LONG-TERM CARE TAX PROVISIONS IN THE CONTRACT WITH AMERICA

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

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LONG-TERM CARE TAX PROVISIONS IN THE CONTRACT WITH AMERICA

FRIDAY, JANUARY 20, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to other business, at 11:40 a.m., in room 1310, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
January 11, 1995
No. HL-1

CONTACT: (202) 225-3943

THOMAS ANNOUNCES *CONTRACT WITH AMERICA* HEARING ON LONG-TERM CARE TAX CLARIFICATION

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the subcommittee will conduct a hearing on tax incentives for long-term care insurance as part of the Senior Citizens' Equity Act (H.R. 8) that is a portion of the Contract with America, the series of 10 bills offered by the Republicans as a national legislative agenda. **The hearing will begin at 11:30 a.m. on Friday, January 20, 1995, in 1310 Longworth House Office Building. An organizational meeting of the subcommittee will precede the hearing and will begin at 11:00 a.m.**

This hearing will feature invited witnesses only. In view of the limited time available to hear witnesses, the Subcommittee will not be able to accommodate requests to be heard other than from those who are invited. Those persons and organizations not scheduled for an oral appearance are encouraged to submit written statements for the record of the hearing.

BACKGROUND:

The costs associated with long-term care are of increasing concern for America's senior citizens and their families. Currently about 7.1 million elderly individuals need long-term care services, and estimates indicate that as many as 13.8 million Americans will need long-term care services by the year 2030. Currently, care is typically paid out-of-pocket by private individuals and by the Medicaid program. Most Americans do not take long-term care needs into consideration as a part of personal financial planning during their working years or when planning for retirement. The financial resources required to meet an individual's long-term care needs are difficult to predict. For most Americans, saving the tens of thousands of dollars necessary to finance a potential extended nursing home stay is impractical and financially impossible. Traditional health care coverage, including Medicare, does not cover most services associated with long-term care. The portion of the Medicaid program devoted to long-term care is designed to care for the nation's poor who require such services. To qualify for Medicaid assistance for long-term care, individuals must first "spend down" a significant portion of their savings and other assets. In addition the disastrous financial impact on families struggling with the costs of long-term care, federal and state governments are finding it increasingly difficult to pay their portion of long-term care costs under the Medicaid program.

Unlike traditional health care insurance, long-term care insurance does not currently enjoy tax favored status. The Senior Citizens' Equity Act of the *Contract With America* clarifies the tax treatment of long-term care insurance policies by treating long-term care insurance in a manner similar to accident and health insurance as a way to encourage individuals to actively plan for their long-term care needs.

FOCUS OF THE HEARING:

The hearing will focus on the provisions in the Senior Citizens' Equity Act of the *Contract With America* -- providing tax favored treatment for long-term care insurance.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement by the close of business, Tuesday, February 7, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

* * * * *

Chairman THOMAS. This is the opening meeting of the Subcommittee on Health, in regard to the Contract provisions with America in terms of long-term care provisions.

Today's hearing will reveal several of the Contract With America provisions within the subcommittee's jurisdiction. It, obviously, reflects a hope to hold a series throughout the course of the year, focusing on new and novel approaches, issues facing not only the delivery of health care, but clearly, the financing as well.

The defeat of health care reform last year means many of the challenges which faced the last Congress remain unresolved. Fortunately, while we failed here at the Federal level in Congress to form a consensus on even limited reforms, the private sector has continued, as it must, to move forward with many innovative approaches to provide high-quality, cost-effective health care coverage.

It is my intent to use this hearing process as a means of highlighting these innovations for use in dragging the Federal Government into the 21st century. In addition, rather than struggling to find problems with the current system, and attempting to add layer on layer of new regulations on the existing system, I hope that out of the hearings, we can focus on what the marketplace is doing today and how the Federal Government can learn from the private sector and, indeed, the States, in modernizing some of our more antiquated programs and blending the structure into a positive one.

The hearing will review the desirability of clarifying the tax treatment of long-term care policies as a means of encouraging the purchase of such policies and the evolution of the private market. The scope of the hearing is limited to the tax clarifications for long-term care policies, including H.R. 8, the Seniors' Equity Act.

Today's hearing, hopefully, will show us that in fact there are solutions that are real and achievable to the long-term care problems plaguing many of our citizens. We will hear, hopefully, from a broad spectrum of individuals and groups that will provide us with the insight we need to make responsible program decisions rather than focus on the high cost of entitlement strategy favored by the previous majority, as the solution to all our difficulties. The panelists we will hear from today, will show us that there is much to be gained from providing the right incentives and empowering individuals and their employers to make better plans for their own particular needs.

Mr. STARK. Mr. Chairman, thank you.

Today, we begin the subcommittee's work in the 104th Congress, and we find that health care costs continue to rise at an unacceptable rate of more than twice the general inflation rate; 40 million Americans remain without health insurance at any one point in time. I suppose under dynamic scoring, that number would approach 60 million.

We weren't successful in the last Congress in confronting these issues. That was certainly not the fault of this committee. This committee took the lead, reported a bill that was fully financed and worked; every American would have had guaranteed health insurance. Although I suspect that a comprehensive reform bill will not be on this subcommittee's or perhaps anybody else's agenda this

year, I do believe that the need for the results of that bill are a high priority among the American people.

There may be some attempts to do a wink and a promise and call some minor tinkering reform, and I believe it is our responsibility to point out to the public the difference between that type of a bill and what real reform would be.

Second, if I can mention the Speaker's name under our rules, when he addressed our full committee the other day, he misspoke. He hammered on Medicare pretty hard, and I think this committee has a long history of great pride in how we have both added oversight and legislation to keep the Medicare system the finest health insurance system in the United States, if not the world.

One of the things the Speaker was sadly misinformed on, is that HMO managed care plans according to GAO and Mathematica, cost us anywhere from 6 to 28 percent more than the current indemnity plan for Medicare. That is not opinion. Those are, in fact, the numbers. And we have to resist on this committee running off on some of these ideas where we hear what might save money, because we have the luxury of astoundingly accurate projections.

Whether we have been under Republican or Democrat administrations, the predictions of HCFA for what will be spent in the years ahead, have been amazingly accurate when you compare it to other government estimating. I think it would auger well for us to continue to support Medicare, indeed, improve it where we can.

It has the lowest overhead of any insurance plan in this country, returns a higher percentage of premium to the beneficiaries than any insurance company in the country, if not the world, and has less than 4,500 bureaucrats serving 35 million people. There is not an insurance company in the world that can come close to matching that, and the Chairman and I would spot our salaries and staff in there.

Admittedly, we have certain advantages, such as mandatory enrollment. We do have 99-plus percent of all the people over the age of 65, which perhaps Prudential could use and lower their overhead if they had that luxury, not having to have the sales cost. But the fact is we don't serve our 35 million constituents who enjoy Medicare well to unnecessarily trash it.

There is a lot of work to do in this committee, and this committee has a long history, and I am confident that the Chairman will continue that in a balanced fashion trying to improve Medicare, to crack down on fraud, to do away with unnecessary procedures, to cut down on overpayment to providers where it is not necessary, and indeed, to provide additional benefits to the beneficiaries where we are able. And I look forward to working with the Chair to continue that.

We in this committee will not deal with the tax reduction or the repeal of the Social Security tax from 85 to 50 percent. It is important for us to remember that those funds were dedicated to the Medicare Hospital Insurance Trust Fund. So if, in fact, we reduce the Social Security tax, we are taking money out of the Medicare Trust Fund.

We could fix that, for those of you who insist on voting to reduce the Social Security tax, by requiring that we hold harmless the Medicare Trust Fund, and I would like to remind you that we have

those responsibilities, not to destroy Medicare because it is a program that has worked for so long. Now, I have to give credit where credit is due. The Insurance Association of America was the leading factor in destroying health reform last year, and it is only fitting that the first order of business of this committee would be to pay them back by rewarding them with the lead spot on our agenda. And the bill really before us is for the rich.

Tax breaks don't very well favor the 85 percent of Social Security beneficiaries who earn below $34,000 a year in income. And we failed to deal with the abusive practices of companies and the bill does nothing do curb those unfair practices in selling coverage without nonforfeiture benefits or without inflation protection.

So I hope that we can, as we pay off the insurance industry, keep in mind that we must protect the public from unnecessary and often unconscionably inadequate and unfair products.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman for his conclusion.

Now we will begin the process with the first panel. Mark Meiners, who is the associate director, University of Maryland Center on Aging; Stanley Wallack, who is the cochairman of the Coalition on Long-Term Care Financing; and Joshua M. Wiener, who is the senior fellow at the Brookings Institution.

From my right it is Wiener, Wallack and Meiners. Your written testimony will be made a part of the record and you will have 5 minutes to proceed in any manner you choose.

STATEMENT OF MARK R. MEINERS, PH.D., ASSOCIATE DIRECTOR, UNIVERSITY OF MARYLAND CENTER ON AGING, AND NATIONAL PROGRAM DIRECTOR, ROBERT WOOD JOHNSON FOUNDATION PARTNERSHIP FOR LONG-TERM CARE

Mr. MEINERS. Thank you.

Mr. Chairman, and members of the committee, I am Mark Meiners, the associate director of the University of Maryland Center on Aging, and I also serve as the national program director for the Robert Wood Johnson Foundation Partnership for Long-Term Care. The partnership for long-term care is a multi-State, public-private long-term care insurance program that is successfully operating in California, Connecticut, Indiana and New York. The program is designed to encourage the sale of high-quality affordable long-term care insurance by offering special protection for Medicaid's resource limits.

I am pleased to have the opportunity to meet with your committee today to discuss the long-term care insurance provisions in H.R. 8, the Senior Citizens' Equity Act. The provisions supporting the long-term care insurance market development will help keep long-term care from continuing to be the forgotten stepchild in the health care forum debate.

I would like to have this opportunity, also, to thank Congresswoman Nancy Johnson, and Barbara Kennelly for the long support that they have given to the partnership program. We very much appreciate it.

The goals of the partnership are compatible with the long-term care provisions in H.R. 8. After careful consideration of the financing dilemma of long-term care, the partnership States have con-

cluded that support for private insurance is needed to balance Medicaid's role as the payer of last resort. The long-term care insurance market needs a boost.

We as a nation have not yet accepted that the blessing of a longer life carries with it the curse of catastrophic long-term care costs for some of us. Willard Scott's visits to the ever growing population of centenarians are all nice but they don't pay the nursing home bills when it comes to long-term care. Denial is rampant.

This is where the tax features in H.R. 8 can help. At least tax-favored treatment lends a much needed assist with the education of consumers about long-term care insurance as a good way to take personal responsibility in preparing for this risk.

Combined with product standards like those which the partnership States have negotiated, the tax breaks will help us achieve good value for consumers. But the effect will be greater than just education. By treating long-term care insurance like other health insurance, we mainstream chronic care as a real problem that deserves our attention and our dollars. It places long-term care insurance on an even footing with other employee benefits that are considered during financial planning.

Tax-free withdrawals from IRAs and other retirement accounts to purchase long-term care insurance serves to both encourage savings and to even the playingfield for those who haven't benefited from the chance to buy long-term care insurance on a pretax basis.

The impoverishment protection offered by the RWJ partnership States is an important additional incentive that should be encouraged. We would like to see the removal of the language in the 1993 Omnibus Budget Reconciliation Act that has held back the growth of partnership States. The partnership program is designed to help the market while, at the same time, serving as an alternative to transfer of assets. Without the partnership, only inflation-protected lifetime coverage gives complete assurance that a person will not be impoverished by long-term care expenses. With the partnership, high-quality protection can be obtained for more limited, less expensive coverage.

Without the partnership approach, important options such as inflation protection and home health benefits may not get consideration because they add to premium costs. With the partnership, shorter coverage can be viewed as a better alternative to giving up quality features such as these.

In summary, the long-term care provisions of H.R. 8, along with the partnership program can work together to broaden the improved market for long-term care insurance as an important piece of a long-term care financing puzzle.

I thank you for the opportunity to share with you my views on long-term care insurance, and I would be very happy to answer any questions. My written testimony elaborates a bit more on the points and the benefits of the Robert Wood Johnson Foundation Partnership for Long-Term Care.

Thank you.

[The prepared statement follows:]

TESTIMONY OF MARK R. MEINERS, PH.D., ASSOCIATE DIRECTOR
UNIVERSITY OF MARYLAND CENTER ON AGING

Mr. Chairman. Members of the Committee. I am Dr. Mark Meiners, Associate Director of the University of Maryland Center on Aging, and the National Program Director of the Robert Wood Johnson Foundation (RWJ) Partnership for Long-Term Care.

The Partnership for Long-Term Care is a multi-state public-private long-term care insurance program successfully operating in California, Connecticut, Indiana, and New York. The program is designed to encourage the sale of high quality, affordable, long-term care insurance by offering special protection from Medicaid's resource limits.

I am pleased to have the opportunity to meet with your committee today to discuss the long-term care insurance provisions in H.R. 8 - "The Senior Citizens Equity Act." It is my strong sense that the provisions supporting long-term care insurance market development will help keep long-term care from continuing to be the forgotten step-child in health care reform.

I would like to take this opportunity to thank Congresswomen Nancy Johnson and Barbara Kennelly for their long standing help in getting the RWJ Partnership for Long-Term Care implemented.

The Partnership program is grounded in the recognition that neither the public nor the private sector could, or indeed should, shoulder the financing burden of long-term care by itself. Yet the way we currently share the burden is a vicious cycle of out-of-pocket spend-down until impoverishment, at which point Medicaid will help. That is, unless you are well-to-do and savvy enough to get yourself a good lawyer to hide your resources. Typically it is the middle class that finds itself most on its own in dealing with long-term care costs. After careful consideration of this financing dilemma the Partnership states have concluded that support for private insurance is needed to balance Medicaid's role as the payer of last resort.

Simply stated, the long-term care insurance market needs a boost. We as a nation have not yet accepted that the blessing of a longer life carries with it the curse of catastrophic long-term care costs for some of us. Willard Scott's visits to the ever growing population of centurgenarians are nice but they don't pay the nursing home bills. When it comes to long-term care, denial is rampant.

This is where the tax features in HR 8 can help. At the very least tax favored treatment lends a much needed assist with the education of consumers about long-term care insurance as an way to take personal responsibility in preparing for this risk. This fact was recognized as far back as 1986 when former Health and Human Services Secretary Bowen's report on catastrophic illness called for a $100 tax credit targeted to the elderly. Though modest in size, the tax credit was included in the recommendations primarily for the education effect it could have on the market.

But the effect will be greater than just eduction. By treating long-term care insurance like other health insurance we mainstream chronic care as a real problem that deserves our attention and our dollars. Allowing long-term care insurance to be purchased on a pre-tax basis will encourage more employers to include this coverage in

their fringe benefit options. It places long-term care insurance on an even footing with other employee benefits that are considered during financial planning. Also, the earlier the purchase the more likely a person is insurable and able to adequately prepare for this risk by prefunding their premiums.

Tax-free withdrawals from IRAs and other retirement accounts to purchase long-term care insurance serves both to encourage saving and to even the playing field for those who hadn't benefited from the chance to buy long-term care insurance on a pre-tax basis. Tax deductions for long-term care insurance is another approach to encourage saving for chronic care needs.

The impoverishment protection incentive offered by the RWJ Partnership States is an important additional incentive that should be encouraged. We would like to see the removal of the language in the1993 Omnibus Reconciliation Act that has held back the growth of Partnership states. The RWJ Partnership strategy for encouraging the market is an excellent compliment to the long-term care insurance tax benefits outlined in HR 8 and states should be allowed to implement the Partnership Program if they so choose.

The Partnership Program is designed to help the market by improving the quality and affordability of long-term care insurance while at the same time serving as an alternative to asset transfers. Without the Partnership, only inflation protected lifetime coverage can give complete assurance that a person will not be impoverished by long-term care expenses. With the Partnership this same assurance can be obtained from more limited, less expensive coverage.

Long-term care insurers are faced with the difficult dilemma of trying to improve products while keeping them affordable. States are additionally interested in making sure that the market includes the many middle income purchasers who might not consider buying long-term care insurance because they had limited resources to protect and could not comfortably spend enough on insurance to get meaningful lifetime protection from impoverishment. Yet they are most at risk of spending down to Medicaid eligibility levels when they need long-term care which also makes them likely candidates for divestiture.

Without the Partnership approach it is likely that the market will go more in the direction of an up-scale sale; the type that would not likely be of much concern to long-term care policy makers except to the extent it could serve as an alternative to divestiture. Important options such as inflation protection and home care benefits would not get appropriate consideration because they add premium costs. With the Partnership, shorter coverage can be viewed as a better alternative to giving up these features.

The Partnership helps make long-term care more affordable and more valuable and therefore more attractive than the benefits of insurance alone. The Partnership States selected the strategy of linking the purchase of long-term care insurance to Medicaid eligibility after considering a number of alternative options. They see it as a way to target their support for the private market directly

to those areas of greatest public interest. The strategy is fiscally conservative, helps middle income people avoid impoverishment, serves as an alternative to divestiture, promotes better quality insurance products, builds consumer protection, and helps maintain support for Medicaid.

The Partnership provides a fiscally conservative form of premium subsidy. Only those who buy a policy and use the benefits get the special protection. Program related expenditures would be well after the program had begun and savings would be occurring to cover those costs. In contrast, traditional premium subsidies (including tax breaks) entail public expenditures at the time of purchase for all purchasers. Our estimates suggest that the Partnership strategy is at least budget neutral with some potential for Medicaid savings.

The Partnership gives middle income people a way to get help with catastrophic long-term care expenses without becoming impoverished. Under special arrangements with the state, insurance companies that specialize in long-term care can assure their policy holders they no longer have to go broke to qualify for Medicaid. The assets protected under the Partnership can mean the difference between autonomy and dependence if a policy holder exhausts their insurance and still needs assistance.

Buyers also don't have to resort to legal maneuvering to hold onto their savings. The Partnership policies are an alternative to transferring assets to relatives or friends to avoid spending hard-earned savings on long-term care. Participants can control their funds instead of worrying about how someone else might be handling their money. They also don't have to worry about current government efforts to stop Medicaid gaming. The States, on the other hand, can now pursue such efforts with less controversy, knowing people are being given a reasonable alternative.

The Partnerships bring the states into a close working relationship with insurers, providing both the means and the incentive to monitor insurer performance. Partnership policies are subject to a rigorous review and carry a stamp of approval from the states indicating they have meet rigid state certification requirements. As part of the program, educational campaigns are increasing awareness about the lack of protection and their financial options.

Finally, the Partnership Program can help mitigate concerns about means-testing; that programs for the poor are poor programs because they lack broad-based political support. By linking the Partnership incentive to Medicaid the constituency for the means-tested program can be enhanced rather than eroded. This is an important consideration as we contemplate health care reform. If a comprehensive long-term care program is neither fiscally or politically feasible, as was indicated by the details of the Clinton Plan, then incremental improvements to Medicaid may be the best bet for positive future developments. However, Medicaid's long-term care benefits cannot be sustained, much less improved, unless affordable and appealing private market financing options can serve to encourage people to plan for their own long-term care needs as much as possible.

In summary, the long-term care provisions of HR 8 along with the Partnership Program can work together to broaden and improve the market for long-term care insurance as an important piece of the long-term care financing puzzle.

Thank you for this opportunity to share with you my views on long-term care insurance market development. I will be happy to answer questions you may have.

Chairman THOMAS. Thank you.
Mr. Wallack.

STATEMENT OF STANLEY WALLACK, CHAIRMAN, COALITION ON LONG-TERM CARE FINANCING; AND DIRECTOR, INSTITUTE FOR HEALTH POLICY, BRANDEIS UNIVERSITY, FACULTY MEMBER, HELLER GRADUATE SCHOOL AT BRANDEIS

Mr. WALLACK. Thank you.

I am here representing a coalition that is involved with long-term care reform. The coalition is made up of people from the research community, insurance companies and providers. I appreciate the opportunity today to discuss the Senior Citizens' Equity Act. Because the coalition agrees with many of the specifics in the act, I really want to spend most of my time discussing the importance of the policy.

This committee knows all too well the problems you face in dealing with the Federal budgets over the next few years and the growth of entitlement programs, and I think you will have to be looking for both solutions in the short run and in the long run. And clearly, for the long-run solutions, you need to think about innovative ways that the Federal Government can solve social problems.

The Federal Government needs to solve social problems not just by taking over the financing of them. I think one of the first tests of this new thinking is with regard to long-term care, and this committee has the opportunity to deal with that.

After looking at this problem, I personally took a leave from Brandeis University in 1987 to get involved with the long-term care insurance development of the marketplace to see if the private sector can help solve this problem. And I think we can solve it with a limited amount of government funds. But I don't think we can solve it without the government getting involved. And I think that one of the big lessons I learned in the last few years is that to solve a social problem we have to have the government involved in a partnership with the private sector.

Now, I think the private sector, as you will learn today, is growing and is trying to solve part of the problem. There are over 100 companies involved in selling long-term care insurance. Over 3 million policies have been sold. But what is most interesting is that the product has really improved over the last 10 years. The benefits are much more comprehensive. Benefits are being triggered when someone hits a disability level.

What is most interesting and most important is that the value of these products has improved over the years. The typical purchaser of a long-term care insurance product is 65 to 70 years of age today. They get between 4 and 5 years' worth of coverage and pay about $100 a month in premiums. Now, if they were to go into care right away, 85 to 90 percent of their expenses would be covered. Less of it is covered depending on when they go in, depending on the rate of increases in inflation.

It is very important to point out that even with this growth, relatively few people have bought long-term care insurance; 4 to 5 percent of the elderly population have bought it. And I think one of the reasons for that is the biggest competitor against the private

market is the Federal Government and the government programs. People look to the Federal Government to deal with social welfare problems, particularly older people. And the government needs to do a number of things to get the population to take over this responsibility for themselves.

Certainly, you have to educate. And we need Federal standards for long-term care insurance. I think we have to rethink the public financing programs and how they fit with the private financing programs. A positive thing to do is tax clarification. I think that the value of this could be very significant.

First of all, long-term care is an ideal event to be insured for. A relatively small percentage of the people have large expenses, therefore insurance makes a great deal of sense. To appreciate the potential of tax clarification, I think the best example is to look at the fifties and the growth of acute care health insurance when we had tax clarification. It is, in fact, when the market developed.

Now, if we have tax clarification, it would be better for the consumer. The price will fall. But what I think is more important is that the attitudes of the consumer will change with regard to their view of insurance. And this, I think will cause the biggest change. A change in attitude about people taking on responsibility.

The likely impact, I think, could be very significant. When LifePlans did a survey of people who were not purchasing long-term care insurance, what we found is that 80 percent of them would reconsider if in fact there was tax clarification. The other savings, and I think Mark will talk about it more, is that Medicaid could save significantly if people buy long-term care insurance. It will stop people from spending down.

LifePlans has estimated in a published study that for each policy that is bought by individuals, Medicaid could save around $2,000.

Let me turn briefly to the specifics of this bill. With much of it, we are in agreement. We certainly believe some technical improvements can still be made. One thing that I find troublesome is with regard to who is qualified to get home care benefits. The way the current bill reads, is that to be qualified for home care, one has to be really needing to go into an institution. That really was not the intention of a lot of long-term care insurance products.

You, in fact, want people to be able to get care in their home. That is why people are buying this product. And we think it would make more sense to have the benefits geared with the level of disability.

Another one, which I don't have time to talk about, is the importance of coordination with private and public programs. And here I think there is a very big issue with regard to Medicare and home health care, which I hope this committee will address, and the growth in Medicare toward becoming a chronic care program.

This rapid growth, I believe, is related to the fact that Medicare is now serving the chronically ill people, as opposed to the acutely ill people. This committee needs to make some policy decisions on that.

I do think that the potential of long-term care is very exceptional in helping individuals have independence and having individual choice. I think that it would take an awful lot of fiscal pressure off of the Federal Government, both Medicare and Medicaid. And I think this committee should look at tax clarification as an investment in the future, because if you don't encourage people to buy private long-term care insurance and take care of their own costs, it is going to lead to more pressure on Medicare and Medicaid.

Thank you.

[The prepared statement follows:]

TESTIMONY OF STANLEY WALLACK
COALITION FOR LONG TERM CARE FINANCING

Good morning, Mr. Chairman and Members of the Subcommittee on Health. My name is Stanley Wallack and I am Chairman of the Coalition on Long-Term Care Financing. I also am the Director of the Institute for Health Policy at Brandeis University and a faculty member of the Heller Graduate School at Brandeis. In 1987, I founded LifePlans, a long-term care managed care company.

I am here today on behalf of the Coalition on Long-Term Care Financing which represents a diverse group of researchers, leading insurance companies offering long-term care insurance coverage and providers of long-term care services. Coalition members are united by a common commitment to the establishment of a strong partnership between the public and private sectors in financing long-term care services.

The Coalition appreciates the opportunity to testify on a matter of critical importance to consumers, providers and insurers of LTC services: to identify the most appropriate and fiscally responsible roles for the public and private sectors in financing LTC services and creating the incentives necessary to promote these roles and responsibilities. To this end, we very much appreciate the leadership demonstrated by sponsors of the Senior Citizens' Equity Act by including tax clarification of LTC insurance products in this bill. We believe that such an action will significantly enhance the marketability of LTC insurance policies by: (1) creating financial incentives to purchase LTC policies; and (2) sending a strong signal to the marketplace that the government considers this a legitimate approach to financing LTC services.

Mr. Chairman, my written testimony addresses several critical issues related to the establishment of a solid public-private partnership in LTC financing. These include:

* clarifying the tax status of LTC policies and other instruments for financing LTC services such as medical savings accounts;

* enacting federal standards governing private LTC insurance policies to assure consumers value in such policies;

* clarifying the role of the federal government in covering home health care services under the Medicare program to eliminate the confusion about Medicare home care coverage and the ambiguity about public and private sector roles in financing these services; and

* identifying more rationale alternatives for government involvement in the financing of LTC services than that represented by current Medicaid programs.

At your request, I will limit the bulk of my oral statement to the tax clarification provisions in the Senior Citizens' Equity Act. However, I ask your indulgence in allowing me briefly to address a related matter that has great fiscal significance to the Federal government and important implications for the development of a growing and innovative private market.

I. BACKGROUND

A. The Problem and Need for Federal Involvement

I want to begin my testimony by emphasizing the importance of a meaningful public/private sector approach in the financing of LTC. This debate is not occurring in a vacuum. Great strides already are being made with respect to innovations in the private market. Little more than ten years ago, many LTC insurance policies were limited primarily to skilled nursing facility services following a hospital stay. In response to consumers' demands for broader coverage of a variety of benefits, however, today's products provide comprehensive coverage of the full range of LTC benefits from home and community-based services through institutional care. Further, virtually all products offered by leading carriers have eliminated provisions limiting access to coverage, such as prior hospitalization and level of care requirements.

All too often, those supporting a public/private partnership are only providing lip service to this idea. We are not far from 2010, when the baby boom generation will reach retirement age and

the number of disabled accelerates rapidly. LTC expenditures will increase exponentially when this happens. Without addressing the issue of public and private sector roles today, there will be pressure for more government assistance in the future.

In 1993, national LTC expenditures totalled $108 billion. About 65% was paid by the Federal and state governments and about 35%, out-of-pocket. If current LTC spending patterns persist, LTC expenditures will more than double in the next 25 years. The Medicare and Medicaid programs represent the two fastest growing entitlement programs. Federal spending for Medicare in 1992 was $119 billion. It is projected to reach $189 Billion by 1995 and $310 billion by 2000. Medicaid spending reached almost $125 billion in 1993 and is projected to reach $360 billion by the year 2000.

Although the elderly accounted for only 11.5 percent of the Medicaid case load in 1993, expenditures for this group totalled 28.4 percent of spending. Likewise, while the disabled accounted for 15.5% of Medicaid beneficiaries, close to 40% of Medicaid dollars were spent on their care. The disproportionate share of Medicaid dollars spent on the elderly and disabled will only continue to increase as the elderly population grows. Between 1992 and 1993, the number of Medicaid beneficiaries grew by 8.8%, but two-thirds of the increase in Medicaid spending during this period was attributed to the growth in enrollment. Per capita spending grew only 2%.

Currently, the fastest rising budget expenditure for both Medicare and Medicaid is for home care. In the next six years, expenditures on home care are expected to double, even in the absence of any major programmatic changes. This growth reflects an increasing need for services as well as an inability to manage acute and chronic populations and to accurately define service norms. If the record growth in Medicare home health care expenditures were to continue, they could exceed Medicare physician payments in the next ten to fifteen years.

For these and other reasons, the Coalition believes that the Federal government must be clear about the services it will and will not pay for and what it expects of individuals in terms of personal and private responsibilities. We should not overlook the opportunity and importance of encouraging private sector involvement in the financing and managing of LTC services.

The history of social welfare programs in this country, as well as the particular interests of the private and public sector strongly suggest that, over time, LTC services will be financed by a mix of public and private programs. To assess what mix would work best, it is important to determine what each sector can do as well as to evaluate what each sector should do. Private LTC policies have evolved over the past decade. Market forces have been effective in shaping policy configurations as well as their cost. In general, policies today are more far more comprehensive than first generation policies. Consumers also receive more value per dollar of premium than in the past. However, the number of policies sold continues to be low in comparison with the proportion of elderly who could afford to buy them. This will remain the case until the Federal government clearly and unequivocally defines its own role in this area.

Older people look to the Federal government for signals on financing LTC needs. At no time was this more evident than in 1993 and 1994 when Congress was debating health care reform. Members considered a series of options for LTC from a non-means tested home care program for the severely disabled to a public insurance program for nursing home services. During this time, interest in LTC insurance dropped noticeably. Insurance company members of the Coalition experienced fewer responses to invitations to discuss LTC insurance products as well as a reduction in actual sales. Following the end of the formal debate in 1994, interest in exploring product options and sales began to rise again. Only if the Federal government is supportive and sends the proper signals will the private market approach its full potential. It must take the lead in recognizing the viability of private LTC insurance and establish incentives that will promote the evolution of this market such as tax clarification and federal standards for policies.

B. Private Market Potential

The private market consistently has spearheaded efforts to enhance financial protection against LTC risk in the past decade. Data collected by the Health Insurance Association of America for policies sold in 1992 reflects the growth in the private market place. Currently, 135 companies offer LTC insurance coverage. Since 1987, the number of policies sold has increased from 815,000 to almost 3 million at the end of 1992. The number of policies sold has grown an average of almost 30 percent annually. The majority of LTC insurance policies, about 82 percent, have been sold to individuals or through group associations.

Sales through the employer market and life insurance market, while a smaller percentage of total sales, also have increased dramatically. In the past five years, the number of policies sold in the employer market has grown from 20,000 in 1988 to over 350,000 in 1992. This represents an average annual growth of over 100 percent. Employer policies comprised over 12 percent of the market at the end of 1992. During the same period, the number of life riders sold has increased to over 157,00 policies, representing an average annual growth of over 300 percent. Life riders now represent over 5 percent of the LTC insurance market.

Coalition members believe that these markets hold great promise for the future expansion of private LTC insurance coverage since the average age of purchasers is much lower than in the individual market and premiums are much lower as a result of younger aged purchasers. While the average age of buyers in the individual market was 68 in 1992, the average age of purchasers in the employer and life insurance markets was 42 and 38, respectively.

LTC insurance coverage has continued to expand in response to consumer demand. HIAA analyzed policies of the top fifteen LTC writers representing 80 percent of the market of all individual and group association policies sold in 1992. All products analyzed offered coverage for skilled, intermediate and custodial nursing home care, home health care and adult day care services, and inflation and nonforfeiture protection. In addition, 80 percent of the policies covered alternate care services and 93 percent covered respite care. Daily benefit offers ranged from $40 to $200 per day for nursing home care and $20 to $100 per day for home care services.

II. COALITION POSITION

A. In General

The Coalition supports four key strategies for promoting public-private partnerships in LTC financing:

* aggressive strategies to educate consumers about LTC risk and options for financial protection;

* tax clarification of LTC insurance policies to provide incentives for consumers to plan for their LTC needs in advance through the purchase of private coverage;

* federal consumer protection standards to ensure that policies provide value to consumers and that this value is maintained over time; and

* public assistance programs for those who cannot afford to protect themselves against LTC risk through private means.

Based on our principles regarding LTC financing reform, Coalition members are pleased to note that the Contract with America includes provisions to clarify the tax status of LTC insurance products. This suggests that Members of Congress recognize the market potential for private LTC insurance. This recognition clearly is warranted by the growth of this market in recent years and the continued refinement of products with a view toward meeting the diverse needs of consumers.

B. Tax Clarification

1. Why Tax Clarification?

The Internal Revenue Service has yet to rule on the treatment of premiums paid for LTC insurance policies and benefits paid out by such policies. The Coalition believes that clarification of the tax status of LTC insurance would significantly enhance the LTC market and is important for the following reasons:

* **Enhance Product Legitimacy:** It would enhance product legitimacy by treating this benefit the same as all accident and health insurance coverage. From a consumer's perspective, if LTC insurance is as important as other insurance coverages such and health, life and disability products, why hasn't the government ruled on its tax status?

* **Expanded Market Penetration:** It would increase consumer interest in purchasing products and employer interest in offering coverage.

* **Reduce Public Spending:** It would reduce the drain on public sector programs, most notably Medicaid and Medicare, through enhanced private sector coverage.

* **Catastrophic Coverage:** LTC is a catastrophic event; those who need LTC services for an extended period of time incur enormous financial expenses. While the government has a responsibility to help consumers determine how to protect themselves against this risk, this does not mean that the government actually has to pay for this risk. Instead, the public sector can encourage individuals to self-finance this risk through insurance mechanisms by providing a financial incentive in the form of a tax benefit.

* **Reduce Costs to Consumers:** Tax clarification of LTC policies will reduce the effective cost of policies to consumers by allowing them to deduct premium expenses as legitimate medical expenses.

We believe the impact on consumer interest would be particularly significant in the group market since most consumers are used to purchasing health insurance benefits through their employer. Based on surveys conducted by the Washington Business Group on Health, the Health Insurance Association of American and others, we believe that tax clarification would increase employer interest in offering LTC coverage and, in some cases, making a premium contribution to this coverage. Employees also would be more likely to purchase policies if their premium contributions were tax free.

2. Potential Impact on Consumer Behavior

During World War II, many employers began offering group health insurance as an employee benefit as a "substitute" for higher wages since there was a wage freeze. Market penetration increased even more dramatically when health insurance coverage was granted favorable tax treatment. By the end of 1991, fully 85 percent of the civilian noninstitutionalized population was covered under a plan. The Coalition believes tax clarification would have a similar impact on the LTC market. The studies identified below provide evidence supporting this belief.

Washington Business Group on Health

The Washington Business Group on Health conducted a survey during the summer of 1991 to determine employer views toward private LTC insurance as a potential employee benefit. Responses were collected from Fortune 500 companies and members of the National Business Coalition Forum on Health, a membership of state, local and regional business coalitions. The two main reasons for offering private LTC insurance cited by survey respondents included: (1) protecting employee/retiree financial security and (2) encouraging greater employee responsibility for benefit planning.

Among the barriers to sponsoring a LTC insurance plan cited by potential plan sponsors were the following:

* Unfavorable tax treatment

* Fear of government mandates for employer contributions

* Feeling that LTC would be added to Medicare or other government programs.

The survey also asked employers about appropriate roles for the Federal government relative to LTC financing. Survey results indicate far more support for Federal roles which promote private sector coverage and individual responsibility than for the expansion of public benefits:

ROLE	PERCENT FAVORING
Tax incentives for personal savings for LTC	86%
Qualification of LTC for flexible benefits plan	70%
Treatment of LTC on same tax basis as medical care	59%
Tax incentives for employer financing of LTC	44%
LTC coverage through Medicare or federal program	23%
LTC coverage through Medicaid	12%

Conference Board

According to a study on employer offerings of LTC insurance protection by the Conference Board in 1991, most sponsors and carriers believe that the provision of a tax credit or deduction to plan participants and/or sponsors will increase both the number of plans offered and participation rates by employees and their families. Employers indicated that the lack of tax clarification "continues to impede their decision making on the best methods to design, administer and upgrade their plans."

Sponsors recommended several approaches for tax clarification of LTC policies:

* Allow employees to pay for all or part of their premiums on a pre-tax basis;

* Develop LTC Income Retirement Accounts and 401(k) plans;

* Provide tax deductions to employers who contribute to LTC benefits.

Employers interviewed for the Conference Board study also stressed two other important roles for the Federal government. First, they felt that the Federal government has a responsibility to increase public awareness about LTC risk and the need to protect themselves. Employers indicated that this would lead to higher participation in employer LTC benefit plans and a consequent reduction in public spending for LTC through Medicaid. Second, employers felt it was critical for the government to define its position on LTC solutions. For example, sponsors suggested that the government focus on the long-term costs of not taking actions to increase private coverage instead of the short-term revenue loss associated with the granting of tax deductions. Sponsors also warned against government responses to LTC financing that would penalize employers who have had the foresight to offer this coverage, such as new entitlement programs.

Buyer-Non Buyer Survey

LifePlans conducted a study on behalf of the Health Insurance Association of America in 1990 to determine who purchases LTC insurance policies, what motivates them to buy such policies and what kind of policies they purchase. LifePlans simultaneously collected data from a group of individuals who elected not to purchase coverage to identify similarities and differences between the purchasers and nonpurchasers.

