

REPORT OF THE
GOVERNOR'S PRIVATE SECTOR
INSURANCE TASK FORCE ON
LONG TERM CARE

January, 1986

Printing of this Report was provided
by CIGNA HEALTHPLAN OF ARIZONA, INC.

Table of Contents

	<u>Page</u>
I. Preface.....	2
II. Members of Task Force.....	2
III. Findings and Recommendations.....	4
IV. Overview of Report.....	7
V. Alternatives for Providing and Financing Long Term Care.....	10
A. Public Funding.....	10
B. Private Funding.....	12
1. Insurance Mechanisms.....	14
a. Medigap or Medicare Supplement Policies...	14
b. Nursing Home Insurance.....	14
c. Income Replacement Insurance.....	15
d. Life Insurance Products.....	15
e. Annuities.....	16
f. Risk Pools.....	16
2. Delivery Systems.....	17
a. Health Maintenance Organizations (HMOs)...	17
b. Social HMOs (S/HMOs).....	18
c. Preferred Provider Organizations (PPOs)...	18
d. Life Care Communities.....	19
3. Financing Mechanisms.....	19
a. Home Equity Conversion.....	19
b. Individual Retirement Accounts (IRAs).....	20
c. Employee Benefit Plans (Pensions).....	20
VI. Marketing and Consumer Education.....	21
VII. Tax Incentives.....	22
VIII. State and Federal Activity.....	25
A-1 Definitions of Services.....	A1-1
A-2 Review of State and Federal Activity.....	A2-1

I. PREFACE

This report presents the work of the Governor's Private Sector Insurance Task Force on Long Term Care. In March 1984, Governor Bruce Babbitt appointed this Task Force in direct response to recommendations contained in the "Long Term Care in Arizona" report prepared by the Pritzlaff Commission on Long Term Care. In his charge to the Task Force, Governor Babbitt asked Task Force members to "review the state of the insurance industry with regard to long term care financing and evaluate the desirability, feasibility and barriers to the development of privately financed long term care products in Arizona".

II. MEMBERS OF THE TASK FORCE

S. David Childers, Task Force Chairman and
Director, Arizona Department of Insurance

The Honorable Tony West, Arizona Senate, Chairman,
Senate Insurance, Retirement and Aging Committee

The Honorable Tony Gabaldon, Arizona Senate

The Honorable Carolyn Walker, Arizona House of
Representatives

The Honorable Nancy Wessel, Arizona House of
Representatives, Chairman of the House Human
Resources and Aging Committee

J. Elliott Hibbs, Director,
Arizona Department of Revenue

Stanley Kleiner, Arizona Department of Health Services

Bert B. Wagener, President of CIGNA Healthplan
of Arizona, Inc.

Laurence M. Linkner M.D., Senior Vice President of
Medical Affairs, Blue Cross/Blue Shield
of Arizona, Inc.

Arthur Ericson, Vice President and Associate Actuary,
The Prudential Insurance Company of America

Jo Ann G. Pedrick Ph.D., Executive Director,
Governor's Advisory Council on Aging

Adam Diaz, Senior Consumer Advocate

Marie Scotti, Certified Safety and Health Professional

Edward H. Hermanson, President and C.E.O.
U.S. Care Corporation

Ruth Becker-Schaller RN, FNP, Chairperson,
Developmentally Disabled Advisory Council

The Task Force met regularly from April, 1985 to December, 1985. During these meetings, which were open to the public, the Task Force focused on organizing and reviewing written materials from a variety of sources. The Task Force received oral and written testimony from Task Force members, insurance industry representatives, and providers of long term care services. During this time, Task Force members also divided into five subcommittees, each of which individually worked to report on the following issues:

1. The Subcommittee on Industry Concerns and Product Development summarized the existing coverages, alternative insuring mechanisms, and barriers to product development which are present in the long term care marketplace. This subcommittee was chaired by Bert Wagener and included Dr. Laurence Linkner.
2. The Subcommittee on Regulation reviewed Arizona and federal laws, and prepared a report on existing laws which would affect product development and marketing. This subcommittee was chaired by Stanley Kleiner.
3. The Subcommittee on Tax Incentives examined potential effects of state tax incentives to encourage the development and availability of long term care insurance. This subcommittee, chaired by Elliott Hibbs, included Senator Tony West.
4. The Subcommittee on Public Perception and Education reviewed the need for increased activity to educate the public regarding long term care financing. This subcommittee was chaired by Dr. Jo Ann Pedrick and included Adam Diaz and Ruth Becker-Schaller.
5. The Subcommittee on Interstate Coordination reviewed current state and federal activity on long term care. This subcommittee was chaired by Marie Scotti and included Representative Nancy Wessel and Arthur Ericson.

The Task Force acknowledges the assistance of the National Association of Insurance Commissioners (NAIC). In January, 1985, the NAIC formed the Medicare Supplement, Long Term and Other Limited Benefits Plans Task Force, which is also chaired by S. David Childers. In turn, this Task Force is being assisted by a national insurance industry advisory committee which is chaired by Arthur Ericson of Prudential Insurance Company of America.

This advisory committee is currently preparing an extensive report on private payment mechanisms which will be presented to the NAIC Task Force in June, 1986. Portions of this report are based on the work prepared by this insurance industry advisory committee.

The Task Force expresses its appreciation to the Stanford Research Institute (SRI). Materials developed by SRI in preparation for a conference and report on long term care were adapted and used by the members of the Task Force to examine the presence or absence of regulatory barriers.

Finally, the Task Force recognizes the contribution of the 1984 Pritzlaff Report on Long Term Care which was completed for the Governor and Legislature. One of the major Pritzlaff Commission recommendations called for expanded private payment options and the Report's findings are carried forward to the Overview Section of the report.

III. FINDINGS AND RECOMMENDATIONS

Regulation

1. The Task Force found that growth of the elderly population, combined with health care trends and demographic changes, is already beginning to strain public and private resources available for long term health care. The public sector and individuals have reached financial limits, and private alternative financing options must be developed. Emphasis should not be placed on developing a single financing method as the only alternative, but rather on developing a wide range of alternatives which can be selected and adapted to meet individual needs and capabilities. Thus, the Task Force identified alternatives for providing and financing long term care, including insurance and noninsurance mechanisms, which are currently available in Arizona or which could be developed. Each alternative was then reviewed for regulatory barriers or limitations which might inhibit or prevent development in Arizona. With several minor exceptions, there were no regulatory barriers identified. Therefore, the Task Force finds that no new legislation or revisions to existing laws or regulations are necessary at this time. However, the Task Force also recommends the Arizona Department of Insurance continue to maintain an extremely flexible regulatory approach to long term care insurance policies, and work with insurers wherever necessary to allow the development and marketing of innovative policies in Arizona.

Product Development

2. Potential insurers of long term care services report that actuarial estimates of losses and appropriate premium levels for long term care policies are difficult to establish. Minimal data is available on costs and utilization of long term care insurance and very little of the data reflects actual experience. However, the Task Force also recognizes that information and statistics available from the Arizona Departments of Insurance, Health Services and Economic Security regarding nursing home utilization, home and community-based care, etc., could be used by private insurers to develop actuarial data. The Task Force recommends these state agencies cooperate with private insurers as necessary to aid in the development of actuarial models and compilation of other vital statistics.

3. There has been a recent increase in the number of nursing home indemnity policies available in Arizona. However, there has been little development of insurance products which would provide coverage for home and community-based care. The Task Force recommends the Arizona Department of Insurance develop "model" policy language to provide coverage for home care and community-based care, and distribute this "model" language to major health insurers with a suggestion this coverage be considered in product development.

