CHIES. Well, Senator, I think it is basically to see the expansion of the long-term care insurance market. We believe this is one tool, one more mechanism to educate the public in terms of the risk factors that they have. The partnership programs are good because it goes in partnership with the State and the Federal Government and the private sector to assure that there are not any missing elements here for an individual who may run through a policy.

I think that is probably the key issue is that if, in fact, you have a truly catastrophic event, somebody is not going to run through a policy and then have to get into their asset base at that point.

The CHAIRMAN. Does private pay allow facilities to provide better care to the people dependent on them, depending on them?

Mr. CHIES. That is a tough question. I think that——

The CHAIRMAN. That is why I ask it.

Mr. CHIES. I know; it is a good question, Senator.

I think that we know in the studies we have done of the Medicaid systems across the country is that the States are under incredible fiscal pressure, and they have had to short the Medicaid program, and that does put pressure on facilities.

We know that 70 percent of our costs are wage and wage-related, and so, as I talked with public policymakers around the country and in my State of Minnesota, I have said that when you have to cut providers' rates, you are really balancing the budget on the backs of our employees, because that is where our expenses are. If we cannot get high quality employees because of pinches in the Medicaid program, it makes it more difficult to provide quality care and services.

The CHAIRMAN. So it is a net benefit to all parties involved.

Mr. CHIES. Yes, Senator.

The CHAIRMAN. In this case, of course, the quality of care.

Evan, do you have any further questions you would like to ask?

Senator BAYH. I am fine, Mr. Chairman.

The CHAIRMAN. All right; lady and gentlemen, thank you all very much for being with us. We appreciate your work in helping us move this issue. We think it is very important as one of those many things that we need to do, recognizing the States' problems and recognizing that future large wave of people my age and a little older who are heading toward these kinds of care needs that America recognizes.

So convincing a majority is going to be important here. We think that can be done for all the reasons you have just stated: that it is a relatively easy sell in what we have to do here, but your help

will be greatly appreciated, and we thank you for being with us today.

Senator BAYH. I would only add one final thing, Mr. Chairman. As you can see, this is a bipartisan effort——

The CHAIRMAN. Absolutely.

Senator BAYH [continuing]. Which is somewhat rare in this town, but it shows how strong the merits of this are, and I am just pleased to work with Senator Craig to help make this happen. So I think that is important to note.

The CHAIRMAN. Evan, thank you very much, and the Committee will stand adjourned.

[Whereupon, at 11:21 a.m., the Committee adjourned.]

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