Respondents who elected not to purchase private coverage were likely to reject coverage based on cost (too expensive), their inability or unwillingness to spend more money on additional insurance coverages or the belief that policies needed to be improved. Further, nonpurchasers were far more likely than purchasers to believe that the federal government should provide universal coverage of LTC benefits.

These findings underscore the critical importance of the government's role in public education about LTC insurance products for several reasons. First, research conducted by LifePlans indicates that about 30 to 40 percent of those 65 and above could afford a private LTC policy that would cover the majority of their expected lifetime expenditures on LTC services. The typical policy purchased by the over 65 population in 1991 provided over five years of nursing home care with benefits of $70 per day and one third of purchasers selected inflation protection. This typical policy cost about $100 per month. The benefits provided under this policy would cover the entire duration of service utilization for 85-90% of those purchasing coverage.

Almost 70 percent of Medicare beneficiaries 65 and older purchase Medigap coverage which costs roughly the same price as an average LTC policy. The affordability of this coverage is even more dramatic for the under 65 population, particularly employees who have the added benefit of receiving a group discount. Therefore, we strongly believe that the affordability issue so often raised is really a matter willingness to pay for LTC coverage, not financial ability to purchase such coverage.

Second, consumers might be more willing to purchase private LTC coverage if they understood the risk they face without insurance. With the tremendous amount of press this issue has received in recent years, it is difficult to conceive of the number of consumers who still believe that their LTC needs will be met by Medicare, private health insurance or other government programs. Public education about this risk is essential to dispelling these misconceptions.

Third, consumers need better information about how to evaluate the quality of products. As mentioned above, products have improved light years since the first generation policies were released. Because the market has received such negative press from advocates of government-sponsored insurance programs, however, consumers are often distrustful of these products. In this regard, the Coalition acknowledges that the insurance industry has to do a better job of promoting the value of these products as well. In addition, we believe that federal product standards would enhance consumer confidence in LTC policies.

Non purchasers indicated that the following government actions would make them more likely to purchase coverage:

	ACTION	PERCENT FAVORING
*	If the government would give them a tax break for purchasing a policy.	80%
*	If the government would give a seal of approval to certain products.	64%
*	If the government provided information on how to choose an insurance policy.	59%

Consistent with the WBGH and Conference Board surveys, the LifePlans study demonstrated that tax clarification of LTC products would increase consumers' interest in purchasing policies. The study also underscores the importance of a "government seal of approval" vis-a-via product standards and a role in public education about LTC risk.

3. Specific Recommendations for Tax Clarification

The Coalition supports most of the provisions in the Senior Citizens' Equity Act with respect to tax clarification. Benefits to the individual up to the maximum limit would be tax-free,

employer contributions toward premiums would be a tax-free fringe benefit, and LTC expenses would be treated as other medical expenses. We also appreciate some of the changes made to the legislation prior to introduction such as modifications made to the treatment of tax reserves and the inclusion of transition rules which would prevent current policy holders from being penalized.

Below is a brief summary of our position on the tax clarification provisions in the Senior Citizens' Equity Act. We believe that several technical changes may be necessary to ensure that the intent of Congress is carried out. The Coalition would like to go on record as supporting the following provisions:

Tax Reserves: The Coalition appreciates the inclusion of a provision to conform the tax treatment of LTC reserves with the statutory reserving requirements. All other insurance lines are permitted to take a deduction for reserves when they are established. Currently, the federal tax code in unclear as to when companies are allowed the deduction for LTC insurance. Consequently, in second year the policy is inforce, the company pays approximately 70% of premium income is taxed. This clarification is of critical importance to the growth of this market.

Effective Date: We support the effective date provisions for newly issued and existing policies. This provision would allow current policy holders to be eligible for tax-favored treatment if their policy met the state requirements at the time it was issued. This provision will prevent individuals who had the foresight to plan in advance prior to the enactment of this law from being penalized and effectively will reward them for planning for their LTC needs.

Maximum Benefits: The Coalition appreciates the inclusion of a maximum daily benefit of $200 since it recognizes the high cost of LTC in certain parts of the country. Previous legislation set this limit much lower and would have penalized those who live in high cost areas. We also appreciate the provision which would tax as income only those benefits that exceed the limit. Prior legislation would have disqualified all benefits under a policy that exceeded the daily limit.

The Coalition requests several additional revisions to the Senior Citizens' Equity Act which are described in more detail in HIAA's testimony. These include the following:

Treatment as Accident and Health: We request that LTC benefits be treated as accident and health insurance for policyholders and insurers. In addition, we request that LTC insurance benefits be treated as payments for the loss of bodily function under Sec. 105(c) of the I.R.S. Code. This clarification would conform to the eligibility criteria employed by most LTC insurance policies today; i.e., benefit eligibility based on the inability to perform a specified number of activities of daily living such as eating, dressing, bathing, etc.

Per Diem Policies: Per diem policies pay a fixed amount when the beneficiary meets the eligibility requirements. These policies should be treated as qualified LTC contracts with respect to coordination with Medicare.

Employer Deduction for LTC Premiums: The legislation should clearly specify that LTC insurance policies are not treated as deferred compensation plans. This will assure employers' ability to deduct contributions to these policies as a legitimate business expense.

LTC Premiums: We request that the current limitation on qualified premium levels be eliminated. This provision is unnecessary since the 7.5 percent AGI floor already limits significantly the amount of premiums individuals would be allowed to deduct. No other health insurance policies limit the amount an individual can deduct. Furthermore, we believe that the implied concern that individuals will "over-insure" or use per diem policies as an annuity benefit is unfounded. Experience to date demonstrates that, if anything, individuals are likely to underinsure for LTC risk. It also is important to note that while the average age of purchase in the individual market is about 68, 10-15 percent of purchasers are 75 and above. These individuals will have higher than average premiums by virtue of their age and should not be penalized by excluding part of their premiums from the tax deduction.

Chronically Ill Individual: The definition of chronically ill individual needs to be clarified. Paragraph (B)(iii) pertaining to Activities of Daily Living should be clarified in two ways. First, (B)(iii)(I) lumps toileting and continence into one single ADL. This is not a clinically accurate definition. The major ADL scales such as Katz separate toileting and continence into 2 different ADLs since they involve disabilities in two different bodily functions -- one voluntary (toileting) and the other involuntary (continence). Second, the legislation should clarify that bathing is also a separate ADL, i.e., not related to toileting or continence. We also request that mobility be dropped from the list of ADLs since it is not commonly used by carriers as an ADL.

These changes would result in the following six clinically accepted measures: bathing, dressing, transferring, toileting, continence and eating. We support setting the eligibility standard at 2 out of 5 ADLs, but recommend that companies be allowed to choose any five out of the six designated ADLs. We believe that it is too early in the product's development cycle to standardize this feature.

Qualified Facility: The bill defines "qualified facility" as an individual's home <u>if a licensed health care practitioner certifies that without home care the individual would have to be cared for in a hospital, skilled or intermediate care or similar facility.</u> This language requires that an individual be nursing home certifiable in order to qualify for tax benefits under a LTC insurance plan. This requirement is completely inconsistent with the intent of private LTC insurance policies which are designed to provide as broad a range of coverage across the continuum of care possible. Such policy design specifically responds to consumers' desire for choice of the type of services and settings they can use to meet their LTC needs. Further, it effectively makes the eligibility criteria much more stringent than the criteria described in Sec. 818A(c)(2)-Chronically Ill Individual. We believe that this discrepancy would be confusing and misleading to consumers. The Coalition requests that this language be modified as follows: "if a licensed health care practitioner certifies that the individual meets the eligibility criteria described in Section 818A(c)(2).

Cafeteria Plans: The legislation should clarify that LTC insurance can be offered through a cafeteria plan as a strategy for increasing employer-based coverage.

Parents and Grandparents: The bill should provide that policies covering parents and grandparents are treated like policies covering dependents.

4. Medicare Duplication

The Coalition supports Sec. 818A(a)(10)(B) which requires coordination between LTC insurance policies and Medicare. Many LTC policies currently include this coordination function. Coordination of Medicare and LTC policies has the following advantages:

* results in lower premiums, since the LTC policy would pay only for excess coverage (and effectively prevents consumers from "overinsuring" by virtue of duplication);

* extends the life of the policy since the lifetime benefits are only reduced by the amount paid for LTC services in excess of other (i.e., Medicare) coverage;

* reduces health care inflation by not requiring multiple payments from different policies for the same services;

* demonstrates consistency with health care reform goals related to integration and coordination of acute and LTC services.

This provision clarifies an amendment to the Social Security Act enacted as part of HR 5252 which would have had the effect of prohibiting coordination of benefits between Medicare and LTC policies for two reasons. First, HR 5252 makes it illegal to sell to Medicare beneficiaries a health insurance policy that duplicates any benefits to which the individual would otherwise be entitled (under Medicare, Medicaid or other private insurance) unless (1) the policy pays benefits without regard to other coverages. We find this provision extremely contradictory. It

essentially says that policies are prohibited from duplicating coverage, but they may duplicate coverage if both policies pay benefits without regard to each other.

The second requirement for "waiving" the prohibition against duplication is that the carrier must disclose the extent to which the LTC policy duplicates coverage with Medicare or other insurers. Currently, it would be impossible to determine where Medicare and LTC insurance policies coordinate because Medicare coverage decisions are not consistent. This is particularly true of coverage decisions regarding home health care benefits. To address this issue, we request further clarification of the amendment in HR 5252 by specifying that LTC policies that coordinate coverage with Medicare are not considered to duplicate Medicare coverage. Without this clarification, the amendment would have the effect of penalizing private insurance companies for the lack of clarity regarding Medicare coverage policies for home care benefits.

C. Medicare Home Care Coverage

The Coalition firmly believes that tax clarification of LTC products and the establishment of federal standards will significantly enhance the growth of this market. As I mentioned above, however, to realize the full potential of this market, it is critical that the Federal government clearly and unequivocally define its role in this market. Medicare coverage of home health care benefits provides a good example of why this is so important.

Medicare coverage of home health care benefits originally was conceived as a short-term benefit. To be eligible for coverage, an individual had to have been hospitalized prior to receiving home care and be in need of skilled nursing services. Had the Medicare program continued to operate under these rules, the consumer's responsibility for covering longer term services related to chronic conditions -- as opposed to short-term services of a recuperative nature -- would be fairly clear. Similarly, the type of coverage needed under private LTC insurance policies to pay for home health care services in excess of the Medicare benefit would be clear.

Throughout its history, however, the Medicare program has changed to incorporate medical services such as skilled nursing care and rehabilitative care and social services such as homemaker and chore services. Perhaps the most important change in the definition of the Medicare home care benefit occurred in August 1988. at that time, HCFA released the modified Health Insurance Manual known as HIM-11. Revised eligibility rules meant that clients with both acute and chronic care needs could receive supportive services and that a range of home care services could be provided to those with purely chronic care needs. The result of these modifications has been a rapid expansion in all facets of Medicare home care and a dramatic escalation in spending. Medicare home care spending grew from about $2.1 billion in 1988 to $7 billion in 1991 to $11.7 billion in 1993.

Below are examples of increases in the percentage rate of growth in Medicare home health care services by category:

CATEGORY	1987-1988 (Pre-HIM-11)	1988-1989	1989-1990
TOTAL VISIT CHARGES	11%	33%	56%
PERSONS SERVED	2.4%	7.7%	14%
AVERAGE CHARGE PER VISIT	6.4%	6.5%	4.9%
AVERAGE NUMBER OF VISITS PER PERSON	4.4%	12.5%	33.3%

The rapid growth in expenditures reflects both a changing profile of individuals receiving the benefits as well as a change in the mix of services needed to care for people. Whereas prior to implementation of the HIM-11 change, most individuals required primarily skilled services, after the change, many people with chronic needs appeared to be served by the program. This was reflected in both the client profile as well as service packages provided to clients. A preliminary study of a sample of beneficiaries conducted by Brandeis University showed that many have limitations in at least two activities of daily living, a common criteria for characterizing a chronic care population or those with cognitive impairments. While almost all receive at least one skilled service, many also received less-skilled services. And irrespective of diagnostic grouping, most individuals received multiple skilled and unskilled services.

A finding of concern from the preliminary study was that no clear pattern existed between the types of services received and their primary diagnosis. This suggests that there is a considerable amount of discretion available to home health care agencies and that factors other than primary diagnosis are likely play an important part in explaining the allocation of services to individuals. Similarly, it was difficult to discern clear norms of care for individuals of similar profiles and significant practice variations across geographic region and by provider type (nonprofit vs proprietary) were observed.

The development of an effective public/private partnership in the financing of home health care and related services will require a clear delineation of responsibilities between Medicare and private insurance or other private financing. The situation insurance carriers currently face with respect to the Medicare non-duplication issue is a case in point. Carriers will be hard pressed to develop "wrap-around" coverage as long as Medicare coverage determinations are determined in an arbitrary fashion, much less advise their clients about their coverage needs.

Equally important, if Congress is serious about getting federal spending under control, it needs to revisit the original intent of the Medicare program to determine if this program should continue to provide coverage for acute and recuperative services or if the program should be expanded to cover long-term chronic illness. This is a critical public policy decision since the latter decision would effectively result in federal LTC insurance for the elderly and disabled. The financial implications of creating a new Federal entitlement for LTC services are enormous and would require a significant shift in current spending priorities.

Coalition members believe that a more rationale policy would be to continue relying on Medicare for acute and recuperative stays of a short term nature and on private financing for longer term illness of a chronic nature. This will require clarifying existing coverage rules under Medicare and possibly reinstating a limit on the number of home care visits for which beneficiaries would be eligible. Program and implementation rules that must be considered include the following:

* **The lack of a clear definition of what constitutes home care:** Almost all services that can be provided in the home and are deemed by a physician to be "medically necessary" are now reimbursable under the program.

* **The lack of consistency across agencies:** The lack of clear benefit triggers leaves great discretion to the physician and agency regarding the type of services to be provided, and leaves significant leeway to agencies regarding the intensity of service delivery.

* **The lack of consistency in patterns of care:** There is little discernable relationship between an individual's primary diagnosis and the package of services she or he receives.

* **The lack of accountability in the role of the physician and home health care agencies** in determining eligibility for services and the nature of services.

Mr. Chairman, the Coalition will be conducting additional research regarding this issue and identifying more specific recommendations on how to solve these problems over the next six months. We will be happy to share these recommendations with you and other Members of

Congress. In fact, we believe this issue warrants further investigation by the committee through a separate hearing devoted to this topic.

D. Federal LTC Insurance Standards

The Coalition supports appropriate federal standards for consumer protection to ensure that LTC insurance policies have initial and continued value. To ensure access to affordable protection, however, any federal legislation must strike an appropriate balance between the extent of policy requirements and affordability. In addition, contrary to several bills introduced last year, states should not have the right to mandate additional measures as a requirement for sale in their state. The state's ability to preempt federal standards is inconsistent with the intent of federal standards which have been designed, in part, to create greater uniformity across products. While we support a state's right to require additional standards in order to receive state certification, carriers should not be prohibited from selling policies that meet federal standards.

We strongly urge the establishment of standards that, when combined with effective enforcement mechanisms, ensure that individuals know the value of what they are purchasing and ultimately receive that value. The Coalition believes that LTC insurance plans must be understandable, fairly and appropriately priced and clearly articulated. To assure that value is maintained over time, we support procedures for appropriate policy pricing, establishment of required reserves and disclosure of information concerning the financial strength of insurance companies -- areas over which the consumer has little or no control. Additionally, we support the establishment of standards at the outset to ensure that benefits will be paid as promised.

Coalition members support most of the provisions included in the 1993 version of the Model Act and Regulation adopted by the National Association of Insurance Commissioners. For example, we support the following consumer protection measures:

1. **Requirements:**
   * guaranteed renewability
   * coverage of Alzheimer's Disease
   * offer of inflation protection
   * offer of nonforfeiture benefits
   * 30 day free-look period
   * delivery of detailed outline of coverage and shopper's guide
   * provision of continuation or conversion coverage for group policyholders
   * auditable marketing standards to assure fair and accurate comparison across policies

2. **Prohibitions:**
   * post claims underwriting
   * prior-hospitalization requirements
   * preexisting conditions exclusions
   * marketing practices such as twisting and churning;

3. **Sanctions:**
   * civil monetary penalties for agents and insurers who violate regulations

The Coalition also supports numerous consumer protection provisions which exceed requirements in the current NAIC Model Act and Regulation such as:

* requiring insurers to establish: LTC education and training programs; procedures for monitoring sales practices of agents; meaningful update protection programs; a thorough claims process which includes a written explanation of filing procedures; clear and thorough written definitions of benefit eligibility criteria to be presented at the point of sale.

* mandating the use of benefit eligibility criteria using clinically-based empirical research in the area of disability and LTC;

* establishing minimum standards for LTC insurance reserves and criteria for evaluating insurer reporting data.

Conclusion

The Coalition believes that sponsors of the Senior Citizens' Equity Act have taken a very important first step toward promoting a public/private partnership in LTC financing by creating strong incentives for the purchase of private policies. We also believe that additional steps must be taken both to enhance consumer confidence in this market and to clarify consumers' understanding and expectations regarding the level of support and protection they can anticipate from the government versus the amount of coverage they will be responsible for themselves.

The Coalition believes that the most efficient way to divide public and private sector responsibilities and minimize confusion regarding coverage is to: (1) relate eligibility for public LTC benefits to financial need; and (2) provide strong incentives for those who can afford to self-insure to do so through savings, private insurance, medical IRAs, etc. Financial incentives will promote wider penetration of private insurance and savings vehicles for those with the financial ability to protect themselves.

Coalition members appreciate the opportunity to address these important issues. We stand ready to assist the Subcommittee in any way we can.

Chairman THOMAS. I thank the gentleman for his timing as well as his statement.

Mr. Wiener.

STATEMENT OF JOSHUA M. WIENER, SENIOR FELLOW, THE BROOKINGS INSTITUTION

Mr. WIENER. Thank you, Mr. Chairman.

The current system of long-term care financing is a mess. Catastrophic costs are routine, welfare dependence on Medicaid is routine. The system is biased toward institutional rather than home care services. To meet this need, a small but growing private long-term care insurance market has developed.

In my testimony, I make basically four points: One, while a lack of clarity about the tax status of private long-term care insurance is a barrier to its growth, the real barrier is the high cost of good-quality policies.

According to data from the Health Insurance Association of America, good-quality policies at age 65 cost $2,228 a year per person. If not bought until the age of 79, they cost $7,000 a year. There are a variety of studies that have found that only 10 to 20 percent of the elderly can afford private long-term care insurance.

Two, employer-sponsored policies are a way to solve the affordability problem. A tiny but growing market is developing. Lower premiums exist in the employer market because people have a chance to pay premiums for a longer period of time; thus, reserves can build and there are slightly lower administrative costs. But employers, even with tax clarification, are unlikely to contribute to the cost of private long-term care insurance.

The reason they will not contribute is that employers face between $187 and $400 billion in unfunded liabilities for retiree acute care health care benefits. What is happening is that they are cutting back on their retiree acute care health benefits; they are not looking for a new benefit to pay for.

I should also mention in terms of the employee-sponsored products, they are, in general, very good. But their inflation protection has been grossly inadequate and needs to be changed.

Three, in terms of recommendations, in principle, I do support tax clarifications. I do not, however, support aggressive tax subsidies to encourage purchase. Analyses that have been done at the Brookings Institution suggest that individual tax credits or deductions for purchase of private long-term care insurance don't do much to promote the market because the subsidy goes mostly to people who would have bought the policies anyway. They are costly in terms of lost revenue, which is not compensated by Medicaid savings, and the benefits flow mostly to upper-middle and upper-income elderly.

I do favor tax clarifications, because it is a precondition for private insurance playing a larger role in the market and it really is not a significant change in the operating assumptions of the current market. What I think is basically lacking in H.R. 8, is standards. If we are going to give large tax benefits to private insurers, there should be higher standards in terms of nonforfeiture benefits, inflation protection, and standards for home care benefits. There ought to be a quid pro quo for those tax clarifications.

Four, I think two questions of priorities must be asked: First, does it make sense to provide long-term care tax benefits for upper-middle and upper-income persons if they are to be financed through large cuts in programs for the poor, the Medicaid program; or for average elderly, the Medicare program? Obviously, no decisions have yet been made, but the press keeps reporting possible Medicare cuts of up to $500 billion over a 5-year period; that is big money, even here in Washington.

Second, given whatever amount of funds are available for new initiatives for the elderly—and there is perhaps $25 to $30 billion over a 5-year period—are tax expenditures for private long-term care insurance the most effective way to spend that money? I, for one, would rather take that money, and put it into a block grant for the States to provide home care for the severely disabled elderly and nonelderly.

In conclusion, we have a serious problem. And long-term care tax clarification can help private insurance play a more important role, but even with tax clarification, the role of private long-term care insurance is likely to remain small.

I disagree with Dr. Wallack about what the potential impact of these tax clarifications could be. And I would, in fact, prefer to spend this money in other ways, providing a block grant to the States to provide home care services for the severely disabled.

But one thing is sure, the elderly population is growing. The disabled population is growing and this problem will not go away.

Thank you.

[The prepared statement follows:]

TESTIMONY OF JOSHUA M. WIENER
THE BROOKINGS INSTITUTION

The current American system of financing and delivering long-term care for the elderly and the younger disabled population is badly broken. At present, the United States does not have, either in the private or the public sectors, satisfactory mechanisms for helping people anticipate and pay for long-term care. In particular, the disabled elderly and their families find, often to their astonishment, that the costs of nursing home and home care are not covered to any significant extent either by Medicare or their private insurance policies. Instead, the disabled elderly must rely on their own resources or, when those have been exhausted, turn to welfare in the form of Medicaid. Moreover, although the vast majority of disabled elderly live in the community, nearly two-thirds of public expenditures for long-term care for the elderly are for nursing home care (Wiener, Illston and Hanley, 1994).

The Growth of Private Insurance

To address these problems, a small, but growing private long-term care insurance market has developed over the last ten years. Although 97 percent of the elderly have Medicare coverage and almost two-thirds have medigap policies, insurance against the potentially devastating costs of long-term care is relatively rare (U.S. House of Representatives, Committee on Ways and Means, 1992). As of the end of 1993, approximately 2.1 million policies were in force, overwhelmingly sold to the elderly on an individual rather than group basis. Employer contributions toward the cost of long-term care insurance are virtually nonexistent.

Long-term care insurance is somewhat of a paradox. On the one hand, good quality long-term care insurance is too expensive to be affordable by all but a relatively few elderly; on the other, many more people can afford policies than currently purchase them. Because of its unique characteristics, long-term care insurance does not fit neatly into the existing tax models of health and accident, life, or disability insurance, pensions or private annuities. For example, it is not clear whether long-term care insurance benefits are excludable from income as are health insurance benefits or countable as income as are pensions. Employers have no guidance as to whether contributions toward the cost of long-term care insurance would be a tax deductible expense as is health insurance and most life insurance (up to a maximum). Moreover, private long-term care insurance relies on a large buildup of reserves, as does whole life or cash-value life insurance but not health insurance. Receipt of benefits depends on having an underlying medical problem, but the individual may not be "sick" as they must be to receive most health insurance benefits. In addition, long-term care benefits may cover not only health services such as skilled nursing care, but also unskilled care, such as homemaker services, which is intrinsically desirable, whether or not a person has a disability. Indeed, some new private long-term care insurance policies provide cash benefits to individuals who have a specified level of impairment, making these products resemble disability insurance rather than health insurance.

Although the uncertainty of the tax treatment of private long-term care insurance is a minor barrier to its expansion, by far the greatest impediment is the high cost of good quality policies. Despite the marked improvement in the financial position of the elderly over the past twenty years, long-term care insurance remains unaffordable for most elderly. The average annual premium for high quality-policies sold by the leading sellers in 1992 was $2,228 a year if purchased at age 65 and $7,202 a year if purchased at age 79 (Health Insurance Association of America, 1994).

The policies are expensive for two reasons: 9 out of 10 are sold individually and, therefore, carry high administrative costs; and, most policies are bought by older people whose risk of needing long-term care is great. Consequently, most studies estimate that only 10 to 20 percent of the elderly can afford good-quality private long-term care insurance (Wiener, Illston and Hanley, 1994; Crown, Capitman and Leutz, 1992; Friedland, 1990; Zedlewski and others, 1990; Rivlin and Wiener, with Hanley and Spence, 1988). Other research has found the percentage of the elderly who can afford private insurance to be higher, but these studies have done so by assuming purchase of policies with limited coverage, by assuming the elderly would use their assets as well as income to pay premiums, or by excluding a large proportion of the elderly from the pool of people considered

interested in purchasing insurance (Cohen, Wallack and Kumar, 1992; Hagen, 1990; and, Cohen, Tell, Greenberg, and Wallack, 1987).

Employer-Sponsored Long-Term Care Insurance

One option to address the affordability problem is to encourage the purchase of private long-term care insurance at younger ages, especially through employers. Since 1987, a tiny but expanding market of employer-sponsored insurance for long-term care has developed. As of the end of 1992, a total of 350,000 policies had been sold through 566 employers. In a key difference from acute care polices, where most employers pay a large proportion of the cost of insurance, virtually all employer-sponsored long-term care policies are offered on an employee-pay-all basis.

Employers are especially unlikely to contribute to the cost of group policies unless they are assured that their contributions are tax deductible, and that the tax consequences of receiving long-term care benefits can be clearly explained to their employees. Employer contributions could make long-term care insurance more affordable by reducing the amount that employees have to pay out-of-pocket and might give employees confidence in the product. Although clarifying the tax code so that employers may deduct the cost of helping their employees pay for private long-term care insurance is unlikely to significantly promote their contributions, it is virtually certain that they will not contribute without it.

The Advantages of the Employer-Sponsored Market

Theoretically, employer-sponsored plans offered to the nonelderly provide several advantages over those purchased individually. First, premiums for younger policyholders can be substantially lower than those for older policyholders because younger policyholders pay premiums over a longer period of time and because earnings on premium reserves have more time to build. For example, we estimate that the premiums for a 42-year-old will be approximately one-quarter to one-third of the premium for a 67-year-old (Wiener, Harris and Hanley, 1990).

Although lower premiums are tied to the age of the purchaser and not necessarily to the fact that policy is employer-sponsored, the nonelderly are easiest to reach through their place of employment. The workplace is where most health, life, and disability insurance is purchased and most retirement savings through pensions are established.

Lower administrative and marketing costs offer another potential source of savings over individual policies. Administrative and marketing costs are high in individual policies because sales have to be made one at a time. Group markets are able to achieve lower costs through economies of scale. Moreover, employers bear many of the costs of administering the policy, such as collecting premium payments through payroll deductions. Employers may also elect to assume part of the costs of marketing the plan to their employees. Informal discussions with insurance actuaries suggest that most assume only a ten percentage point difference in the anticipated loss ratio between individual and group plans.[1] Thus, although administrative savings are desirable and not trivial, they will not dramatically lower premiums.

Enrolling people at younger ages through the workplace also reduces the risk of adverse selection and therefore the need for medical underwriting. Disability is relatively rare at younger ages. The less frequent underwriting typical of employer-based policies is an improvement over the universally strict practices used for purchase of individual insurance policies. However, most disabled persons with significant disabilities are not in the work force and would not, therefore, be eligible for these policies.

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[1]The loss ratio is the percentage of the premium that is for benefits rather than administrative and other overhead. Many companies assume a loss ratio of 60 percent for individual policies and 70 percent for group policies.

Finally, advocates of employer-sponsored insurance argue that the quality of policies should improve through the involvement of company benefit managers. Large groups have more market power than individuals to negotiate with insurance carriers for less restrictive policies with richer benefits and lower prices. In general, the quality of policies in the employer market is quite good, especially in providing home care benefits. On the other hand, most employer-sponsored policies have grossly inadequate inflation protection. Under most policies, the insured must purchase additional coverage from time-to-time to compensate for inflation, but at the new older age and therefore at a substantially higher premium.[2]

Impediments to an Employer-Sponsored Strategy

Despite the potential advantages of selling to the nonelderly population through employer groups, the employer-sponsored market may not expand enough to play a significant role in financing long-term care. Employers are reluctant to offer the policies, and employees are not rushing to purchase them.

The uncertain tax status of long-term care insurance has no doubt prevented some employers from offering long-term care insurance policies to their employees. But tax factors are likely to be overwhelmed by the financial problems facing employer-sponsored acute health benefits for retired employees; these benefits supplement the acute care services of the Medicare program. Unlike pensions, virtually all corporations offering post-retirement health benefits have financed them on a pay-as-you-go basis rather than prefunding them. Prodded by accounting rules established by the Financial Accounting Standards Board that require companies to disclose their future financial liability for these benefits, corporations are now aware that, collectively, they have an estimated $187 billion to $400 billion in unfunded liabilities (U.S. GAO, 1993; U.S. GAO, 1989; EBRI, 1988; and, Warshawsky, 1992).

As a result, large numbers of employers, concerned about health care costs for both their active employees and retirees, are cutting back on retiree benefits or dropping that coverage altogether. For example, in 1991, 41 percent of the employees of medium and large firms with health benefits for retirees aged 65 and older paid none of the insurance costs, down from 55 percent in 1988 (U.S. Bureau of Labor Statistics, 1993; and, EBRI, 1992). In this environment, it seems unlikely that many additional employers will want to contribute to a new, potentially expensive insurance plan that will primarily benefit retirees twenty to thirty years after they have left the company.

To date, employee demand has not played a large role in the decision of companies to add long-term care insurance to their benefit package. The desire to maintain a company's image as a leader in employee benefits or a personal sensitivity to the problem by a senior officer or employee benefit manager have been larger factors. Nonetheless, surveys of large employers suggest the possibility of a large increase in the number of companies offering policies, if not paying for them.

Employees also have been reluctant to purchase insurance. The Health Insurance Association of America estimates that, depending on how the universe of eligibles is defined, only 5.3 percent to 8.8 percent of those offered employer-sponsored long-term care insurance have purchased policies (HIAA, 1991).

Several factors limit employee demand. First, although premiums for policies without inflation adjustment are quite low at younger ages, they cost more than many people are willing to pay voluntarily. Moreover, a high quality long-term care insurance policy with a level premium, inflation protection, and nonforfeiture benefits purchased at age 50 can cost

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[2]For example, if a person buys a policy at age 42 that pays $60 a day in nursing home benefits and if inflation is 33 percent during the next five years, then the insured can buy additional coverage of $20 a day to compensate for the inflation but at the price charged 47-year-olds, not 42-year-olds. We estimate that to retain purchasing power, the inflation-adjusted premium at age 82 would be approximately ten times what they were at age 42. This is because nursing home use is exponential by age.

more than $1,000 a year (Wiener, Harris and Hanley, 1990). In a survey of nonpurchasers of employer-sponsored policies offered by two major insurers, LifePlans, Inc., reported that 82 percent of respondents felt that the fact that "the policy costs too much" was either "very important" or "important" in their decision not to purchase a policy (LifePlans, 1992). Even though economists contend that increased employer contributions for fringe benefits are mostly offset by reduced wages, 90 percent of respondents in this survey said that they would be more willing to purchase a policy if their employer contributed to the cost.

In addition, middle-age workers usually must contend with other, more immediate expenses, such as child care, mortgage payments, and college education for their children. In the LifePlans, Inc., survey, 80 percent of nonpurchasers stated that they had "more important things to spend money on at this time" was either "very important" or "important" in their decision not to purchase a policy. The risk of needing long-term care is too distant to galvanize many people into buying insurance.

Finally, selling to the nonelderly population raises difficult considerations of pricing and product design. An actuary pricing a private long-term care insurance product for a 45-year-old must predict what is going to happen forty years into the future, when the insured is age 85. To say the least, this is difficult. Ironically, although one of the advantages commonly claimed for private insurance is its flexibility to respond to the needs and wants of consumers, policyholders who buy insurance at younger ages are locked into the existing model of service delivery decades before they use services. Who knows what the optimal delivery system will be a half century from now?

Recommendations

Private long-term care insurance is likely to grow, but products geared toward the elderly face critical affordability barriers. The emerging employer-sponsored private insurance market offers the promise of solving much of the affordability problem, but that market is likely to remain small because of the difficulties in persuading employers to offer policies and employees to purchase them. In particular, the major barrier to employer contributions to the cost of private long-term care insurance is the large unfunded liability that employers currently face for retiree acute care benefits. The ambiguity of the current tax code does not help, but employer contributions probably will not increase substantially even with changes in the tax code.

Although there are gray areas, a sharp distinction should be made between proposals to clarify the tax treatment of private long-term care insurance and proposals to actively promote its purchase. In principle, many of the tax clarification proposals are worthy of support; the proposals to actively promote private long-term care insurance are not.

Many proposals have been made to provide tax incentives to subsidize purchase of private insurance. As a rule, these proposals either primarily benefit upper-income people who can already afford to purchase insurance or provide too small a subsidy to make policies affordable for people of more modest means. Consequently, public subsidies are likely to have only small effects on long-term care financing in relation to the amount of federal revenue lost.

In particular, tax deductions or tax credits for the purchase of private long-term care insurance are ineffective ways to subsidize long-term care; at least in the range that has generally been discussed. Because only half the elderly pay any income tax at all, few low- or middle-income elderly would receive any benefit from a tax deduction or credit (Grist, 1992). Only about 30 percent of all tax returns include itemized deductions (Prizzi and Curry, 1992).

In an analysis of an earlier proposal put forth by then-Representative Willis Gradison (R-Ohio, now president of the Health Insurance Association of America), which is roughly similar to the tax incentive included in the "Contract with America," we found that the impact in 2018 to be small, especially compared to the tax loss (Wiener, Illston and Hanley, 1994).

First, the proportion of the elderly with private insurance would increase by only 8 percentage points; the vast majority of older persons would still not have private insurance. Second, because of the higher income of insurance purchasers, the increased number of people with private insurance would have virtually no effect on Medicaid for nursing home care. Third, the tax loss would be four times the Medicaid savings. Moreover, the tax loss per additional person insured would be high; approximately $1,700 per additional insured. Finally, most benefits would flow to the upper-income elderly population; approximately two-thirds of insurance nursing home benefits would be paid to elderly persons with incomes over $40,000 a year.

While tax incentives for the purchase of private long-term care insurance should not be enacted, favorable tax clarification of the status of long-term care insurance is desirable in principle. The rationale for reasonably favorable tax clarification is that it is a precondition to private insurance playing a larger role in the financing of long-term care and to a large extent is not a significant departure from the operating assumptions of the current market. In essence, the tax code should make it clear that private long-term care insurance can build up reserves on a tax-free basis and that the product should otherwise be treated like health insurance. For the insured, that means that any benefits paid from long-term care policies or from riders on life insurance policies should not be considered taxable income. Moreover, employer contributions for long-term care insurance should be a tax-deductible expense and should not be counted as taxable income for employees.

Supporters of private insurance who oppose increased direct federal spending for long-term care insurance face a dilemma regarding the revenue loss inherent in tax clarifications, especially regarding employer contributions. On the one hand, if advocates contend that the revenue loss will be small, they are implicitly admitting that the change will not encourage many employers to contribute. On the other hand, if they say that tax benefits will encourage a great many employers to contribute to the cost of insurance, the potential revenue loss could be large, partly defeating the purpose of relying on private rather than public spending.

While favorable tax clarification of private long-term care insurance is desirable, two questions of priorities must be asked. First, does it make sense to provide long-term care tax benefits for the upper-middle class, while financing these tax breaks in part by cutting Medicaid, which is targeted on lower-income persons and individuals who have incurred catastrophic out-of-pocket expenses? While only 27 percent of Medicaid beneficiaries in 1993 were elderly and disabled, two-thirds of Medicaid expenditures were for acute and long-term care services for this population (Rowland, 1994). Persons needing long-term care services will almost certainly be worse off if Medicaid is cut substantially. Similarly, drastically cutting Medicare to finance these tax incentives will leave the average beneficiary with less rather than more confidence that they will receive the services they need.

Second, would the money included in the "Contract with America" for favorable tax clarification of private long-term care insurance and services, tax incentives for purchase of private long-term care insurance, and tax credits for care of the disabled elderly be better spent some other way? I would much prefer spending this money on a new block grant to the states for the provision of home care for the severely disabled population. Such a program would help create a more balanced delivery system and could be a significant increase in public funding for home care. Versions of this type of program were included in many health reform proposals last year.

Changing demographics ensure that Congress will have to deal with long-term care well before the baby boom generation starts needing large amounts of long-term care. Rather, by the end of this decade, virtually all of the parents of the baby boom generation will be elderly; many of them will be very elderly and starting to use long-term care. The elderly will turn to their adult children for care and, in some cases, financial assistance. Long-term care will no longer be an academic issue, but an intensely personal one from which the baby boomers will not be able to escape. The question of "How are we going to take care of Mom?" will become a major concern for a substantial portion of a very large and influential generation. When that happens, long-term care will be an issue that neither Congress nor the president will be able to ignore.

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Chairman THOMAS. Thank you very much.

Mrs. Johnson.

Mrs. JOHNSON OF CONNECTICUT. Thank you, Mr. Chairman.

And I thank the panel for their testimony.

It certainly is true that tax-favored treatment of health insurance did lead to the explosion of the provision of health insurance by employers.

I am interested, Mr. Wiener, that you dicker with the panelists as to your evaluation of the impact of providing tax-favored treatment. I am particularly interested, because you believe that a better solution to long-term care would be government appropriations.