4. A number of states have developed risk pooling health insurance plans to provide coverage of situations not covered by traditional health insurance programs. Risk pools typically offer health insurance coverage at a reasonable cost to persons who are actuarially uninsurable by virtue of a high risk medical condition. It is feasible, however, that similar pooling arrangements could be established to fund long term care needs. The Task Force recommends the Arizona Department of Insurance assess the need for and the feasibility of developing a long term care risk pool for Arizona. This report should include a complete assessment of the potential costs to consumers, insurers, and the state if a pooling arrangement is established. If a pooling arrangement is considered a viable alternative, the Department of Insurance should then prepare a report and recommendations, including recommendations for benefit levels; funding of pool, including adequate premiums; administration of the pool; and the anticipated costs to the state, if any. This report and recommendations should be submitted to the Governor's Office by October 31, 1986.

5. Health maintenance organizations (HMOs) provide prepaid, capitated medical care to enrollees and guarantee the delivery of a fixed set of benefits. Recent federal legislation, as well as a desire to expand their marketshare by offering increased benefits, have encouraged HMOs to enroll more elderly members and

explore the possibility of adding long term care benefits. The Task Force recommends that health maintenance organizations be encouraged to explore alternative long term care delivery systems, and that the Arizona Department of Insurance work closely with these plans to develop innovative programs.

State Administration

6. Responsibilities for long term care delivery systems and financing mechanisms are divided among several state agencies, including the Department of Economic Security, Health Services, Insurance, and the Governor's Councils on Aging and Developmentally Disabled. Several of these agencies control a combination of state funds and federal monies, while others provide consumer education and assistance. However, there is no overall point of control and coordination for long term care, and there is currently no formal mechanism through which state agencies can identify common problems and potential solutions, as well as combine or share information. Therefore, the Task Force recommends the Governor appoint an interagency task force, comprised of representatives from the aforementioned state agencies and other agencies or departments as appropriate. The Task Force further recommends the Governor designate a single agency to lead this task force, and to appoint this same agency to be the lead agency for all long term care issues.

Taxation

7. State tax laws do not impede the development of long term care insurance. There is every indication the demands of the marketplace will result in long term care insurance being more readily available in the future without the necessity of providing tax incentives. The cost of such insurance or the ability to purchase insurance, however, could be made marginally more attractive if a state tax deduction for such a purchase existed. Tax incentives could also aid public education about the risks of needing long term care by drawing attention through an item on the tax return. However, these advantages must be weighed against the disadvantages of state tax incentives, such as: erosion of the tax base; state incentives without parallel federal incentives would likely be somewhat ineffective; and incentives can lead to stifling of alternatives being developed that may not have related tax benefits. It is the recommendation of the Task Force that state tax incentives not be adopted at this time, but given future consideration after recent private industry efforts to produce and market long term care insurance products can be evaluated.

Consumer Education

8. The National Association of Insurance Commissioners (NAIC) is currently preparing an extensive report on long term care

private payment mechanisms which will be available in June 1986. In conjunction with this report, a consumer guide is being designed which will answer, in easy to read language, the most commonly asked questions about long term care products. Upon completion, the guide will be distributed to all state insurance departments. The Task force recommends that when available, the Department of Insurance obtain and adapt this guide for long term care consumers in Arizona. This guide should then be distributed by the Department of Insurance to other state agencies involved in long term care services, area agencies on the aging and other parties as requested. This guide should provide information regarding the limitations of Medicare and Medicare Supplement insurance in financing long term care; the increasing availability of nursing home insurance; other financing options which may be available to the consumer, such as home equity conversion, and the use of health maintenance organizations to provide acute and long term care services to the elderly.

9. A uniform and coordinated method of providing information and education about long term care services and costs to the elderly, their families and advisors is needed in Arizona. One method for disseminating information is through the use of a volunteer peer counseling service. The Task Force recommends the Arizona Departments of Insurance, Health Services, and Economic Services develop and implement a statewide counseling service, utilizing volunteers from the Retired Senior Volunteer Programs (RSVP). In addition to information about long term care financing, senior counselors should be trained to supply information about the different modes of long term care services, especially community alternatives to institutionalization.

10. The Task Force has compiled within this report a listing of alternatives for providing and financing long term care, including insurance and non-insurance mechanisms. Each option is described along with discussion of the application or potential use of each and the limitations to use of the option. The Task Force also has assessed the relative usefulness of each product as a guide for both present and future application. The Task Force recommends this section of the report be adapted and printed by the Department of Insurance, and distributed to potential consumers and other interested parties. The Department of Insurance should utilize other state agencies and various organizations, as well as printed and televised media, to promote this educational effort.

IV. OVERVIEW

Long term care is the prolonged day to day assistance required by individuals who have become dependent on others as a result of some physical or mental disorder causing functional limitations or disabilities. The prolonged assistance -- while

always requiring the services of others -- may vary in degree from simple, non-medical support to intense, continuous monitoring and services. Those most likely to need long term care assistance are the older elderly, chronic mentally ill, developmentally disabled and severely physically disabled. Although the elderly represent the majority of those who are most likely to need long term care, people of any age can have mental and physical impairments that cause dependency requiring the assistance of others.

The elderly -- or those people age sixty-five or over -- are the fastest growing segment of the U. S. population. In 1960, persons over sixty-five represented nine per cent of the United States population. That percentage of elderly increased to eleven per cent in 1980 and is expected to increase to twelve per cent by the year 2000 and twenty per cent by 2020. Within this elderly category, the number of very old (defined as those aged eighty-five or older) have experienced the greatest percentage gain. By the end of this century, only fifteen years from now, this very old group will number 5.1 million, about two per cent of all Americans. Similar but more extreme patterns of growth are projected for Arizona where those over sixty-five will represent fifteen per cent of the state's population by the year 2000. In absolute numbers, this means a doubling in the numbers of Arizona elderly from approximately 385,000 in 1985 to projected 775,000 in 2000.

In Arizona there are approximately 65,000 elderly and another 63,000 disabled residents who now require some type of long term care assistance. The following section, "Financial Alternatives", contains a detailed discussion of the financing options available to these residents. Conservative estimates predict the total number will grow to 225,000 by the year 2000. This number includes over 125,000 elderly residents, most of whom will be in their seventies and eighties and approximately 100,000 developmentally disabled, chronic mentally ill, and severely physically disabled residents.

There is a vast array of medical and support services required by individuals who require long term care. These services can be provided in a variety of settings, ranging from the individual's home to a hospital or nursing home, and ranging in non-medical activities from meal preparation and household chores to medical care in skilled nursing facilities.

Between eighty and ninety per cent of all long term care needs are in the form of noninstitutional social / supportive / personal care assistance. Only ten to twenty per cent require more intensive medically related care. Further, of this total assistance, approximately two-thirds is provided without charge by informal care givers, usually family members. The remaining third is provided formally, for a charge, by a variety of agencies and institutions.

The formally provided services require reimbursement by either private or public means. Much of the formal care is provided to individuals in home and community settings who are also concurrently receiving informal assistance. Generally, these dual sources of formal and informal assistance tend to complement, rather than overlap. Examples of such formal care include home health nursing, homemakers, adult day care and home health aides.

The remaining portion of formal care is for those individuals who require alternative residential living or institutional nursing facilities. Please refer to Appendix A-1 of this report for a list of definitions of these services, as defined by the Pritzlaff Commission. This group comprises approximately twenty-five per cent of the elderly needing formal long term care and uses about eighty per cent of the funds spent (public and private) for formal long term care. Conversely, this means that the other seventy-five per cent receiving formal long term care assistance are using just twenty per cent of total formal payments. Long term care expenditures for formal assistance are heavily weighted toward institutional care:

Home/Community Based Care	\$1,000/person/year
Alternative Residential Care	\$5,000/person/year
Nursing Home Care	\$15,000/person/year

In 1983, just over \$200 million was spent for organized long term care services in Arizona. Half of this amount was paid through private funds and the other half was paid by federal, state and county governments. Less than two per cent of the private payments for long term care were from commercial insurers. This is in sharp contrast to the cost of acute care, of which forty-seven per cent of the total cost is paid from private sources, but seventy-one per cent of the private share is covered by insurance. Further, with the major responsibility for private payment placed directly on individuals, many people become impoverished and dependent on public assistance.

