

**Statement of**

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before the

**SENATE SPECIAL COMMITTEE ON AGING**

on

**LONG TERM CARE INSURANCE PARTNERSHIPS**

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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 on the critical issue of long-term care.

### **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**

However, there have always been significant gaps in Medicare's coverage. 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% of all paid long term care services delivered in this country, which is almost twice as much as Medicare and private insurance combined.

Furthermore, Medicaid is the financial sponsor for approximately 70% 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 the 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 policies 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 state 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 any effort 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 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%, State of Michigan employees/retirees achieved a participation rate of 16%. (The MI marketing program has been discontinued due to budget restraints). In 2002, Federal Employees/Retirees were offered the option of signing up for LTC Insurance. Out of 8 million employees/retirees that OPM/Met Life/John Hancock could find to contact, 1.2 million requested information about the LTC offering, and 265,000 (22%) applied for coverage.
- Providing an Above-The-Line Deduction for LTC Insurance Premiums:** This proposal, supported by HIAA and the Bush Administration (also S.100 Collins/ME), would provide for a phased-in 100 percent above-the-line tax deduction for tax-qualified LTC insurance premiums up to the annual dollar limitations that currently apply to the deductibility of LTC insurance. The current maximum qualified LTC premium deductions are as follows: (These amounts are adjusted annually for increases in the medical care cost component of the consumer price index.)

<b>Attained Age Before Close of Year</b>	<b>2003</b>
40 or Less	\$ 250
More Than 40 But No More Than 50	\$ 470
More Than 50 But No More Than 60	\$ 940
More Than 60 But No More Than 70	\$2,510
More Than 70	\$3,130

The tax deduction would be available for everyone including those who receive their coverage through their employer, provided that the employee pays at least 50 percent of the cost of LTC coverage. The deduction would be phased in as follows: 25 percent for 2004; 35 percent for 2005; 65 percent for 2006; and 100 percent for 2007 and thereafter.

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.

- 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% of ADB policies specify one type of condition (terminal illness) that will accelerate benefits. About 7% 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% 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 policies 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 provide 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 Kempthorne 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.