When you look at what long-term care costs are doing to State Medicaid budgets, and what they are doing to Federal Medicaid and Medicare budgets, I don't know where you think that money is going to come from. So I think this issue of, can we make the tax clarifications and other things induce participation so that people can begin preparing for their own future at age 20, with a 50-cent additional premium on an employer policy, is a similar, very critical issue. We could get people to insure for 2 years, and the vast majority of people are not in long-term care more than 2 years, and we let the government take it up after that. I think we have an insurable, affordable item there, and I see no other way than a partnership to bear the costs of long-term care.

So I would like to start by asking the first two speakers: What makes you believe that providing favorable tax treatment will increase the long-term care insurance market?

And, Mr. Meiners, particularly with the added inducement of asset protection, do you see any developments in that market that are different than the ordinary policy market that would lead us to believe that the more incentives we provide, the more likely we are to have solid participation, broad participation in this market?

Mr. MEINERS. Sure. One of the things we have done in the partnership program was to try to examine the various incentives, tax breaks being one, the asset protection being another. And we looked at the cost effectiveness of those. And since we were working with States, and working in an environment where we were trying to be budget neutral or produce savings, and States really can't offer as effective tax breaks, we really came upon this idea of taking the Medicaid program as it was, which was acting as a backup, and make it more of a certain part of the package that people who bought insurance would be getting. By doing that, we are able to offer the people the opportunity to buy a higher-quality product because we have been able to negotiate with the insurers for higher-quality standards as part of the deal. Also given consumers the certainty that if they buy this product, and use up those benefits, they can avoid impoverishment and gain access to public assistance.

Mrs. JOHNSON OF CONNECTICUT. So, effectively, your program, if every American participated in an asset protection long-term care policy, it would shift the cost of the first year or two, depending on how many years of asset protection they chose, to the private sector, and leave the public sector with the truly long-term care institutional costs. Isn't that, in effect, how it works, and at the same

time preserves the right of families to have some small measure of assets to pass on to their children?

Mr. MEINERS. That is right. It introduces an incentive to prepare on their own for this risk and makes explicit the idea that the public program is there to help. Medicaid is there to help for a lot of people. Unfortunately, it is only the people who are already poor or the people who are savvy enough or well-to-do enough to hire a good lawyer and to hide their assets that now benefit from Medicaid. The middle class is on its own. Rather than have that gaming go on, we try to create an incentive that serves as an alternative to that gaming of the system, but more importantly, helps make shorter-term, affordable high-quality coverage available to a broad spectrum of people. We feel it is a strategy that will really bring long-term care to people on a much wider basis.

Mr. WALLACK. Thank you.

One has to make their best guesstimate as to the likely impact of long-term care insurance tax clarification. However, there are, and I mention in my brief comments some surveys of nonpurchasers. In LifePlans' study we found that 80 percent of nonpurchasers would reconsider if there was tax clarification.

The Washington Business Group on Health did something comparable and asked the employer community: What do you think would be the most important step that the Federal Government could make? And they said, tax clarification. And so it would be an opportunity for employers to look at long-term care again. And I would think they have been innovators in solving other problems and we can't predict how that market is going to evolve if employers begin to engage and see the signal from the Federal Government that they want employers to help take this problem on.

If you just look at this as nothing more than a price reduction because we are giving people a tax break, then I think the effect would be rather limited; maybe a 20-percent increase, because you had a 28-percent tax break. But that is not all. It is the change in attitudes that you have to create and for this insurance makes sense. The attitude toward insurance is key. And that is why we had the tremendous growth in the fifties of health insurance. The idea that people should be taking care of themselves. And the potential there is very significant.

Mrs. JOHNSON OF CONNECTICUT. Thank you.

Mr. Wiener, would you like to comment?

Mr. WIENER. Yes, first of all, in terms of some of the tax clarifications, I think the market is already operating in that way. I think if you told people who bought private long-term care insurance that it wasn't clear that the benefits they received were excludable from income, they would be shocked. I don't believe anybody is reporting that as income now. So some of that is already operational.

In terms of employers, I think the bottom line is that they face huge, huge, unfunded liabilities for retiree acute care health benefits, $200, $400 million. And basically, retiree acute care health benefits are falling through the floor.

Employers are running away from retiree health benefits as fast as lawyers will let them do that. And so the last thing in the world that they are looking for is another large potentially expensive benefit to provide to their retirees. Some employers will contribute, but

I think it is just not realistic, given that unfunded liability, to think that large numbers of employers are going to move in that direction.

You asked the question about where is all this money going to come from? I am merely proposing that you take the money that is already in the Contract, that you have already budgeted in some shape, manner or form, and instead of spending it on tax clarification, instead of spending it on reducing the taxes on upper-income elderly, that you take that money and put it into a long-term care block grant. And, indeed, I think if you talked to the Republican Governors, they would love that additional money as a way to try to create a more balanced delivery system. It is something that they have been struggling to do.

Chairman THOMAS. Mr. Wiener, the gentlewoman's time has expired.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Something tells me in my sixth sense that a bill similar to the one we are discussing might pass out of this subcommittee. And anticipating that, Mr. Wallack has identified my concerns in his testimony where he, I think, pretty generally follows the model act for regulation by the National Association of Insurance Commissioners.

And I would like to ask the other two witnesses if they agree with Mr. Wallack's suggestion, that in addition to making this more available, there should be some requirements, prohibitions and sanctions to protect the consumers generally along the lines as outlined in this testimony.

Would that be your feeling Mr. Meiners and Mr. Wiener?

Mr. MEINERS. Yes——

Mr. STARK. I mean, I don't want to go into them. There are a lot of them here, and some great group of insurance commissioners figured out what we ought to do, and I am sure we will get a lot of discussion about which are better than others, but I do feel it is important.

Let me then go to the basis for the questions that I would like to ask you further. In this committee in the past, I think we have accepted the idea that long-term care has very little to do with medical costs. It is a brand of happenstance, and generally a person who may need long-term care may not, because of that long-term care, need more pharmaceutical treatment and more doctors. In other words, some people need long-term care for a variety of reasons and some do not.

If you accept $36,000 a year, $30,000 a year, somewhere in that range is what it costs—$3,000 a month—for some kind of long-term care maintenance, and if you take the figures again that I think are uncontrovertible, that 13 percent or about 4 million of the 35 million seniors fit into the category where they have income of $34,000 or $44,000 for a family, arguably they could pay for it. They wouldn't have much left, but they could make it.

The remainder, 30 million-plus, are pretty low income, and to come up with a couple of thousand bucks is tough. Thus it is an income transfer problem. It doesn't have a whole lot to do with

stopping Alzheimer's or cutting back on AIDS. We have got about 30 million people who can't afford it, period.

And if you look at how they got to that income level at the age of 65, they probably didn't have a lot of extra discretionary money when they were working and younger. I doubt in the average coverage of life insurance is $10,000 or $15,000, and probably that costs less than this would cost. You have got to get to a substantial cash value. And that is pretty difficult.

So if this program costs $1 to $1½ billion—and it is my understanding there is no cost estimate yet? I would ask the gentlelady? Brookings and the Treasury have talked in the neighborhood of $1 to $1½ billion a year.

Chairman THOMAS. Will the gentleman yield on that point?

We do not have a cost estimate. And as has been the tradition in the committee and this subcommittee, we will not move product until we get a cost estimate.

Mr. STARK. If the witnesses will accept that as a reasonable range with some windage, we are talking about providing 600,000 people with a $2,500 premium, if you wish. And I heard the witnesses suggest that maybe there is a better way to go about this. That maybe we could spread the aid more fairly across the income spectrum, or take, as Mr. Wiener has suggested, the savings that would have to go to subsidize upper-income people who arguably have the money to make it. My time has expired with my question, but I would ask you if any of the witnesses find anything that they feel was incorrect or misleading in the numbers that I suggested and the outline of the problem?

Does that concur, Mr. Wiener, with how you see it, or Mr. Meiners? Are we talking about the right problem?

Mr. WALLACK. We certainly are talking about huge catastrophic expenses for people. And I think it is fair to say that a relatively small percentage of older people can afford that $35,000 or $50,000. Insurance, therefore, works. If you believe in insurance with regard to catastrophic coverage, it is when, in fact, there are relatively few going in, you spread that risk. And we have had this debate many times. This is really affordable for a large percentage of the population if they come on early enough. So the issue is spreading the risk.

Another thing you have to remember is that today about 50 percent of the costs or so, are being paid privately. So there are individuals, there are families taking this burden. And what we want to try to do is take the pressure off the population about this burden. An insurance mechanism is private, but it spreads that risk.

Mr. STARK. Don't you think it is a random risk for somebody under 65 years old? If you are going to start at the age of 45, the risk of being committed in your elderly years, it is my understanding, is pretty random, and if that is the case, you make a good case for social insurance. I don't think you can underwrite it with any accuracy.

Mr. WALLACK. The employers' policies do not use underwriting. You used the word "social" and I use the word "insurance." I think that is the real debate here. Do we want to socialize programs or do we want to use insurance?

And I think insurance is exactly the key concept. And that is why the employer comes in and takes everybody, that is a way to go about it. And as Mrs. Johnson was saying, with small payments, so we can go with insurance? Then we could have the debate, should it be social or private?

All I am suggesting is that to the extent we want private solutions to help with the Federal budget, this is an area where people are willing to do it and they have the wherewithal and we should be encouraging it.

Chairman THOMAS. The gentleman's time has expired.

The gentleman from Nebraska, Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I guess a little bit of history about myself for I have personally experienced this problem that we are seeing. As an insurance agent with Connecticut Mutual Life Insurance Co., not only did I sell life insurance, but I sold health insurance, and I also attempted to sell long-term care insurance. And the word "attempt" is put there for a reason, because when my wife and I would be doing estate planning, we would say the second-to-die policy would take care of their needs and whatever else they needed. But when it came to taking care of long-term care needs and providing for the future, there was no need. They felt like the government would take care of them if there was ever a problem in the future. If they had a catastrophic problem, it would be handled.

I guess my question would be for Mr. Wallack, that when the Federal Government expanded the tax incentives for health care insurance, you saw a real boom in the market for health insurance and a lot of people went ahead and took advantage of that and purchased it. Would you see the same thing as far as long-term care insurance? And do you have any numbers to back up your thoughts on that?

Mr. WALLACK. I think we talked a little bit about that. I think there is potential. I really think that is the potential of this market.

I think the individuals that really want to protect themselves are older people, and I think you will see a growth in that market. Only 4 percent of the older people are protecting themselves now. It could be much higher than that. I think the key to this in the future is going to be the employer market and how employers look at this.

I think Josh made a good point; they have huge liabilities right now and they don't want to take out something that is undefined for the future. If employers do contribute, they can look at this as a defined contribution and limit their risk and still have a real opportunity to help. And they pay only a small percentage of the total premium. I think the key is the employer, and individuals wanting to take care of themselves. There are numerous different vehicles for the employer to use.

Mr. CHRISTENSEN. I can tell you that if there is an incentive there to purchase long-term care insurance, you are going to see a lot of things happen in this country as far as the purchase of long-term care, but you are going to see a residual effect of people not depending on the government. And it is going to be a cost shifting to the private sector which we are all trying to move toward.

Chairman THOMAS. The gentleman from Maryland, Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

First, let me say I think that we should have some tax clarification as relates to long-term care insurance and would hope that we could get more private insurance coverage, particularly with the employers. I have listened very carefully to the testimony of the witnesses, and I think that could be useful. It certainly won't solve the problem, but it could be useful.

Where I think we are at a disadvantage today, Mr. Chairman, is that we don't have the cost estimates from joint tax. It would be interesting to find out the answer to the point that Mr. Christensen made as to whether this particular proposal will produce savings.

To a certain degree, those people who do buy long-term care insurance and do not go on the Medicaid rolls, that clearly would be a savings to the public Treasury. But as Mr. Wiener pointed out, to the extent that we are just subsidizing people who currently have these policies, then it is a loss of revenue to the Federal Government, without improving the circumstances for long-term care.

I don't really have a good grip from the information we currently have. We have Treasury estimates that indicate this is going to be a $5.9 billion loss over a 5-year period. That concerns me.

The other point is that in addition to tax clarification, if I understand, the proposal before us also allows withdrawals from IRAs, tax free, to buy long-term care insurance. I am curious as to whether that may not lead to certain types of practices that are not what we would want to encourage.

So let me just pose a question to Mr. Wiener, because I do believe that Brookings has some figures on this. What type of savings can we anticipate from this type of proposal? Is it a good cost benefit proposal?

Mr. WIENER. First of all, let me clarify that we have no estimates specifically on this proposal. We have done other estimates of somewhat more aggressive tax credits for the purchase of private long-term care insurance that former Representative Gradison put forward.

Basically, we find negligible Medicaid savings even 25 years out into the future. We find that there is a 4 to 1 tax loss to Medicaid savings. So this is not a revenue-neutral proposal. I would also note that it is in the nature of tax subsidies for private long-term care insurance that you would take any tax loss early or up front, because the tax loss goes with the premiums. And any savings you would get would be further down the line as those people get older and start using long-term care services. So, you are guaranteed short-term tax losses even if you get benefits in the long run.

Mr. CARDIN. There are several provisions here, and I am curious as to whether your testimony applies to each of those provisions. One of the provisions here is to allow tax preference for employers who provide the benefits. Another is to treat these premiums similar to health costs as far as the deductibility by the individual. A third is to allow tax-free withdrawals from IRAs. Do your views apply to each of those different provisions or is there a difference on which approach we take?

Mr. WIENER. I am most enthusiastic about allowing employers to take that as a tax deduction. I agree with Stan that the future of

private long-term care insurance lies in the employer market. I think we probably disagree as to how far that would take us. Products sold to the elderly are simply too expensive. So I think that is where we need to go.

In terms of deductibility for the 7.5-percent cap, I am somewhat less enthusiastic about that. But I would be willing to go along with it. I favor these things in principle. I supported them as part of overall health care reform. But at that point, that was a small part of a much larger initiative. This is now the ball game. And I guess I would prefer to take that money and spend it elsewhere.

Mr. CARDIN. Do either of the other two witnesses want to comment quickly?

Mr. WALLACK. I would like to comment about the assumption that you are making about who is going to buy this policy. The long-term care financing problem is really catastrophic expenses for the middle class. And the people that really are going to take advantage of this, I believe are going to be people who in fact really need that insurance coverage.

Mr. CARDIN. Is that through the deductibility or is that through the employer-provided benefits or the IRAs?

Mr. WALLACK. I think it will be employer provided. And who really needs it——I think we need to look rationally at who needs insurance to cover those costs. It is the middle-income people. That is what our long-term care financing problem is about.

Mr. CARDIN. Which tool is going to be the most useful? If you had to pick one, which is the most important?

Mr. WALLACK. The provision? I think—that is a tougher one for me. I guess—I don't really want to say, because I don't know what the cost elements are. I think the employer one is important, but I think the individual deduction for premiums is very important, because I think most older people see the risk 5 or 10 years out and those are the people that really want to buy insurance. You have to see the risk to want to buy it, and I think there are good products that give good coverage for older people.

Mr. MEINERS. One of the things to keep in mind, there was an awful lot of talk in the Clinton plan of the integration of acute and long-term care. I think that long-term care needs to become more of the mainstream when we think of our health care reform package. And to have people when they are deciding about their health insurance face different tax structures for acute versus long-term care, it erodes the chances for integrated care.

Cost aside, we need to jump start the market and have people planning for their long-term care needs. And acute care is not long-term care. But it is an important expense that people need to plan for and that needs to happen. In that sense, we don't have an even playingfield.

Chairman THOMAS. The gentleman's time has expired.

Mr. Houghton.

Mr. HOUGHTON. I would like to ask Mr. Meiners a question.

I am from New York and I think that the Robert Wood Johnson Foundation had a big impact on many of the plans which are promoted in New York following the waiver that New York State got to mix the Medicaid and private long-term care insurance.

I wonder what the experience has been. I understand that the basis here is that it helps people with incomes above $20,000 and $50,000 in assets. And once that coverage is exhausted, maybe you can clarify this, the State is going to provide Medicaid coverage. That is the line policy in order for people to keep their assets. How has that worked? Because I think New York is a little different from some of the other States.

Mr. MEINERS. Basically, all States have made the link between the special asset protection and the purchase of a State-certified long-term care insurance policy. In the State of New York, they have gone in the direction of simplified approach. If you buy 3 years' worth of nursing home care or the equivalent of 6 years' worth of home and community care and exhaust that coverage, your total assets are protected.

In the other States, their model that is used is called the dollar-for-dollar approach. It allows for the purchase of different amounts of insurance. And if you use that up, you get asset protection equal to the amount the insurance has paid out.

The New York approach is very much an incentive to act as an alternative to divestiture and Medicaid gaming, which from reports and research that have been done, is apparently more rampant in New York than any other place in the country. That is one of the major differences. But both are designed to basically make quality insurance more affordable. In other words, rather than having to buy lifetime protection to avoid impoverishment, you can buy some lesser amount which is going to be more affordable.

Mr. HOUGHTON. Are there any contrary examples in any other State, or have they pretty much followed this pattern?

Mr. MEINERS. Well, I think in terms of comparing the market as it is today, what we are trying to do with this program is to really make long-term care insurance more affordable so that if, for example, in these States that are using the dollar-for-dollar approach, a person can only afford 1 years' worth of benefits, prior to this time, they might have looked at that option and said, gee, my risk in a nursing home is possibly 2.5 years. I am still going to be impoverished. Why bother?

Now we have created a vehicle where people can look at lesser amounts that are more compatible with the amounts of resources they have to spend and protect, and look at that decision and say it makes sense for me. I can afford to buy 1 or 2 or 3 years' worth of coverage, and if I use that up, I am not going to be impoverished.

That is a big difference and, from my point of view, makes the overture that you make to the consumer an easier overture, you can guarantee them they won't be impoverished because of the deal. And I think that is an important extra incentive.

Mr. WIENER. I think a key question in evaluating the partnership is whether having easier access to Medicaid is much of an incentive to buy private long-term care insurance. And while it is still relatively early in the process, I don't think we have seen the kind of jump starting of the market in the partnership States that I think some people had hoped we would get. We have had a couple thousand policies sold, and that is about it.

Mr. MEINERS. Well, that is not exactly our take on it.

Mr. HOUGHTON. If I might just interrupt?

It is relatively new, though, isn't it? Some of the States haven't got it. New York started in 1992, end of 1992. So it is really awfully hard to tell.

Mr. MEINERS. Right. And I would say a couple of things in response to that. First of all, insurance, the benefits of insurance are there right up front. Insurance is what pays the bills first. OK. So whatever you are getting from insurance, why people would be interested in long-term care insurance, is there. This is an extra benefit over and above that.

In essence, it is the State coming in and saying we are going to insure your assets or help insure you to help you avoid impoverishment. And in terms of policies sold, New York alone has sold 4,000 policies in about a year. And that is in an environment where we have been talking about health care reform and the possibility of a new national long-term care strategy. So the environment is now changing and we expect people to be more receptive.

The taxes, as I mentioned in my testimony, the tax clarification and some of the tax provisions can only help that knowledge and attention.

Mr. WALLACK. Can I make one footnote to that, please?

When you actually go out and look at what people are willing to pay for long-term care insurance, they may have the means to pay a lot, but basically when you look at the marketplace, most people who are buying it, at the ages of 65 to 70, are spending between $80 and $120 a month.

That effectively gives you about 3 to 5 years of coverage. And so that is what people want to do. People want to insure themselves. They don't necessarily want to go out and insure themselves for every single contingency. People should not overinsure. So the concept of a Federal reinsurance notion here, which is what is in the New York program, I think fits in well with how people are taking care of themselves.

Mr. HOUGHTON. Thank you very much.

Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Let me start by asking a quick question to Mr. Meiners. In your testimony, you indicated that it would be wise for us to repeal a portion of OBRA 1993, and I can't identify which portion, unless you were saying the entire OBRA.

Mr. MEINERS. No, it was specifically the provision that limited the growth of partnership States by basically saying that any new—the four States were grandfathered in, but any new States were required to do a State recovery on the protected assets. So, in essence, the person couldn't pass those assets on to someone else.

About that time, we had as many as 20 other States that had legislation of one sort or another interested in doing a partnership. That put a damper on that. Although some States have, nonetheless, gone forward and are doing a modified partnership, it is our sense that that limits both enthusiasm, frankly, for the States that are in the partnership and new States.

Mr. KLECZKA. Thank you.

Mr. Wallack, you indicated that if, in fact, this tax-free treatment were to be enacted, that the price of long-term care insurance would fall. Are you talking premiums or the actual cost to the consumer?

Mr. WALLACK. I am talking net cost to the consumer. I think premiums have pretty well settled down. They haven't come down, but people are getting more for what they are paying. You are seeing in the market $100 a month for a premium. So if they get a deduction, the net price to them would come down.

Mr. KLECZKA. What is the profitability experience in the industry out selling these policies? What is the loss ratio?

Does anyone know?

Mr. WALLACK. This legislation has requirements. I don't know if it is 65 or 70 percent.

Mr. KLECZKA. What is the actual?

Mr. WIENER. I don't think we know. And I don't think we will know for a very long period of time, because it is the nature of this product that you are selling policies to people who won't use the benefit for years in the future. So the yearly loss ratios are not useful. What you want is over the lifetime of the policy.

Mr. KLECZKA. Well, it has been mentioned here that it would be ideal if 20-year-olds would go into this type of insurance because of the relatively cheap cost. But we found last year that 20-year-olds don't buy health insurance today because they are healthy. Once they turn 42, they are not so healthy and then they start looking around for a policy.

And I can see the same thing happening with this type of insurance for a 50-year-old. All right?

I am quasi-healthy, but I am never going to need long-term care until I am 65 or 69, and then I will think about buying that policy. That is the way the public thinks on this. You can dispute that, but I think that is the way we are handling this today.

Mr. WIENER. I think that is absolutely right. The time when you can afford these policies is when you are young and when you think you are going to live forever and you will never need long-term care. It is when you are elderly and start thinking about your own mortality that this becomes more of an issue and, at that point, you can't afford good-quality policies. You may be able to afford a less good policy. But the policies with inflation protection and nonforfeiture benefits, according to HIAA, costs over $2,000 a year at age 65.

Mr. KLECZKA. Well, if this program hinges on employer participation, we found out in the health care debate last year many employers today don't offer health insurance. Mr. Houghton and I served on the Oversight Committee last year and spent a lot of time working on the PBGC and, as you said, Mr. Wiener, knowing the unfunded liability in that program, to think that an employer on his own motion would go into this type of a policy or coverage for the employee is just whistling Dixie.

Yes, there is a rationale for health insurance. Healthy employees are productive employees. But after that employee leaves your workplace and is now 70, whether that person needs long-term care or not, providing it is not to the employer's advantage. But if employers are going to take on a gigantic liability in this country,

knowing what is going on in the pension area, this is not going to happen to my friends in my lifetime, unless everyone was organized and this was the bottom line at the bargaining table, and that is naturally being reversed as we all know.

Mr. MEINERS. One of the things that struck me in terms of the various proposals on the table is it is unclear which ones might have the most effect. I think as I said before, I think leveling the playingfield is an important consideration. I think it is very possible that people at that financial planning stage, if they are given the chance to draw money out of their IRAs for long-term care insurance, that they are more likely to feel positively toward this important decision.

In a funny way—and the other consideration is that if they are not successful, it isn't going to cost much. It is not going to cost much in the sense that people won't take advantage of the tax break. And if they are successful, you have accomplished getting people more involved in preparing for long-term care.

Mr. KLECZKA. On the IRA withdrawal, pending before the Ways and Means Committee are several proposals dealing with IRAs. One that I have supported for years is a withdrawal from your IRA for a downpayment on a home. That is why a lot of young couples can't get in, because they can't afford the downpayment. It is not because they can't afford the monthly payments. So we are going to permit that. We are going to draw that down. And then when the kids get to college, you can draw down for that. And now we can draw down for the long-term care.

How much money do you think these people have in these IRAs?

Mr. WALLACK. People at different points in their life cycle need different things, and we are talking about choice.

Mr. KLECZKA. But one family unit is going to find out when they got to that IRA at age 65 for the long-term health care, very little is left.

Chairman THOMAS. The gentleman's time has expired.

Mr. Johnson.

Mr. JOHNSON OF TEXAS. Thank you, Mr. Chairman.

I just would like to ask Mr. Wallack, it appears to me that you believe in cutting out the States. And I would like for you to discuss why you think the Federal Government ought to make standards that eliminate the States from the process. Speak to that if you would.

Mr. WALLACK. OK. I am not sure I am saying cutting out the States. I think there is a lot of variation. And people buy these policies, they move to other States, and I think we would benefit by having good national standards at least as an option for selling this policy, so that people would have them.

If the States, in fact, want to go beyond that, they may go beyond that. But I believe policies should meet these Federal standards and insurers should be able to sell them in all States.

Mr. JOHNSON OF TEXAS. Do you disagree with Mr. Houghton's New York concept?

Mr. WALLACK. No, in fact, I think there is a real role here—that is one model. The government has to participate in the solution in some real ways. Without it, it just isn't going to happen. To say blindly that the private sector is going to solve this problem is im-

possible given how we develop social welfare solutions in this country. The government has got to participate at the State level and at the Federal level with these solutions. That is the only way the private sector is really going to be successful.

Mr. JOHNSON OF TEXAS. OK. It is a matter of degree.

Mr. WALLACK. Yes, it is.

Mr. JOHNSON OF TEXAS. Thank you, Mr. Chairman. I don't have any further questions.

Chairman THOMAS. I thank the gentleman.

And I recognize our friend and colleague, the gentleman from Georgia, who was not here during the initial introductions but is a returning member of the subcommittee, Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Mr. Wiener, I agree that we should look for both private and public solutions, but we must remember tax incentives cost money. They cost taxpayers money. Could you talk more about whether this is the best way to spend the taxpayers' money.

Mr. WIENER. Certainly. I think there are two questions, one of equity and one of efficiency. The analyses that we have done of private long-term care insurance, and especially of the tax credit that Representative Gradison put forward, suggested that the overwhelming majority of private long-term care insurance expenditures or benefits would go to upper-income elderly.

And so especially if we are talking about cutting the Medicaid program, which is our primary mechanism of financing long-term care, I think we have a real equity problem. Medicaid basically is targeted on poor people and people who have really impoverished themselves. I think it is unfair to take money from that program to give to upper-income persons.

Another question is one of efficiency. And I think our history of tax incentives has been that you largely end up subsidizing people who would otherwise have done what you are trying to get them to do. And so what we have found in our analysis is that you don't increase the number of people with private insurance under the Gradison proposal by very much, but you lose a fair amount of money.

And we estimate that the additional costs per additional person with insurance in the year 2018 would be about $2,000 a policy. So you are losing—your cost per additional person insured is almost as much as the cost of the policy. That is not a very efficient way of getting things done.

My own preference is to build on what we have in this country in terms of long-term care financing delivery and that is largely a State system. States are innovators in terms of home care and other things in long-term care. And I think it makes a lot of sense to give them a pot of money and be flexible with that and let them expand home care. We have a system right now that is very heavily geared toward institutional care, and I think we need to balance that.

Mr. LEWIS. Mr. Wiener, can you help me out for a moment here. Are you suggesting—or would it be fair to say that this proposal takes from the middle class and the poor to give to the wealthy?

Mr. WIENER. Well, I don't think in and of itself you can say that. The question is, where is the money going to be found to pay for

this? Many of the proposals, certainly the one cutting Medicaid, would take services from poor people.

The primary beneficiaries of tax clarification will clearly be upper-income people. You could finance that by raising other taxes on upper-income people. But that is not inherent in tax clarification.

Mr. LEWIS. What does this really mean for the poor elderly and the average working-class person?

Mr. WIENER. With good-quality policies costing over $2,500 a year, I don't think moderate and working-class elderly are going to purchase policies. They may buy policies and then find they can't afford it and then drop it.

Mr. LEWIS. Thank you very much.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

And once again, the gentleman who was not with us earlier because of his other subcommittee assignments, but a new member of the subcommittee is a new Member of Congress, the gentleman from Nevada, Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Mr. Wallack, a tremendous amount of the money that is spent from the public sector toward long-term care is spent in what Mr. Wiener described as the public institutions, or in institutional long-term-care type care. Can you address how the private sector has encouraged more of the home care and how you think that this tax clarification would encourage, discourage, or otherwise, those reforms from increasing or decreasing?

Mr. WALLACK. Sure. One of the nice things about a private market is that it has to respond to consumers' interest and consumers have clearly said what they want to do is stay at home and have broad-based benefits. And, therefore, if you look at the change in this product over the last few years, it has, in fact, become extremely comprehensive in terms of home care, assisted living, all sorts of benefits. And what the products are now doing is giving people almost a pot of money and letting them have a lot of choice.

So the products have been very responsive to individuals, in terms of their wanting to stay independent and giving themselves choice. And one of the things that I was worried about with some of the things in this bill is that we don't want to restrict that. We want to, in fact, let people be able to stay at home. They want to stay home and that is why I think most people are buying long-term care insurance, not because of institutional care, but because it gives them choice and the ability to get services in other settings.

Mr. ENSIGN. Home care is less expensive than institutionalized care, obviously; right?

Mr. WALLACK. Well, it should be and could be. And I think the real issue for people is that by giving that option to people with regard to home care, you in fact don't force them into expensive institutions, and that is where people really do spend down.

You can make home care extremely expensive if people want to make a nursing home in their home, but that is not usually the case. Usually it is for people who are not quite as disabled and who, therefore, can be kept at a low level of care, so, therefore, it is less expensive.

Mr. ENSIGN. Mr. Wiener, let me follow that up with you, and that is if this is moving toward the trend in home care, especially in the private sector, you mentioned in the States as well, but if we can get that moving toward long-term home care, where it is more compassionate, where people want to be, wouldn't that also lower the cost and not hurt the lower-income people?

Mr. WIENER. I think you have to be very careful here. There is a large, rigorous research literature that suggests that total cost for long-term care with expanded home care is, in fact, higher than a long-term care system with relatively restricted home care services.

And the reason for that is given a choice between nursing home care and nothing, many people would choose nothing. But given a choice between nursing home, home care, and nothing, many people choose home care. And so what you get is large increases in home care use, which more than offset a relatively small reduction in nursing home use.

I am a strong supporter of home care. I think there is a place for institutional care as well, but I don't think you can make the argument for home care based on the idea that we are going to have a much cheaper, much more cost-effective system.

Mr. ENSIGN. But I think that sometimes you are looking at that as too much of an isolated case. You also have to consider the people that if they had help with long-term home care, could also remain productive. In other words, a lot of those people are staying home and taking care of somebody and they can't be in the workplace remaining productive and paying tax revenues into our system.

I think that overall the advantages clearly outweigh the disadvantages as far as encouraging home care. And I think in the long term, my personal opinion is long term, it is going to end up being less expensive when you take the whole picture into account.

Mr. WIENER. While there are certainly people who quit jobs or work less because of the caring for relatives, the available evidence suggests that those numbers are quite small. And remember, the children of 85-year-olds are in their late fifties and early sixties themselves, and are likely to be pulling out of the work force. So those are the children, and their workplace participation is not likely to be high.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. I want to thank the panel. Obviously it is difficult in making clearer decisions without cost estimates as we go forward, and this committee has always been uncomfortable without cost estimates and we will get those as I said.

In addition, this is the only item in front of us, so I think we are putting a bit of inordinate focus on it. If it were part of a more comprehensive reform plan, I think, as was clearly indicated, we would all agree it would be part of that program.

And finally let me just say that one of the things that we cannot predict now, but one of the reasons I think everyone is for this very modest adjustment is that the private sector would be afforded one more tool in its arsenal of innovation and coordination of various policies. You could create an insurance environment for an entire lifetime continuum that could be seamless and that investments in one type of insurance could then be moved into another, so that all

the predictions about the consumption of this product I think are in an atmosphere in which no one knows what the dynamic will be if we provided that full spectrum. And I think that is one of the things that we are hopeful in doing. This is a small part of it. But I thank the first panel for their focus and enlightenment that they provided us. Thank you very much.

The second panel is Barbara Fosberg, Bethesda, Md.; David Allen, executive officer, Professional Staff Congress—City University of New York Welfare Fund; David Guttchen, project director, Connecticut Partnership for Long-Term Care; Gail Holubinka, director, New York State Partnership for Long-Term Care; and Kevin Mahoney, project director, California Partnership for Long-Term Care.

I believe the lineup will be from my right to your left, from your left to my right. It will follow the introductions. Ms. Fosberg. All of the panelists' testimony will be made a part of the record without dissent, and you will have 5 minutes to expand on your interests however you choose.

STATEMENT OF BARBARA B. FOSBERG, BETHESDA, MD.

Ms. FOSBERG. Mr. Chairman, members of the subcommittee, good afternoon. My name is Barbara Fosberg. I am an attorney representing neglected and abused children in the D.C. Superior Court. My 35 little clients would not have my assistance and considerable attention were it not for the fact that I have a long-term care policy with the Travelers Insurance Co. which provides a trained home health aide to care for my husband who has Alzheimer's.

I would like to share with you the events leading up to the purchase of the policy and what it has meant to our family. My husband retired from the State Department Foreign Service after 32 years with the government. After his retirement and after our children were "grown and gone," I entered the American University's College of Law and I graduated at age 60.

Because I had had some health problems while in law school, I began to think about the possible eventual need for home health and nursing home care. A friend who had a policy with Travelers recommended them, but, in keeping with my methodical bent, I drew up a detailed chart of some dozen companies, listing premiums, coverage, and so forth, and interviewed representatives from each before deciding that Travelers offered our family the most comprehensive protection available. Little did I realize, when I was doing this in 1990, that in 1994 my husband would be diagnosed with Alzheimer's, the type with quick onset and rapid deterioration.

At that most difficult time, it was both helpful and reassuring to be assisted by our insurance agent, John Haslett, who facilitated an orderly and smooth transition through the approval of our claim process. The first step in seeking a care provider was a referral to a local hospital with a geriatric department that had trained care coordinators.

This home management team from Suburban Hospital evaluated our personal health care needs and found a highly qualified home health aide. These services, which include periodic visits by the

geriatric nurse and the socialworker, are covered by our Travelers policy.

For awhile, my husband was able to attend a senior day care center twice a week and to be cared for at home 3 days a week while I was in court. Not only is the home care covered by this policy, but the day care is also covered. Because his condition now precludes his attending day care, he is cared for 5 days a week by the excellent home health aide. I have recently contracted for additional help on weekends in order to make home visits to my young clients. And this extra help is also covered by the policy.

Because my husband is in the "sundowning" stage of Alzheimer's, meaning that he wanders throughout the house all night, I do not know how much longer I shall be able to keep him at home, perhaps for as long as I can subsist on 4 hours sleep a night.

I do, however, want to keep him in his own home for as long as he is able to recognize his surroundings and to recognize his loved ones. When the time comes that he can only be cared for in the nursing home, then our long-term care policy will also cover 100 percent of the expense up to $100 a day.

This long-term care policy has given me peace of mind knowing my husband is well cared for; moreover, it has given me the opportunity to continue my work with abused and neglected children.

I hope that your subcommittee can facilitate expanded coverage and tax incentives to more people who would otherwise not be able to continue their outside worthwhile endeavors.

Thank you.

Chairman THOMAS. Ms. Fosberg, thank you for your personal difficult testimony. We appreciate it.

Mr. Allen.

STATEMENT OF DAVID ALLEN, EXECUTIVE OFFICER, PROFESSOR, CITY UNIVERSITY OF NEW YORK WELFARE FUND

Mr. ALLEN. Good afternoon, Mr. Chairman and members of the subcommittee. My name is David Allen. I am a professor in the City University of New York. And I would like to thank you for the opportunity of appearing here this afternoon.

In addition to teaching economics, I am a trustee and executive officer of the Professional Staff Congress, City University of New York Welfare Fund, a program of fringe benefits for the faculty of the City University.

I am here today to personally attest to the valuable role long-term care coverage plays in our benefit plan and to urge your support of the private long-term care market through the tax clarifications provided in H.R. 8. And Mr. Chairman, I am very proud to say that our union was the first union in the United States to offer a group long-term care plan to its members and the City University was the first university in the United States to do that.

The impetus for our plan came in 1988 and it came neither from our own staff nor from an insurance company. Instead it came from our own members, our retirees. They are organized in a special retirees' chapter of the union and members of that chapter knew from firsthand experience the number of Americans in need of long-term care and the high cost of providing it.

Because long-term care insurance was a new concept and because of the complexity of evaluating different plans, they came to us and asked if our welfare fund would provide them with a good group plan that they could have confidence in. We solicited bids from a number of insurance carriers and we were successful in finding a large company, John Hancock, which was willing to offer a plan similar to what our members wanted.

Approximately 2,500 of our 13,000 members now purchase our group long-term care insurance and it has been very well received. Our members have had the confidence of knowing that even if they didn't read all the fine print in the policy, they knew somebody who did.

As I mentioned, about 20 percent of our members, including my wife and myself, purchase long-term care insurance. Judged by other group plans, we are considered very successful, but I believe we could do better. The 10,000 people in our group who have not yet purchased long-term care insurance have not been given divine assurance that they are never going to need the care nor are they independently wealthy.

What they need is a message from Congress encouraging them to take action now to provide themselves with protection from the high cost of long-term care. I believe H.R. 8 is a step in the right direction. The bill will provide official recognition of long-term care insurance and much needed clarification of its tax implications.