The growth of the elderly population, combined with health care trends and demographic changes in family support structures, is already beginning to strain the resources available for long term health care. The public sector will be increasingly unable to meet the financial burden of long term care. Concurrently, many individuals in need of care and their families will be hard-pressed to continue paying for their long term care needs solely from their own pockets. Both the public and private sector have reached their financial limits and must be balanced through private alternative financing options. Thus, although the Task Force focused its efforts on the development of private financing options, the need to develop and implement

integrated public and private financing systems is recognized. The emphasis should not be placed on developing one financing method as the only alternative, but rather on developing a wide range of alternatives from which knowledgeable individuals can select the options they consider most feasible for their needs.

Given the considerations mentioned above, the Task Force has compiled in its report a list of alternatives for providing and financing long term care, including insurance and non-insurance mechanisms, which are currently available in Arizona or which could be developed. Each option is described along with a discussion of the application or potential use of each and the limitations or barriers to the product. The Task Force also has assessed the relative usefulness of each product as a guide for both present and future application.

The report next provides a discussion of state tax incentives which might be a tool for encouraging insurers to develop and individuals to purchase, long term care insurance. Public education, which has been identified by insurers as one of the biggest barriers to marketing of a long term care product, is also discussed. Additionally, a brief review of other states' activity in the area of long term care is provided.

V. ALTERNATIVES FOR PROVIDING AND FINANCING LONG TERM CARE

This section addresses private financing options for long term care. Before proceeding, however, it is helpful to underscore the close interrelationship between public and private funding. Many believe the availability of public assistance for long term care has restricted consumer interest and commercial development of private funding mechanisms. At the same time, public assistance has been a vital safety net for those who are impoverished or those who use all their private funds to pay for long term care assistance, become impoverished and then seek public aid.

A. Public Funding

According to the Pritzlaff Commission, \$200 million is currently spent for organized long term care services in Arizona. Half of this amount is paid by individuals privately and the other half is paid by public agencies. Nationally, over eighty per cent of public funds for long term care are from one source -- Medicaid. This is a shared federal/state program for indigents in which each state determines program parameters related to both acute and long term care. Medicaid serves two very different populations: young families and the elderly. On the average, the elderly represent about twenty-five per cent of all Medicaid recipients and account for seventy per cent of all Medicaid expenditures, due to their use of long term care

services. With limited exception, Medicaid pays for nursing home care and does not pay for the non-medical home or community based care. In Arizona, which has no Medicaid funding for long term care, county governments have legal responsibility to pay for the elderly indigent in nursing homes. In 1982-1983, counties spent \$40 million on 4,000 indigent patients and by 1985, this amount was projected to be \$58 million.

Some additional public funds are available for home and community based care. There are two federal sources, Title III (Older Americans Act) and Title XX (Social Services Block Grants). These funds are administered in conjunction with some state funds through the Arizona Department of Economic Security. Although limited to approximately \$13 million in 1985, these funds are critical for the support of programs that provide home assistance, medical case management and adult day care.

There is a widely held misbelief that Medicare is also a public resource for long term care. Medicare primarily provides short term physician, hospital and rehabilitative care for acute disorders, not long term care. Skilled nursing home benefits from Medicare cover a maximum of one hundred days. The first twenty days are covered in full; however, the remaining eighty days require a daily copayment equal to one-eighth of the hospital deductible. In 1985, the copayment was \$50 per day and in 1986, this copayment was increased to \$61.50 per day. To be eligible for nursing home benefits, the Medicare patient must be hospitalized for at least three days for the same illness or injury, and be transferred by a physician's order to a skilled nursing facility (SNF) within thirty days of the hospital discharge. The patient must need and be receiving daily skilled nursing care or rehabilitation therapy.

Utilization of Medicare SNF benefits is low because the eligibility criteria is restrictive and only a portion of all nursing home beds are certified for Medicare patients. For the average Medicare patient, only seventeen SNF days per year are used.

Medicare home health benefits are also restricted. To be eligible for these benefits, a patient must be housebound and in need of skilled nursing, physical therapy or speech therapy as documented by a physician. Homemaker services can be covered if they are incidental to personal care and do not substantially increase the time required of a home health aide. Utilization of home health services is low, providing only twenty-three visits per year for the average Medicare patient. Nevertheless, unlike its limited role for nursing home payments, Medicare is a major third party source of payment for home health care services.

In summary, Medicare covers elderly individuals for a major portion of their acute medical care provided by physicians

and hospitals. Some skilled nursing home and home health services are provided, but only for very limited periods following an acute care hospitalization. Nevertheless, many people continue to think Medicare is a major source for long term care reimbursement. The myth of adequate long term coverage is also supported by the myriad of Medicare supplemental policies owned by sixty per cent of all Medicare covered individuals. These supplemental policies will be discussed in detail in the next section of this Report.

B. Private Funding

Private payments for long term care comprise half of all reimbursements for formal care. Approximately ninety per cent of all private payments are made directly by individuals as an out-of-pocket expense and are not reimbursed by insurers. Private insurance for long term care has been very limited. Existing policies have covered nursing home care, the most expensive method of formal care. The less expensive formal services that are social and supportive are not generally included in private insurance options.

There are many reasons for the underdeveloped private insurance market. Insurance industry representatives point to concerns of adverse selection, insurance induced demand, pricing difficulties and lack of consumer understanding as barriers to product development. Some insurers have expressed fear that the open-ended liability which could result from long term care policies would be financially devastating to their companies. Perhaps more importantly, traditional thinking within the health insurance field is that non-medical, personal services such as homemaker care and respite care are not insurable. In many instances, patients progress from the need for highly skilled medical services to lower levels of custodial care as the aging process continues. As a result, targeting coverage on the basis of level of care is thought to be arbitrary and open to challenge from the insured and the provider of the services.

Insurers also find that actuarial estimates of future losses and premium level determination for long term care policies are difficult to make. Minimal data is available on costs and utilization of long term care insurance and very little of the data reflects actual experience. It may be that only high risk individuals will be attracted to long term care insurance. At present, however, there is no reliable actuarial model applicable to a long term care policy which would differentiate the high risk purchaser from the low risk purchaser and allow for a variable rate scale.

Consumers' capacity to finance long term care insurance may be another barrier to product development. The need for long term care typically occurs at a time when the patient's income

level is fixed or declining. Because Medigap policies dominate the private health insurance market for the elderly, there may be only limited amounts of money available for other insurance products such as long term care insurance.

However, economic conditions of the elderly continue to improve. The elderly today enjoy more discretionary income than the elderly in the past, making them better able to afford insurance. Significantly, a recent report prepared for the United States Department of Health and Human Services indicated long term care insurance premiums would represent less than ten per cent of the cash income of eighty per cent of those individuals in the sixty-five to sixty-nine age group. This report also estimates that by the year 2005, ninety per cent of all married couples at age sixty-five and almost sixty per cent of all single persons at that age, would be able to purchase long term care insurance with less than five per cent of their cash income.

Finally, marketing and distribution mechanisms for long term care insurance products are largely undeveloped. At this time, most long term care financing products are sold on an individual basis. Current commissions on individual long term care insurance products are frequently as high as fifty per cent of the initial year's premium, plus an additional fifteen to twenty per cent commission for each subsequent year of renewal. This relatively substantial marketing cost leaves less funds available for the payment of actual benefits.

Some national groups of the elderly, such as the American Association of Retired Persons (AARP) and the National Retired Teachers Association (NRTA), offer some potential group marketing efficiencies. However, these advantages may be offset by the problems of designing a national long term care insurance policy with a uniform premium that also meets the individual skilled nursing and custodial care definitions of each state. Greater uniformity in benefit definitions may eventually overcome such barriers. Alternately, the establishment of statewide associations or other groups of the elderly might provide an effective marketing umbrella without the need to standardize definitions.

The following sections describe a variety of insurance and non-insurance options which may be available for the private financing of long term care services. There is, in the opinion of the Task Force, no single option that will meet the needs of all people. Rather, the options are choices ranging from insurance policies covering specified services to general funds that can be used at the discretion of the private individual for

whatever type of services are needed, including non-medical assistance.