With regard to the City University, Mr. Chairman, there are two changes to H.R. 8 that I would like to suggest that would make it more beneficial to our members. First, I encourage the committee to clarify the eligibility of long-term care plans for inclusion in section 125 plans. The ability of employers to offer long-term care coverage in a section 125 cafeteria plan would be a very substantial encouragement to individuals to purchase group long-term care insurance.

Second, and more importantly, I encourage the committee to amend this legislation by adding 403(b) to the 401(k) provisions. Since 403(b) plans are to those of us in the educational community what 401(k) plans are to those in the private sector, I believe we should be given the same incentives as people with 401(k) plans.

The reality of the history of our country is that Congress has through the Tax Code provided people with incentives to do hundreds of things. When those incentives are carefully thought out, I believe they constitute good public policy. I believe that most members of this committee want to do something to ease the growing costs to Medicaid of providing long-term care.

If that is true, I encourage you to join me in supporting H.R. 8. I encourage you to add 403(b) to the bill's 401(k) provisions and to clarify that long-term care benefits can be offered through section 125 plans. If you do that, I believe you will see many more Americans choosing to protect themselves from future long-term care costs through the purchase of private insurance.

And, Mr. Chairman and members of the subcommittee, I just want to conclude by thanking you very much for giving me the opportunity to be here and let an ordinary American citizen come before this important subcommittee and express his point of view.

[The prepared statement follows:]

TESTIMONY OF DAVID ALLEN, EXECUTIVE OFFICER
CITY UNIVERSITY OF NEW YORK WELFARE FUND

Good afternoon. Mr. Chairman and Members of the Subcommittee, my name is David Allen. I am a professor in the City University of New York. I would like to thank you for the opportunity to appear before your subcommittee.

In addition to teaching economics at the University, I am a trustee and Executive Officer of the Professional Staff Congress - City University of New York Welfare Fund. The Welfare Fund is a program of fringe benefits for the professional staff of the City University of New York. In addition to policymaking responsibilities as a trustee of the Fund, as Executive Officer I have special responsibility for member relations. It falls to me to meet with our 13,000 active and retired members around the University, to listen to their complaints and suggestions and to explain to them the programs of the Fund.

I am a believer in private long term care insurance and I encourage you to provide incentives to Americans to purchase protection now against the future possibility of long term care costs. I am here today to personally attest to the valuable role long term care coverage plays in our benefit plan and to urge your support of the private long term care market through the tax clarifications provided in H.R. 8, the Senior Citizens' Equity Act.

The Professional Staff Congress, which is a local of the American Federation of Teachers, was the first union in the United States to sponsor a group long-term care insurance program and the City University of New York was the first university in the United States to offer its professional staff long-term care insurance.

The impetus for our plan came in 1988 and it came neither from our own staff nor from an insurance company anxious to sell its product. Instead, it came from our own retirees. They are organized in a special retirees' chapter of the union. Members of that chapter knew from first-hand experience the number of Americans in need of long term care and the high cost of providing it. Because long term care insurance was a new concept and because of the complexity of evaluating different plans, they came to us and asked that our Welfare Fund provide them with a good group plan that they could have confidence in. Group plans cannot meet the needs of 100% of the population. I do believe, however, that group plans have a special role to play in meeting the need for long term care insurance. Because long term care insurance is new and because of the variety of plans on the market, groups can do for members what they cannot do for themselves -- hire professionals to read the fine print, evaluate competing plans and select a plan that represents good value for the money, a plan designed to meet the specific needs of that particular group. In addition, group plans have the advantage of lower rates, thanks to group purchasing power and the ability to attract all age ranges.

We solicited bids from insurance carriers for a plan that met out needs. Although negotiations with carriers are always a process of give and take, we were successful in finding a large insurance carrier, John Hancock, willing to offer a plan similar to what our members wanted. Approximately 3,000 of our 13,000 members now purchase our group long-term care insurance and it has been very well received by our members from the beginning. Furthermore, the Fund through the years has been able to modify the plan and make it even more attractive to our members. Our members have had the confidence of knowing that even if they did not read all the fine print in the policy, they knew someone who did. And, of course, they have the security of knowing that their hard-earned assets are protected by the policy should they need long term care. Although our long term care coverage has not yet generated many claims, our employees' experience to date with the Welfare Fund's long term care benefit has been uniformly positive -- as reflected in our low lapse rate. And I really should be saying "we" instead of "they" because my wife and I were among the very first persons to enroll in our long term care plan.

As I mentioned, about 23% of our members chose long term care insurance. Judged by other group plans, we are considered very successful, but I believe we could do better. The 10,000 people in our group who have not yet purchased long-term care insurance have not been given divine assurance that they will never need this protection. Nor are they independently wealthy. What they need is a message from Congress encouraging them to take action now to provide themselves with protection from the high cost of long-term care. I believe that H.R. 8 is a step in the right direction. The bill will provide official recognition of long term care insurance and much-needed clarification of its tax implications, and thus additional incentives for its purchase.

With regard to the Welfare Fund, there are two changes to H.R. 8 I would like to suggest that would make it more beneficial to our members. First, I encourage the committee to clarify the eligibility of long term care plans for inclusion in Section 125 plans. The ability of employers to offer long term care coverage in a Section 125 "cafeteria" plan would be a very substantial encouragement to individuals to purchase group long term care insurance. Second, and most importantly, I encourage the Committee to amend this legislation by adding 403(b) to the 401(k) provisions. There is no rational public policy reason for offering an incentive to those covered by 401(k) plans but denying them to the millions of Americans employed in the educational community who are covered by 403(b).

One way or another, the cost of long term care is going to be paid, but Americans need and want an alternative to public programs for financing their long term care needs. We will always need Medicaid for those who never had the financial means to purchase private long term care insurance, for those whose expenses are so catastrophic that they exceed the parameters of a reasonable long term care plan, and for those who are already too old to buy long term care insurance. But for the majority of Americans, I believe private long term care plans are the best choice.

The reality of the history of our country is that Congress has, through the tax code, provided people with incentives to do hundreds of things. When those incentives are carefully thought out, I believe that they constitute good public policy. I believe that most members of this committee want to do something to ease the growing costs to Medicaid of providing long term care. If that is true, I encourage you to join me in supporting H.R. 8. I also encourage you to add 403(b) to the bill's 401(k) provisions and to clarify that long term care benefits can be offered through Section 125 plans. If you do that, I believe you will see many more Americans choosing to protect themselves from future long term care costs through the purchase of private insurance.

Thank you.

Chairman THOMAS. Thank you very much, Mr. Allen.
Mr. Guttchen.

STATEMENT OF DAVID J. GUTTCHEN, PROJECT DIRECTOR, CONNECTICUT PARTNERSHIP FOR LONG-TERM CARE, STATE OF CONNECTICUT OFFICE OF POLICY AND MANAGEMENT, HARTFORD, CONN.

Mr. GUTTCHEN. Thank you, Mr. Chairman. Mr. Chairman, members of the subcommittee, thank you for the opportunity to present testimony today regarding the long-term care insurance provisions found in H.R. 8. I am pleased to be here to discuss the long-term care financing issue from a State government perspective.

My name is David Guttchen. I am the project director for the Connecticut Partnership for Long-Term Care, and I work out of the State of Connecticut Office of Policy and Management which is our Governor's executive staff agency. The financing of long-term care is a serious concern for State governments because of the financial devastation our residents face and the increasing burden long-term care places on the Medicaid program.

As you know, Medicare and general health insurance do not cover most long-term care. And it is unlikely there will be new Federal benefits coming for long-term care in the near future. Medicaid has become by default the primary public payer for long-term care.

However, because poverty is a criteria for Medicaid eligibility, individuals and families are wiping out a lifetime of savings paying for their care. Representative Stark mentioned the cost of care is about $30,000 or $36,000. In the State of Connecticut, as in a State like New York, on average, a year in a nursing home will cost over $60,000. With these costs, it does not take long for individuals to wipe out their hard-earned savings.

Individuals are also resorting to transferring or sheltering their assets in order to become eligible for Medicaid. In either case, people are losing their financial independence and Medicaid long-term care costs are skyrocketing. In fact, in Connecticut this last fiscal year we spent over $850 million in our Medicaid program for long-term care. That is over 50 percent of our Medicaid budget and close to 10 percent of our total State budget. And it represents a 300-percent increase in long-term care Medicaid costs since 1987.

I am proud to say Connecticut has been a leader in addressing the long-term care financing dilemma that I believe all States are facing. Beginning in 1986, Connecticut has been working on innovative financing approaches for its citizens. One such program is the Connecticut Partnership for Long-Term Care, and while she is not in the room, I would like to thank Representative Johnson as well as Representative Kennelly for all their support over the years for the development of the partnership plan as well as the Robert Wood Johnson Foundation for their initial support and continued support for the partnership projects.

The Connecticut partnership launched in 1992 and the first program of its kind in the country, as Dr. Meiners earlier described, is a unique alliance between State government and private insurance companies that uses a combination of private long-term care insurance and coverage through the Medicaid program to provide Connecticut residents with long-term care protection without the

fear of impoverishment. As was noted, similar programs are up and running in New York and California as well as the State of Indiana and other programs are being launched in Illinois, Iowa, and Maryland.

The Connecticut partnership seeks to reduce the reliance on Medicaid as the primary public payer of long-term care as more individuals privately insure for their long-term care risks. The program offers through participating insurers specially certified, high-quality, affordable long-term care insurance that can protect the individuals' hard-earned resources and help them retain their financial independence and dignity.

A significant achievement for the partnership programs are the standards we have developed for insurance policies sold through our programs. These standards such as mandatory inflation protection and specialized agent training were developed to address consumer concerns about the adequacy of the coverage they were purchasing and assure that a meaningful benefit is provided.

These standards, while protecting consumers, also increase confidence in the insurance being purchased. The Connecticut partnership is targeted to and most advantageous for those with modest incomes and assets. These are the most likely candidates to spend down their resources and end up on Medicaid and the least likely to be able to afford adequate private insurance.

By offering back-end coverage through Medicaid without the requirement that one be impoverished, the Connecticut partnership makes the purchase of quality private insurance more affordable and accessible for the middle class.

The partnership was developed to provide an incentive for individuals to buy quality private long-term care insurance. The program has proven to be a win-win formula. Individual purchasers win as they take personal responsibility for their long-term care costs with the knowledge that if their needs exceed their insurance coverage, they can access Medicaid and not impoverish themselves.

Insurance companies win as the market for private long-term care insurance expands and State and Federal Governments win as the growth in Medicaid long-term care expenditures is constrained. The long-term care provisions found in H.R. 8 should prove to be an additional incentive for the purpose of long-term care insurance. As with the partnership projects, the provisions could create a win-win situation as long-term care insurance is made more affordable, sales increase, and the reliance on Medicaid is reduced.

I see my time is up. I just want to make one last technical point that Dr. Wallack mentioned earlier in terms of a concern with the bill. We certainly support the provision in H.R. 8 that requires long-term care policies to coordinate benefits with Medicare, but we also need to point out the contradiction with H.R. 5252, the Social Security Act Amendments of 1994 which was passed in October of last session which prohibits long-term care insurance policies from coordinating benefits, and we urge the subcommittee and full committee to look at amending the Social Security Act to remove this inherent contradiction between the two bills.

Thank you for the opportunity to testify today.

[The prepared statement follows:]

Testimony of
David J. Guttchen
Project Director
Connecticut Partnership for Long-Term Care
State of Connecticut Office of Policy and Management

Mr. Chairman. Members of the Subcommittee. Thank you for the opportunity to present testimony today regarding the long-term care insurance provisions found in H.R. 8 - "The Senior Citizens Equity Act". I am the Project Director for the Connecticut Partnership for Long-Term Care and work out of the State of Connecticut Office of Policy and Management, our Governor's executive staff agency. I am very grateful to be able to represent the views of the State of Connecticut on the important issue of how we as a society will pay for future nursing home and home care costs.

The financing of long-term care is a serious issue for state governments because of the financial devastation our residents face and the increasing burden long-term care puts on the Medicaid program. As you know, Medicare and general health insurance do not cover most long-term care. Medicaid has become, by default, the primary public payor for long-term care. However, because poverty is a criteria for Medicaid eligibility, individuals and families are either wiping out a lifetime of savings paying for their long-term care - which does not take long in Connecticut where the average cost for nursing home care is over $60,000 a year - or are resorting to transferring or sheltering their assets in order to appear poor and become eligible for Medicaid. In either case, people are losing their financial independence and Medicaid long-term care costs are skyrocketing. In fact, in fiscal year 1987, Connecticut's Medicaid program spent $275 million on long-term care - that figure has risen to over $850 million for fiscal year 1994, a total that represents 53% of our Medicaid budget and close to 10% of Connecticut's total state government budget. With people living longer and the large numbers of "Baby Boomers" turning 65 years of age in the next 20 to 30 years, the financial strain long-term care will put on Medicaid will be enormous.

Connecticut has been a leader in addressing the long-term care financing dilemma that, I believe, all states are facing. Dating back to a special commission developed in 1986 to look at the private and public responsibilities for financing long-term care, Connecticut has been working on innovative long-term care financing approaches for its citizens. One such program is the Connecticut Partnership for Long-Term Care.

The Connecticut Partnership, launched in April 1992 and the first program of its kind in the country, is a unique alliance between state government and private insurance companies that uses a combination of private long-term care insurance and coverage through the Medicaid program to provide Connecticut residents with long-term care protection without the fear of impoverishment. Similar programs are now operational in California, Indiana and New York and are being planned in Illinois, Iowa and Maryland.

The Connecticut Partnership seeks to reduce the reliance on Medicaid as the primary public payor of long-term care as more individuals privately insure for their long-term care risks. The program offers, through participating insurers, specially certified, high-quality, affordable long-term care insurance that can protect the individual's hard earned resources and help them retain their financial independence and dignity. A significant achievement for the Partnership programs are the standards developed for the insurance policies sold through the projects. These standards were developed to address consumer concerns about the adequacy of the coverage they were purchasing and assure that a meaningful benefit is provided to the policyholder. These standards, while protecting consumers, also increase confidence in the insurance being purchased.

The Connecticut Partnership is targeted to, and most advantageous for, those with modest incomes and assets. These are the most likely candidates to spend down their resources and end up on the Medicaid program and also the least likely to be able to afford adequate private insurance in the absence of our program. By offering back-end coverage through Medicaid, without the requirement that one be impoverished, the Connecticut Partnership makes the purchase of quality private insurance more affordable and accessible for the middle class.

The Connecticut Partnership was developed to provide an incentive for individuals, especially those with more modest incomes and assets, to buy private long-term care insurance. The program has proven to be a win-win formula. Individual purchasers win since they are able to take personal responsibility for their long-term care costs with the knowledge that if their needs exceed their insurance coverage they can access the Medicaid program and not impoverish themselves. Insurance companies win as the market for private long-term care insurance expands. And state and federal governments win as the growth in Medicaid long-term care expenditures is constrained. To date, close to 2,000 Connecticut residents have purchased a Connecticut Partnership policy and well over 16,000 individuals have been provided long-term care information through our program's consumer education campaign.

The long-term care provisions found in H.R. 8 should prove to be an additional incentive for the purchase of long-term care insurance. If these provisions help to make long-term care insurance more affordable and attractive they have the potential to positively impact consumers, insurers and state governments. As with the Connecticut Partnership, the long-term care provisions in H.R. 8 can create a win-win situation as long-term care insurance is made more affordable, sales increase and the reliance on Medicaid is reduced.

The long-term care provisions in H.R. 8 should work as a compliment to the efforts of the Connecticut Partnership and the other Partnership projects. Hopefully, the combination of these incentives will help to expand the market for quality long-term care insurance and make for a more equitable financing system that relies less on Medicaid.

There is, however, one technical point that is worth mentioning. While we fully support the section of H.R. 8 that requires long-term care policies to coordinate benefits with the Medicare program, it is important to note that H.R. 5252, the Social Security Amendments Act of 1994 (passed by Congress in October 1994) prohibits long-term care policies from coordinating benefits with Medicare creating an obvious conflict with H.R. 8. We strongly urge that the Social Security Act be amended to allow for long-term care policies to coordinate benefits thus removing the contradiction with H.R. 8.

In conclusion, while certainly private long-term care insurance is not appropriate for, or accessible to, everyone, a growing market will enable state governments, such as Connecticut, to utilize its scarce resources for those greatest in need. The tax provisions found in H.R. 8, and programs such as the Connecticut Partnership and Partnership programs in other states, can provide incentives to expand the private market and benefit both the private and public sectors.

Thank you again for the opportunity to provide this testimony regarding H.R. 8's long-term care provisions. Please contact my office if the State of Connecticut can be of further help as the subcommittee and full committee deliberates this matter.

Chairman THOMAS. Thank you very much.
Ms. Holubinka.

STATEMENT OF GAIL HOLUBINKA, DIRECTOR, NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE, ALBANY, N.Y.

Ms. HOLUBINKA. Good afternoon, Mr. Chairman, members of the committee. I am Gail Holubinka. I am director of the New York State Partnership for Long-Term Care, and I would like to thank you for the opportunity to speak before this committee on the important issue of offering tax incentives to purchasers of long-term care insurance.

As in most States, New York's Medicaid expenditures are escalating and as in most States, the fastest growing and most difficult area to control is long-term care. New York is justly proud of the extent and quality of the care that it provides to elderly Medicaid recipients, but with total Medicaid long-term care costs exceeding $7 billion, that is with a B, in 1994, the State believes that the current system of long-term care financing must change.

Medicaid was established to provide health care to the poor. However, poverty can be situational as well as historical. In the event of a financially catastrophic long-term care episode, those who have always lived comfortably could find themselves at risk of impoverishment.

For example, the average cost of a semiprivate nursing home for a year in New York would range from $62,000 to $75,000. Given an average stay of 2½ years, even New Yorkers with resources of $175,000 will wind up as Medicaid recipients. This is not the type of poverty the designers of the Medicaid program envisioned addressing.

However, this is a scenario that is a reality in New York. Compounding the problem is the fact that with such large amounts of life savings at stake, the incentive to take advantage of divestiture tactics to gain Medicaid's assistance is enormous. In either case, whether the impoverishment is actual or artificial, the result is the same. In New York State, Medicaid has become the safety net for the middle and even the upper middle class citizen when long-term care is needed. This is the reality in New York that we have faced and we have taken action.

In 1988, under a grant from the Robert Wood Johnson Foundation, New York accepted the challenge to create an alternative to the unpalatable choices of impoverishment or divestiture that would be attractive to its citizens and save Medicaid funds. The result of that effort is the New York State partnership.

In selecting a financing alternative that would be affordable to residents but would not require increased public expenditure, New York looked to the source of personal financial protection against most catastrophic events, private insurance, and combined it with a concept of shared risk between the individual citizen and the State.

Under the New York partnership, residents who purchase a time-limited amount of long-term care insurance from participating private insurers and who subsequently exhaust the benefits under such insurance are allowed to apply for Medicaid, contributing their income, but retaining all of their assets. The use of insurance

has also created the opportunity to improve and promulgate the relatively new long-term care insurance product in a way that will help all the State residents regardless of whether they participate in the partnership.

By establishing standards of quality for partnership policies, New York has created guidelines by which residents may judge all long-term care insurance. By embarking on extensive educational campaigns to inform the public of the risks, costs, and options of long-term care financing, the partnership has made residents aware of the problems they face.

Indeed, partnership activity has raised the issues of long-term care financing to an integral component of retirement planning. In New York, the strategy is paying off. The incentive and affordability offered by the partnership has stimulated the long-term care insurance market. Since the partnership became operational in 1993, the sale of long-term care insurance has increased by over 50 percent, with two-thirds of that increase being in the sale of nonpartnership policies.

Clearly New York's approach has struck a chord with its citizens. However, as impressive as that response has been and as vital as the partnership is, there is a long way to go before long-term care insurance becomes as accepted as private health insurance. And New York believes that the major factor that hinders its acceptance is the lack of clarification regarding the tax status of long-term care insurance.

New Yorkers who have heeded the call for the personal responsibility in terms of taking care of their own long-term care needs, need support and encouragement in their effort to pay their own way and so do the millions of others who are also going to care for themselves if given the opportunity to do so without negative tax implications.

There is a cost, but we believe that the cost can be overcome through the savings in other programs. Where the reliance on Medicaid can be delayed or avoided, savings will accrue to offset any investment.

We therefore ask you to support the clarification of the tax incentives for long-term care.

Thank you.

[The prepared statement follows:]

TESTIMONY OF GAIL HOLUBINKA
NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE

Good afternoon. Mr. Chairman. Members of the Committee. I am Gail Holubinka, Director of the New York State Partnership for Long Term Care. Thank you for the opportunity to speak before this committee on the important issue of offering tax incentives to purchasers of long term care insurance.

As in most states, New York's Medicaid expenditures are escalating. And, as in most states, the fastest growing and most difficult to control area of spending is long term care. New York is justly proud of the extent and quality of the care it provides to elder Medicaid recipients, but, with total Medicaid long term care costs exceeding $7 billion in 1994, the state believes that the current system of long term care financing must change.

Medicaid was established to provide health care to the poor. However, poverty can be situational as well as historical. In the event of a financially catastrophic long term care episode, those who have always lived comfortably could find themselves at risk of impoverishment. For example, the annual semi-private rate for nursing home care in New York ranges from $62,000 to $75,000. Given an average stay of two and one-half years, even New Yorkers with resources of $175,000 could become Medicaid recipients. This is not the type of poverty the designers of the Medicaid program envisioned addressing, but this scenario has become a reality in New York. Compounding the problem is the fact that with such large amounts of life savings at stake, the incentive to take advantage of divestiture techniques to gain Medicaid's assistance is enormous. In either case, whether the impoverishment is actual or artificial, the result is the same: in New York State, Medicaid has become the safety net for middle and even upper middle-class citizens when long term care is needed. This is a reality New York has faced and it has taken action.

In 1988, under a grant from the Robert Wood Johnson Foundation, New York accepted the challenge to create an alternative to the unpalatable choices of impoverishment or divestiture that would be attractive to its citizens and save Medicaid funds. The result of the effort is the New York State Partnership for Long Term Care.

In selecting a financing alternative that would be affordable to residents but not require increased public expenditure, New York looked to the source of personal financial protection against most catastrophic events, private insurance, and combined it with the concept of shared risk between the individual citizen and the state. Under the New York Partnership, residents who purchase a time-limited amount of long term care insurance from participating private insurers and who subsequently exhaust the benefits under such insurance are allowed to apply for Medicaid contributing their income but retaining all assets.

The use of insurance also created the opportunity to improve and promulgate the relatively new long term care insurance product in a way that would help all state residents regardless of whether they participate in the Partnership. By establishing standards of quality for Partnership policies, New York has created guidelines by which residents may judge all long term care insurance. By embarking on extensive educational campaigns to inform the public of the risks, costs, and options of long term care financing, the Partnership has made residents aware of the problems they may face. Indeed, Partnership activity has raised the issue of long term care financing as an integral component of retirement planning.

New York's strategy is paying off. The incentive and affordability offered by the Partnership has stimulated the long term care insurance market. Since the Partnership became operational in 1993, the sale of long term care insurance has increased by over 50 percent, with two thirds of that increase being in the sale of non-Partnership policies. Clearly, New York's approach has struck a chord with its citizens. However, as impressive as the response has been and as vital as the Partnership is in providing affordable coverage, there is a long

the major factors hindering this acceptance is the lack of clarification regarding the tax status of long term care insurance.

The New Yorkers who have heeded the call for personal responsibility need support and encouragement in their effort to pay their own way. So do the millions of other citizens who are willing to care for themselves if given the opportunity to do so without negative tax implications. There is a cost in tax clarification that would place long term care insurance on the same level as health insurance. However, where reliance on Medicaid can be delayed or avoided, savings will accrue to offset that investment. Specifically, New York has estimated that for each divestiture avoided, Medicaid could well save over $100,000 on an average stay; for each impoverishment avoided, Medicaid could save over $75,000. While potential savings in states with lower long term care costs might be less dramatic, the concept is sound. Replacing public dollars with private dollars makes sense.

Government must recognize the dilemma of long term care financing that the public faces and assist citizens in doing what they can to help themselves. The Partnership concept is definitely a part of the answer, but the first step should be for government to encourage and acknowledge the benefit of personal planning for possible long term care costs to both the citizen and society as a whole . By declaring that tax-wise, long term care insurance will be treated like health insurance and, therefore, be considered as desirable as health insurance, government will send its citizen's the clear message that must be heard if reasonable solutions to paying for the care of our elderly, now and in the future, are to be found.

Chairman THOMAS. Thank you very much.
Mr. Mahoney.

STATEMENT OF KEVIN J. MAHONEY, PH.D., PROJECT DIRECTOR, CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE, SACRAMENTO, CALIF.

Mr. MAHONEY. Thank you, Mr. Chairman. On July 29, 1994, Governor Pete Wilson launched California's Partnership for Long-Term Care program. This partnership between private insurers and Medicaid aims to provide individuals a way they can plan ahead to meet their needs for nursing home and community care without fear of impoverishment. At the same time, this program works to constrain the growth of the Medicaid program. Though our program is less than 6 months old, we are receiving about 1,000 inquiries a month at our toll-free telephone number.

Under current California law, individuals must spend down their assets to just $2,000 in order to qualify for MediCal benefits to pay for their long-term care needs. Under the partnership program, a person who buys a State-certified policy is entitled to keep additional assets equal to the amount his or her insurance has paid out and still receive Medicaid benefits. This dollar-for-dollar approach allows for a variety of product designs ranging from 1 to 5 years of coverage.

This program encourages individuals to plan for their long-term care needs by offering affordable quality protection to people with varying financial needs. As opposed to what you heard on the earlier panel, prices for a 65-year-old, even for these high-quality products, start from $65 to $85 a month.

This partnership is based on the premise that neither the public nor the private sector alone can solve the long-term care financing problem. There is an important role for private insurance. There is a key role for the public sector and they can work in concert. Title III of H.R. 8 builds on that same foundation. Clarifying the tax status of long-term care insurance will play a significant role in legitimizing the private market, and increasing the affordability and attractiveness of coverage.

But should we stop there? Here again, the experience of these successful State partnership programs may give some guidance. The goal of the California partnership is not merely to increase the sale of private long-term care insurance, rather it is to increase the number and proportion of middle- and modest-income individuals with long-term care protection. The well to do have a number of ways to pay for care. Medicaid can provide protection for the poor. The dollar-for-dollar partnership approach helps make coverage more affordable for those with modest means and it is our hope that the income tax deduction or credits contained in H.R. 8 will do the same.

Furthermore, whereas the sale of additional long-term care insurance is a prerequisite to meeting our goals, it is a means to an end. It is also important that the coverage be in place 20 or 30 years from now when people need the care and that that coverage really cover a substantial portion of the care that those people need.

The goals of the California Partnership for Long-Term Care include keeping the coverage in place and diminishing the number of people who spend down to Medicaid. In this respect, the standards the partnership policy must meet are key. As the recent study in this fall's issue of Health Affairs shows, unless policies provide adequate coverage and inflation protection, purchasers run a significant chance of still ending up on Medicaid.

The California Partnership for Long-Term Care created a consumer standards working group made up of consumers, providers, insurers, and State officials to develop standards that would give the public the necessary confidence in the private market.

Among the features we pioneered were a stepdown provision, which enabled people to lower their coverage if their economic situation worsened without losing all the reserves they had already built up. Tax clarification might be enhanced if it, too, included standards for the private policies, such as the consensus standards developed by the National Association of Insurance Commissioners. Certainly we in State Medicaid offices value attention to basic consumer standards ensuring the adequacy of the coverage.

I appreciate the chance to appear and speak on private long-term care insurance and the value of clarifying its tax status. I hope that the example of California's public, private partnership for long-term care can offer some useful insights, particularly in the areas of targeting benefits to the middle- and modest-income individuals who lack coverage and establishing basic insurance standards so that private coverage will increase, that coverage will persist, and the reliance on Medicaid will diminish.

Thank you.

[The prepared statement follows:]

TESTIMONY OF KEVIN J. MAHONEY, PH.D.
CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

Mr. Chairman and Members of the Committee. I am Kevin J. Mahoney, Ph.D., Project Director for the State of California's Partnership for Long-Term Care.

On July 29, 1994 Governor Pete Wilson launched the California Partnership for Long-Term Care. This Partnership between private insurers and Medicaid aims to provide individuals a way to plan ahead to meet their needs for nursing home and community care without fear of impoverishment. At the same time, this program works to constrain the growth of the Medicaid program. Though this program is less than six months old, we are receiving about 1,000 inquiries a month at our toll-free telephone number.

Under current California law, individuals must "spend down" their assets to just $2,000 in order to qualify for Medi-Cal benefits to pay for their long-term care needs. Under the Partnership program, a person who buys a state-certified policy is entitled to keep additional assets, equal to the amount his or her insurance has paid out, and still receive Medi-Cal benefits. Individuals will still need to use their incomes to pay their share of the cost.

When a policyholder requires long-term care (whether in a nursing home or at home), he or she will first receive benefits under their certified private insurance policy. If the policyholder requires care above and beyond what the policy provides, the individual can apply for Medi-Cal without impoverishing himself or herself.

This dollar-for-dollar approach allows for a variety of product designs with benefits ranging from one year to five years of coverage. The program encourages individuals to plan for their long-term care needs by offering affordable, quality protection to people with varying financial means.

This Partnership is based on the premise that neither the public nor the private sector alone can solve the long-term care financing problem. There is an important role for private insurance. There is a key role for the public sector--and they can work in concert.

Title III of H.R. 8, "The Senior Citizens' Equity Act", builds on this same foundation. Clarifying the tax status of long-term care insurance will play a significant role in legitimizing the private market, and increasing the affordability and attractiveness of private coverage.

But should we stop there? Here again the experience of these successful state Partnership programs may give some guidance. The goal of the California Partnership for Long-Term Care is not merely to increase the sale of private long-term care insurance. Rather, it is to increase the number and proportion of middle and modest income individuals with long-term care protection. The well-to-do have a number of ways to pay for needed care. Medicaid offers protection to the poor. The dollar-for-dollar Partnership approach helps make coverage more affordable for those with modest means. It is our hope that the income tax deduction (or credits) contained in H.R. 8 will do the same.

Furthermore, whereas the sale of additional long-term care insurance is a prerequisite for meeting our goals, it is a means not an end. It is also important that coverage be in place twenty to thirty years from now when the individual needs care, and that the benefits cover a substantial portion of the costs of care. The goals of the California Partnership for Long-Term Care include keeping the coverage in place, and diminishing the number of people who spend-down to Medicaid. In this respect, the standards Partnership policies must meet are key. As the recent study by Cohen, Kumar and Wallack (published in the Fall, 1994 issue of Health Affairs) shows, unless policies provide adequate coverage and inflation protection, purchasers run a significant chance of still ending up on Medicaid. The California Partnership for Long-Term Care created a Consumer Standards Working Group (made up of consumers, providers, issuers and state officials) to develop the standards that would give the public the necessary confidence in

the private market. Among the features we pioneered were a step down provision which enabled people to lower their coverage if their economic situation worsened--without losing all of the reserves they had already built up. Tax clarification might be enhanced if it, too, included standards for the private policies--such as those developed by the National Association of Insurance Commissioners. Certainly, we in state Medicaid offices value attention to basic consumer standards assuring the adequacy of the coverage.

I appreciate the chance to appear before you today to speak on the importance of private long-term care insurance, and the value of clarifying its tax status. I hope that the example of California's Public/Private Partnership for Long-Term Care can offer some useful insights, particularly in the areas of targeting benefits to the middle and modest-income individuals who have lacked coverage, and establishing basic insurance standards so that private coverage will increase, that coverage will persist, and reliance on Medicaid will diminish.

We will be very happy to share our experience as you continue your deliberations.

Chairman THOMAS. I want to thank the panel. Ms. Fosberg, I want to thank you for your testimony because obviously if everyone approached their living conditions as precisely and succinctly as you did, we would have less reliance on folks having to spend their entire savings to achieve the level of concern and care that you have.

Mr. Allen, I appreciate your testimony, especially because it isn't just the tax incentive. Obviously you had a group who had felt a need and they approached you to try to resolve their problem. It just seems to me that if this is part of a package that is offered, more and more people, word of mouth or otherwise, will begin to focus on it. Agents will obviously begin to put this in their portfolio as they discuss with you what your options are.

And last, because I have to go to a vote, we will start the third panel when I come back. Could we have a relatively brief response if you have any data because what we are talking about is getting people to fall back on their own resources more through an intelligent way of relying on their own resources and not spending it down to qualify for a public program. It would have to work itself out over time, do we have any estimates at all of what creating an incentive for individuals to spend their own money through a private insurance program would save the public funds at all over any period of time?

Do any of you have any information in that regard?

Mr. MAHONEY. I could start to answer. In the projections that we did for the California partnership, simulations showed that in the early years the partnership was basically a break-even for the State. A good part of that was due to the help of the Robert Wood Johnson Foundation and the seed money they gave to develop and evaluate the partnership program.

Our projections show that, carried out into the next century, our partnerships will lead to savings ranging from 1 to 7 percent of the Medicaid long-term care budget; that is part of what these State demonstrations are intended to show.

Chairman THOMAS. Some of us were looking in the last Congress for methods to save in the 5- to 6-percent range in terms of Medicaid. It is interesting that if we simply set up a private option for individuals that that savings would be achieved. I want to thank the panel very much and we will begin the third panel as soon as we get back after the vote.

Thank you.

[Recess.]

Mr. CHRISTENSEN [presiding]. We are going to go ahead and call our hearing back into order. Could we get Mr. Garner and Mr. Chies and Mr. Hagen? The committee would be pleased to hear your testimony, and, Mr. Garner, why don't you start first?

STATEMENT OF RICHARD GARNER, VICE PRESIDENT, LONG-TERM CARE DIVISION, CNA INSURANCE COS., CHICAGO, ILL., ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA (HIAA)

Mr. GARNER. Good afternoon, Mr. Chairman, and members of the Ways and Means Subcommittee on Health. My name is Richard Garner and I am vice president, Long-Term Care Division, for the

CNA Insurance Cos. I am here today on behalf of the Health Insurance Association of America, which represents many of the Nation's leading commercial insurance companies. About 60 percent of the long-term care insurance policies sold have been issued by HIAA member companies.

We welcome the opportunity to testify today on the important issue of long-term care tax clarification. We strongly support the tax clarifications that are contained in the Senior Citizens' Equity Act. These provisions will directly benefit millions of consumers. Further, it demonstrates the cooperation between the public and private sectors that is essential for improving our system for financing long-term care.

Though much of the health care reform debate in the past has focused on acute medical care, millions of Americans of all ages, but especially the elderly, also face potentially catastrophic expenditures for long-term care services.

HIAA believes that our country's long-term care financing system can be improved by using the following three strategies:

One, emphasizing individual responsibility in financial planning for the exposure to long-term care risks; two, promoting the growth of the private long-term care insurance market by providing tax incentives for purchasing coverage; and three, expanding public assistance for those who are unable to finance their own long-term care expenses.

Insurers can foster individual responsibility by providing quality products which meet the needs of consumers. Insurers must also participate in educational efforts to increase the public's awareness of the potential financial burden of long-term care. For its part, Congress can help foster individual responsibility by dispelling the notion that a new government entitlement program is just around the corner.

Congress has an equally important role in encouraging the growth of the private long-term care market by enacting tax clarification. Tax clarification for long-term care insurance would reduce its costs for many Americans, increase its appeal for employers, and increase public confidence in this tremendously important private insurance coverage.

The Senior Citizens' Equity Act supports the strategies I outlined above. It demonstrates the government's commitment to the private long-term care insurance market. It reinforces individual responsibility, and it provides the necessary clarification to remove uncertainty the public now has about the tax treatment of long-term care.

HIAA believes that tax incentives will stimulate individuals to plan for their own financial security and will stimulate employers to sponsor group plans as employee benefits. In turn, this expansion of the private long-term care insurance market will have the effect of reducing future costs to the government by reducing Medicaid outlays.

Let me emphasize again that the tax clarification provisions will directly benefit consumers. In particular, policy benefits to the individual would be tax free up to the maximum limit. Employer contributions toward premiums would be a tax-free fringe benefit to

the employee and long-term care expenses would be deductible as medical expenses.

Some provisions in the proposed bill need reinforcement or technical corrections. In particular, employer deductibility of premiums should be added; long-term care should be included as a qualified benefit in a cafeteria plan; the effective date provisions should be adjusted to give sufficient time for newly issued policies to conform with the act; and the requirement that policies coordinate with Medicare to receive tax-favored treatment should be reconciled with the Health Care Financing Administration's apparent interpretation that such coordination is disallowed. HIAA will be pleased to assist the subcommittee in crafting these and other technical revisions.

Mr. Chairman, our written statement addresses these issues in greater detail and I would be pleased to answer questions. We appreciate the opportunity to participate on an ongoing basis as this legislation evolves.

Thank you.

[The prepared statement and attachments follow:]

TESTIMONY OF RICHARD GARNER
HEALTH INSURANCE ASSOCIATION OF AMERCA

Good morning Mr. Chairman and Members of the Ways and Means Subcommittee on Health. My name is Richard Garner and I am Vice President, Long Term Care Division, for the CNA Insurance Companies. I am here today on behalf of the Health Insurance Association of America (HIAA) which represents many of the nation's leading commercial insurance companies. About 60 percent of the long-term care insurance policies sold have been issued by HIAA's member companies.

HIAA welcomes the opportunity to testify today on the important issue of long-term care and, in particular, on the long-term care tax clarification provisions in the Senior Citizens' Equity Act. Mr. Chairman, we commend the Republican Leadership for coming forward with this ambitious legislative program for early consideration in the 104th Congress. Cooperation between the public and private sectors is essential for financing and delivering long-term care services, and tax clarification is a critical element of that cooperation.