1. Insurance Mechanisms

a. **Medigap or Medicare Supplement Policies**

Presently, most private insurance simply fills the gaps in Medicare nursing home coverage. "Medigap" policies are purchased by approximately fifty-nine per cent of the sixty-five and over population. Premiums for these supplemental policies range from \$150 to \$1,000 per year. These products historically have covered people for acute care (not long term care) services normally provided by physicians and hospitals. The primary long term care benefit is nursing home care; the beneficiary is reimbursed for the Medicare copayment for the twentieth through the one hundredth day of an approved stay in a skilled nursing facility. From a practical viewpoint, however, little coverage for long term care results from Medigap policies. Few patients qualify for Medicare skilled nursing facility benefits beyond the first twenty days, and generally there are few, if any, home health benefits provided. A major need with respect to Medigap policies is to educate the current and future policyholders that they are NOT protected against long term care expenses.

b. **Nursing Home Insurance**

Nursing home insurance policies are individual policies for patients in nursing homes and are usually applicable only to skilled nursing facilities. These products are regulated by the Arizona Department of Insurance with specific statutes addressing financial, investment and other requirements of the companies. Additional regulation is not needed and there is clear indication that these indemnity policies are becoming one of the best insurance options for financing the cost of private nursing home care for the elderly. For example, in the last six months of 1985, the Department of Insurance approved for sale in Arizona fifteen new nursing home indemnity policies.

Impeding the development of this product is a lack of understanding on the part of consumers who confuse this option with Medicare supplemental policies and Medicare coverage itself. While nursing home policies fill a void, they fall far short of insuring individuals for long term care expenses that are not received in a skilled nursing facility (e.g.: home and community based

services). It is the consensus of the Task Force that private insurance companies should expand these narrowly-focused nursing home policies to include coverages for home and community based insurance plans.

c. Income Replacement Insurance

Income replacement insurance coverage generally provides for the replacement of lost income resulting from an injury occurring away from the work place. Usually, there is a waiting period after the accident before the income payments commence. Further, the disability must be one that prevents the insured from carrying on his or her usual occupation. Most policies continue payment of benefits only for a specified maximum number of years, but lifetime benefits are available in some contracts. Under all such loss of income policies, the benefits are terminated as soon as the disability ends.

These products are regulated by the Arizona Department of Insurance under the statutes regulating the financial condition of insurance companies and statutory requirements relating to the sale and contents of health insurance policies. Income replacement coverage is usually available as part of an employee benefit package and is normally terminated when a person reaches retirement age. Thus, the limitation of such insurance is that it is not usually in force for those people who are over sixty-five and most likely to need long term care coverage. The major barrier to the use of this option for the elderly is not caused by existing regulation, but by the fact that this is insurance designed and priced for those who are still in the work force. However, income replacement insurance is a viable and useful product for younger individuals who become disabled.

d. Life Insurance Products

Life insurance products provide funds at the time of an insured's death. A number of different life insurance programs are available, including term, whole life, universal life and endowment policies. However, with the exception of term insurance, life insurance policies also accumulate a cash value that can be paid to the insured while living, in the form of a lump sum surrender or, in some insurance contracts, as an annuity.

Life insurance products and life insurers are heavily regulated by the Arizona Department of

Insurance. In the opinion of the Task Force, no additional regulations are needed. Consumers are protected by a variety of statutory and regulatory requirements relating to the pricing, sale, and contents of life insurance contracts.

The main deficiency of life insurance products as a potential source of long term care payment is that they typically do not accumulate cash value in an amount adequate to finance the long term care needs of a disabled person. It would be unusual for a life insurance contract to carry a cash value of more than several thousand dollars -- an amount that would pay for only a small portion of typical long term care costs. In addition, the interest return on life insurance is normally quite conservative. In the case of death and a possibly higher term insurance award, the money would be useful only if a surviving beneficiary had need for long term care services.

e. Annuities

An annuity is generally defined as a stream of periodic payments made for a fixed period during a person's life. Annuities typically are used to provide protection against the possibility of outliving one's immediate financial resources. They can be used to pay income currently or in the future at regular intervals, usually monthly. Most annuities are intended to provide guaranteed retirement income of a predetermined amount, most commonly for life. Annuity plans are available on a group basis, most often as pension plans set up by employers, or can be purchased individually through a life insurance company. Annuities are heavily regulated by many of the same statutes and regulations that apply to life insurance products. In the view of the Task Force, there is no need for further regulation of annuities. Like life insurance products and other forms of cash accumulation instruments, the value of most annuities is not large enough to pay for any significant portion of long term care expenses. Again, however, this depends upon the size of the initial capital investment

f. Risk Pools

The risk pool concept is one of participation by individuals in a common pool into which premiums are paid, with the pool assuming the risk of loss to any of the participants. Such a program does not presently exist in Arizona, but if it did, it would be classified as insurance and would be prohibited by the Arizona

insurance code since only an insurance company can provide coverage under the current law. If such individual risk pools were developed, regulation would be needed to assure financial stability and proper performance. In addition, for such an arrangement to become reality, many different facets of its purpose and operation would have to be carefully analyzed. Determination of benefit structure and rate levels; contributions from insureds, insurers, employers, and the state; and methods of coping with entrance to and exit from the pool are only a few of the details which would have to be addressed.

2. Delivery Systems

a. **Health Maintenance Organizations (HMOs)**

HMOs are health plans which provide prepaid, capitated medical care to enrolled members and which guarantee the delivery of a fixed set of benefits. HMOs are regulated as health care service organizations by the Arizona Department of Insurance. Significant regulation already exists and while in general these regulations are not significant obstacles to HMO activities, at least one existing regulation may impede HMOs' ability to add long term care benefits. In order to offer membership to Medicare eligible elderly, HMOs must comply with regulations governing Medicare supplement policies (described previously). Present Medicare supplement regulations require HMOs to cover, on a certain percentage basis, all services and benefits covered by Medicare. In the past, there has been a trend to mandate all types of benefits under the laws governing health care service organizations. In the event long term care is offered by HMOs, similar mandates may be developed to specify the types of long term care which must be provided. In such a situation, HMOs could lose their ability to tailor-make benefit packages for their members resulting in fewer HMOs entering the long term care market.

Many HMOs are considering the enrollment of more elderly members for acute care and long term care benefits. However, it is unlikely that significant long term care options will be marketed for several years. HMOs may be an effective source of long term care in the future; however, a great deal more study needs to be done towards developing satisfactory methods of controlling the financial risk associated with such long term care coverage.

b. Social HMOs

Social HMOs (S/HMOs) are based upon conventional prepaid capitation health plans. Yet, S/HMOs are experimental in that they provide all services paid by Medicare, as well as other benefits which may encourage substitution of ambulatory and home health care for care in hospitals and nursing homes. S/HMOs are currently being tested in New York, Minnesota, Oregon and California. S/HMOs emphasize comprehensive home care for chronic or disabling conditions which require rehabilitation, support and maintenance care that may not meet Medicare criteria. By providing personal care services at home, it is expected that institutionalization will be prevented, resulting in greater patient satisfaction and a tremendous cost savings to the health plan. Home care benefits may include medical transportation, home delivered meals, adult day care, and homemaker services, as well as nursing, therapy and home health aid services.

The utilization of S/HMO benefits is controlled by strong case management, copayment requirements for enrollees and benefit ceilings. It is important to note that S/HMO benefits are likely to cover only part of the costs for the most impaired members, especially those needing nursing home care. Community and home-based benefits are renewable annually, but institutionalized care is not always renewable.

The efficiency of S/HMOs in providing long term care benefits and controlling the associated financial risk remains to be determined. The experimental S/HMOs have been in operation for only a short time. Adding social services to the more intensive health care services of the HMO makes the S/HMO's risk control task all the more challenging. Recognizing that HMOs can provide acute care benefits efficiently, those participating in the experimental project feel S/HMOs should be able to provide less than acute care benefits efficiently as well.

c. Preferred Provider Organization (PPOs)

PPOs are organized arrangements in which member groups receive discounted fee-for-service care. A PPO contract gives members of the covered groups a financial incentive to use providers on a preferred list. Because of favorable agreements negotiated with providers, a PPO can provide medical coverage for a plan at ten to twenty per cent below normal cost. These agreements usually incorporate discounts and controls on inflation and

utilization. At the present time, there is no state regulation of PPOs. The PPO system is relatively new and primarily organized to attract employed, working age individuals. Therefore, at this time, PPOs have little potential for the elderly long term care user.

d. Life Care Communities:

Life care communities for the elderly are usually residential housing programs which also provide short and long term nursing care within a continuing care community nursing unit. These facilities require a monthly service fee and may also require an up-front payment for the residential living unit. A resident of the facility who must be transferred from a housing unit to a nursing home is guaranteed payment for the nursing home care. Life care communities can be quite expensive with the initial endowment or "front end" payment for a residential unit varying from \$50,000 to \$100,000, plus a monthly service fee of \$400 to \$1,500.

Life care communities are regulated by the Arizona Department of Insurance and the Arizona Department of Health Services, with the latter agency being responsible for regulating the separately licensed nursing home associated with the life care facility. Life care communities are not an alternative for many senior citizens because of the high cost associated with the endowment and monthly service fee. Additionally, the residents of life care communities are generally those persons who are "aging well", in full possession of their faculties, who are interested in maintaining continuity with their local community and peers. However, the Task Force acknowledges that for those seniors who have sufficient funds, life care communities are a viable and attractive option for long term care costs in the nursing home.

3. Financing Mechanisms

a. Home Equity Conversion:

Several programs currently exist which enable seniors who fully own or nearly own their own homes to continue living in those homes while receiving up-front and on-going monthly payments based on the equity in their homes. These programs are generally referred to as home equity conversions. There are no state agencies having any significant regulatory authority over home equity conversion options. There is, however, federal regulation of the savings and loan institutions or lending agencies which would make home equity loans.

It is the view of the Task Force that additional regulation will ultimately be needed for home equity conversion programs. At the least, there should be a requirement that any potential user of this product be carefully counseled because of the complexity in selecting the best type of home equity arrangement for the individual and because of the impact of such a conversion on the borrower's estate. Another major barrier to the home equity conversion is not the presence or absence of regulation, but the limited interest by banks and other lenders in making home equity loans. When compared to ordinary home loans, the lender must provide far more counseling and information and be willing to make less profit on the loan. Home equity conversions are, nevertheless, a useful financing mechanism for people who have substantial equity in their home and want to remain in the home, but need additional funds to pay for the long term care of a family member.

b. Individual Retirement Accounts (IRAs):

IRAs are part of a mechanism whereby pretax income can be deposited in an account with income taxes on the interest earnings deferred until the money is withdrawn, normally after retirement. Such funds could be used to pay for long term care expenses. IRAs are regulated by the Arizona Department of Banking as well as by the Securities Division of the Corporation Commission and federal regulations. Any individual can set up an IRA account with the intent of withdrawing the money when necessary for long term care.

While additional regulations are not required for this type of funding option, the Task Force recognizes the need for public education in this area. Individuals must be made aware, during the early stages of financial and estate planning, that IRA accounts can be used to meet the high costs associated with long term care.

c. Employee Benefit Plans (Pensions):

Most employee benefit plans provide for a pension which is usually in the form of an annuity (already discussed). These pension programs are controlled under the Federal Employee Retirement Income Security Act of 1974 (ERISA). As such, these plans are exempt from state regulation because the pension component of an employer benefit package is employer generated and there is no association with insurance products. As with the above options, the pension is a source of funds that in later years could be used for long term care. One

potential option to increase the private financing of long term care would be to allow individuals to elect a variation on a life annuity. Under this option, individuals would be able, at their own discretion, to receive an extra year's pension at any time. This option does not reduce the present value of one's pension benefits, but simply modifies the timing of the benefit payments. Any funds not used for long term care could be used for other purposes or become part of one's state. It is our view that additional state regulations are not needed for such variations of pension benefits to be developed as long term care financing mechanisms.

VI. MARKETING AND CONSUMER EDUCATION

As stated previously, consumer education has been identified as a major barrier to the development of effective, affordable long term care insurance. The Task Force recognizes this lack of consumer education encompasses all age groups. For example, younger individuals and their families (ages twenty-five to forty) do not understand the need for financial planning in order to meet their potential long term care needs in what will probably be the distant future. This same group also does not recognize the possibility of someday having a child or other dependent who may require long term care due to physical or mental impairment.

The next age category, ages forty-one to sixty-four, are typically in a transitional period. These individuals may be responsible for the long term care needs of their parents and/or grandparents. Thus, while this group may be more aware of the problems arising from the lack of adequate long term care financing, they may not have the financial capacity to provide for their own future long term care needs.

More than any other group of insurance purchasers, however, the elderly do not have an adequate understanding of their insurance coverages and the health care risks they face, resulting in a general inability to effectively arrange for long term care protection. For example, in a survey of its membership conducted in 1984, the American Association of Retired Persons (AARP) found that eighty per cent of its membership thought they had long term care coverage under Medicare. Almost fifty per cent of these people thought they had adequate coverage under their private Medicare Supplement policies. Of course, Medicare and Medicare Supplement policies actually cover only short term nursing home care for those recuperating from a hospital stay. When questioned about gaps in their insurance coverage, only two per cent of the AARP members mentioned the lack of extended care benefits. This survey documents the widespread confusion about

long term care financing, and highlights the need for an immediate, effective consumer education program.

There is also a preference among the elderly, as with all insurance consumers, for "first dollar" coverage. Currently, the gap-filling insurance products which dominate the private health insurance market for the elderly indemnify insureds for the deductibles and copayments required by Medicare. Purchase of these policies may, however, limit the amount of money available for purchasing other insurance products such as long term care policies. Again, this highlights the need for an educational program which will provide seniors with information regarding the need for both types of coverage -- both "first dollar" and "catastrophic" -- and which will assist seniors in making the best use of their funds.

A study for the United States Department of Health and Human Services, published in January, 1985, projected that forty-seven per cent of people between the ages of sixty-seven and sixty-nine having assets of at least \$3,000 would buy long term care insurance if it cost ten per cent or less of their annual income. That would reduce federal government expenditures for long term care by as much as twenty-three per cent -- or nine billion dollars -- over a thirty-five year period. Using a more conservative assumption that people would purchase the insurance only if the premiums cost less than five per cent of their annual income, the study found that twenty-one per cent of the same group would buy the insurance, producing about an eight per cent savings of federal dollars over the same period. We can conclude, based on this study, that a viable, interested market for private long term care insurance coverage could be developed if consumers were made aware of their potential long term care needs.

Regulators and insurers have been reluctant to institute educational programs regarding long term care financing, because so few alternatives have been available. With the increase in the number of financing alternatives, such as the increased number of nursing home indemnity products now available in Arizona, and growing interest in home equity conversions and life care communities, the need for an organized, formal educational program is evident.

VII. TAX INCENTIVES

Tax incentives may be a tool for encouraging development and availability of long term care insurance. Too often, however, tax incentives are viewed as an answer to accomplish an economic or social purpose.

Tax incentives may be a way to influence or affect insurance purchase decisions by potential consumers. It is not presumed that tax laws act as a barrier to the availability of this insurance, but that the cost of the insurance or ability to purchase the insurance could be made more attractive through tax incentives.

Tax preferences for the elderly are not new. Federal and state tax laws already provide special treatment designed to increase the spending power of elderly and disabled persons. Federal income tax laws, for example, provide an additional personal exemption allowance for those sixty-five and over, allow special capital gains tax treatment when the elderly sell their residences, and encourage savings for retirement through IRAs. Current Arizona income tax law adopts the federal capital gains and IRA treatment. Specifically, Arizona provides a deduction of \$800 for income tax purposes for a taxpayer who pays more than one-quarter of the cost of maintaining an individual aged sixty-five or over in a nursing care institution or supervisory care home, or an adult foster care home. The deduction is also available if the taxpayer makes payments of \$800 or more for home health care or other types of medical care for an individual who is not institutionalized.