Though much of the health care reform debate in the past has focused on acute medical care, millions of Americans of all ages, but especially the elderly, also face potentially catastrophic expenditures for long term care services.

HIAA believes that our country's long-term care financing system can be improved by using the three following strategies:

(1) emphasizing individual responsibility in financial planning for the exposure to long-term care risks;

(2) promoting the growth of the private long-term care insurance market by providing tax incentives for purchasing coverage; and

(3) expanding public assistance for those who are unable to finance their own long-term care expenses.

Both the private insurance industry and the government have roles to play in accomplishing these strategies.

Insurers can foster individual responsibility by providing quality products which meet the needs and expectations of consumers and by providing well-trained agents to sell them. Insurers must also participate in educational efforts to increase the public's awareness of the potential financial burden of long-term care. For its part, Congress can help foster individual responsibility by dispelling the notion that a government entitlement program is just around the corner.

Congress also has an important role in encouraging the growth of the private long-term care market by enacting tax clarification and reasonable federal standards for long-term care insurance. Tax clarification for these products would reduce the cost of long-term care insurance for many Americans, would increase their appeal to employers, and would increase public confidence in this relatively new private insurance coverage.

In conjunction with tax clarification, we would support establishing reasonable federal standards for long-term care insurance products that would serve as a "seal of approval," further building consumer confidence in private long-term care insurance products. However, such standards must not be so onerous that they prohibit all but "cadillac" policies from being sold. It is critical to ensure that consumers will have the opportunity to choose appropriate protection for their individual circumstances from a wide range of coverage options. Equally important, we propose that consumer access to products that meet federal standards be dramatically increased. This could be accomplished by requiring that only an insurer's state of domicile must certify that a new policy meets the federal standards in order to sell that policy in all states where the insurer is licensed.

Congress also has a role in expanding assistance to those in financial need. Such assistance could take the form of enhancements to the Medicaid program. HIAA believes it is far better to use limited tax dollars to target care to those unable to protect themselves, and to encourage those who can afford to do so, to purchase private protection.

Mr. Chairman, the testimony below will focus on HIAA's views on the importance of addressing long-term care financing issues and our recommendations on how long-term care financing improvements can best be accomplished. We appreciate the opportunity to present our views on the provisions in the Senior Citizens' Equity Act and hope the Subcommittee would be receptive to further comments from HIAA as the legislation evolves.

I. TAX CLARIFICATION

The focus of this hearing is on one of three strategies for improving our long-term care financing system, specifically, tax clarification of private long-term care insurance and services. HIAA applauds the sponsors of the Senior Citizens' Equity Act for including the long-term care tax clarification title. The current uncertain tax treatment of long-term care insurance is a hindrance to market acceptance. Clear tax rules will add confidence in, and further the establishment of, the private long-term care insurance market.

This legislation demonstrates the government's support for and its commitment to the private long-term care insurance market as the primary means of helping Americans to fund for future long-term care needs. It reinforces the message to the public about individual responsibility. This will lead to an increase in the portion of the population who seek to protect themselves against catastrophic long-term care expenses. Furthermore, the expansion of this market will have the parallel effect of reducing future costs to the government by reducing Medicaid outlays.

We also are very pleased that the Senior Citizens' Equity Act contains provisions which clarify the tax status of life insurance policies that accelerate benefits because of terminal illness or long-term care needs. Since accelerated benefit policies were introduced in the early 1980's, we have sought clarification of the federal tax issues surrounding these products. As a result of this clarification, policyholders will be able to utilize their life insurance policies to assist them in dealing with extraordinary medical expenses without adverse tax consequences.

Most of the tax clarification provisions directly benefit consumers. In particular, policy benefits to the individual up to the maximum limit would be tax-free, employer contributions toward premiums would be a tax-free fringe benefit, and long-term care expenses would be treated as other deductible medical expenses. HIAA believes that these tax incentives will stimulate individuals to plan for their own financial security and will stimulate employers to sponsor group plans as part of their employee benefit package. In addition, the social policy reasons that Congress has, for years, supported tax incentives for the purchase of accident and health insurance are equally applicable to support for tax incentives for the purchase of long-term care insurance.

HIAA supports the majority of the tax clarification provisions contained in the Senior Citizens' Equity Act. We believe that some of these important provisions need technical correction. We have identified these below and will be pleased to assist the Subcommittee in crafting these revisions.

Maximum Benefit/Treatment of Excess Benefits: HIAA supports the bill's provision giving tax favored treatment for a maximum daily benefit of $200, indexed for inflation. The bill treats as taxable income the aggregate amount of excess benefits received during the taxable year. HIAA supports this provision because disqualifying all benefits when a policyholder receives excess benefits is particularly unfair to individuals living in high cost areas where daily costs of institutional care already exceed the maximum benefit of $200. These individuals would be penalized twice -- having to pay higher daily costs and losing tax favored treatment of the first $200 in benefits. If the intent of the bill is to require aggregation of multiple policies, this provision may need to be clarified.

Effective Date/Transitions Rules: HIAA supports the effective date provisions for both newly issued and existing policies. Technical revisions may be necessary to ensure that policies issued after the date of enactment, but before the state approves new policies that conform to federal tax requirements, are granted favorable tax treatment. This is needed so there is no unintended effect of discouraging the market until new policies are approved.

Medicare Coordination: HIAA supports the requirement that a long-term care policy must coordinate with Medicare to be qualified for tax favored treatment. Long-term care carriers face a dilemma, however, resulting from indications from representatives of the Health Care Financing Administration (HCFA) with respect to its interpretation of the Medicare Technical Amendments (H.R. 5252) adopted at the end of the last session. We understand HCFA may interpret these amendments as prohibiting the sale of long-term care policies which coordinate with Medicare. We concur with Chairman Archer's view in his recent letter to the National Association of Insurance Commissioners (NAIC) that such interpretation does not reflect Congressional intent. (See attached letters.) This issue is discussed separately in Section II below.

Tax Reserves: HIAA supports the bill's provision which conforms the tax treatment of long-term care reserves with the statutory reserving requirements. This important provision updates the Internal Revenue Code to reflect recent changes by the National Association of Insurance Commissioners (NAIC) regarding long-term care reserve requirements. Treating tax reserves and statutory reserves consistently for the companies will result in lower long-term care premiums for consumers.

Treatment as Accident and Health: The bill intends to treat long-term care insurance as accident and health insurance for both policyholders and insurers. To accomplish this, we recommend a technical change to treat long-term care insurance as accident and health insurance for purposes of the entire income tax title. As currently drafted, the bill refers to the Internal Revenue Code part on company taxation and then has specific references to the I.R.C. sections 104 and 106, but not section 105, regarding individual taxation. Further, the bill should include language that long-term care insurance benefits are also qualified as payments to compensate for the loss of a function of the body under I.R.C. section 105(c). This criteria is closely related to the inability to perform activities of daily living and, therefore, is more consistent with the eligibility criteria used in most long-term care insurance products.

Long-Term Care Riders: HIAA supports the long-term care rider provisions included in the section pertaining to the tax treatment of accelerated death benefits under life insurance contracts. Many life insurance products include riders which accelerate benefits for long-term care needs in varied types of facilities, including

home care. The bill includes an important clarification of the tax treatment for accelerated death benefits paid under a life insurance contract for chronically ill individuals, ensuring the same treatment is available for individuals confined to all qualified facilities and not just nursing homes.

There are other provisions in the bill which HIAA believes need substantive changes in order to accomplish the objective of encouraging the development of the private long-term care market.

Activities of Daily Living: The bill uses activities of daily living (ADLs) as a benefit trigger, requiring the policyholder to be certified as unable to perform at least 2 out of the listed ADLs. It includes mobility, dressing, transfer, eating, and effectively treats bathing, toileting and continence as one ADL. This does not reflect the "Katz scale" of ADLs which have become standard practice in the industry. We recommend that the bill include the six activities of daily living that are most prevalent in the market (and reflect Katz' research) -- eating, dressing, transferring, bathing, toileting, and continence. HIAA will be pleased to work with the Subcommittee to craft an appropriate benefit trigger.

Per Diem Policies: The bill should ensure that a level playing field is created among different types of long-term care policies, including expense-reimbursement contracts and per diem contracts (which pay a fixed amount upon the determination of benefit eligibility). Per diem contracts should be treated as complying with the requirements of the definition of qualified long-term care contracts with respect to providing other coverage and coordination with Medicare, if they meet the other definitional requirements. Further, premiums paid for per diem contracts should be eligible for the individual tax deduction.

Long-Term Care Premiums: The bill allows individuals to deduct as medical expenses under I.R.C. section 213 the amount of long-term care insurance premiums, up to a specified limit based on age. The tax treatment for long-term care premiums should be consistent with the treatment for accident and health premiums in that the deduction should not be limited in amount (beyond the medical expense deduction floor). Individuals living in high cost areas who want to purchase adequate coverage should not be penalized by losing the deduction for the premiums, especially since benefits in excess of $200 (indexed) will be taxable income to them.

There are additional provisions that HIAA believes could stimulate the private market and should be included in the bill.

Employer Deduction for Long-Term Care Premiums: The bill should specifically permit employers to deduct, as a business expense, contributions to long-term care plans by including a provision that long-term care insurance does not have the effect of deferring compensation. Employers may not currently deduct any item which would otherwise qualify as an ordinary and necessary business expense but which has the effect of deferring compensation. Employer deduction is critical because the employer market is an effective way to expand the long-term care insurance coverage to the non-elderly population. Long-term care insurance is more affordable when purchased at a younger age and allowing employers to deduct contributions will encourage employers to offer, and possibly contribute toward, long-term care group plans.

Cafeteria Plans: The bill should specifically permit long-term care insurance to be offered through a cafeteria plan, including a provision that long-term care insurance does not have the effect of deferring compensation. This would provide an incentive for employers to offer long-term care insurance plans as a part of their benefits package. Because employees typically purchase group long-term care insurance at a earlier age, the cost is much lower, thereby encouraging more private protection.

Parents: Many companies now permit covered employees to enroll their parents in their employee benefit plan. To help encourage this trend, HIAA recommends that, for the purposes of determining the tax treatment for long-term care insurance, parents be treated as dependents of the covered employee, when the premium is paid by the employee.

II. MEDICARE DUPLICATION

In the final hours of the 103rd Congress, certain "technical amendments" to the Omnibus Reconciliation Act of 1990 (OBRA '90) were adopted. H.R. 5252 deals with the sale of health insurance that duplicates Medicare, Medicaid or other coverage. It was an attempt to clarify confusion that resulted from provisions in OBRA '90. Representatives of the Health Care Financing Administration (HCFA) recently indicated at public meetings that H.R. 5252 could be interpreted as prohibiting the sale of long-term care policies that coordinate benefits with Medicare. Under such interpretation, it would be a criminal offense to sell a long-term care policy that coordinates with Medicare after October 31, 1994. On the other hand, the Senior Citizens' Equity Act requires long-term care policies to coordinate with Medicare to be qualified long-term care contracts for tax purposes. This presents an irreconcilable difference for companies selling long-term care insurance. Clearly Congress would not in one bill prohibit the sale of long-term care policies which coordinate with Medicare and in another bill require long-term care policies to coordinate with Medicare.

In a recent letter to the NAIC, Ways and Means Chairman Archer and Senate Finance Chairman Packwood identified two areas of further confusion regarding what constitutes duplication within the meaning of H.R. 5252. With respect to the sale of long-term care policies that coordinate benefits with Medicare benefits, the Chairmen noted that requiring policies to pay directly regardless of Medicare payments would exhaust the policy benefits sooner or make it more expensive. The Chairmen further stated that this was not their intent. If an administrative resolution is not achieved, the Chairmen indicated their intent to seek clarifying legislation.

We believe that HCFA's interpretation of the duplication rules in H.R. 5252 is incorrect and concur with the Chairmen that it conflicts with Congressional intent. HIAA has also written to HCFA to express our views and to request further consideration of this issue so that it could be resolved administratively. The Senior Citizens' Equity Act presents the Committee with the opportunity to add language to clarify that H.R. 5252 does not prohibit the sale of long-term care insurance policies that coordinate with Medicare.

III. CONSUMER PROTECTION STANDARDS

A. HIAA Consumer Protection Standards

HIAA and its members agree with policy makers and consumers that strong consumer protection laws and their full enforcement are critical to the development and growth of the private long-term care insurance market. HIAA believes that the cumulative effect of government regulation should be to create an environment where the benefits of regulation outweigh their costs to consumers, the private sector and government. Regulations should aid, not hinder, the development of the private insurance market. There are multiple provisions in the current NAIC Model Act and Regulation which HIAA firmly supports as appropriate consumer protection. These include:

* Requirement that individual policies be guaranteed renewable.
* Required offer of inflation protection.
* Prohibition against post-claims underwriting.
* Requirement that insurers establish auditable marketing standards, for fair and accurate comparisons of policies, notification of limitations of coverage, and notification of senior counseling programs if one exists in the state.
* Prohibition against prior-hospitalization requirements.
* Required 30 day free-look period with full refund of paid premiums upon return of policy within this period.
* Penalties on agents and insurers for violations of sales and marketing laws equal to three times the commission rate, or $10,000, whichever is greater.
* Required delivery of detailed outline of coverage.
* Required coverage of Alzheimer's Disease.
* Prohibition of preexisting condition exclusion period of longer than six months.
* Minimum standards for home care, including prohibitions against tying benefits for home care to the need for skilled nursing care, covering only services by registered or licensed practical nurses, or limiting coverage to services provided by Medicare-certified agencies or providers.
* Prohibition against conditioning eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.
* Requirement that group policies provide for continuation and conversion.
* Loss ratio requirements at least equal to 60 percent for individual and group policies.
* Prohibition against twisting, high pressure sales tactics and cold lead advertising.
* Requirement that agent determine appropriateness of a recommended purchase prior to sale.
* Required delivery of buyers' guide prior to sale.

In addition, there are several provisions which HIAA supports which go beyond the current NAIC Long-Term Care Model Act and Regulation. They include:

* Require that insurers establish and implement long-term care education and training programs and materials for their marketing representatives and appropriate home office staff.
* Require that insurers establish procedures for monitoring the sales practices of their agents. Measures of agent conduct include lapse rates, replacement rates, rescission rates, and application denial rates. Such agent specific data shall not be required until it reaches a credible level.
* If states have continuing education requirements, require agents licensed as accident and health agents to earn long-term care insurance credits.
* Require policies to waive premiums while the insured is receiving nursing home benefits.
* Require insurers to establish and maintain a meaningful update protection program that offers policyholders information on new policy forms, improvements and coverage currently marketed by the insurer.
* Require insurers to base benefit eligibility criteria upon clinically-based empirical research in the area of disability and long-term care which accounts for the inability of the insured to perform an appropriate number of activities of daily living; or a similar level of disability due to cognitive impairment.
* Require insurers to provide a clear and thorough written definition of the benefit eligibility criteria at the point of sale.
* Require insurers to inform an applicant about coverage decisions within 60 days after receiving a completed application and all necessary supporting documentation requested by the insurer.
* Require insurers to establish a thorough claims process which will be explained clearly in written form at the time a claim is filed.
* Require insurance departments and the NAIC to develop and specify minimum standards for establishing long-term care reserves. In addition, the NAIC should, working with insurers, develop criteria for evaluating insurer reporting data.
* Require states to report the finally adjudicated violations of a state's long-term care insurance laws or regulations.

B. Relation to State Law

HIAA's support for federal long-term care insurance standards is conditioned upon adoption of a "federal option." A federal option would allow an insurer to sell a policy that meets the federal standards, approved by its state of domicile, in any state in which the company is licensed to do business. HIAA believes that separate state requirements would limit consumers' access to a wide range of long-term care insurance products by stifling competition in the market.

Such a policy would benefit consumers by increasing the number of carriers selling long-term care insurance products, by expanding the type and number of products available to consumers, by reducing the time lag between product filings and product availability in the market place, and by lowering the costs of products. Furthermore, this would increase competition among insurance companies on the basis of quality products, competitive prices, and service to their customers.

CONCLUSIONS

HIAA believes that our current long-term care financing system can best be enhanced by implementing three strategies. First, individual responsibility in planning for long-term care risk must be promoted. Second, the development of a strong private long-term care insurance market must be facilitated through tax incentives that increase the affordabilty of long-term care products and lend credibility to this market. Federal standards, in conjunction with tax clarification, can further increase consumer confidence in long-term care products and spur market growth. Third, for those who are unable to finance their own long-term care services, a program of public assistance must be provided.

HIAA applauds the sponsors of the Senior Citizens' Equity Act for recognizing the need to address long-term care insurance reform through the establishment of incentives for the development of the private long-term care market. Only through a strong commitment of cooperation between the public and private sectors in long-term care financing will we be able to address the long-term care needs of our aging population. Clearly the magnitude of the financing dilemma suggests the need for such cooperation to ensure access to long-term care services for all Americans. Though HIAA supports adoption of reasonable federal standards, tax clarification of private long-term care insurance is so important that it should not be delayed while the Committee considers appropriate long-term care standards. In the event that future legislative proposals deal with standards for long-term care insurance, HIAA would appreciate the opportunity to provide additional specific comments.

The Health Insurance Association of America would like to serve as a resource to Members of Congress and the Administration in refining proposals to improve our country's system for financing long-term care services. We stand ready to assist the Subcommittee in this process in the coming months.

Health Insurance Association of America

Bill Gradison
President

January 3, 1995

Bruce C. Vladeck, Ph.D.
Administrator
Health Care Financing Administration
Room 314G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Bruce:

We at the Health Insurance Association of America (HIAA) are very concerned about the effects that an adverse interpretation of Public Law 103-432, the Social Security Amendments of 1994, may have on the availability and affordability of long-term care insurance. The problem relates to the interpretation of § 171(d) of P.L. 103-432 that amends § 1882 (d)(3) of the Social Security Act. That section deals with the sale of health insurance that duplicates Medicare, Medicaid or other coverage.

The law, as amended in 1994, provides that health insurance policies that duplicate Medicare may be sold to persons on Medicare and Medicaid only if two conditions are met. First, the insurance application form must be accompanied by a prominent disclosure stating the extent to which the policy's benefits duplicate Medicare. Second, the policy must pay all its benefits in full without regard to other health coverage the person may have. We have learned that the Health Care Financing Administration (HCFA) is considering interpreting the latter requirement to mean that it is now not permissible for a long-term care insurance policy sold to a person on Medicare to contain language that makes it secondary payer to Medicare benefits or to exclude charges where benefits are payable under Medicare. It is this interpretation that has triggered a crisis for many long-term care insurers.

HIAA believes that coordination with Medicare is consistent with an emerging national policy that duplicative coverages should be discouraged. You are probably aware that most of the health care reform bills that have addressed long-term care – including the President's proposed Health Security Act – would require that private policies coordinate with Medicare. In addition, almost all the Congressional proposals that would clarify the tax treatment of long-term care insurance have consistently required coordination with Medicare. For those reasons, many leading long-term care insurers have changed their products to include provisions that coordinate policy benefits with Medicare.

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If under the HCFA interpretation, coordination of benefits with Medicare can no longer be employed, long-term care policies sold in the future will have to duplicate Medicare payments. Ironically, the section of the 1994 legislation that creates this problem is labeled "Preventing Duplication." Such an interpretation would result in the following adverse effects:

- The greatest damage done will be inflicted upon Medicare beneficiaries. Their long-term care insurance premium dollars will be spent on duplicative coverage when they could be better spent on extending their private benefits beyond the limited protection afforded by Medicare.
- If insurers whose policies currently coordinate against Medicare have to delete that feature and obtain approval of their revised policies in all 50 states, then there would be substantial expenses and market disruption associated with such a revision to both insurers and state insurance departments. This price tag will then have to be passed on to the consumers in the form of higher insurance premiums.
- Such an interpretation will also impair the Public-Private Partnerships for Long-Term Care that have been implemented in four states and which several other states are interested in establishing. These programs enable purchasers of long-term care insurance to protect some of their assets for the purpose of Medicaid eligibility. A fundamental principle of the Partnership programs is that asset protection should not be granted for policies that make duplicative payments.

All of this disruption can be avoided by an interpretation of this legislation that more clearly matches its legislative intent and legislative history. **Of paramount importance is to recognize that long-term care insurance policies with Medicare coordination provisions by definition do not duplicate Medicare. Therefore, they should be subject to neither the disclosure requirements nor the requirement to pay in addition to Medicare.**

HIAA believes that these adverse effects are not the objectives of this legislation. There is also further evidence in the legislative history of P.L. 103-432 that Congress did not intend to prohibit long-term care insurance from coordinating with Medicare. When the 1994 amendments reached the floor of the Senate, a colloquy took place between Chairman Moynihan of the Finance Committee and Senator Dodd of Connecticut. Chairman Moynihan assured Senator Dodd that the Senate Finance Committee did not intend to prevent coordination of benefits by long-term care insurance policies and expressed the hope that the administration's regulations, applicable to all long-term care insurance, would address coordination, "... in a way that encourages cost-effective long-term care coverage..." (Congressional Record, October 8, 1994, page S15025.)

Clearly, for Medicare beneficiaries, lower premiums and extended coverage that coordination makes possible are in the public's best interest. HIAA, therefore recommends that HCFA clarify that long-term care insurance policies

that coordinate against Medicare are not prohibited. An interpretation of § 1882(d)(3) that permits coordination is based upon two elements:

1. Certainly no duplication in benefit payment exists when an expense-incurred long-term care insurance coordinates with Medicare. A Medicare beneficiary would not be reimbursed twice for the same service, either from Medicare or from a private long-term care insurance policy. Since policies that explicitly make their payments secondary to Medicare do not duplicate payments made by Medicare, HCFA can conclude that the requirement that duplicative policies pay their benefits without regard to other coverage is not applicable to them.

2. With respect to long-term care insurance policies that have the potential to duplicate Medicare benefits, because their benefits are payable on an indemnity basis or otherwise do not specifically coordinate with Medicare, it is appropriate for HCFA to conclude that the law requires disclosure of this potential and require payment of its benefits in full without regard to other coverage to which the insured may be entitled.

In the longer term, it may be appropriate for Congress to enact further amendments to § 1882(d)(3) to clarify exactly how it wishes long-term care insurance to be treated. However, given the fact that it took the Congress four years to enact technical amendments to its 1990 revision of that section, it is imperative that the Department of Health and Human Services act now to avoid repeating the type of confusion in the long-term care insurance market place and disservice to Medicare beneficiaries that resulted when OBRA '90 misstated Congressional intent with regard to "duplicative" health insurance. The action recommended above would serve as an interim measure until Congress does more to clearly express its intent.

Thank you for your prompt attention to this matter. I appreciate the opportunity to provide you with HIAA's views on this important subject. If you have any questions or need further information, please feel free to contact Alan Richards at (202) 223-7785 or Susan Coronel at (202) 223-7873.

Sincerely,

Bill Gradison

Congress of the United States
House of Representatives
Washington, DC 20515

December 19, 1994

Mr. Lee Douglass
President
National Association of Insurance Commissioners
Hall of the States
444 N. Capitol St. NW, Suite 309
Washington, D.C. 20201-1512

Dear Mr. Douglass:

The Congress recently enacted H.R. 5252, The Social Security Act Amendments of 1994 (P.L. 103-432). One of the provisions in these technical amendments attempts to clarify confusion that resulted from provisions in the Omnibus Reconciliation Act of 1990 (OBRA 1990) regarding the sale of health insurance policies to Medicare beneficiaries that duplicate benefits to which they are already entitled.

The intent of the OBRA 1990 Medigap provision was to prohibit the sale to Medicare beneficiaries of policies that overlap and coordinate benefits. The specific wording of the provision led to confusion as to whether the sale of any health insurance product to a Medicare beneficiary was prohibited.

To clarify the issue, P.L. 103-432 states that the sale of health insurance policies that duplicate Medicare or Medicaid benefits is not prohibited if (1) the benefits are fully payable directly to the insured without regard to other health benefit coverage, and (2) a statement disclosing the extent of duplication is displayed prominently on the written statement.

The legislation provides the opportunity for the NAIC to develop the disclosure statements, subject to approval by the Secretary of Health and Human Services. We understand that the NAIC has begun the process of developing these statements.

Unfortunately, our attempt to clarify this issue has resulted in further confusion as to what constitutes duplication. We would like to call your attention to two areas where we feel confusion still exists.

First, there continues to be confusion over the definition of duplication. The primary intent of the duplication provisions in P.L. 103-432 was to make sure that Medicare beneficiaries

understood the health insurance coverage they were purchasing and how it related to other coverage that they now have. The statements mandated in the legislation are expected to be straightforward, simple, and recommended only for policies where there is unquestionable duplication.

Secondly, the wording of P.L. 103-432 appears to make illegal the sale of any long term care policies that coordinate benefits with Medicare benefits. Many long term care policies coordinated benefits so that the beneficiary is covered for a longer period of time. Requiring these policies to pay directly regardless of Medicare payment would exhaust the policy sooner or make it more expensive. This was certainly not our intent.

We would like this problem to be addressed administratively, and will work with the Administration to this end. However, if this cannot be resolved satisfactorily, we would like to alert you to our intent to seek legislation as soon as possible during the next Congress to clarify this exception.

We appreciate your continued cooperation on these Medigap insurance provisions.

Sincerely,

Bob Packwood
Committee on Finance

Bill Archer
Committee on Ways and Means

Mrs. JOHNSON OF CONNECTICUT [presiding]. We appreciate your testimony.

Mr. Hagen.

STATEMENT OF RON HAGEN, VICE PRESIDENT FOR PRODUCT DEVELOPMENT AND GOVERNMENT RELATIONS, AMEX LIFE ASSURANCE CO., SAN RAFAEL, CALIF.

Mr. HAGEN. Thank you, Madam Chair. AMEX Life is the largest and oldest writer of long-term care insurance in the country. We insure over a quarter of a million individuals against the catastrophic risk of nursing home as well as home and community-based care expense.

By way of background and since Congressman Stark mentioned our name earlier on, I would like to indicate to you also that our latest generation of product is an expense-incurred reimbursement policy covering nursing home as well as assisted living and other alternate care facilities, as well as a full range of home and community-based care expenses up to the daily benefit amount purchased by the insured.

The product is, as we euphemistically term it, a care-managed or managed-care product that provides very strong incentives to look at individuals' needs and match those up to the appropriate range of home and community-based services. The typical policy sold by AMEX Life provides a daily benefit of $100 a day for unlimited nursing facility expenses and/or institutional expenses with a 100-day elimination period, which acts like a deductible.

In addition, most individuals under the age of 70 choose to purchase inflation—automatic inflation protection so that a daily benefit amount keeps pace with inflation. The price varies with the age of the insured at the time of purchase, but once bought is level, like a whole life insurance policy. Typically, a 50-year-old individual in the marketplace here would pay about $450 a year for such coverage, while a 65-year-old will pay approximately $1,250 a year. This latter amount is about what many seniors spend annually on Medicare supplement insurance policies, and I just wanted to make that clear since there was a variety of different types of average premium numbers thrown around today in one of the earlier panels.

In order for the private long-term care insurance market to reach its full potential, private industry must offer the public high-value products, government must clarify that these products are treated like health insurance policies for tax purposes, and there must be a joint educational effort to inform the public of Medicare and Medicaid's limited long-term care benefits, the likelihood of needing long-term care services, and their catastrophic costs.

I would specifically like to thank Congresswomen Nancy Johnson and Barbara Kennelly for their leadership in the fight to establish just such a public-private partnership and the Republican leadership for including the necessary tax clarifications in the Contract With America.

The provisions contained in the Senior Citizens' Equity Act, H.R. 8, do a number of critically important things. First, the bill clarifies that qualified long-term care insurance policies are treated like other accident and health policies. This means that benefits paid

under a policy are excluded from the gross income of the insured, and any portion of the premium paid by the employer is excluded from the employee's income and deductible by the employer.

Second, H.R. 8 clarifies that insurance companies can deduct their reserves for these polices, when, in fact, States require reserves to be established or set aside. All other lines of insurance are permitted to take a deduction at the same time that the reserves are set up and long-term care should be treated equitably in this regard.

Third, the Senior Citizens' Equity Act "grandfathers" existing policies. Virtually no existing policy meets the definition of the qualified long-term care policy contained in H.R. 8. Consequently, it is extremely important not to penalize those people who have taken personal responsibility for themselves and purchased quality long-term care insurance coverage which met or exceeded existing State standards when purchased instead of relying on government for assistance.

AMEX Life fully agrees with the recommendations of the Health Insurance Association of America and the Coalition for Long-Term Care Financing. Specifically, I would like to emphasize several of these. The Contract With America, like most, if not all, long-term care bills introduced during the last Congress, requires policies to coordinate with Medicare.

Unfortunately, the Health Care Financing Administration seemingly is interpretating legislation passed last year, H.R. 5252, to prohibit the sale of such policies. I don't believe that Congress intended last year's Social Security amendments to have this effect, and I urge the committee to include technical and conforming amendments stating that long-term care insurance policies that coordinate with Medicare do not duplicate Medicare and therefore would not be prohibited from sale.

In addition, I encourage the subcommittee to reexamine the activities of the daily living provisions used to determine if an individual is in fact chronically ill and eligible for benefits. No carrier that I know uses the particular set of the ADLs, activities of daily living, listed in H.R. 8.

The ADLs in the Senior Citizens' Equity Act would cause several problems. First, mobility is not, according to most experts, even considered to be an ADL and is actually part of most other ADLs as typically defined. For example, if an individual is unable to move, they would fail bathing because they could not go to and from the bathroom. Second, H.R. 8 combines what are almost always—and what most experts consider three distinct functions—toileting, continence, and bathing—into a single ADL. These are in fact separate and distinct functions and should be treated as such.

Finally, there are six ADLs in widespread use in the industry today. We would suggest that since most companies select five of these six and pay benefits when an individual is unable to perform two of them, that a company be allowed to select the five of six standard ADLs they wish to use.

Finally, I think this will enable the market to continue to develop and grant consumers the greatest range of choice possible.

I thank the subcommittee for holding this hearing and considering this important piece of legislation. I would be happy to answer any questions the subcommittee may have.

Thank you.

[The prepared statement follows:]

TESTIMONY OF RON HAGEN
AMEX LIFE ASSURANCE CO.

Thank you Mr. Chairman. I am Ron Hagen, Vice President for Product Development and Government Relations at AMEX Life Assurance Company, a subsidiary of American Express. AMEX Life is the largest and oldest writer of long-term care insurance in the country. We insure over one-quarter of a million individuals against the catastrophic risk of nursing home and home care expenses.

Our latest generation product is an expense reimbursement policy covering nursing and assisted living facilities and a full range of home and community based care expenses up to the daily benefit amount purchased by the insured. The home and community based care coverage is a managed care arrangement where AMEX Life pays the full cost of these services if you use one of our recommended case managers or consultants, or 80 percent for aides and other personal care services in the home (up to the daily benefit limit) if you do not.

The typical policy sold by AMEX Life provides a daily benefit of $100 per day for unlimited nursing facility expenses with a 100 day elimination period during which the individual pays his own expenses. (This acts like a deductible.) In addition, most individuals under the age of 70 choose to purchase inflation protection so that their daily benefit amount keeps pace with inflation. The price varies with the age of the insured at the time of purchase, but once bought is level, like a whole life policy. Typically, a 50 year-old will pay $350 per year while a 65 year-old will pay $1,200. The latter is about what seniors annually spend on Medicare supplement insurance policies.

The need for long-term care insurance is large and will grow tremendously over the next few decades as the baby boom ages. Neither the public sector nor private individuals has the resources to solve our long-term care financing problem; it is just too expensive. We need to form a public/private partnership in which the government helps those who are unable to provide for themselves, while encouraging those that can to save for their own needs, either through the purchase of a private insurance policy or through a variety of savings instruments.

In order for the private long-term care insurance market to reach its full potential, private industry must offer the public high value products, government must clarify that these products are treated like health insurance policies for tax purposes, and there must be a joint educational effort to inform the public of Medicare and Medicaid's limited long-term care benefits, the likelihood of needing long-term care services and their catastrophic costs.

I would like to thank Congresswomen Nancy Johnson and Barbara Kennelly for their leadership in the fight to establish just such a public/private partnership and the Republican Leadership for including the necessary tax clarification in the "Contract with America".

The provisions contained in the Senior Citizens' Equity Act, HR 8, do a number of critically important things. First, the bill clarifies that qualified long-term care insurance policies are treated like other accident and health policies. This means that benefits paid under a policy are excluded from the gross income of the insured, and any portion of the premium paid by an employer is excluded from an employee's income and deductible for the employer.

Second, HR 8 clarifies that insurance companies can deduct their reserves for these policies when the reserves are established. Currently, the National Association of Insurance Commissioners and the states require companies to establish reserves under a one-year, full preliminary term reserve method. The Internal Revenue Code, however, requires companies to use a two-year method. This timing mismatch prevents companies from taking a deduction until one year after the reserves are actually established. All other lines of insurance are permitted to take a deduction at the same time the reserves are set up.

Third, the Senior Citizens' Equity Act grandfathers existing policies. Virtually no existing policy meets the definition of a qualified long-term care insurance policy

contained in HR 8. Consequently, it is extremely important not to penalize those people who took responsibility for themselves and purchased quality LTC insurance coverage which met or exceeded existing state standards when purchased instead of relying on the government for assistance.

AMEX Life fully agrees with the recommendations of the Health Insurance Association of America and the Coalition for Long-Term Care Financing. Nevertheless, I would like to emphasize a few of them. The "Contract with America", like most, if not all, long-term care bills introduced during the last Congress, requires policies to coordinate with Medicare. Unfortunately, the Health Care Financing Administration is interpreting legislation passed last year to prohibit the sale of such policies. I do not believe that Congress intended last year's Social Security Amendments to have this effect, and I urge the Committee to include a technical and conforming amendment stating that long-term care insurance policies that coordinate with Medicare do not duplicate Medicare and, therefore, would not be prohibited from sale.

In addition, I encourage the Committee to reexamine the activities of daily living (ADLs) used to determine if an individual is chronically ill. No carrier that I know of uses the particular set of ADLs listed in HR 8. The ADLs in the Senior Citizens' Equity Act would cause several problems. First, "mobility" is not considered by experts even to be an ADL, and is actually a part of most of the other ADLs. For example, if an individual is unable to move, he would fail bathing because he could not go to and from the bathroom. Second, HR 8 combines what are almost always three distinct functions – toileting, continence and bathing – into a single ADL. These are in fact three separate functions and should be treated as such.

There are six ADLs in widespread use in the industry today: bathing, dressing, toileting, transferring, eating and continence. Most companies select 5 of these 6, and pay benefits when and individual is unable to perform 2 or more of them. There is, however, little agreement on which 5 to use. I suggest that the Committee amend this section to allow companies the flexibility to choose which 5 of the 6 listed above to use in their policies. This will enable the market to continue to develop, and grant consumers the greatest range of choice.

Finally, I would like to point out that while the $200 per day benefit limit would allow most Americans to fully insure against their long-term care risks, it does not meet everyone's needs. In many Northeast urban areas, it is not unusual to find skilled nursing facilities that cost $250 per day. Consequently, persons living in high-cost areas would be prohibited from fully insuring on a tax favored basis like those living in low-cost areas.

I thank the Committee for holding this hearing and for considering this important piece of legislation. I am happy to answer any questions the Committee may have.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much, Mr. Hagen.

Mr. Chies.

STATEMENT OF STEVEN E. CHIES, PRESIDENT, NORTH CITIES HEALTH CARE, INC., COON RAPIDS, MINN., AND CHAIRMAN, LEGISLATIVE COMMITTEE, AMERICAN HEALTH CARE ASSOCIATION

Mr. CHIES. Thank you, Madam Chair, members of the subcommittee. My name is Steve Chies. I am president of North Cities Health Care, a provider of long-term care services. I also serve as the chairman of the legislative committee for the American Health Care Association.

AHCA represents more than 11,000 long-term care facilities caring for over 1 million elderly, frail, and disabled individuals. On behalf of AHCA's membership and the individuals we care for, we thank you for the opportunity to speak at this very important hearing.

AHCA has long supported private long-term care insurance as a means to increase the proportion of nursing facility residents not dependent on Medicaid as a primary payment source. For the past several years we have worked with the Coalition of Long-Term Care Insurers and Providers to promote appropriate Federal standards for long-term care insurance, for legislation that would clarify the Federal tax status of private long-term care insurance, and for other appropriate steps to begin to shift the cost of long-term care from Medicaid to private insurance sources.

We support the provisions of the Senior Citizens' Equity Act that would help Americans plan and prepare to meet the costs of long-term care. We look forward to working with the members of the committee to improve the legislation and to secure enactment.

Madam Chair, as you and the members of the committee are well aware, caring for the elderly is costly both to the elderly and their families along with the Federal and State government. We heard a lot of testimony on that today.

The demographics of the aging population will only compound this problem as we go forward, and clearly overall costs of providing long-term care services will increase at alarming rates. We know the Federal budget is in fiscal crisis, and I am not aware of many States that will be able to address future budgetary needs of the elderly.

Long-term care insurance is important both to the Federal and State governments as it offers citizens the opportunity to plan for their own future health care needs and not to depend on government programs like Medicaid for their long-term care needs. Making medical assistance available for the truly needy will expand benefits for all Americans.