Additional tax incentives could further enhance the spending ability of the elderly and families who are in need of long term care services. This could serve a dual purpose. First, the incentives would increase the funds taxpayers might have available to purchase long term care insurance. Secondly, if more elderly individuals can afford and purchase the insurance, the increased participation will potentially result in decreased overall costs of the insurance.

Tax incentives could also draw attention to the risks of needing long term care. The average life expectancy continues to grow, making the probability of needing long term care much greater for larger numbers of people. Without proper coverage or income/assets to pay for the costs, many elderly and their families could be financially devastated by the unplanned, expensive nature of the care required. Tax incentives may help draw attention to this future risk and encourage taxpayers to take preventive action.

Tax incentives can be targeted to affect a particular group. The wealthy may be able to afford the care needed, but low and lower middle income persons and families may not be able to afford coverage without aid. Income tax incentives in the form of deductions or credits, directed toward those truly in need of financial assistance, might allow more of these persons to protect themselves rather than fall into government assistance programs later when they can no longer afford to care for

themselves. Targeting specific groups would minimize the loss of tax dollars while broadening the base of those who could afford private coverage.

The advantages that some tax preference would give toward the development and availability of long term care insurance must be weighed against the disadvantages. There has been growing sentiment against the proliferation of tax incentives and the erosion of the tax base. Only if an incentive is cost effective should it be adopted. It is beyond the scope of this study to make the determination of the cost effectiveness of the various incentives mentioned later. The following are simply points which should be considered prior to formal adoption of a tax preference program for long term care insurance.

First, innumerable factors are important in the decision to buy insurance. Current health, income stability, net worth, prior knowledge or experience regarding the need for long term care, perceptions of one's own future health, understanding of other medical cost protections (such as Medicare and AHCCCS), and a person's lifestyle are just a few of the variables that will influence a decision. There is no guarantee that a tax incentive will achieve an intended objective.

Second, state income tax incentives without comparable or parallel federal incentives would possibly be ineffective because of relatively low state tax rates. Some of the various tax preferences for the elderly were mentioned earlier in this study. They all serve to reduce state taxes on the elderly. With a maximum rate for individuals of only eight per cent, compared to federal rates that range from fourteen to fifty per cent, most individual taxpayers cannot achieve much real tax relief from state incentives alone. Persons with the greatest need for assistance, the low income earners, already pay little or no state tax.

Third, the fairness of any tax incentive would be difficult to ensure. Some investment income is not taxed by the states. The income on which an incentive might be based may not reflect true financial ability of the taxpayer. To attempt to put all taxpayers on a level basis would greatly increase the complexity of filing and the costs of administering the incentive.

Fourth, many incentives are used by recipients for unintended purposes, or are given to persons who have no demonstrated need. To avoid these pitfalls, an incentive should explicitly target the persons and the subject to be given special tax treatment. Targeting, however, has its own shortcomings. For example, targeting may unknowingly ignore alternatives and limit development to programs that are aided by the incentives. New concepts or alternative approaches to a problem will receive

far less attention. This would discourage economic efficiency.

Finally, tax-based incentives are being more critically examined in light of a tight fiscal outlook for Arizona. Preferential tax treatment for some reduce the level of tax receipts and raises the financial burden for other taxpayers. This is magnified many times when an incentive is abused. Unless substantial protections are built into the reporting system, the costs can often escalate while little of the benefits may actually be used for long term care insurance.

The Task Force concluded that existing state tax laws do not impede the development of long term care insurance. Given the amount of interest in developing long term care policies currently demonstrated by the insurance industry, there is every indication that market demand will result in the development of a broad range of policies without the necessity of providing tax incentives to the public or insurers.

VIII. STATE AND FEDERAL ACTIVITY

In conjunction with the National Association of Insurance Commissioners' (NAIC) Long Term Care Advisory Committee, the Task Force reviewed state and federal activity in the long term care arena. Appendix A-2 to this report is a detailed outline of state and federal efforts to date.

At least twenty-five states, including Arizona, have proposed or authorized some type of study or legislation regarding long term care. These efforts range from the establishment of task forces or study committees charged with exploring the availability of long term care insurance and long term care delivery systems to passage of legislation which requires health insurers to extend coverage to parents of the insured who reside in the insured's home. Several states have proposed legislation which relates to tax credits or tax exemptions. For example, Minnesota has considered legislation which would exempt from the state income tax the pension income which is used to purchase long term care insurance.

A lesson in the problems surrounding the "over-regulation" of long term care insurance can be gathered from the experience of the State of Wisconsin. In 1981, the Office of the Commissioner of Insurance in Wisconsin promulgated administrative rule standards (Ins. 3.46, November 1, 1981) which defined the type of nursing home insurance which might be sold within that state. The rule sought to reduce abuses and confusion associated with the sale of nursing home insurance by providing for minimum levels of coverage. Minimum coverages required by law included minimum benefits of ten dollars per day; deductibles not to exceed sixty days; lifetime maximum of 365 days; and coverage of

care certified by a physician as being necessary. In addition policies could not contain exclusions which would limit levels of care; limit coverage to care received as a result of sickness or injury; or limit coverage to care received after hospital confinement.

The reaction of insurers to this regulation was immediate and devastating; all but one ceased to offer any long term care insurance within the state. The sole remaining insurer raised its prices and ceased advertising, citing the "experimental" nature of the policy shaped by the new rules. From an actuarial point of view, their concerns were understandable. Coverage of care needed simply as a result of the natural effects of aging, and not because of any acute medical condition, would be mandatory. The inability of insurers to limit their risks by requiring a prior hospitalization or some evidence of sickness or injury removed the insurance from the usual health insurance realms as described in the section of this report entitled "Private Funding".

Wisconsin is currently seeking to amend its rule to allow insurers more flexibility in policy design. The Office of the Commissioner has proposed changes which would allow insurers to limit coverage to certain levels of care, such as skilled nursing care, and to allow insurers to limit coverage to care received in a nursing home after a hospitalization of at most, three days.

The federal government has also taken measures recently to address long term care issues. Representative Ron Wyden (D-Oregon) has introduced legislation which would establish a task force on long term care insurance. This task force, which would be comprised of representatives from the NAIC, private insurers, providers of long term care services, consumer advocates, and federal and state agencies responsible for the elderly, would develop guidelines regarding the certification of long term health care policies. In addition, several bills which would provide tax relief for families of elderly dependents who require long term care have been introduced in Congress.

S E R V I C E S

Services Delivered in the Client's Own Home

1. **Home Health Care:** In-home nursing and personal care are essential services for many impaired and disabled people. Most frequent nursing services needed are skilled observation, diabetic care, care of terminal or bedbound patients, care of wound or incisions, administration of medications, decubitus (bed sores) care, and care regarding incontinence or catheterization. (Nursing services of a home health agency also are provided to clients in the alternative residential homes described below).

In addition to licensed nurses, other frequently used staff of home health care agencies are home health aides who provide personal care, do incidental homemaking chores and monitor health status. Home health care agencies in Arizona also provide physical therapy, speech therapy, occupational therapy, and medical social work as supplemental services. Other services include respiratory therapy, laboratory work, patient care, providing equipment and supplies, nutrition counseling, and psychiatric nursing. Arizona has 45 medical licensed home health care agencies. In addition, another five home care agencies working in 10 counties that are not licensed by the state or Medicare-certified, provide many of the same services, but are not eligible for Medicare reimbursement.

2. **Home Repair:** Modification to the home often is needed to maintain or increase the individual's self-sufficiency. This involves recommending and making structural repairs and adaptations which increase the individual's ability to perform the activities of daily living or decrease environmental hazards.