According to the 1993 Gallup survey 79 percent of Americans agree that private long-term care insurance should play a more active role in paying for nursing home bills for most Americans. They have recognized that long-term care insurance should play a significant role in the protection of the elderly and their families from the catastrophic cost of a long-term illness.

Having long-term care insurance policies that provide the elderly and their families choices and options for the amount of services is what the American public wants. Most elderly do want to be cared for in their own homes or communities, yet financial resources at times drive the decision to a different direction.

Long-term care insurance can address that need, and I think the testimony of the previous panel, from Ms. Fosberg, is indicative of the options and choices that people have when they do have adequate long-term care insurance. While a long-term care insurance policy is available and being marketed, only a couple million policies have been sold.

We think this legislation that you have proposed will remove some of the barriers for purchasing long-term care insurance, including the need for tax clarification of long-term care insurance. We support and applaud your efforts with this legislation.

Unfortunately, there are other barriers to the development of a strong long-term care insurance market. They include a need for Federal standards for long-term care insurance policies and basic consumer protections. To allow for the addition of new public, private partnerships to purchase long-term care insurance similar to the demonstration projects you heard testimony from Connecticut, New York, Indiana, and California.

Consumer education on the need for health care insurance is very important. As a provider of health care insurance, I can tell you that many elderly believe that Medicare will pay for the full cost of a nursing home stay or they will pay for unlimited home care visits, and that is just not the case. Medicare has a very limited amount they will pay and the elderly do not understand that.

Finally, we need to clarify the law to assure the coordination of Medicaid benefits with long-term care insurance policies. Clearly it will take a number of years before we will see significant numbers of long-term care insurance policies that will actually pay for long-term care services and will offset the cost of Medicaid and the Medicare programs. This will take a number of years.

However, it is imperative that Congress does take action in the very near future. Because of the built-in delay of purchasing policies and the long timeframe before people actually need long-term care services, it could take anywhere from 10, 15, or even 20 years before we would see the value in the Federal and State budgets.

We would urge the passage of this act and hope Congress will continue to respond to the desires of the population and remove other barriers for planning for our future health care cost needs.

Thank you.

[The prepared statement follows:]

TESTIMONY OF STEVEN E. CHIES
AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman, Members of the Subcommittee, I am Steve Chies, President of North Cities Health Care, Inc., a provider of long term care. I also serve as Chairman of the Legislative Committee of the American Health Care Association (AHCA). The more than 11,000 long term care facilities that make up the AHCA care for more than one million elderly, frail, and/or disabled residents. On behalf of AHCA's members, and the residents of our member facilities, thank you for the opportunity to speak at this important hearing.

AHCA has long supported private long term care insurance as a means to increase the proportion of nursing facility residents not dependent on Medicaid. For the past several years, AHCA has worked as part of a coalition of long term care insurers and providers, the Coalition for Long Term Care Financing, to promote appropriate federal standards for long term care insurance, for legislation that would clarify the federal tax status of private long term care insurance, and for other appropriate steps to begin to shift the long term care cost burden from Medicaid to private insurance.

AHCA supports the provisions of the Senior Citizens' Equity Act that would help Americans plan and prepare to meet the costs of long term care. We look forward to working with the Members of this Subcommittee to improve the bill and to secure its enactment.

My testimony will emphasize AHCA's position that:

- the private sector must play a much more significant role in supporting long term care;
- private long term care insurance can be the cornerstone of strong private/public partnership; and
- legislation to clarify the federal tax treatment of long term care insurance -- and other legislative steps -- will help establish a significant role for private long term care insurance in financing long term care.

THE NEED FOR CHANGE IN LONG TERM CARE FINANCING

Our society, individually and collectively, has not made adequate provision for financing the costs of long term care. Individuals and families are not saving for, or insuring themselves against, the costs of long term care. The federal/state Medicaid program is stretched to the breaking point. Families and governments are going broke.

Without action to address these problems, our growing elderly population will come to rely much more heavily on Medicaid to pay for long term care. In 1993 Medicaid accounted for approximately 52 percent of all long term care payment -- and about 69 percent of all nursing facility residents -- in the United States. If current trends continue unchecked, Medicaid will be burdened with an ever increasing share of the nation's long term care costs as the baby boomers reach retirement. But these current trends cannot continue. Federal and state budgets -- already strained badly by current Medicaid long term care obligations -- cannot bear such costs. Nor would the elderly be well served by an overwhelmed Medicaid program.

February 1993 Gallup Organization survey results indicated that 76 percent of Americans agree that "government should pay the cost of nursing home care only for those who cannot afford it." In order to meet the nation's growing long term care needs without both emptying the public purse and sacrificing quality of care, our society cannot afford to rely solely on government. Instead we must encourage and enforce an expectation of personal responsibility on the part of those with the means to plan for and pay for potential long term care costs. Government can -- and must -- help in this effort by working to see that individuals have the information and resources needed to accept responsibility for meeting their own long term care needs.

LONG TERM CARE COSTS ARE IMPOVERISHING SENIOR CITIZENS

Most elderly Americans are unaware of the magnitude of long term care costs and of the limits of government assistance. Most Americans do not foresee needing long term care. Most probably do not realize how costly months or years of long term care can be. Many Americans wrongly assume that government programs or their general health insurance will cover the costs of any long term care services they might need. For all these reasons, individuals and families face long term care costs for which they have not planned and which they cannot afford.

The cost of long term care can quickly wipe out the assets even of those who have worked and saved for a lifetime. The cost of one year of nursing home care is more than triple the average annual income for an elderly American. But the nation's current long term care policy does not promote personal planning, saving, or the purchase of insurance against the financial risk of long term care costs. Nor does our nation provide comprehensive social insurance against the financial catastrophe of long term care costs. Only after a long term care recipient has been impoverished does government assistance become available through Medicaid -- a "welfare" program.

MEDICAID IS IMPOVERISHING THE FEDERAL AND STATE GOVERNMENTS

According to the Health Care Financing Administration (HCFA), total Medicaid payments (state and federal) have nearly doubled over recent years -- from $54.5 billion in FY 1989 to $101.7 billion in fiscal year 1993. The countless court battles over Medicaid reimbursement, and the protracted battle over "provider specific taxes" well illustrate the strain that Medicaid is putting on state and federal resources. This strain jeopardizes the availability and quality of both acute and long term care for those who must depend on Medicaid. Clearly, if current long term care needs have stretched federal and state budgets to their limits, the future needs of a burgeoning population of elderly will overwhelm our current arrangements for long term care financing. Therefore, the nation must look to sources other than government for additional resources to meet the future long term care needs.

We believe that long term care reform should have the following goals:

- providing appropriate access to the full continuum of long term care services;
- ensuring that all Americans have the means to meet the cost of long term care;
- moving individuals and families away from dependence on government welfare programs for long term care financing; and
- addressing the nation's long term care needs in a fiscally responsible way.

Fostering a robust long term care insurance market is key to meeting these long term care reform goals.

THE ROLE OF PRIVATE LONG TERM CARE INSURANCE

Results from a March 1993 Gallup Organization survey indicate that 79 percent of Americans agree that "to keep government costs as low as possible, private insurance should play a more active role in paying for nursing home bills for most Americans."

Private insurance, so useful in protecting individuals and families from the financial risk of acute illness, has great potential also for marshaling private sector resources to meet long term care costs. Insurance offers a very good means to preserve an individual's choice from among various long term care arrangements and competing providers. Its expanded use would make an appropriate private/public long term care partnership viable. It has great potential for lessening the long term care cost burden that the graying of America will otherwise put on the American taxpayer.

To date, private insurance accounts for less than two percent of all payments for long term care services. AHCA is confident, however, that with appropriate changes in federal policies private long term care insurance can and will take on a larger role in meeting long term care costs. AHCA is looking 15 to 20 years into the future to a time when private long term care insurance will represent 15% or more of payments for long term care services. In order to reach such a future, however, we must take steps now.

AHCA's members feel strongly that, with the right federal policies, private long term care insurance can become the centerpiece of a private/public long term care partnership that would help families, states, and the federal government meet the costs of long term care. Therefore, we strongly support the provisions of the Senior Citizens' Equity Act that would foster the development of the private long term care insurance market and increase private sector resources available to meet the costs of long term care. Specifically, AHCA supports the provisions of the Senior Citizens' Equity Act that would:

- make it clear that private long term care insurance enjoys the same federal tax treatment as accident and health insurance;
- clarify that benefits provided under long term care insurance are excluded from income;
- clarify that employer-provided long term care coverage is excluded from income;
- treat qualified long term care services as medical care;
- clarify that taxpayers can include long term care premiums in calculations of deductions for medical expenses;
- exclude from taxation IRA withdrawals used to pay long term care expenses or insurance premiums; and
- exclude from taxable income accelerated death benefits.

In addition, AHCA members believe that Congress must consider seriously tax incentives for the purchase of long term care insurance that are stronger than those already contained in the Senior Citizens' Equity Act. Demographic trends guarantee that the current level of public resources will fall far short of future long term care needs. Although the Congress may be reluctant to provide for tax expenditures greater than those currently before this subcommittee, short-run tax expenditures that build a long term care insurance market will pay great dividends in the long-run. Therefore, AHCA suggests that the Congress consider such measures as a targeted tax credit for the purchase of long term care insurance.

Furthermore, in order to improve the Senior Citizens' Equity Act, AHCA would like to suggest that the Subcommittee amend the legislation to address the following specific points:

- Federal standards and consumer protections for long term care insurance would help ensure that policies offer value to consumers and that policies would pay appropriately and adequately for quality long term care when needed. AHCA supports standards as written in the "Quality Care for Life Act" (S. 2205) as introduced in the 103d Congress by Senator Hatch.
- We urge the repeal of provisions of the Omnibus Budget Reconciliation Act (OBRA '93) that discourage states from establishing private/public long term care partnerships along the lines of those already in place in Connecticut, New York, Indiana, and California. The provisions in question undercut partnership incentives to purchase private long term care insurance through raising the level of asset protection under Medicaid.
- We hope the Congress will take steps this year to promote awareness on the part of senior citizens and their families of the potential costs of long term care, the limits of

current public long term care assistance, long term care insurance options, and of information necessary to be a smart long term care insurance consumer.

- We hope that you will be able to include in the Senior Citizens' Equity Act provisions to make clear that long term care insurance policies are not prohibited because of "Medicare duplication."

FEDERAL STANDARDS AND CONSUMER PROTECTIONS

Appropriate federal standards and consumer protections for long term care insurance would inspire consumer confidence; foster the growth of the private long term care insurance market; and ensure that elderly consumers are spared the problems that once plagued the "Medigap" insurance business. As long term care providers, AHCA's members do not benefit from private insurance policies that provide inadequate coverage. Nor do providers do not benefit from sales practices that lead individuals to purchase inappropriate policies or policies that they cannot afford to pay for. Accordingly, AHCA supports federal standards to ensure appropriate policy design and sales practices.

At the same time, providers cannot benefit from private insurance policies priced out of the reach of consumers by federal regulation that is too heavy-handed. Therefore, AHCA recommends that proposed federal standards be balanced by considerations of affordability. Congress needs to consider carefully the trade-off between the value of a policy feature and the cost to consumers of mandating that feature.

PRIVATE/PUBLIC PARTNERSHIPS FOR LONG TERM CARE

Working with the Robert Wood Johnson Foundation, Connecticut, New York, Indiana, and California have established private/public long term care partnerships that encourage the purchase of approved long term care insurance policies by offering purchasers enhanced asset protection under the Medicaid program. Generally, under such a partnership program, if a long term care insurance purchaser requires long term care and eventually exhausts his or her insurance benefits, the state will raise the Medicaid asset eligibility threshold by the amount of the long term care coverage purchased.

In a number of states -- including, I understand the Chairman's state -- there is considerable interest in establishing private/public partnerships along the lines of those already underway in Connecticut, New York, Indiana, and California. However, the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) included provisions [Section 13612 (a) (C)] that discourage states from implementing such partnerships. Specifically, these provisions require states to make recovery from the estates of those who had enjoyed enhanced Medicaid asset protection. That is, these provisions make a partnership's asset protection only temporary.

Many states are interested in encouraging residents to purchase private long term care insurance because they see an opportunity to slow the growth of their Medicaid spending by shifting a significant share of long term care costs to private insurance. We are now beginning to see evidence that this opportunity is real. Publishing in Health Affairs in the Fall of 1994, Marc Cohen, Nanda Kumar, and Stanley Wallack estimated that having a long term care insurance policy reduces the probability of spending down to Medicaid eligibility levels by some 39 percent. The authors estimate that, in the aggregate, Medicaid expenditures would be reduced by $7,945 to $15,519 for every nursing home entrant who had a long term care insurance policy. According to the analysis of Cohen, Kumar, and Wallack, this translates into cutting what Medicaid pays per nursing home entrant in half for long term care purchasers.

AHCA hopes that the Congress will remove the obstacle that Section 13612 (a) (C) of OBRA '93 presents to states that would like to pursue a private/public long term care partnership. Indeed, we hope that following the enactment of the long term care insurance provisions of the Senior Citizens' Equity Act, the Congress will give serious consideration to measures that will encourage all states to establish long term care partnerships.

LONG TERM CARE CONSUMER EDUCATION

A public opinion survey conducted for the Employee Benefit Research Institute in the summer of 1994 found that 45 percent of respondents believe that Medicare pays for long term care. This means that even after nearly 30 years of Medicare, many beneficiaries are in for a rude awakening should they need long term care coverage.

We hope the Congress will take steps this year to promote awareness on the part of senior citizens and their families of the potential costs of long term care, the limits of current public long term care assistance, long term care insurance options, and of information necessary to be a smart long term care insurance consumer. To this end AHCA suggests that the Ways and Means Committee might specify that Internal Revenue Service tax forms and reference material explicity address long term care insurance tax treatment once it is clarified. In addition, the federal government's Medicare and Social Security beneficiary information mailings could include long term care insurance consumer information. At the least, the use of Social Security and Medicare beneficiary information could provide the public service of correcting the widespread belief that Medicare covers long term care.

MEDICARE DUPLICATION

The long term care private/public partnerships underway in Connecticut, Indiana, New York, and California (and others under development in Maryland, Iowa, and Illinois) promote the sale of long term care insurance policies that "coordinate" with the Medicare program. That is, such insurance policies are designed to combine with Medicare coverage to pay benefits that cover the costs of long term care services, but not more than 100 percent of the cost of services. This coordination feature helps to keep the cost of the private insurance policies down and, hence, affordable to a greater number of purchasers.

Shortly before adjournment, the 103d Congress adopted a Medicare technical amendments bill, H.R. 5252. A provision of this legislation prohibits the sale to Medicare beneficiaries a health insurance policy that duplicates any benefits to which the beneficiary would be entitled under Medicare, Medicaid, or other private insurance unless:

1. the policy pays benefits without regard to other coverage and

2. the carrier discloses "the extent to which the policy duplicates" other coverage.

The practical effect of this provision is to outlaw the sale of long term care insurance policies that coordinate benefits with Medicare. The Health Care Financing Administration has put long term care insurers on notice that this is indeed their interpretation of the provisions in question. We believe, however, that this interpretation in inconsistent with Congressional intent. In any case, such an interpretation contradicts the Senior Citizens' Equity Act. Therefore, AHCA hopes that the Ways and Means Committee will amend the Senior Citizens' Equity Act to clarify that the sale of long term care insurance policies that coordinate with Medicare coverage is permitted.

CONCLUSION

Fiscal necessity and pragmatism clearly show that government cannot continue to bear an increasing financial burden of long term care. Private sector ways and means must be harnessed in partnership with public programs and resources. In order to form the required partnership, Congress should seek to maximize the role of private long term care insurance through:

- long term care insurance federal standards and consumer protections:
- tax clarification for long term care insurance products; and
- public education.

AHCA is pleased that the Congress is discussing long term care in the context of the "Contract with America" – and we are pleased to have been included in that conversation. We commend you for holding this hearing.

Thank you for your attention and your consideration.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much for your testimony.

I agree that it will be some number of years before the purchase of long-term care policies will affect public costs, but it was only about 5 short years ago that we sat here talking about what managed care was accomplishing in the private sector in terms of cost reduction and had much testimony from companies saying if more people would do this, you would see. And more people are doing it and we are seeing.

So what is so important about this initiative is it is going to start the process that in the long run is going to be very fruitful, and it is one that both Barbara Kennelly and I and people from both sides of the aisle have worked hard to try to initiate for 3 or 4 years and so we consider it not only important, but long overdue.

There are two questions that I wanted to ask the panel and I regret I had to miss the preceding panel. First of all, is the ADL structure in our bill too rigid to serve the home care needs of our seniors? Are any policies offering home care outside of that structure? What thoughts would you have on that aspect of the long-term care policies?

Mr. GARNER. I can take that question. I believe that the language in the bill is too restrictive. If we look at the products that are available today in the marketplace, a more typical definition is one that just requires substantial assistance or supervision, and I think that is more typical of what we are seeing in the marketplace, and I also think it better fits consumers' ideas of what is a reasonable benefit trigger.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much. Would you care to comment?

Mr. HAGEN. Yes, I would. I agree with Dick. We certainly see in the marketplace now language in contracts that would allow for supervisory or standby assistance and that is all that is necessary sometimes. It is very difficult to predetermine whether the person will actually need hands-on care every time they perform the function.

The other thing that is important to recognize, whether we are talking institutional or home care benefits, is that there needs to be separate pathways to benefits for people that are cognitively impaired, have Alzheimer's, senile dementia, things of that nature. A number of chronically ill individuals, as much as 15 to 20 percent, do not have any ADL limitations at all yet due to dementia need care.

I would also suggest again that there is a standard list of six ADLs, as I mentioned in our testimony, which we probably would be wise to go back and take a look at. Typically, "mobility" is defined as a part of defining those ADLs and traditionally we don't see that as a standard ADL.

Mrs. JOHNSON OF CONNECTICUT. One of my concerns is that government will define this too narrowly and the market will not be able to serve the growing needs of seniors. I have been through this with my own mother over the last 10 years, and the need is certainly much greater than the ADL need and if there are policies already out there, we don't want to restrict it.

That leads me to my next question. In my original legislation, there was a long section on standards. You heard from one of my colleagues on the other side of the aisle how concerned he would be with standards. That is why all that stuff was in there.

On the other hand, in the new environment, I would have to say I have a lot of concern about putting the standards language that parallels the NAIC standards in Federal statutes. Again, it will retard the flexibility and the development of the product.

Is there anything else we could turn to, any simpler index of standards or any governing language that would be preferable to delegating it to the NAIC? We are thinking about those kinds of things because there is such a serious problem with enormous detail in Federal law, setting standards for private sector products.

Mr. GARNER. Yes, the Health Insurance Association of America has looked very carefully at a set of standards and I have included some of those in my written testimony. In some places, those standards are more stringent than what the NAIC would require. In other areas, they do not impose certain minimum benefit standards on the individuals as the NAIC proposal has done. I would recommend that we look at the Health Insurance Association of America's consumer protection paper as an outline for standards.

Mr. HAGEN. I agree with that, Congresswoman Johnson. The Coalition for Long-Term Care Financing, which I cochair along with Stan Wallack, who testified earlier, also has a very similar package of standards that we would recommend looking at.

Again, as Dick said, some of which exceed the NAIC Act and Regulation, some of which really focuses much more on providing options and choices for people on things like nonforfeiture as opposed to mandating the benefit because we believe, and frankly the marketplace tells us this right now today, that people make reasonable choices when given those choices, and that mandating inflation or mandating nonforfeiture benefits for everyone may not be a rational choice, but that we have standards or guidelines that are in place to dictate, if you will, so as to assure that these benefits, should they be purchased, provide real value to the consumer.

Mrs. JOHNSON OF CONNECTICUT. Thank you. I would ask you to look back at your proposal. I talked to Mr. Wallack about this on my way to vote last time, and tried to cut them down, because if we have standards not all States are complying with them. I think probably the most important issue is making sure consumers understand clearly what they are getting, what they are told, and what would commonly be understood by the language is in fact what you get. So some aspects of the standards are more important.

Last, let me just ask you to enlarge briefly on the H.R. 5252 coordinating problem, if you would. I guess it was Mr. Hagen who spoke about that, or anyone who wants to.

Mr. HAGEN. Yes. We really do believe that the intent here—at least we hope the intent here in providing a technical correction under H.R. 5252 to this duplication or Medicare nonduplication issue was to not prohibit long-term care insurers from coordinating with Medicare as most carriers do on most of the products that are out there now.

Our reimbursement products do coordinate with Medicare. That is the most fail-safe way of making sure that there is no significant duplication and, for the most part, the duplication that exists between long-term care policies and Medicare is rather insignificant and at the margin.

The best way we found of doing that while making sure that the person who has a real need gets compensation for that need but doesn't get paid two or three times for that need is in fact to coordinate and require coordination in all cases and most of the bills that have been introduced into Congress—the standards bill, the tax bills—have all required coordination with Medicare as a way to make sure there is no duplication, and we think that makes a lot of sense, and we hope that that in fact was—believe that that in fact was the intent of the Congress.

Mrs. JOHNSON OF CONNECTICUT. Thank you. I believe that was the intent of Congress, too. And so I wanted to get clearly on the record that there is that problem and we will do our best to fix it.

Mr. Christensen, would you like to go on?

Mr. CHRISTENSEN. Sure.

I wanted to say to Mr. Garner, since my colleague, Mr. Stark, earlier gave you credit for stopping last year's health care proposal, I wanted to add my two cents and say thank you, too. I don't know if you should get full credit, but I do want to thank everybody for stopping what I thought was a bad bill and would have really caused this country to go in the wrong direction, and I do like what we are doing now, more private type of corrections, and I think that Madam Chairman is definitely leading the charge in the right direction.

I wanted to ask the question to Chies, Chies, Chies?

Mr. CHIES. Chies, that is correct.

Mr. CHRISTENSEN. What kind of long-term care business do you see down the road, 15 years from now? Thirty years? When do you see the private sector and if we can get this implemented and taken in effect? When do you see the real impact and the pluses for us moving to this more of a private way of doing business? If Mr. Hagen has a viewpoint on that, I would be open.

Mr. CHIES. If you start today by passing this legislation, you will not see the impact next year. Clearly, I would say you are looking at 15 years before you feel the full impact. At that point, hopefully, the funding sources for long-term care will be balanced out. Right now it is so skewed to either private resources or medical assistance, a more balanced approach to where a third and a third and a third perhaps in 15 years.

Mr. HAGEN. I really don't disagree with that. I think the important thing here is doing the kind of tax clarification that we are talking about. And putting the long-term care insurance market on a level playingfield with other types of accident and health insurance, we will give credibility and send a message to the people out there who have maybe been delaying the purchase of good, quality coverage that is available with the anticipation that the government may step into the breach if they don't believe that government already is there, that we will create some significant incentive to get back to the kinds of growth rates in the private marketplace that we saw before the most recent round of the health care

reform debate which I think added to some considerable extent to the confusion about whether government was going to pay for long-term care in the future.

We saw 45- and 50-percent growth rates over the period 1988 to 1992. Since then and since the debate went on for health care reform with the potential for home care being part of a government program, we saw those growth rates coming down to the 20- to 30-percent range.

There is no reason based on a good effort to educate the public about what is real and not real about what they can expect from the government on long-term care that we can't see growth rates in excess of 45 or 50 percent.

People need to understand what the choices are, and we need to make sure that there are good-quality products, and we need to make sure that they provide value, and we need to work in partnership with government, both State and Federal, to that end.

Mr. CHRISTENSEN. Do you think if we implement this with the effective day of January 1, 1996, is that going to give you enough leadtime to get your products on the market?

Mr. HAGEN. This is an excellent point. We are in the process of introducing a new portfolio of products and we anticipate, if the last time around is any guide, that that takes fully a year to achieve the necessary individual State approvals. In other words, if you have a January 1, 1996, effective date, we would have to start right now and we would have to know right now what those standards are. The ADLs we talked about before, for example.

We are going to be in a difficult position, each hopefully being on bended knee to the States and asking them to speed the process along. A number of States, a number of very large States take a considerable period of time in reviewing these policies and the rates that we charge for the policies.

Mr. CHRISTENSEN. And then to get your brokers and your agents also up to speed. That is where I come in and where I understand that there is a lag period there and it takes a while.

Mr. HAGEN. Right.

Mr. CHRISTENSEN. So your opinion is, it is probably going to be tough to get it done by then?

Mr. HAGEN. Yes, I think it will be.

Mr. CHRISTENSEN. Thank you, Madam Chairman.

Mrs. JOHNSON OF CONNECTICUT. Mr. Ensign will inquire.

Mr. ENSIGN. Thank you, Madam Chairman. I just want some general comments, anyone who chooses to respond. I recently visited a rehabilitation type hospital fairly new—I am from Las Vegas—fairly new to the Las Vegas area. Actually, the reason I was invited there—it wasn't by the company; it was one of my supporters in the campaign; her father was being treated at this as a day patient. He had been institutionalized. He suffered from a stroke and no place had been able to help him.

But being able to be home and then going as a day patient through all the rehabilitation is sort of a free market reform that is coming about through insurance. And I think that what Madam Chairman addressed about the flexibility that the marketplace can have is important and I too share the concerns that we will tie the hands too much by language that is too stringent.

Mr. GARNER. I would agree with that. Insurance companies today just aren't able to foresee all of the provider delivery mechanisms that will exist for long-term care over the next 15 or 20 years, and that is the time over which we will be paying the benefits on many of the policies that are being purchased today.

So I agree completely with you that we need to have some sort of flexibility in the language that we use to develop products that do qualify for favorable treatment.

Mr. HAGEN. I would just add to that that what we are all about here is providing meaningful catastrophic protection for people against the risk of long-term custodial or personal care services, whether that be in a home or institutional setting. And what we have seen is that nursing facilities are changing and they are not necessarily the only place where institutional services of that nature are being provided. We are looking at assisted living facilities and a broadening out of the definition of what an institution is that provides those types of services as well as a whole range of community care providers.

I think that gets back to the point we made earlier about the importance of the eligibility criteria for the benefit here. The ADLs, if you will, and cognitive impairment, as a separate pathway to benefits, because increasingly we are having difficulty with different States defining providers differently. We see a whole new range of providers coming on the horizon.

We want to cover the need here, which is for custodial or personal care services that can cost $50,000 or $60,000 a year, if it is institution based. But we also have to understand that we are not clairvoyant here. We are broadening our definitions and we are providing a continuum of services in these policies now that, frankly, didn't exist 4 or 5 years ago. And in many cases government doesn't even provide that range of services in the public programs or social insurance programs that we have.

But I say all that to get back to the point that it is very, very important, as we move toward a disability model in these products, that the ADLs and the eligibility criteria for the benefits are absolutely critical that we get it right.

Mr. CHIES. As a provider, I would agree with both the gentlemen. The only caveat I would give you is that you need to be careful about allowing the insurance companies to become too specific in their policies. We have situations where only the benefit can be used if it is in a licensed nursing home. There are other types of facilities out there. There are other opportunities for people, including assisted living day care, home care, et cetera. And I would be real concerned if we are only talking about nursing home coverage here.

Second, we can't predict the future. We can't predict what is going to happen 15 years from now. And as much flexibility as Congress can afford would be of assistance in selling the policies and then people purchasing the policies and actually using them.

Mr. ENSIGN. Thank you.

Mrs. JOHNSON OF CONNECTICUT. Thank you, very much. And your description, Mr. Hagen, of how the services are developing, and each of you during the course of your testimony, is a clear indi-

cation of how important it is that we not limit the growth of services in this area.

On the other hand, it is also true that the consumer information requirements cannot allow companies to use words like "licensed" that the public doesn't understand the implications of in terms of their restrictions.

So, recognizing those two problems, we have to be sure to write this correctly and we look forward to your continued input. Thank you. I thank this panel and call up the next panel.

Robert Shreve, chairman of the board of the American Association of Retired Persons; Max Richtman, executive vice president of the National Committee to Preserve Social Security and Medicare; and Jake Hansen, director of government affairs, The Seniors Coalition.

I thank this panel for being with us. You have long followed and been helpful in guiding policy for seniors in America and we welcome your testimony today. I will have to leave at about 27 after, so if we could move right into the statements, I would appreciate that. And I will have worthy colleagues who will succeed me in the chair.

We will start with Mr. Shreve.

STATEMENT OF ROBERT SHREVE, CHAIRMAN OF THE BOARD, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. SHREVE. Thank you, Madam Chair. My name is Robert Shreve. I am chairman of the board of directors of AARP. We appreciate this opportunity to present our views on long-term care tax treatment in the Contract With America.

We are pleased that the Contract includes provisions that attempt to address long-term care because this is an issue that strikes at the heart and the economic security of many millions of families across America.

Tax treatment of long-term care insurance should be clarified. New expansions of such tax incentives in isolation from broader reforms, however, raise some concerns. Unfortunately, most older persons would derive relatively little benefit from these tax preferences, including the close to one-half of older Americans with insufficient income to even owe taxes.

Before changes are enacted, it will be important to understand how much they would cost and who would benefit. Such tax breaks are not our priority for spending limited new dollars on long-term care. Of greater priority would be to help make home and community-based care more available to middle-class families in the form of grants to States.

Absent a new public program, the needs that cause financial chaos for many families will continue unabated. If the proposed tax clarifications are enacted, strong consumer protection standards, at least as strong as those developed by the NAIC, must be included as a condition for receiving favorable tax treatment. Federal dollars should not be used to encourage the purchase of policies that fail to provide meaningful coverage.

With regard to specific long-term care proposals in the Senior Citizens' Equity Act, the provision to treat qualified long-term care services as medical care could be the most significant for consum-

ers because it will help families deal with catastrophic out-of-pocket expenses and is not limited to those who purchase long-term care insurance.

Allowing employers to provide tax-free long-term care insurance and permitting exclusions for insurance benefits could promote the growth of the group market. And such incentives should be extended to include employees' parents. Under the proposal to allow tax-free exchanges of life insurance for long-term care policies, certain beneficiaries of life insurance, particularly spouses, should be required to consent.

And permitting tax-free distributions of IRA and 401(k) plans to purchase long-term care insurance would only help the higher-income individuals.

To improve the market for consumers, major limitations still must be addressed, particularly exclusions for preexisting conditions, lack of affordability, and poor coverage of home care.

For example, first, preexisting condition exclusions must be prohibited or minimized, as most agree must be done for medical insurance. Government reinsurance should be made available to companies that meet strong underwriting standards which reduce discrimination.

Second, incentives should be created for companies to offer several standard policies among others offered. Consumers could more easily compare benefits, price competition would increase, and premiums may be reduced.

Third, we should create strong national standards to stabilize premiums. While initial premiums are lower for younger purchasers, the key to affordability is affordability over time. Absent premium stability requirements, premiums may increase so much over 30 or 40 years that many could not afford to continue paying.

Fourth, companies should be encouraged to offer paid up policies so that after a period of time payments are no longer needed to receive full benefits as is often the case in the life insurance market.

Fifth, strong standards should be created for covering home and community-based care.

Let me close with a critical consideration for us about how tax breaks proposed here and elsewhere will be financed. AARP urges that the Medicare program not be singled out as a financing source. Medicare has been cut by nearly $200 billion since 1980. Beneficiaries are only starting to feel the impact of the 1993 reductions of $56 billion. Medicare cannot sustain the level of cuts required to pay for the lion's share of a balanced budget and other provisions in the Contract.

AARP stands ready and willing to work with this subcommittee to develop effective responses to the long-term care crisis whether the proposals are in the public or private sectors. Thank you.

[The prepared statement follows:]

TESTIMONY OF ROBERT SHREVE
AMERICAN ASSOCIATION OF RETIRED PERSONS

The American Association of Retired Persons (AARP) appreciates this opportunity to present its view on the provisions of the Contract with America relating to tax clarifications for long-term care included in the Senior Citizens' Equity Act. The Association has a deep, long-standing interest in long-term care and looks forward to working with the members of this Subcommittee to address not only this but other facets of this important issue. Not only has AARP been very active on the long-term care legislative and regulatory fronts, we also offer a long-term care insurance product as a service to our members through the Prudential Insurance company. We appreciate the fact that the Contract with America includes provisions that attempt to ease the substantial financial burden many families face when the need for long-term care arises.

THE NEED FOR LONG-TERM CARE REFORM

Critical to the economic security and peace of mind of America's families is protection and coverage for long-term care. For the millions of families with a loved one suffering from a chronic disability, the long-term care issue strikes at the core of their economic, physical and emotional well-being. While struggling with the trauma of doing everything in their power to avoid placing family members in an institution for the rest of their lives, Americans are faced with the daunting task of finding the resources and assistance to keep loved ones at home where they belong. Not only are the costs to families' budgets potentially enormous, but the emotional and physical toll on family caregivers -- typically women in their 50's -- is often debilitating. Caregivers continue to risk jobs, future pension and Social Security benefits, while placing their own health in serious jeopardy.

Long-term care is an intergenerational issue in which family members of all ages are vulnerable, particularly middle-class families. Approximately one-third of those who need home and community-based long-term care are under 65 years of age, whether they are children born with a disability or parents paralyzed in an accident. Surveys over the years have consistently shown very strong support for a program to address the problem among the young and old. For example, in a survey conducted last June, 94% of respondents agreed that it was important to include a new home and community-based coverage in a health care reform proposal.

Long-term care has also traditionally received strong bipartisan support in the Congress. Members of this Committee spoke out strongly last year favoring the inclusion of a long-term care benefit in health care reform legislation. And in the Senate Finance Committee, when Senator Pryor offered an amendment last July to include coverage for home and community-based long-term care, a majority of both Republicans and Democrats on the Committee voted in favor of the amendment.

Our nation's current long-term care system suffers from serious fragmentation, an institutional bias, and lack of decent coverage in both the public and private sectors. For the most part, our system requires families to deplete their life savings until they are bankrupt and eligible for Medicaid, a means-tested welfare program. With nursing home stays, on average, costing about $37,000 per year (much more in some geographic areas), and home health visits, on average, costing almost $85 per day (much more if complex services are needed), spending-down to impoverishment can happen quickly. A recent study reported in the Journal of the American Medical Association found that, of a sample of seriously ill adults discharged home from the hospital, loss of most or all of the family savings was reported by 31% of the families surveyed.[1] In addition, since very few states have good Medicaid home care programs, too many disabled persons are forced into institutional settings prematurely, ultimately costing the state and federal governments even more. As a nation, we cannot be proud of such a "non-system." Japan, Israel, Canada and most European nations have devised far more compassionate, rational approaches for their elderly and disabled citizens in need of long-term care. America can do better.

[1] Covinsky, K.E. et al, "The Impact of Serious Illness on Patients' Families," Journal of the American Medical Association, Vol. 272, No. 23 (pp. 1839-1844).

LONG-TERM CARE TAX CLARIFICATION

In general, AARP agrees that clarifications of how long-term care insurance should be treated under the tax code, such as treatment similar to accident and health insurance, are important. New expansions of such tax incentives in isolation from broader reforms, however, raise some concerns. Of particular concern is the fact that the majority of older persons would benefit little or not at all from these tax preferences. Indeed, close to one-half of older Americans have insufficient incomes to owe taxes and would receive no relief from these proposals. Distributional analyses and resolution of apparent discrepancies between Joint Tax Committee and Treasury Department revenue estimates on these provisions would be welcome. Such tax breaks are not the Association's highest priority for spending limited additional dollars on long-term care. Before these changes are enacted, it would be very useful to understand more clearly how much they would cost and who would benefit.

Of greater priority to the Association would be for the federal government to help make home and community-based care more available to middle class families. A program in the form of a grant to states in which they could participate at their option could be effective. Federal contributions could be capped so that no new entitlement would be created. With some criteria set by the federal government, the public sector would provide a foundation for support and the private sector would play an important supplemental role. This is not unlike our nation's income security program for older Americans, where Social Security provides the foundation, supplemented by private pensions and savings. While Social Security helps to provide some peace of mind for millions of retirees, it does not address their needs when a long-term disability strikes, nor does Medicare. If a public home and community-based program were put into place for severely disabled individuals of all ages and incomes, the proposed new tax incentives, if accompanied by consumer protection standards, would be an appropriate complement.

Absent a new public program, the chronic care needs that cause spenddown and financial chaos for many middle-class families will continue unabated. Medicaid generally is available only to those with low incomes and tax breaks and private insurance largely benefit only higher income persons. Of the over 3 million Americans with severe disabilities living in the community, approximately **one-half** have incomes between 100% and 400% of the federal poverty line ($9,500 to $38,000 for couples and $7,400 to $29,600 for singles). Something must be done to address their very serious needs.

THE NEED FOR CONSUMER PROTECTION STANDARDS

If a decision is made to move forward on the proposed tax incentives, we strongly urge that federal consumer protection standards be included as a condition for policies receiving favorable tax treatment. These standards should be at least as strong as those included in the most recent version of the Model Law and Regulation passed by the National Association of Insurance Commissioners (NAIC).

Unfortunately, despite recent improvements, the long-term care insurance market continues to be one in which the large print giveth and the small print taketh away. Too many consumers continue to spend significant sums of money on policies providing largely illusory benefits. Although states have had the option to adopt the standards drafted by the NAIC, constructed with great deliberation over the past eight years by expert state Insurance Commissioners, along with industry and consumer representatives, many have not yet adopted a number of the most important provisions in the models. Consensus among consumer and industry groups exists that we need nationwide, uniform standards for these products. Such standards would accrue to the benefit not only of consumers but to the many responsible companies offering decent policies who desire stability and are being placed at a disadvantage for lack of a level playing field vis-à-vis industry members offering substandard policies.