3. **Reassurance Service and Emergency Response System:** Regular phone or in-person interaction, usually with a volunteer, aimed at reducing social isolation and insuring health and safety, determining if special assistance is required, providing psychological reassurance and notifying a contact person if the person does not respond. Emergency response systems, such as Lifeline, consist of a call button on a telephone or a mobile unit which the person can wear. Pushing the button automatically activates a call to a base station from which emergency aid can be sent.

4. **Home Delivered Meals:** Commonly called Meals on Wheels, this service uses community volunteers to deliver either hot or cold meals to people who are unable to leave home or cook. A

secondary benefit of the program is the social contact facilitated through the regular visits of the volunteers.

5. **Respite Care:** Respite care -- relief for caregivers -- may free the family member for a few hours to handle personal business or may relieve him or her for a week or more, either for vacation or recuperation from illness or exhaustion. Services may take the form of a sitter or attendant who comes to the home, a congregate day program or temporary institutional care.

6. **Hospice:** Hospice is a service based on a philosophy that has as its foremost goal the reduction of physical, emotional, and psychological pain in the terminally ill. Home-based hospice services are usually provided only to those who have a primary caregiver in the home. Inpatient services fill a respite role or take over when symptoms cannot be adequately controlled in the home. In addition to pain control, goals include management of symptoms (e.g.: nausea) and the maintenance of alertness and mood. Hospice involves the family in planning and provision of care. Pharmacy consultation, oncology, expert nursing care, clergy service, volunteer involvement, bereavement support, social work and psychiatric consultation are all important components of a hospice program.

Services in Community Based Settings

1. **Adult Day Care/Adult Day Health Care:** All day care programs provide, as basic services, transportation, nutritious meals, personal assistance, socialization, and therapeutic activities. Most also include health education, monitoring, and counseling. In addition, those programs with a medical component provide a full range of health-related service beginning with comprehensive assessment and the development of an individualized care plan. Services may include physical, occupational and speech therapy, skilled nursing, and training or retraining in independent living skills. Some mental health agencies sponsor day treatment programs emphasizing counseling and the development of survival skills such as job seeking, personal financial management, and social skills.

2. **Congregate Meals:** Primarily for the elderly population, congregate meals are provided in senior centers, churches, and schools. This program serves the dual purposes of socialization and nutrition.

3. **Outreach Information and Referral:** Many of those in need of long term care services are not familiar with the availability of community-based and home-delivered services. A well publicized, identifiable source of information must be available to anyone on demand.

4. **Rehabilitation/Job Training/Sheltered Work:** Younger physically and/or mentally disabled people can frequently benefit

from special training. Job placement assistance supplements this training. For those whose disabilities preclude functioning appropriately in unadapted environments, sheltered employment provides productive roles in a controlled and protected environment.

5. **Transportation:** Special transportation services often make the difference between "housebound at home" and the ability to maintain social roles in the community. Transportation is necessary not only for getting to appointments for medical services and personal business, but also for visiting, shopping, and participating in recreational and social activities. Expense, fear of assault, and lack of accessibility contribute to the difficulties that some individuals experience in using the general public transportation system.

Alternative Residential Homes

1. **Adult Foster Care/Private Home Care:** An individual or family provides a place of residence, meals, housekeeping, surveillance, and/or personal care to five or fewer unrelated individuals. Adult foster care homes are certified by the county when public monies are being spent for indigent care. If no public funding is involved, licensing is not required.

2. **Supervisory Care Homes/Private Board and Care Homes:** More than five unrelated individuals are provided with housing, meals, housekeeping, supervision, and minor assistance with personal care and self-administration of medications. State licensing is required for supervisory care homes.

3. **Congregate Housing:** Individuals keep their own apartment in a complex which may make available meals, escort and transportation, some housekeeping, and personal care.

Institutional Care

Long term care institutions, which include nursing homes, are important when the person's need for assistance becomes so intense that 24-hour care is required. In addition to shelter, meals, and housekeeping, nursing homes provide professional nursing care, personal assistance, therapies, direct administration of medications, activities, religious and social services, and therapeutic diets according to physician's orders and a care plan developed by the professional staff. Nursing homes may serve as convalescent centers after an acute illness or accident, or they may become the long term home of the person, depending on the rehabilitation potential shown. Three levels of care exist: (1) personal care, which is less medically oriented and serves people who are less disabled but who lack social supports; (2) intermediate care, which serves a moderately

disabled group who require more than personal care offers; and (3) skilled nursing care, which provides intensive nursing and personal care services to the most dependent population. State licensing is required. In Arizona approximately 80% of nursing home beds are licensed for skilled care.

GOVERNOR'S TASK FORCE ON
LONG TERM CARE INSURANCE

Review of Current State and Federal Activity

A. Studies Currently Underway or Authorized

1. **Virginia:** HJR 210 - A resolution to continue the Joint Subcommittee Study concerning alternatives for long term state indigent health care begun in 1984.

S.543 - Established the Long Term Care Council to develop community based continuum of care services for the elderly in order to deter unnecessary institutionalization.

2. **Minnesota:** S.543 - Instituted a Feasibility Study of a home equity conversion program to finance long term health care and long term health care insurance.

3. **Georgia:** S.128 - Established the Senate Private Long Term Care Insurance Study Committee to study the availability of long term care insurance in the state and to explore various public policy initiatives which might encourage greater private sector involvement.

4. **Alaska:** The Governor has appointed a task force to study long term care, focusing on public and private financing. Task Force is chaired by Commissioner, Department of Health and Social Services.

5. **Arizona:** The Governor has appointed a task force, chaired by the Director of the Department of Insurance and charged with indentifying methods of promoting private sector financing of long term care.

6. **Iowa:** The Governor implemented a task force in 1984 to review the current system of providing long term care to the public. The task force developed a set of recommendations, including the establishment of a long term care commission by January 1, 1986.

7. **Illinois:** H.306 - A task force within the Department of Insurance to study a private market approach to long term care insurance has been established.

8. **Kansas:** The Department of Health and Environment implemented a study of long term health care in March, 1985.

9. **New Mexico:** Legislature established a task force to study present long term care system and formulate a statewide long term care plan including a community based services system.

10 **North Carolina:** Legislature authorized the Legislative Research Commission to study the availability and coverage of long term care insurance and to make recommendations to overcome any barriers.

11. **Texas:** Legislature authorized the State Board of Insurance to study the feasibility of providing long term care benefits through private insurers.

B. States Proposing Studies

1. **Maryland:** HJR5 - Would have established a task force to examine the state's current system of continuum of care services for frail elderly and disabled individuals. Failed to pass.

2. **Hawaii:** H.450 - Would develop a plan to implement a single access system to long term health care services in Hawaii. Would provide two functions: 1) pre-screen applicants who are, or will be within 180 days of institutionalization, eligible for Medicaid, and 2) determine a program of community based services most appropriate to prevent unnecessary institutionalization.

3. **North Dakota:** SCR 4025 - Would have initiated an interim study on the availability and coverage of health care insurance plans providing long term care insurance. Has been withdrawn from consideration.

4. **Connecticut:** HCB 5109 - Would create a task force to study the need for a private or state administered program offering long term health care insurance at group rates.

HCB 6435 - Would allow the Commissioner of Health Care Services to establish a pilot preadmission screening program for applicants to long term care facilities to collect data on their various conditions and needs.

5. **New Mexico:** H.180 - Would establish a task force to study in depth the present long term care system, (including private, state, and voluntary programs) and formulate a state-wide long term care plan including a community based services system.

6. **Maine:** The Department of Human Services has proposed to established a study group on long term care by June, 1986.

C. Existing State Laws or Regulations Dealing With Long Term Care

1. **Wisconsin:** §647.01-.08, Wisconsin Statutes. Continuing Care Contracts: Continuing care contracts are not considered to be insurance under Wisconsin law. They are entered into directly between the health care provider and the individual; the provider must obtain a permit from the insurance Commissioner before offering such contracts. The provider is under strict statutory guidelines regarding contents, duration, and cost of the contract. Contracts are both restrictive and expensive.

§15.105(10) Wisconsin Statutes. Established the Board on Aging and Long Term Care.