National standards are particularly important as a condition for granting favorable tax status. Federal tax expenditure dollars should not be used to encourage the purchase of

long-term care insurance policies that fail to provide meaningful coverage. Almost all of the legislative proposals on long-term care insurance tax incentives introduced over the years by members of both parties have included consumer protection standards. We understand that this subcommittee intends to examine appropriate standards for long-term care insurance policies in the near future and look forward to working with subcommittee members to construct strong standards for qualifying policies, based on the work already accomplished by the NAIC. In our view, the market improvements recommended below also should be tied directly to eligibility for proposed tax breaks. It will also be important to ensure that the proposed definition of "chronically ill individual" in the legislation does not leave out important populations needing long-term care.

LONG-TERM CARE PROPOSALS IN THE SENIOR CITIZENS' EQUITY ACT

Treatment of long-term care services and insurance premiums as medical care -- Section 303(a) of the Act would treat qualified long-term care services as medical care for purposes of the medical expense deduction allowed individuals under Section 213 of the Internal Revenue Code when such expenses are in excess of 7.5% of adjusted gross income. Because its benefits are not limited only to those who purchase a private long-term care insurance policy and because it will help families burdened with catastrophic out-of-pocket expenses, we believe this proposal could be the most significant for consumers under this Title of the Act. For some, the proposal could delay nursing home placement and spenddown to Medicaid eligibility. Treating long-term care insurance premium payments as medical care in the same way would have a much more limited impact.

Treatment of employer-provided long-term care insurance and long-term care insurance benefits -- The proposals under Section 302 to allow employers to provide employees with tax-free long-term care insurance and to permit exclusions for benefits provided under long-term care insurance, in theory, could help to promote the growth of the group market for younger purchasers. As we explain later in our testimony, such growth is one way to make long-term care insurance more affordable. Many employers, however, are already having difficulty funding health benefits for current workers and retirees and would likely be reluctant to take on new liabilities. Of the relatively small but growing number of companies that offer long-term care benefits to their employees (approximately 360 companies in 1992), virtually all only serve as sponsors and do not contribute to premium payments. To the extent that this proposed tax incentive might motivate some employers to consider making even a small contribution toward the premium, or help to get the issue on the collective bargaining table, this could be a positive step for future generations of retirees. To have a noticeable, immediate impact, however, such tax incentives would have to be extended to long-term care insurance for the parents of employees.

Exchanges of life insurance for long-term care insurance -- Section 304 would allow individuals to make tax-free exchanges of their life insurance policies for long-term care policies. The Association believes that certain beneficiaries of the life insurance policies -- spouses in particular -- should have their interests protected by requiring their consent to such an exchange. This would recognize both the economic partnership and the need to ensure a sound understanding by the spouse of the implications of an exchange decision.

Distributions from IRAs and 401(k) plans -- The Association has concerns with Section 305, which would permit tax-free distributions from IRAs and Section 401(k) plans to purchase long-term care insurance. In all likelihood, only a small percentage of better-off individuals would take advantage of this option, further limited to those who have qualified retirement plan funds. The proposal would create horizontal inequities in the tax code because benefits would vary with income.

LIMITATIONS OF PRIVATE LONG-TERM CARE INSURANCE AND RECOMMENDATIONS FOR IMPROVING THE MARKET FOR CONSUMERS

Even if strong federal standards to improve the quality of private long-term care insurance products were enacted, there still are three major limitations in the private market that need to be addressed for a private sector solution to be viable for the vast majority of middle income American families: (1) exclusions based on pre-existing conditions; (2) lack of affordability; and (3) poor coverage of home and community-based services. These problems can be traced largely to fundamental ground rules which govern all kinds of private insurance, namely: (1) insure only manageable risks; (2) avoid ambiguous risks; and (3) control induced demand.[2] These factors also explain why the Association believes that a public sector program, with private insurance playing a significant supplemental role, is the only solution that could address effectively the long-term care needs of **all** Americans, including the middle class and persons with disabilities. In addition, a public program would more efficiently distribute benefits, since it would not be subject to the types of marketing and administrative costs that can absorb up to 40% of private long-term care insurance premiums.

A fundamental problem with private long-term care insurance is that it discriminates against millions of Americans with pre-existing conditions. Private long-term care insurance companies only sell policies to healthy persons because of their desire to minimize the risk of someone using long-term care services. To illustrate our concern, we have attached a long-term care insurance application form which makes it clear in the "insurability profile" section that anyone at risk of needing long-term care should not apply. We do not mean to be critical of this particular product (the company offers one of the better policies on the market); similar forms are used by virtually every company selling long-term care insurance in order to weed out bad and ambiguous risks. By enrolling only healthy people, companies exclude millions of Americans who may now need or will soon need long-term care, including persons over 80 or 85 years of age. A recent study conducted for AARP by Coopers & Lybrand and William M. Mercer estimated that **approximately 23% of persons over age 65 are uninsurable and cannot purchase a long-term care insurance policy** for these reasons.[3]

In order for a private sector solution to be a serious option for those in need, pre-existing condition exclusions would have to be prohibited or minimized, as most members of Congress agree must be done for private medical insurance policies. The concern, of course, is that if companies are not able to underwrite their products, adverse selection will take place and premiums will escalate dramatically. There are at least two ways this could be addressed. First, efforts need to focus on expanding the **group market**. The larger the group, the more risk sharing among purchasers can take place. This is why Medicare, which has a very large risk pool, can accept older Americans regardless of pre-existing conditions, at a relatively low per-enrollee cost. Most long-term care insurance policies, however, are now sold on an individual basis. While risk pooling is relatively easier in this market for employer groups, in order to have much usefulness for those who currently purchase this insurance -- older retired persons -- creative ideas for developing risk pooling will be essential.

A second response to the problem of insurance exclusions based on pre-existing conditions is to examine how companies underwrite their products and develop standards to reduce these discriminatory practices. Incentives, such as the proposed tax breaks, should be created to significantly reduce exclusions by making government **reinsurance** available to companies that meet the standards or substantially improve their underwriting policies. Limiting some of the risk for companies selling these products has the potential for creating incentives for them to accept more ambiguous

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[2] Ball, Robert, Because We're All in This Together, Part 5 (1989).
[3] Munson, Bart et al, Affordability of Private Long-Term Care Insurance -- New Perspectives, July 1994 (Table 6).

risks than they have been willing to historically. Reinsurance might be financed, in part, by premium taxes, consistent with some current state practices.

Another fundamental problem with private long-term care insurance is that these products, if they provide meaningful protection, are simply too expensive for most older Americans. According to the aforementioned Coopers & Lybrand and William M. Mercer study, annual premiums for the average age purchaser (approximately 70 years), for a policy that provides good protection, are approximately $3,500, or almost $300 per month. Very few older Americans, most of whom are on fixed incomes, can afford these premiums. Roughly half of all elderly couples are living on less than $25,000 per year. The study found that **fewer than 10% of persons over age 65 can afford a good policy**, assuming they would be willing to spend up to 7% of their income and 25% of their annuitized assets on premiums. A Long-Term Care Insurance Personal Worksheet recently developed by the NAIC, for example, advises that it may not be a good idea to buy a long-term care insurance policy if the premiums will be more than 7% of prospective purchasers' incomes and if they have assets of less than $30,000 (excluding their home). Absent substantial government-sponsored premium subsidies, it is difficult to see how meaningful private insurance protection could be made affordable to most older Americans.

There are methods, however, to help make policies somewhat more affordable, in addition to the tax breaks discussed earlier. One important improvement, for example, would be to create an environment in which greater **price competition** existed for a limited number of standard policies. AARP has resisted the temptation to suggest moving the long-term care insurance industry in the same direction as Medicare Supplemental policies by mandating standard packages, because we do not want to stifle innovation in a relatively new market where some progressive companies are offering bold, innovative products to consumers. However, if incentives, such as the proposed tax breaks, were created for companies to offer, for example, four standard policies, without limiting their ability to offer other products, consumers could more easily compare benefits (an extremely complex task in the current market), companies would compete primarily on the basis of price, and this increased competition could reduce premiums.

Without question, the affordability issue could be addressed, in part, if younger adults could be persuaded to purchase private long-term care insurance. The younger the purchaser, the less expensive the product (even though good inflation protection is critical for younger purchasers and can increase premiums significantly). However, most younger adults have other pressing financial priorities, such as home mortgages and paying for education expenses. General denial about the probability of needing long-term care any time in the foreseeable future also has kept younger persons from purchasing such insurance. One response to this problem is public education. Another response, as discussed above, is to provide incentives for employers to offer this coverage to employees (and their parents).

While the **initial** premium for a long-term care insurance policy will be lower for younger purchasers, the key concern is affordability **over time**. Most policyholders probably will not need to use long-term care benefits until they are in their 70's or 80's. We are concerned that over the life of a 30-40 year old policy, the premiums may increase so much that many policyholders, by the time they reach age 75 or 80, could not afford to continue paying premiums. These policyholders would be forced to drop the policy after paying many thousands of dollars in premiums, but before benefits are actually needed or used. This is particularly the case with a large number of products in which premiums are designed to increase along with inflation protection. For younger purchasers, if a policy does not have inflation protection it will be almost worthless by the time they need long-term care. The primary issue, therefore, is **premium stability** (and providing incentives to offer level premium products that include inflation protection). Unlike typical medical insurance, most long-term care insurance policies pay a fixed indemnity amount and, therefore, cannot justify premium increases on the basis of the rising cost of care. Although there have not been

widespread premium increases in this market to date, this is a relatively young product (only a few companies sold long-term care insurance prior to the late 1980's) and most policyholders will not need benefits for 10 to 20 years after they have bought a policy. Therefore, we still do not know how many purchasers will ultimately use their insurance coverage (whether companies' actuaries accurately estimated utilization) and whether the policies are properly priced.

Unfortunately, accurately pricing long-term care insurance policies is not easy, particularly for younger purchasers. Even the most experienced actuaries have a difficult time. This is illustrated by a NAIC report in which the best actuaries in the industry attempted to price various policies. Alarming variation existed even for the base policy (without inflation or nonforfeiture protection), where price for the **same product** for a 40-year old purchaser **varied by over 300%** ($248 vs. $793). For an 85-year old purchaser, prices varied by over $3,500 ($7,506 vs. $11,035).[4]

Without question, if long-term care insurance is to be available in a meaningful way to younger purchasers, strong national standards on premium stability must be established. The NAIC recently passed standards to promote long-term care insurance premium stability. While the standards do not go as far as we would ideally like, they are the result of much deliberation and give and take on both sides and should be included as part of a broader set of national long-term care insurance standards.

To bolster the market for younger purchasers, incentives should also be created to encourage companies to develop and offer **paid-up policies**. Under such policies, after premiums have been paid for a certain period of time (e.g. 10, 20 or 30 years), no additional payments are needed to receive full benefits. These could, for example, be designed to be paid-up just prior to retirement. A few creative companies are just starting to offer paid-up policies.

Finally, private long-term care insurance needs to do a much better job **covering home and community-based care**. Like Medicare and Medicaid, private products suffer from a clear institutional bias. Unlike nursing home care, where no one wants to have to use these benefits, insurance companies are uncertain about future home care utilization and cost patterns and are concerned about the potential for induced demand. Thus, some companies limit home care coverage by requiring prior nursing home care, paying only a small fraction of the nursing home benefit, covering only medically necessary services, and/or excluding coverage for homemaker services. This can be addressed, in part, by developing stronger home care coverage standards for policies to meet, and by making the aforementioned reinsurance program available for companies willing to take on these more ambiguous risks.

FINANCING LONG-TERM CARE TAX CLARIFICATIONS

The Association has serious concerns about how tax breaks proposed here and elsewhere in the Contract with America will be financed. AARP urges that the Medicare program not be singled out as a financing source. Medicare has been cut substantially over the last several years -- by nearly $200 billion since 1980. Moreover, the program and its beneficiaries are only now beginning to feel the impact of the $56 billion in reductions recently made as part of OBRA' 93. Without question, Medicare could not sustain the level of cuts required to pay the lion's share of a balanced budget and for the other provisions in the Contract.

While it has been said that cuts in Medicare spending would simply be reductions in the program's rate of growth, increases of the magnitude needed to finance the Contract, including the Balanced Budget Amendment, would translate into real and substantial out-of-pocket costs for 36 million disabled and aged beneficiaries who depend on Medicare as their primary source of health insurance. Older Americans already have the highest out-

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[4] Final Report from the NAIC Long-Term Care Insurance Nonforfeiture Benefits Ad Hoc Actuarial Group, June 2, 1992 (p. 9).

of-pocket expenditures for health care than any other age group. Health care expenses already account for 23 percent of the average older person's household income as compared with 8 percent for the non-elderly. Cuts in Medicare of the magnitude required to pay for the provisions of the Contract would create a barrier to care for many beneficiaries, or would limit their choices of health plans, providers and coverage.

Deep cuts in Medicare are also fiscally short-sighted. Cutting Medicare means that costs will simply be shifted to businesses and individuals -- driving up the costs of private health insurance. For businesses, this added expense means that employers will scale back coverage, require workers to pay more or eliminate health insurance coverage for their workers all together.

By making deep cuts in Medicare as a way to pay for the Contract, Congress will be turning its back on the commitment it made to Americans: pay into the Medicare system during your working years and you will have protection against health care costs when you need it most.

CONCLUSION

AARP believes that a variety of methods exist to improve the market for private long-term care insurance. Tax incentives would make these policies more attractive to prospective purchasers, assuming favorable treatment is conditioned on meeting strong consumer protection standards as well as on key market reforms. The proposal to treat qualified long-term care services as medical care for purposes of the medical expense deduction may be of even greater importance to consumers.

Additional recommendations to improve the private market for consumers include: (1) extension of tax-free employer provided long-term care insurance to the parents of employees; (2) the availability of government reinsurance in exchange for accepting ambiguous risks and meeting certain underwriting standards; (3) strong standards on premium stability; (4) incentives for companies to offer a limited number of standardized benefit packages to promote price competition; (5) incentives for companies to develop paid-up policies; and (6) strong standards on home care coverage.

Unfortunately, all of these proposals would still fail to address the needs of most middle-income families in need of long-term care. The proposed tax incentives would favor higher income individuals. Exclusions on the basis of pre-existing conditions and problems of affordability and institutional bias persuade us that a public program, emphasizing home and community-based care and supplemented by private insurance, is the most logical way to solve our nation's long-term care crisis.

AARP stands willing to work with this subcommittee and other interested Members of Congress to develop effective responses to the long-term care crisis facing America, whether the proposals are primarily in the public or private sectors.

Chairman THOMAS [presiding]. Is it Mr. Richtman? I don't see your name up there, but I thought it was you. Go ahead.

STATEMENT OF MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. RICHTMAN. Thank you, Mr. Chairman.

I am Max Richtman, executive vice president of the National Committee to Preserve Social Security and Medicare. The national committee supports the tax incentives for long-term care private insurance included in the Contract With America.

The national committee agrees about the need to clarify these areas in the Tax Code. While we support a long-term care public program, especially for home and community-based long-term care, private insurance is an important part of the long-term care solution.

The number of people willing and able to purchase long-term care policies, while still relatively small, is likely to increase as the baby boom generation matures. By passing these tax incentives, the government would, in effect, be endorsing private long-term care insurance. This is a relatively low-cost initiative.

The national committee believes it is equally important to link these tax incentives with the kinds of standards proposed in H.R. 3651, by Congresswoman Johnson, in the last Congress and supported by you, Mr. Chairman. We believe a bipartisan consensus will exist—we hope it will—for standards for private long-term care insurance.

Currently, the Tax Code makes no reference to long-term care insurance. As long as health insurance is taxed favored, we believe long-term care insurance should be treated similarly. The need for long-term care most often is related to chronic illness and the financial risk is substantial. But the cost of policies is significant and the potential need uncertain and far into the future. Purchasing long-term care insurance requires foresight and planning. Individuals would have to buy even more insurance if benefits would be taxable. Taxing contributions or benefits would simply stack the deck against private long-term care insurance.

The Contract With America would provide an exclusion for employer-provided coverage. While some employers have arranged for group coverage, few employers contribute toward the cost. Employer contributions, we believe, would make a big difference in the affordability and availability of private long-term care insurance.

While it would be unreasonable to expect many employers in the near future to enter into a new commitment to pay for long-term care insurance, some employers undoubtedly would be willing to make it part of a flexible benefit plan. But if the tax laws are not changed and clarified, it is unlikely that employers will ever pay for long-term care insurance.

Employers whose employees are relatively young and healthy might even desire to provide this insurance. Premiums are much more affordable, as you know, for younger Americans, but younger Americans need more incentive to begin to plan for their long-term care. This incentive could be provided by employer-provided coverage.

Tax equity would require full deductibility we think for premiums, including long-term care insurance premiums. There is no reason that insurance paid by an employer should be tax free but premiums paid by individuals should be nondeductible.

Given the favorable experience with the 1990 Medigap reforms and concerns about poor quality of long-term care policies, the national committee hopes this subcommittee will also pass long-term care insurance standards. The NAIC, with the participation of the insurance industry, continues to work on standards which could be the basis for national standards. These standards should include inflation protection, nonforfeiture protection, State approval of premium increases, standardized language, a 6-month limit on the use of preexisting condition limits, and limitations on agents' sales practices. Without adequate standards, we think many people will end up with a false sense of security if they buy long-term care insurance.

In conclusion, the national committee strongly supports the initiative of the House Republicans in the area of senior benefits. These initiatives have been given a significant boost by the new majority. Long-term care tax incentives are an important beginning to what we hope will be an ongoing process in providing all Americans with greater access to quality, affordable health care. Thank you very much.

Chairman THOMAS. Thank you, Mr. Richtman.

[The prepared statement follows:]

TESTIMONY OF MAX RICHTMAN
NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am Max Richtman, Executive Vice President of the National Committee to Preserve Social Security and Medicare, a grassroots, education and advocacy organization representing millions of senior Americans. The National Committee supports the tax incentives for long-term care private insurance included in the Contract with America.

The National Committee agrees about the need to clarify these gray areas in the tax code. While the National Committee supports a long-term care public program, especially for home and community-based long-term care, private insurance is an important piece to the long-term care solution. The number of people willing and able to purchase long-term care policies, while still relatively small, is likely to increase as the baby boom generation matures. By passing these tax incentives, the government would in effect be "endorsing" private long-term care insurance. This is a relatively low cost initiative costing only $1.3 billion over five years.

The National Committee believes it is equally important to link these tax incentives with the kinds of standards proposed in H.R. 3651 by Congresswoman Nancy Johnson in the last Congress and supported by you, Mr. Chairman. We believe that a bipartisan consensus exists for standards for private long-term care insurance similar to the 1990 medigap insurance reforms.

Currently the tax code makes no reference to long-term care insurance. As long as health insurance is tax favored, so also should long-term care insurance. The need for long-term care most often is related to chronic illness and the financial risk is substantial. But the cost of policies is also significant and the potential need uncertain and far into the future. Purchasing long-term care insurance requires foresight and planning. Individuals would have to buy even more insurance if benefits would be taxable. Taxing contributions or benefits would stack the deck against private long-term care insurance.

The Contract with America would provide an exclusion for employer provided coverage. While some employers have arranged for group coverage, few employers contribute toward the cost. Employer contributions would make a big difference in the affordability and availability of private long-term care insurance. Considering the burden on employers for health insurance for current employees and retirees, it would be unreasonable to expect many employers in the near future to enter into a new commitment to pay for long-term care insurance. Some employers, however, undoubtedly would be willing to make it part of a flexible benefit plan. But if the tax laws are not changed, it is unlikely that employers will ever pay for long-term care insurance.

The exclusion of employer provided coverage is also key to encouraging younger Americans to purchase insurance. Employers whose employees are relatively young and healthy might even desire to provide this insurance. Premiums are much more affordable for younger Americans, but younger Americans need more incentive to begin to plan for their long-term care needs. This incentive could be provided by employers.

Another provision would allow premiums for long-term care insurance to be deductible under current law as a medical expense. Unfortunately medical expenses are only deductible to the extent that total medical expenses exceed 7.5 percent of Adjusted Gross Income (AGI). This provision will help seniors more than younger Americans. Long-term care premiums are higher for seniors who already tend to have higher medical expenses relative to their total income.

Tax equity, however, would require full deductibility for premiums, including long-term care insurance premiums. There is no reason that insurance paid by an employer should be tax free but premiums paid by individuals should be non-deductible.

Tax incentives for long-term care insurance and long-term care insurance standards were part of most major health care reform bills in the last Congress, including the Bipartisan Bill sponsored by former Congressman Roy Rowland and Congressman Michael Bilirakis and the Dole/Packwood bill in the Senate. It was not part of the Republican leadership bill in the House, however, which probably explains why it has not been included in the Contract with America even though standards are supported by most of the House Republican health care leaders.

Given the favorable experience with the 1990 medigap reforms and concerns about poor quality long-term care policies, the National Committee hopes that this Subcommittee will also pass long-term care insurance standards. The NAIC, with the participation of the insurance industry, continues to work on standards which could be the basis for national standards. These standards should include inflation protection , non-forfeiture protection, State approval of premium increases, standardized language, a six-month limit on the use of preexisting condition limits and limitations on agent sales practices. Without adequate standards, many will end up with a false sense of security if they buy long-term care insurance.

In conclusion, the National Committee strongly supports the initiative of House Republicans in the area of senior benefits. Initiatives, which languished in the previous Congresses, have been given a significant boost by the new majority. Long-term care tax incentives are an important beginning to what we hope will be an ongoing process in providing all Americans with greater access to quality, affordable health care.

Chairman THOMAS. Mr. Hansen.

STATEMENT OF JAKE HANSEN, DIRECTOR OF GOVERNMENT AFFAIRS, THE SENIORS COALITION

Mr. HANSEN. Thank you, Mr. Chairman. I represent the 1 million members of The Seniors Coalition. Our members believe that free individuals working together——

Chairman THOMAS. Excuse me, Mr. Hansen, would you take the mike.

Mr. HANSEN. I am sorry about that.

Our members believe that free individuals working together in free markets can find solutions to most of the problems facing older Americans. They believe there is already too much bureaucratic regulation and redtape in our society, and they believe we should turn to the Federal Government for help only if solutions cannot be found at the level of the State, the city or the county, the neighborhood, the family, or the individual.

The Seniors Coalition is pleased that Congress is addressing the problem of long-term care. Too many senior citizens are forced to spend down the accumulated resources of a lifetime because of serious illness that requires nursing home care. Among millions of older Americans, there is a constant fear that at any time they might lose most of what they own.

Because of changes in our country's population, the problem of paying for long-term care will probably get worse. The oldest segment of our population, those over age 85, will grow the fastest. It is estimated that by the year 2050 nearly a quarter of all people over 65 will be 85 years of age or older. By 1990, people age 65 or older face a 43-percent lifetime risk of entering a nursing home. About 1 in every 5 seniors face a nursing home stay of over 1 year and about 1 in 10 would be in a facility for 5 years or longer.

The cost of such care can be astronomical. The cost of care in a nursing home in 1992 was about $28,500 a year for unskilled care and about $32,000 a year for skilled care. Private insurance policies account for only 1 percent of long-term care. Medicaid paid the vast majority.

According to HCFA, under current law, Medicaid by the year 2025, will pay for two-thirds of all long-term care. Congress is now facing the tough choices that will be necessary to balance the budget, but if we do not make reforms in long-term care, those choices will be even tougher.

In recent years, there has been significant progress in the development of private insurance for long-term care. The public is beginning to understand the magnitude of the problem of paying for long-term care. People are beginning to realize the importance of taking steps now to alleviate hardship later in life.

In 1993, a poll by the Employee Benefit Research Institute showed that, by a ratio of 2 to 1, people expected to use private means to pay for long-term care rather than depending on the government. After survey participants were given more information about long-term care, nearly two-thirds said they would be interested in purchasing a long-term care policy directly from an insurance company or through an employer. So we see that while many of today's seniors are forced to bankrupt themselves to qualify for

Medicaid, most of tomorrow's seniors look for ways to avoid that indignity.

The question is, how do we build a system that makes private long-term care insurance attractive and affordable to consumers of all ages? The Seniors Coalition believes that the Senior Citizens' Equity Act in the Contract With America is a big step toward that goal.

Some say that changing the Tax Code is no way to provide long-term care to America's seniors, but I believe they are wrong for three reasons. First, last year's health care debate, as well as changes in the insurance industry, have heightened people's awareness of long-term care, its cost and its methods. They recognize that there are alternatives to a government-run system.

Second, they recognize that the government's programs don't always live up to their promise. Today's seniors want options that will let them provide for themselves and determine their own fates.

Third, the fact is, taxpayers change their habits in response to changes in the tax system. If long-term care insurance is affordable and accessible, people will take advantage of this opportunity. The opportunity is before us to dramatically change the way Americans view their long-term health care. Medical technology is extending the length and improving the quality of life in ways that no one imagined. We must build a system that places primary responsibility on individuals and families with the government stepping in only when absolutely necessary.

We believe long-term care provisions of the Contract With America will take us in the direction we need to go. The Seniors Coalition will assist you in any way possible to assure the passage of these provisions.

Chairman THOMAS. Thank you, Mr. Hansen, for your testimony.

[The prepared statement follows:]

THE SENIORS COALITION
11166 MAIN STREET, STE. 302 ♦ FAIRFAX, VA 22030 ♦ (703)591-0663

STATEMENT OF JAKE HANSEN
DIRECTOR OF GOVERNMENT AFFAIRS
THE SENIORS COALITION

PRESENTED TO THE
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

FRIDAY, JANUARY 20, 1995

Mr. Chairman, thank you for inviting me to address the committee on the Long Term Care Provisions that are part of the Contract With America.

I represent the one million members of The Seniors Coalition. Our members believe that free individuals, working together in free markets, can find solutions to most of the problems facing older Americans. They believe there is already too much bureaucratic regulation and red tape in our society. And they believe we should turn to the federal government for help only if solutions cannot be found at the level of the state, the city or county, the neighborhood, the family, or the individual.

The Seniors Coalition is pleased that Congress is addressing the problem of Long Term Care. Too many senior citizens are forced to "spend down" the accumulated resources of a lifetime because of a serious illness that requires nursing home care. Among millions of older Americans, there is a constant fear that, at any time, they might lose everything they own.

Because of changes in our country's population, the Long Term Care problem will probably get worse. Life expectancy has steadily increased in the United States, with almost all of the increase since 1970 being attributable to decreasing death rates for those over 65 years of age. According to U.S. Census Bureau figures, the oldest segment of the population, those over age 85, will grow the fastest. It is estimated that by the year 2050, nearly a quarter of all people over 65 will be 85 years of age or older.

By 1990, people age 65 or older faced a 43% lifetime risk of entering a nursing home. About one of every five seniors faced a nursing home stay over one year, and about one in ten would be in a facility for five years or longer. The cost of such care can be astronomical. The cost of care in a nursing home in 1992 was about $28,500 a year for unskilled care and about $32,000 a year for skilled care.

Private insurance policies account for only one percent of Long Term Care. Medicaid pays the vast majority. According to the Health Care Financing Administration, under current law Medicaid, by the year 2025, will pay for two-thirds of all Long Term Care.

Congress is now facing the tough choices that will be necessary to balance the budget. But if we do not make reforms in Long Term Care, those choices will be even tougher.

In recent years, there has been significant progress in the development of private insurance for Long Term Care. The public is beginning to understand the magnitude of the problem of paying for Long Term Care. People are beginning to realize the importance of taking steps now to alleviate hardship later on in life.

Consider the results of a 1993 poll by the Employee Benefit Research Institute. Asked how they expect to pay for Long Term Care, 18% of respondents said they expected to use personal savings; 42% said they expected to use private Long Term Care insurance; and only 28% expected the government to pay for it. In other words, by two to one, people expected to use private means to pay for Long Term Care rather than depending on the government. After participants in the survey were given some information about Long Term Care, about two-thirds said they would be interested in purchasing a Long Term Care policy directly from an insurance company or through an employer.

Thus, we see that, while many of today's seniors are forced to bankrupt themselves to qualify for Medicaid coverage, most of tomorrow's seniors look for ways to avoid that indignity.

The question is, how do we build a system that makes private long term health care insurance attractive and affordable to consumers of all ages?

The Seniors Coalition believes that the Senior Citizens Equity Act in the Contract with America is a big step toward that goal.

No longer should America's seniors be forced into bankruptcy to pay for health care services. Likewise, the federal government should not be expected to continue picking up the tab through Medicaid; most Americans are ready and willing to pay for private Long Term Care insurance. As the figures I quoted earlier aptly illustrate, with the aging trend we're facing, Long Term Care will bankrupt the government. The provisions in HR 8 provide the avenue for shared responsibility between the government, the consumer, and the insurance industry.

Promoting the private market will undoubtedly lead to reduced public financing of Long Term Care. Long Term Care insurance policies have expanded greatly over the past few years and now offer a wide variety of benefit options and more flexible eligibility criteria. As these reforms are passed, I believe we will see a dramatic growth in the employer-sponsored market. If we can make it possible and realistic for working-age people to provide for their long term health care needs now, we can eventually reduce public financing to a bare minimum.

To successfully shepherd this transition, Congress should be careful to set standards and guidelines to ensure consistency between Long Term Care policies. Now this does not mean that we should establish a government-run health care system. But it does mean that there are some inequities between competing plans and carriers that must be addressed to guarantee that consumers are given the best options from which to select a policy.

I would also suggest that Congress take this opportunity to evaluate the role of private Long Term Care insurance in overall Medicaid reforms. It is vital that regulations governing this system be uniform, that they provide adequate reimbursement to care providers. We also must end the bias toward institutionalized care. Not only have Medicaid and Medicare regulations pushed people toward institutionalized care, but the absence of market-driven private policies have made non-institutionalized care too expensive for the vast majority of people. These reforms will end the cycle that encourages the elderly to intentionally divest themselves to qualify for Medicaid coverage.

Some say that changing the tax code is no way to provide Long Term Care to America's seniors, but I believe they are wrong for three reasons.

First, last year's health care debate, as well as changes in the insurance industry, have heightened people's awareness of Long Term Care, its costs and its methods. Just as they

rejected the notion of a government run health care system, seniors are rejecting the notion that the only way to provide for their Long Term Care needs is through a government-run, taxpayer-financed bureaucracy.

Second, there is a growing realization among America's seniors that one federal program after another has, in the name of helping seniors, hurt them. Many of these programs have weakened the economy, raided the Treasury, sent taxes skyrocketing, created rivers of red tape and has taken away peoples' freedom and self-sufficiency. Today's seniors are dismayed that time and time again they are expected to quietly become wards of the welfare state in exchange for their contributions throughout their working years. Today's seniors want options that will let them provide for themselves and determine their own fates.

Third, the fact is that taxpayers change their habits in response to changes in the tax system. For example, if Congress imposes a hefty gas tax, people tend to vacation closer to home, thereby reducing the expected revenues from increasing the tax. If Long Term Care insurance is affordable and accessible, people will take advantage of this opportunity.

The Long Term Care problem is too big and too serious for the solution to come directly from a federal government that can't even balance its own books. Any proposed solution that relies mostly on the federal government is a dead end. The responsibility to finance Long Term Care must be a shared one. The vast majority of people can provide for themselves, and should be expected to. The federal government can help those who, through no fault of their own, cannot provide for themselves.

The opportunity is before us to dramatically change the way American's view their long term health care. Medical technology is extending the length and improving the quality of life in ways that no one imagined. Our nation's policy on Long Term Care will fail if it is based on outmoded and failed notions of centralized government control. Instead, we must build a system that places primary responsibility on individuals and families, with the government stepping in only when absolutely necessary.

We believe the Long Term Care provisions of the Contract With America will take us in the direction we need to go. The Seniors Coalition will assist you in any way possible to ensure the passage of these provisions.

Chairman THOMAS. If my colleagues will allow me, Mr. Richtman, your statement, I think is entirely accurate that the gentlewoman from Connecticut and I sponsored very similar legislation. We had some minimum standards in it.

In his opening statement, you may or may not have been here, but the ranking member of the committee has become much more prescient in recent days. He predicted the vote on this measure when we get to a markup on it, and I believe his prediction is going to be correct.

He also in some initial testimony ferreted out the standards of the National Association of Insurance Commissioners and pressed others to support them. So I am pleased to see that he has not only discovered prescience, but some new found wisdom in the National Association of Insurance Commissioners, which I hadn't heard him express in the past.

We will be looking at a number of options. This is just a particular piece of the Contract With America. There will be a number of other issues coming before us. My hope, of course, is that it amalgams into a larger reform package that will move forward. This will either stand alone or will be blended.

There are a number of issues that we will be looking at that hopefully will be pulled together in a way in which—that which was wise in the previous Congress will not only be carried forward but will become law in this Congress.

So we are very—I am sure the gentlewoman from Connecticut would tell you if she were here, we are cognizant of the legislation that we have sponsored in the past and we are anxious to continue forward in the direction that we enunciated, but as a minority we were unable to deliver on and which we hope we will be able to as a majority.

Mr. RICHTMAN. Mr. Chairman, in response to that, there is of course a lot of room for debate and different kinds of standards. And even in the bills that you sponsored, cosponsored, the Rowland-Bilirakis bill, as you know, the standards involved in that bill especially as to nonforfeiture, that was something companies had to offer, but were not required to offer.

Some of the other legislation sponsored by members of this subcommittee required that it be in the policy. So there is room there and we hope we can work with you in deciding the best course of action.

Chairman THOMAS. You certainly can work with us. And I anticipate working with the minority as we have in other areas where there is agreement. This is the only piece in front of us, so we are looking at it in more detail than we would if it were part of a larger package. It is needed. The final details will be worked out as we move forward.

Mr. Shreve, is it my understanding that AARP in terms of various services that it offers to seniors has a long-term care insurance component in terms of the panoply of products you offer?

Mr. SHREVE. Yes, sir, we have a number of years ago, began to offer long-term care insurance programs that are available to members of the association.

Chairman THOMAS. But how long ago, just ballpark?

Mr. SHREVE. Maybe 5 years ago.

Chairman THOMAS. A felt need of the members in terms of questionnaires or leadership thinking, this was an appropriate way to go?

Mr. SHREVE. In any effort to produce a new program, we have tried to determine what the members' needs are by sampling the membership.

Chairman THOMAS. And was this one of the areas that the membership said they wanted to go?

Mr. SHREVE. Yes, there was a need for that or a demand for that on the part of a number, a substantial number of members.

Chairman THOMAS. In terms of coverage—primarily nursing home? Home-based health care? Over the 5 years, have you shifted the policy in terms of emphasis?

Mr. SHREVE. We have made two or three changes. I think we are offering four different programs now that have different components so that people can determine themselves. We are also in favor of nonforfeiture and inflation protection in programs and we offer that to members that want them.

Chairman THOMAS. Now, in offering an expanded product in this area, has this, once again, been in response to the members desiring a different-looking product?

Mr. SHREVE. Exactly.

Chairman THOMAS. And my assumption is that there has been a growing demand for this product?

Mr. SHREVE. Yes, there has.

Chairman THOMAS. Have you done any projecting forward in terms of increased growth or can you give me some idea of the growth over the 5 years that the program has been in effect?

Mr. SHREVE. I think there are between—and I apologize that I didn't come prepared to answer that specifically, but we are——

Chairman THOMAS. And you certainly can for the record correct any answer that you give. I am not trying to put you on the spot.

Mr. SHREVE. I appreciate that. And we will provide you with the numbers.

[The following was subsequently received:]

Long-Term Care Insurance Sales—AARP/Prudential

1986	1,121
1987	29,244
1988	34,102
1989	5,985
1990	7,028
1991	9,731
1992	10,751
1993	7,935
1994	4,728
Total	110,625

These figures do not include the number of policies that have lapsed.

Off the top of my head, I am thinking in terms of 40,000 to 50,000 policyholders.

Chairman THOMAS. From obviously an initial offering which was some small thousands and then it has grown to that?

Mr. SHREVE. Yes.

Chairman THOMAS. And response back to you indicate, obviously because it is growing, that this seems to be something that they are satisfied with?

Mr. SHREVE. Yes, so far. Of course, there again you never know as an individual until you need to use the policy yourself. And there are people that have bought the policy and are, you know, keeping it in force. And if they need those benefits some day, they will be available to them.

Chairman THOMAS. And your magazine, which has stories, useful stories, helpful hints and other things, along with I don't want to say advertisements but boxes for choices that you can make in some of the offerings, I would be anxious—and I know you didn't come prepared for this, but I would be interested in knowing if you have run some articles focusing on long-term care in the last year or two and has there been any increased response from the educational arrangement of talking about the need for it and on the next page having a form that the seniors could fill out and send in for that insurance?

Mr. SHREVE. I think that—we will provide that information to you.

Chairman THOMAS. If, in fact, that has been done. My guess is that maybe would be something useful to look at in terms of growth.

Mr. SHREVE. We will provide that information to you.

Chairman THOMAS. Again, since it is new and novel and since the opportunity from a previous panel for a real full understanding of the number of people who would respond to a program being cut off by government policy of the former majority not allowing this to expand, I am looking for whatever models we can find to begin to get a feel on the growth of long-term care insurance coverage. And anything you can serve us from the thousands of folks that utilize your structure would be very much appreciated.

Mr. SHREVE. We will get it to you.

[The following was subsequently received:]

Bringing lifetimes of experience and leadership to serve all generations.