2. **Arkansas:** §82-2208 to 2233, Arkansas Statutes. Long Term Care: Established the Long term Care Facility Advisory Board to regulate long term care facilities and facility administrators.

3. **West Virginia:** §16-5D-1 to 5, West Virginia Code. Continuum of Care: Established the Continuum of Care Board to promote and implement a system of nursing, medical and social services for the elderly, disabled, terminally ill, and their families. Specifically established the Hospice Care Program to provide long term care in a form other than institutionalization.

4. **North Dakota:** §50-10-.1-01 to 07, North Dakota Century Code. Long Term Care ombudsman: Provides for the appointment of a long term care ombudsman to oversee administrative actions against long term care facilities and monitor the development of federal, state and local laws and policies relating to long term care.

5. **Colorado:** §10-8-401, Colorado Revised Statutes. Requires all individual and group accident and sickness policies to offer insureds the opportunity to purchase home health care and hospice care benefits.

There is also an interim study on health care cost containment, which will include investigating long term care issues.

6. **Georgia:** H.190 was passed to encourage health insurers to make available coverage for long term care services, either as a part of or as an optional endorsement to their policies.

D. States Proposing Laws or Regulations Dealing With Long Term Care

1. **Nebraska:** L3 647 - Would require insurers to provide group long term care insurance policies by June 1, 1986. The Director of Insurance may adopt rules and regulations establishing standards for group long term care policies.

LE 147 - Would implement a reimbursement system for long term health care facilities caring for acutely ill or disabled persons, within certain guidelines.

2. **New Jersey:** S.3085 and S.3087 would require certain insurers to offer group indemnity policies for confinement in long term care facilities.

A.4141 would establish a New Jersey State Reverse Annuity Mortgage Program for senior citizens.

A.113 would require health insurers to make available long term care insurance for senior citizens and would set minimum standards for such coverage.

3. **New York:** S.238 - Would establish long term health care programs available at home or at adult care facilities, other than a shelter for adults (i.e.: nursing home). Adult care facilities would be considered intermediate care facilities, and services would be provided on a community oriented basis.

4. **Washington:** H.1168 - Would enact the Nursing Home Insurance Act, intended to govern the content and sale of nursing home insurance. Would apply to group or individual policies covering any type of nursing home care; such policies could not be sold to individuals receiving or eligible for Medicaid.

5. **Michigan:** H.4082 - Would require an individual, group or blanket nursing home care insurance policy to cover care and services that are not covered by Medicare or by a Medicare Supplemental policy. Requires that this type of policy cover intermediate care costs and custodial care costs.

6. **Illinois:** S.389 - Would amend the Illinois Insurance Code requiring all health and accident insurance policies to cover care and treatment of Alzheimer's disease (including hospitalization, nursing home care, surgery and medication). These policies must include disability income protection.

7. **Connecticut:** H.5416 - Would establish a state administered long term health care insurance program for the elderly and disabled

E. Other State Activity

1. **Minnesota:** S.725 - Would exempt from state income tax any pension income which is used to purchase long term care insurance. (1985)
2. **West Virginia:** H.1521 - Would allow a personal income tax exemption for taxpayers providing general maintenance and care to certain people (i.e.: family members) 65 or over; limited to two exemptions per year. (1985)
3. **Florida:** S.17 - Would create a commission for the study of catastrophic illness and accident compensation; would study the need for a procedure to compensate persons who are subjected to catastrophic illnesses or accident costs which are compensated by insurance or another third party. (1985)
4. **California:** AB 1344 - Would allow a tax credit of 50% for the reasonable costs of health maintenance care of a taxpayer's dependent who is cared for in the home. Also provides for a 50% tax credit for the cost of long term health care insurance. (1985)
5. **Idaho:** H-84 - Would allow a tax deduction for the cost of nursing home care insurance. (1985)
6. **Massachusetts:** S.1043 - Would mandate the inclusion of custodial or nursing home care costs for persons with Alzheimer's Disease in health insurance policies. (1985)
7. **Michigan:** S.102 - Would provide health insurance coverage be extended to cover parents of the insured who reside in the insured's home. (1985)

F. Federal Activity

1. **Bills dealing with long term care**

The Long Term Care Insurance Promotion and Protection Act (Representative Wyden, Oregon) - Provides for the establishment of a task force charged with reviewing the state of the insurance industry with regard to long term care and making recommendations to Congress for voluntary guidelines to be issued to state regulators.

Home Equity Conversion, S.324 (Specter) - Home Equity Conversion Act of 1985. Facilitates home equity conversions through sale-leasebacks. Not specifically for financing long term care, and available to homeowners regardless of age, but noted due to long term care financing interest in this

approach. Introduced in similar form in 1983 as S.1914, which generated controversy about homeowner rights under the arrangement. Outlook uncertain.

Medical Expense Deduction, H.R. 803 (Lent) - Medical expenses (including insurance premiums of persons over 65 or handicapped would be deductible without regard to current income-tested level.

Special credits, deductions and exemptions for care of elderly family members:

S.779 (Heinz) - Income tested tax credit for expenses for the care of an elderly family member. Covered expenses include home health, homemaker and adult day care, respite care, and certain supplies and equipment. Introduced in 1983 as S.1301.

S.263 (Metzenbaum) and H.R. 468 (Snowe) - Similar bills for deduction in household that includes "dependent" with Alzheimer's.

H.R. 467 (Snowe) - Extend dependent care credit for expenses of dependent incapable of self-care regardless of whether expenses will permit dependent to be gainfully employed.

H.R. 723 (Spence) - Deduction for cost of medically necessary custodial care for elderly.

H.R. 406 (Quillian) - Tax credit for households with elderly disabled persons.

H.R. 644 (Conte) - Tax credit for expenses of care for certain elderly family members.

H.R. 915 (Byron) - Deduction for expenses of maintaining dependent age 64 or over.

H.R. 196 (Oakar) - Additional personal exemption for handicapped taxpayer, spouse or dependent.

2. **Expansion of Medicare to Cover Long Term Care:**

Medicare/Medicaid Coordination S.780 (Heinz) - Health Care Coordination of 1985. Optional program for Medicare/Medicaid dual eligibles except ESRD beneficiaries. Enrollees would be required to have access to all Medicare A/B services; all Medicaid services to which the enrollee would otherwise be entitled; case management including health assessments; home-maker, home health aide, and adult day health

services if determined appropriate by the state; and any other services determined by the state to be needed to avoid institutionalization. Payment would be 95% of the AAPCC and the method could be by the usual Medicare and Medicaid methods, by HMO/CMP capitation, or by negotiation. Medicare and Medicaid waivers would be granted from requirements such as "statewideness", and numerous enrollment, reporting, and similar requirements would be established.

Medicare demonstrations: H.R. 1163 (Hughes) - Would establish demonstrations to make per diem payments to Medicare beneficiaries and to Medicaid enrollees who are receiving, or eligible to receive covered SNF or ICF nursing home services. Payments would be used for non-institutional living arrangements and would be 50% of the state's average daily benefit payment for nursing home services (bill is unclear if single overall average or separate rates for XVIII-SNF, XIX-SNF and XIX-ICF would apply).

S.788 (Bradley) - Senior Citizens Independent Community Care Act. Would provide for a long term care demonstration program in four states to test cost-effectiveness of prepaid capitation for acute and long term care services to elderly Medicare beneficiaries. Services include all Part A and B services, homemaker/home health aide care, facility-based adult day care, respite care and service coordination. Very similar bills were introduced in the 98th Congress as S.1244 (Packwood), H.R. 3710 (Harkin) and H.R. 3838 (Rangel).

S.751 (D'Amato) and H.R. 67 (Bilirakis) - Both bills would establish demonstration programs for beneficiaries with Alzheimer's.

Medicare Coverage Expansion, S.778 (Heinz) - Home Care Protection Act of 1985. Expands Medicare home health services to include coverage of nursing care and home health aide services on a daily basis for up to 60 days, with an additional 60 days upon physician certification of medical necessity. A similar bill was filed in 1984 by Representative Waxman but has not been re-filed.