March 23, 1995

The Honorable William M. Thomas, Chairman
Subcommittee on Health
Committee on Ways and Means
1136 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

This letter is in response to your question to Robert Shreve, Chairman of AARP's Board of Directors, at the January 20 hearing before the Subcommittee on the subject of Long-Term Care Tax Clarification.

There are issues of our publications in which both educational articles on health or long-term care and advertising may appear. You raised an interesting question as to whether the inclusion of an article affects response to an ad in the same publication. But, since we do not coordinate publication of articles with advertising, we do not look for a correlation with response rates.

Enclosed are materials regarding the long-term care insurance policies that AARP makes available to our members through Prudential Insurance Company. Among the enclosures are:

- Advertisements printed in Modern Maturity or the AARP Bulletin;
- The reply card that appeared with the long-term care insurance ads;
- Informational articles appearing in the Bulletin or our Health Insurance News publication;
- Product information describing the current long-term care insurance plans; and
- A question and answer brochure included with the product descriptions.

I hope these materials are helpful. If you have any further questions or if we can be of any further assistance, please ask your staff to contact Howard Bedlin of our Federal Affairs staff at (202) 434-3781. I apologize for the delay in delivering these materials to you.

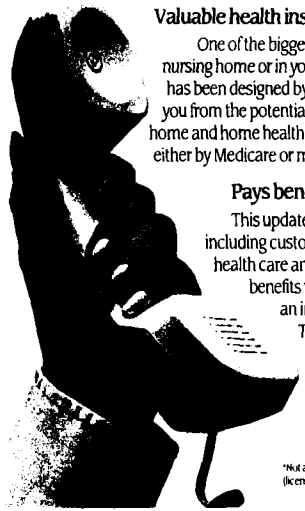
Sincerely,

Martin Corry, Director
Federal Affairs

Enclosures

cc: The Honorable Fortney "Pete" Stark

One quick call puts information about AARP's Long-Term Care Plan right in your hands.



Valuable health insurance coverage for long-term care.

One of the biggest worries about long-term care - either in a nursing home or in your home - is high costs. That's why this plan has been designed by AARP and The Prudential to help protect you from the potentially heavy expenses of long-term nursing home and home health care - expenses not likely to be covered either by Medicare or most private insurance policies.

Pays benefits for up to four years.

This updated plan will help pay for all levels of nursing home care, including custodial care for up to four years, as well as providing benefits for home health care and adult day care visits. And it's specially designed to help keep pace with inflation. Your benefits will increase by 5% *compounded* annually to help keep you covered when costs rise. Call now for an important information kit that includes details on plan benefits, costs, limitations and exclusions. This is a limited-time offer and is available in most states to AARP members aged 50-79 who meet certain eligibility requirements.* Your request must be received by **October 10, 1990.** (Ask for Operator 59.) **1-800-245-1212**

AARP Group Health Insurance Program

*Not available in Kansas. Group Policy Form No. GRP-79(71 A-101. The Prudential Insurance Company of America (licensed in all states), Fort Washington, PA 19034 NB224

The**Prudential**

AARP Bulletin
September, 1990
Job Number 0G5455021
1/2 page, 2 color
W.B. Doner and Company

Control

Lots Of Long-Term Care Insurance Plans Protect You Today. But What About Tomorrow.

The expense of long-term care can deplete a lifetime of savings. That's why AARP and The Prudential have worked together to develop AARP's Long-Term Care Plan. It's an insurance plan that helps protect you and your savings from nursing home, home health care, and adult day care expenses not likely to be covered by Medicare or your basic health insurance. Not just now, but in the future, too.

Unlike some other similar plans, AARP's Long-Term Care Plan helps protect you against inflation as well. Your benefits will increase by 5% *compounded* annually to help keep you covered when costs rise.

While not inexpensive, AARP's Long-Term Care Plan provides a range of benefits few other long-term care plans can match. And it's available to AARP members age 50-79 who meet certain eligibility requirements.

This is a limited-time offer and available in most states.* For more information on plan benefits, costs and limitations, call us no later than October 10, 1990.

(Ask for Operator 74.) 1-800-245-1212

AARP Group Health Insurance Program

*Not available in Kansas. Group Policy Form No. GRP-79171 A-101. The Prudential Insurance Company of America (licensed in all states). Fort Washington, PA 19034 NB228.

The**Prudential**

AARP Bulletin
September, 1990
Job Number 0G5455016
1/2 page, 2 color
W.B. Doner and Company

Test

Lots Of Long-Term Care Insurance Plans Protect You Today. But What About Tomorrow.

The expense of long-term care can deplete a lifetime of savings. And erase the careful plans you've made to ensure a comfortable retirement.

In response to members' requests, and to help you plan better for the future, AARP has worked with The Prudential to develop AARP's Long-Term Care Plan. It's an insurance plan that helps protect you and your savings from nursing home and home health care expenses not likely to be covered by Medicare or your basic health insurance.

Not just now. But in the future, too. Unlike some other long-term care plans, AARP's Long-Term Care Plan helps protect you against inflation as well. Your benefits will increase by 5% *compounded* annually to help keep you covered when costs rise.

While not inexpensive, AARP's Long-Term Care Plan provides a range of benefits few other plans can match. It helps cover all levels of nursing home care, including custodial care, as well as providing home health care benefits. And it's available to AARP members aged 50–79 who meet certain eligibility requirements. Perhaps most importantly, AARP's Long-Term Care Plan helps keep pace with inflation. AARP and The Prudential won't have it any other way.

For more information about AARP's Long-Term Care Plan, including plan benefits, costs and limitations, send in the attached card. This is a limited time offer and available in most states.* However, your request for information must be received by October 10, 1990. If you prefer, you can call toll-free Operator 31 1-800-245-1212

AARP Group Health Insurance Program

ThePrudential

*Not available in Kansas. Group Policy Form No. GRP-79171-A101. The Prudential Insurance Co. of America (licensed in all states). Fort Washington, PA 19034-3123

Long Term Care Insurance Covers Things You May Not Even Think Of As Long Term Care.

There's a lot more to long term care than nursing homes. Which is why our long term care insurance covers more than just nursing home care.

A long term care plan from the AARP Group Health Insurance Program, provided by The Prudential, can help cover the costs of recovering at home after an injury or illness. Or a visiting nurse or a qualified therapist if you need personalized care. And, of course, we can help cover the cost of nursing home care, which can exceed $30,000 a year*.

There is a waiting period before coverage takes effect. For complete information about our plans, including benefits, costs, eligibility, limitations and exclusions, just call us toll-free, or send in the attached card. We can also send you a free copy of AARP's *Before You Buy: A Guide to Long Term Care Insurance*.

Call today. Because there are some very good reasons to get long term care insurance — even if you never set foot in a nursing home.

NO ONE HAS MORE ANSWERS TO YOUR SUPPLEMENTAL HEALTH INSURANCE NEEDS. CALL US.

1-800-523-5800

OPERATOR # 16,

MON. - FRI. 9-5 ET.

Modern Maturity
July/August '94

AARP Group Health Insurance Program

ThePrudential

AS219 *American Hospital Association, "Economic Trends," Fall 1992, Vol. 8, No. 3, data through June 1992, based on a 3-year average. Group Policy Nos. G-36000-2-4-10. The Prudential Insurance Company of America (licensed in all states) Fort Washington, PA 19034. All plans may not be available in your state. AARP's Medicare Supplement Plans do not duplicate Medicare's benefits, and unless specifically stated, will only pay for benefits that are Medicare eligible expenses. All plans may not be available to persons eligible for Medicare by reason of disability. Not connected with or endorsed by the U.S. Government or the Federal Medicare Program. These Long Term Care plans are not available in California, Delaware, Kansas, Minnesota or New Hampshire, and are available only to AARP members age 50-79 who meet certain eligibility requirements. AARP's Hospital Advantage Plans are no-major medical plans, and are only available to AARP members age 50-64 who meet certain eligibility requirements.

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YOUR MONTHLY PAYMENT WILL BE LOWER IF YOU
APPLY FOR LONG TERM CARE INSURANCE NOW AND
ARE ACCEPTED BEFORE YOUR BIRTHDAY. CALL US
TODAY FOR COMPLETE DETAILS.
IF YOU WOULD LIKE THE FREE AARP BOOKLET,
CHECK HERE .

1) Please send me information on AARP's:
- ☐ Group Hospital Plans
- ☐ Medicare Supplement Plans
- ☐ Long Term Care Plans

2) AARP Membership number:

_____
(see mailing label for number)

3) My date of birth is: ____ / ____ / ____
Month Day Year

4) Name _____
(Mr., Miss, Mrs., Ms.) Please Print

Address _____

City _____

State _____ Zip _____

Phone(____) _____
Area Code

AARP Group Health Insurance Program

MS200

ThePrudential

Sample of card that goes with LTC ad in Modern Maturity

AARP offers care plan

Deadline for information requests Oct. 10

The Association's Nursing Home and Home Health Care Plan is now available for a limited time period in nearly every state. This plan is part of the AARP Group Health Insurance Program provided by the Prudential Insurance Co. of America.

The benefits of this plan are $50 per day in any state-licensed nursing home, with an option for a higher level of benefits; $35 per visit for physical therapy, occupational therapy and skilled nursing care received in the home; $30 per day for adult day care; and $25 per visit for personal care and home health-aide services.

Maximum allowable days of coverage are 1,095 days for nursing home stays and 730 visits for home health/adult day care visits.

Under the plan, benefits will increase 5 percent per year, beginning Jan. 1, 1991. As already indicated, plan participants will be offered a standard plan and an optional, higher benefit amount plan. The plan is "guaranteed renewable" to those insured under it.

The plan is open only to AARP members aged 50 through 79. There are certain other eligibility requirements, and thus members must complete a brief medical questionnaire. To receive benefits, the insured member must meet a 90-day deductible for nursing home stays and a 45-day deductible for home health/adult day care visits. Once in a nursing home for 90 days, the monthly premium is waived.

Premiums will be on a sliding scale based on age at purchase. The rates will be available in the information kit sent to those inquiring. Rates will not increase as an insured member ages. The only way the rates may increase is if they are changed for everyone in a member's class and state.

Although persons age 80 and over aren't eligible to enroll, those who are already in the plan may not be disenrolled on the basis of age, regardless of how old they are.

Requests for information must be received no later than Oct. 10, 1989. For information, call (800) 245-1212, Operator 94. The deadline for applications is Oct. 31.

1989 AARP Bulletin

AARP Forum

DO YOU KNOW WHAT YOU NEED TO KNOW ABOUT LONG-TERM CARE?

Many people don't find out until they – or loved ones – need care for a chronic illness.

QUIZ YOURSELF!

The Answers are on Page 8

1. Nursing home use is declining because todays elderly are healthier. ❑ True ❑ False
2. A 65-year-old man today has a one-in-three chance of spending time in a nursing home during his lifetime. ❑ True ❑ False
3. The number of workers who are responsible for the care of elderly relatives is expected to increase almost 10 percent in this decade. ❑ True ❑ False
4. More than one-third of those who need long-term care are under 65. ❑ True ❑ False
5. Generally, most people over 65 don't have to worry about long-term care expenses. Medicare pays most nursing home and home care costs. ❑ True ❑ False
6. Medicaid pays for home and community care as well as nursing homes. ❑ True ❑ False
7. The national long-term care system isn't perfect, but disabled people, who really need long-term care, can get it. ❑ True ❑ False

AARP Health Insurance News is a quarterly newsletter for AARP Members Insured by the AARP Group Health Insurance Program provided by The Prudential.

Address inquiries to the editors at:

AARP Health Insurance News,
P.O. Box 25601, Lehigh Valley, PA 18002-5601

Editors	AARP Editor	Graphic Design
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Chris Joiner	AARP Group Health Insurance Program	Matthew Fine

ANSWERS: from page 3

1. **False.**
   The elderly may be getting healthier, but increasing numbers of people over 85 are driving up nursing home use. The nursing home population grew 24 percent in the 1980s, mostly among people over 85.* However, experts say this trend could change. Better home and community services could help healthier older Americans stay out of nursing homes.
2. **True.**
   One-third of men who became 65 in 1990 will need nursing home care during their lifetimes. Their wives have an even greater chance of entering a nursing home – more than one-half of women this age will need such care.**
3. **False.**
   The increase will be much higher, employers predict. In 1992, employers estimated that 20 percent of their workers were responsible for the care of elderly family members. They expected the percentage to double to 40 percent by 1997 as baby boomers' parents grow older.***
4. **True.**
   There are 3.5 million people under 65 who need long-term care. They include children and adults with severe mental retardation, cerebral palsy, multiple sclerosis, AIDS and other chronic diseases. Some were disabled in accidents causing head or spinal cord injuries.†
5. **False.**
   Most people don't realize that Medicare doesn't cover long-term care – just some short-term skilled nursing home and home care. Medicaid, the federal/state health program, does pay for long-term care. But it only pays when your income is low and most of your savings are used up.
6. **True.**
   But Medicaid is much more likely to pay for nursing home care. In 1990, Medicaid paid less than $5 billion for home and community care, compared with $24 billion for nursing homes.††
7. **False.**
   Almost a third of severely disabled persons who responded to a government survey said they did not receive any help at all.† ■

* 1990 United States Census
** United States Census Projections
*** "Families and Work Institute Surveys", Wall Street Journal.
† "A Call For Action," U.S. Bipartisan Commission on Comprehensive Health Care, (Pepper Commission), 1990.
†† Health Care Financing Administration

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The AARP Group Health Insurance Program

HEALTH INSURANCE NEWS

ThePrudential

"Value, Service, Commitment"
1-800-523-5800

Summer 1992
Volume 9, No. 3

Fast Facts

- **PAYMENT OPTIONS:** Although your coupon payment book is set up for monthly payments, you may pay in advance for up to one year at a time. Simply send in one coupon and a check or money order for the total amount of any advance payments you are making. We will credit your AARP Group Health Insurance account.
- **FOR YOUR RECORDS I:** If you are using money orders to pay for your AARP Group Health Insurance coverage, be sure to keep the receipt portion for your records. Unlike personal checks, no record of payment is returned to you by the money order provider to indicate that your payment has been processed. It is a good practice to keep the receipt you receive at the time you purchase your money order.
- **FOR YOUR RECORDS II:** You have the legal right to obtain copies of anything you sign. If you are asked to sign any papers regarding medical treatment you are about to receive or regarding the manner in which your medical expenses will be handled, be sure to ask for a copy of the signed material. ■

AARP'S LONG TERM CARE PLANS: Important Benefits for All Levels of Care

The cost of long-term care (the care you need when you are unable to take care of yourself – due to either prolonged illness or disability) can be considerable. That's why choosing the right long-term care insurance plan is an important financial decision. An average year in a nursing home can cost $25,000.00 or more. And the cost of home health care (3 visits a week) averages $7,200.00 a year.*

AARP's Long Term Care Plans provide benefits not covered by most major medical plans, Medicare, or Medicare supplement plans, including AARP's Medicare Supplement Plans. They pay daily benefits for stays in a nursing home for up to four years. Benefits are also provided for visits from home health care professionals and visits to adult day care facilities. These are paid for a lifetime maximum of 730 visits.

These plans are designed to help AARP Members protect their savings, assets, and income from the high cost of extended long-term nursing home stays and home health care. Long-term care insurance is recommended for those who have substantial assets to protect ($30,000.00 excluding real estate) and who can afford to pay the premiums for a number of years.

Your age at the time you apply for a long-term care plan will affect the cost of your coverage. AARP's Long Term Care Plans allow you to obtain coverage at a rate based on your current age. For many AARP Members, this will help make your Long Term Care coverage more affordable. And your rate is guaranteed not to increase for at least five years. Only AARP Members ages 50 through 79 are eligible to apply for AARP's Long Term Care Plans. To keep rates as affordable for as many members as possible, there are certain eligibility requirements, including completion of a brief health questionnaire. Individuals who are eligible for Medicaid benefits should not apply for an AARP Long Term Care Plan.

...continued on page 3

AARP's Long Term Care *...continued from page 1*

Three Levels of Care

AARP's Long Term Care Plans offer benefits for all three levels of care:

Skilled nursing care is the highest level of treatment a nursing home resident can receive. It provides comprehensive, planned care, including rehabilitative or restorative therapy, medical or drug therapy, dietary supervision, and/or professional observation and judgement. These vital services are generally needed on a short term basis to enable a patient to recover initially from a serious accident or illness.

Intermediate nursing care is usually prescribed for patients who need medical attention on a 24-hour-a-day basis, but do not require constant skilled nursing care. Intermediate nursing care can be provided by a trained or certified aide or licensed professional.

"Long-term care is defined as the care you need when you are unable to take care of yourself—due to either prolonged illness or disability."

Custodial Care provides assistance in the activities of daily living, such as eating, bathing, and moving about. This type of care can be provided by an aide rather than a licensed professional.

For More Information . . .

If you'd like detailed information on plan benefits, limitations, exclusions, costs, and other terms of coverage for AARP's Long Term Care Plans, an information kit is available. **Just call toll free 1-800-245-1212 and ask for Operator 91.** ■

Plans available only to members ages 50-79 who meet certain eligibility requirements. All Plans may not be available in your state. Not available in Kansas. Group Policy Form G-36000-10. The Prudential Insurance Co. of America (licensed in all states). Ft. Washington, PA 19034.

*SOURCE: 1991 Consumer Guide to Long-Term Care Insurance, Health Insurance Association of America, February 1991.

6 TIPS FOR CHOOSING A GOOD LONG-TERM CARE INSURANCE POLICY

1. **Policy Provisions** – Make sure you know what the policy covers and what it doesn't. If you don't understand something, don't hesitate to contact the insurance company underwriting the coverage. Do not purchase any coverage unless you have a full understanding of the policy's benefits, provisions and limitations.
2. **Inflation Protection** – To help keep up with inflation, some policies increase your daily benefits by a certain percentage each year. Other plans may give you the opportunity to purchase increased daily benefit amounts after four or five years.
3. **Rate Guarantee** – Some long-term care policies guarantee that your rates will not increase for a certain number of years after your coverage becomes effective.
4. **Stability of Insurer** – Always check up on the financial health of the company underwriting the policy. Make sure you're confident that the company will be around when you need the benefits.
5. **Local Costs** – Before making a decision, check out the average cost for nursing homes, home health care and adult day care facilities in your area. Remember, inflation will increase the cost of care over time.
6. **Non-Forfeiture** – Some long-term care policies include a non-forfeiture feature. This feature guarantees that you will be covered to receive full benefit amounts, for covered visits and stays during a specified period of time, even if you cancel your coverage. This feature applies only if you have continuously paid the plan's premium for a pre-determined number of years. ■

AARP Group Health Insurance Program

Post Office Box 13999
Philadelphia, PA 19187

Underwritten by The Prudential

Dear Friend,

I am pleased you have requested the enclosed information on AARP's Long Term Care Insurance Plan. AARP has worked closely with The Prudential to develop this valuable insurance coverage. You must be a member of AARP to take advantage of this long term care protection and all the other membership benefits. The enclosed membership benefits sheet will tell you why I think AARP Membership is one of the best values in America today. Now, here's the information you requested.

The rising cost of long term care is a serious issue facing mature Americans. Currently, home health care can cost as much as $600.00 a month. For those who need nursing home care, the cost can be as high as $2,500.00 a month.* Medicare provides little coverage for these types of costs. The same is true of many major medical plans.

A New Plan with a Flexible Benefits Structure

One advantage of AARP's new Plan is that there are no preset limits on the total number of home health care visits, adult day care visits or nursing home days. This means that you can use your benefits for the covered service you need the most (up to the lifetime maximum) — whether it's strictly home health care and adult day care, solely nursing home care, or a combination of all three.

Up to $150,000.00 in Long Term Care Coverage

AARP's Long Term Care Plan (FO) provides a combined lifetime maximum of up to $150,000.00 to help pay for covered home health care visits, adult day care visits, nursing home stays and respite care.

The new Plan pays up to $50.00 to $70.00 per visit for home health care, up to $60.00 per visit for adult day care, and up to $100.00 a day for nursing home care. Daily and per visit benefits are paid up to the combined maximum dollar amount of $150,000.00.

There are many more reasons to apply for AARP's New Plan, including...

- **RESPITE CARE COVERAGE** ... The Plan provides benefits for covered short-term stays in a nursing home, or home health care or adult day care services. Benefits would be paid for actual costs up to $50.00 a day. Please see the enclosed brochure for more details about Respite Care Coverage.
- **EXTENDED PROTECTION** ... This valuable feature guarantees that you will receive continued coverage at FULL benefit amounts, for covered stays and visits during a specified time period, if you have to cancel your protection, for whatever reason. With Plan FO, as long as your coverage has been in effect for at least 10 continuous years, you will receive this Extended Protection. The lifetime maximum benefit of up to $150,000.00 still applies.
- **20% OFF MONTHLY RATES** ... Either you or your spouse (whoever is younger) will receive a 20% discount on monthly rates when both of you are covered under the Plan.
- **RATE GUARANTEE** ... Rates are guaranteed not to increase for at least 10 years for any reason under Plan FO.

- **INTERCHANGEABLE DEDUCTIBLES** ... Any covered Home Health Care or Adult Day Care visit that counts toward one of these treatment plan's deductibles may also be counted as a day in satisfying the nursing home deductible. Similarly, a covered Nursing Home Day that counts toward the nursing home deductible may be used to satisfy your Home Health Care or Adult Day Care deductible.
- **NO LENGTHY MEDICAL QUESTIONNAIRES** ... Unlike many similar policies on the market, this Plan has no lengthy medical questionnaires. AARP Members and their spouses age 50-79 who are in generally good health and are able to answer "no" to all the health statements on the Application will be accepted for coverage.

If you would like a Plan with the same broad spectrum of coverage as Plan FO, but with a lower monthly rate, apply for AARP's Optional Plan (FG). This Plan has a lower monthly rate because it does not offer Extended Protection. Complete details of AARP's Long Term Care Plan (FO) and Optional Plan (FG) are outlined in the enclosed brochure including the benefits, costs, limitations and exclusions. Please study it carefully.

How to Apply for This Valuable Coverage

To apply, you must first complete the enclosed Membership Acceptance Form. Then, complete all the appropriate areas on the enclosed Long Term Care Insurance Application. Return the Application along with your Membership Acceptance Form and payment in the envelope provided. **For the earliest Effective Date, your Application must be received and approved by the date at the top.**

I think you'll find this coverage to be among the very best values for your health insurance dollar. In fact, it's the only long term care insurance approved by AARP. Because of the high costs of home health care, adult day care and nursing home care, AARP believes the protection provided by AARP's Long Term Care Plan is very important. I hope you'll review this coverage in consideration of your future financial well-being.

Sincerely,

Allen M. Haight, CLU
Senior Vice President
Prudential/AARP Operations

P.S. The sooner your Form is received, the sooner it can be processed. Should you have any questions about this coverage, call toll-free 1-800-247-2335 weekdays from 9:00 a.m. to 5:00 p.m., Eastern Time. You can expect superior personal service from the Prudential Service Representatives.

* The 1991 Consumer Guide to Long Term Care Insurance, Health Insurance Association of America. The home health care figure is based on a national average of 3 visits per week. The nursing home figure is also based on a national average.

LA8240

AARP's Long Term Care Insurance Plan (FO)

Benefits Up to $150,000.00

Combined Lifetime Maximum Coverage For Home Health Care, Adult Day Care, Nursing Home and Respite Care Expenses.

This New Plan Features:

- No preset limit on the total **number of visits** for covered home health care and covered adult day care – benefits up to **$50.00 - $70.00 per visit.**
- No preset limit on the total **number of days** for covered nursing home stays – benefits up to **$100.00 per day**.
- **Respite Care benefits of up to $50.00 a day for 20 days per year.**
- 20% discount on monthly rates when both you and your spouse are accepted into the Plan.

PLUS:

- Extended Protection continues your coverage, for a specified period, should you have to cancel your Plan.
- Rates are guaranteed not to increase for at least 10 years for any reason.
- Opportunity to purchase increased daily and per visit benefit amounts at least once every 4 years.

AARP Group Health Insurance Program

ThePrudential

This New Plan is available exclusively to AARP Members and spouses.
See inside for details.
Please reply before the date on your Application.

The Benefits of the New AARP Long Term Care Plan (FO)

Home Health Care and Adult Day Care Visits

How much the Plan pays:

- **Actual charges up to $70.00** for each covered visit by a nurse (RN or LPN) or qualified therapist.
- **Actual charges up to $50.00** for each covered visit by a qualified home health aide.
- **Actual charges up to $60.00** for each covered adult day care visit.

Home Health Care and Adult Day Care Benefit Payments will begin with the 46th covered home health care or adult day care visit in any one benefit period. Any covered nursing home day that counts toward the nursing home deductible during a benefit period may also be counted as a visit towards satisfying the 45-visit home health care and adult day care deductible. (See **COVERAGE REQUIREMENTS** section of this brochure.) Benefits are paid for up to 7 visits per calendar week.

Nursing Home Care

How much the Plan pays:

- **Actual charges up to $100.00** for each covered day in a skilled nursing facility.
- **Actual charges up to $100.00** for each covered day in an intermediate care facility.
- **Actual charges up to $100.00** for each covered day in a custodial care facility.

Nursing Home Benefit Payments will begin with the 91st covered day of your confinement in an eligible nursing home in any one benefit period. Any covered home health care or adult day care visit that counts toward the home health care/adult day care deductible during a benefit period may also be counted as a day towards satisfying the 90-day nursing home deductible. (See **COVERAGE REQUIREMENTS** section of this brochure.)

Automatic Benefits Increase

The daily and per visit benefits stated above will increase 8% annually – with no corresponding rate increase to you – when you are in the same benefit period (receiving benefits for covered services or care) for one year. This increase will become effective one year after your home health care visits, adult day care visits or nursing home stay begins. When your benefit period ends, your benefit amounts return to the benefit amounts in effect before the increase(s).

PLAN OPTION: The New AARP Long Term Care Plan (FG)

If you would like a Plan with the same broad spectrum of coverage as the featured Plan FO, but without the Extended Protection feature, apply for the Optional AARP Long Term Care Plan, FG. Plan FG is also a new Plan and has the same **$150,000.00** combined lifetime maximum as Plan FO. The monthly rates of this Plan are lower than Plan FO.

The benefits for Optional Plan FG are as follows:

- **Actual charges up to $70.00** for each covered visit by a nurse (RN or LPN) or qualified therapist.
- **Actual charges up to $50.00** for each covered visit by a qualified home health aide.
- **Actual charges up to $60.00** for each covered visit to an adult day care facility.
- **Actual charges up to $100.00** per day for covered nursing home stays.

The rates for Plan FG are guaranteed for at least 5 years and are included in the MONTHLY INDIVIDUAL RATES chart. All other provisions, limitations and exclusions described in this Brochure apply to both the featured Plan FO and the Optional Plan FG.

Introducing the most flexible Plan in AARP's Long Term Care portfolio – with a lifetime maximum of up to $150,000.00 in benefits.

Up to $150,000.00 in Benefits

AARP's Long Term Care Plan can provide daily and per visit benefits up to **$150,000.00**. Benefits help pay for covered home health care visits, adult day care visits, nursing home stays and Respite Care. Plus, this new Plan also offers you several appealing advantages:

- ***Flexible Benefits***

  Many long term care plans have set limits for the total number of home health care and adult day care visits you will be paid for, as well as another set limit on the number of nursing home days you can receive.

  One advantage of the new AARP Plan is that there are no preset limits for the total number of home health care visits, adult day care visits or nursing home days. You can use part or all of your benefits for the covered service you need the most – whether it's strictly home health care and adult day care, solely nursing home care, or a combination of all three.

- ***Respite Care Benefits***

  Family members who provide care at home sometimes need to take time away from their care-giving responsibilities – due to business travel, family emergencies or just temporary relief. Respite Care benefits will provide benefits for covered short-term stays in a nursing home, or for home health care or adult day care services. **For example:**

  - A family member is providing care (at no cost) at home for a relative.
  - The family member needs to visit his or her grandchildren.
  - Respite Care would provide benefits for a home health aide to come in and help out until the family member returns.

  Informal care must be provided by an **informal caregiver** (a relative) in your home for at least six months beginning on or after the effective date of insurance. Services received under this Plan benefit are not subject to the deductible period. Respite Care benefits would be paid for actual costs up to $50.00 a day for covered services. The Plan provides respite coverage for up to 20 days per year and a lifetime maximum of 100 days. This benefit applies to both Plans FO and FG.

  Please note that the **Lifetime Maximum** under this Plan and the Group Policy for **Nursing Home Stays, Home Health Care Visits, Adult Day Care Visits,** and **Respite Care** combined is $150,000.00.

- ***You do not have a preset limit on the total number of visits for home health care and adult day care.***

  Unlike some other plans, the new AARP Long Term Care Plan does not limit you to a preset total number of visits for home health care and adult day care. Should you be able to recuperate at home from an illness or injury, you can use the Plan benefits to help pay for as many visits as you need – **up to the combined lifetime maximum of $150,000.00**. Your at-home care must be administered by a qualified nurse (RN or LPN), qualified therapist or qualified home health aide. Home health care and adult day care cannot exceed more than 7 visits per week. Benefits start after the deductible period.

  This new Plan will pay actual charges **up to $50.00 - $70.00 per visit** for covered home health care.

- ***You do not have a preset limit on the total number of days for nursing home stays.***

  Some Plans have a set limit on the number of days benefits are paid for nursing home stays. AARP's Plan does not limit you to a certain number of days for covered nursing home stays. If you need the special attention that only a nursing home can provide, the Plan will pay benefits for as long as you are confined – **up to the combined lifetime maximum of $150,000.00**. Nursing home care must be provided by an eligible facility. Benefits start after the deductible period.

  This new Plan will pay actual charges **up to $100.00 a day** for covered nursing home care.

HERE'S HOW EXTENDED PROTECTION WORKS

Continued Coverage at FULL Benefit Amounts If You Have To Cancel Plan FO

We're confident that, if accepted, you will be fully satisfied with the new AARP Long Term Care Plan (FO) and want to continue the coverage for as long as you can. However, should you have to cancel the Plan for whatever reason, FULL benefit amounts would still be payable for a specific period of time for covered home health care, adult day care, nursing home stays and respite care. The amount of time your coverage would continue is determined by your age at the time you are accepted into the Plan, as well as the length of time your premiums are paid. Under Plan FO, your coverage must be in effect for at least 10 continuous years to receive any Extended Protection. Further, you can not resume your payments once you have cancelled the Plan. At the end of the Extended Protection period, all benefits will cease.

The following are three examples of how Extended Protection works:

Age Accepted Into Plan FO	Age You Cancel Plan FO	Years of Coverage paid for	Years of Extended Protection After You Cancel Plan FO*
55	65	10	9 years, 5 months
55	70	15	8 years, 3 months
65	80	15	4 years

- **The lifetime maximum benefits of $150,000.00 still applies under Extended Protection. Extended Protection will not apply while your monthly payments have been waived under the Waiver of Premium Provision.**

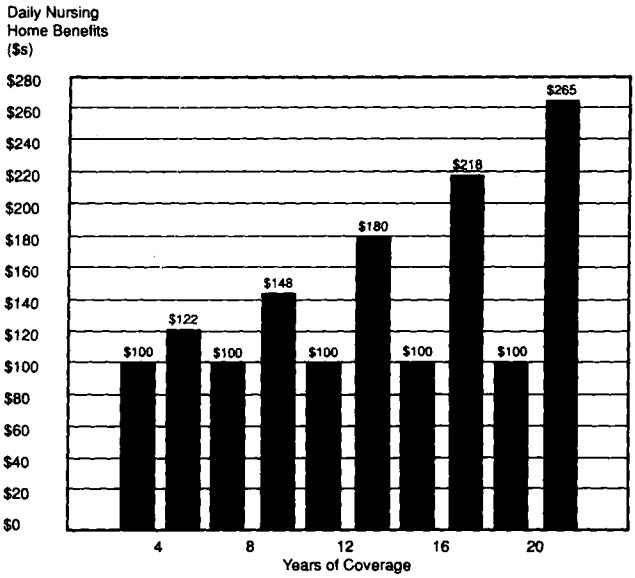
Save 20% on monthly rates

AARP's new Plan gives you and your spouse an outstanding opportunity to save money on your monthly rates. When you and your spouse are both accepted into the Plan, the younger person applying will receive a 20% discount on their monthly rate. This discount will remain in effect for as long as both you and your spouse are covered under the Plan. If one insured discontinues coverage, the continuing spouse would not receive a discounted monthly rate.

Further, rates for you and your spouse are guaranteed not to increase, for any reason, for at least 10 years under Plan FO. Plan FG rates are guaranteed for at least 5 years. Your effective date will be the first of the month following Prudential's receipt and approval of your Application.

Optional Inflation Protection

Under this Plan, you'll have the opportunity to purchase increased daily and per visit benefits at least once every four years. This feature was designed to help you prepare for the rising costs of home health care, adult day care, and nursing home stays. The chart below shows an example of how your benefits might increase over time if you purchase the optional inflation protection.



■ Benefits if you elect not to enroll in upgrade offers.

■ Benefits if you elect to enroll in ALL upgrade offers. (Based on 5% Compounded Annually)

NOTE: Actual Upgrade Increases May Vary

This Optional Inflation Protection will not be offered while your coverage is being continued under Extended Protection. Rates for the increased benefits are based on your age at the time you enroll for the increase.

ADDITIONAL PLAN FEATURES

20% DISCOUNT ON MONTHLY RATES

This feature allows you and your spouse to save money when both of you are accepted into the Plan. Upon acceptance, the younger person with this new coverage – either you or your spouse – will receive a 20% discount on monthly rates. It's an outstanding opportunity to lower the cost of long-term care insurance coverage. Discount rates will remain in effect only while both you and your spouse maintain coverage.

RATE GUARANTEE

You are guaranteed that the rates for Plan FO will not increase ... for any reason ... for at least 10 years. Plan FG rates are guaranteed for at least 5 years. After the guaranteed time periods, your rates can only change if changed for all members of the same class insured under this Plan who reside in your state. Additionally, all rate changes must first be approved by your Association.

WAIVER OF PREMIUM

If benefits for a nursing home stay have been payable for 90 nursing home days during a benefit period, The Prudential will waive your monthly payment for any month you receive benefits for the remainder of that benefit period.

CONTINUATION OF COVERAGE

You will not lose coverage unless you fail to make your payments when due or reach the Plan's maximum benefits, regardless of the number of claims you make (up to the maximum benefits). In the event that the Group Policy is terminated and not replaced by another insurance policy providing similar coverage and conditions within 31 days, Prudential will, at its option, provide you with a basis for either maintaining coverage under a group policy or conversion to an individual policy.

COVERAGE REQUIREMENTS

To be covered for Home Health Care, Adult Day Care, and/or Nursing Home Benefits, the visit or stay must meet the following requirements.

- A "Plan of Treatment" must be developed by your physician, must specify the type and frequency of treatment, and must be recertified within 60 days of the end of the deductible period and at least once every six months thereafter. A "Plan of Treatment" that includes home health care or adult day care must include a certification that you would require an inpatient stay in a nursing home if the home health care or adult day care were not provided. Or, it must certify that you are unable to perform, without direct human assistance, 2 or more of the Activities of Daily Living (bathing, dressing, toileting, transferring, and eating).
- You must receive services provided by an eligible Adult Day Care Facility or an eligible Home Health Care Agency or be confined in an eligible Nursing Home.
- You or your physician must notify The Prudential of your "Plan of Treatment" by phone or mail at least 7 days before the end of the deductible period.
- The home health care visit must be made by a nurse (RN or LPN), qualified therapist, or qualified home health aide provided by an eligible Home Health Care Agency, licensed referral agency, licensed nurse registry, or provided by an independent health care professional to you in your home on a visiting basis. A qualified home health aide visit must be of at least 2 hours duration. A qualified adult day care visit must be at least 3 hours in duration.

Respite Care for Nursing Home Stays, Home Health Care Visits, and **Adult Day Care Visits** are covered when:

- You have received informal care from an **Informal Caregiver** for at least six months beginning on or after the effective date of the Certificate. This benefit will not duplicate other benefits payable under the Plan.
- Respite Care benefits for nursing home care, home health care or adult day care are subject to the Coverage Requirements.

Note: A preceding hospital stay is not required for you to collect home health care, adult day care, or nursing home benefits. A preceding nursing home confinement is not necessary for you to collect home health care or adult day care benefits.

ELIGIBILITY FOR THE PLAN

Members age 50 through 79 who are able to answer "No" to each one of the Health Statements in Section B of the Application are eligible to apply for coverage under the AARP Long Term Care Plans. Spouses may also apply for protection, provided they meet the same requirements.

American Association of Retired Persons
601 E Street, N.W., Washington, DC 20049

Dear AARP Member,

I am pleased you have requested the enclosed information on AARP's Long Term Care Insurance Plan. Your Association has worked closely with The Prudential to develop this valuable insurance coverage.

A lot of people believe that Medicare, a major medical plan, or a Medicare Supplement Plan will cover the costs of home health care and adult day care, as well as extended nursing home care. The truth is Medicare and many types of private insurance provide little or no protection against these costs, which can easily reach as much as $600.00 a month for home health care ... and $2,500.00 a month for nursing home care.*

AARP's Long Term Care Plan (LL) offers many important benefits and features for AARP Members to help prevent the possible loss of savings, assets, and income to the potentially overwhelming expenses of long term care.

AARP's Long Term Care Insurance Plan (LL)

AARP's Long Term Care Plan (LL) was designed to provide a broad range of long term care benefits, including home health care, adult day care, and nursing home care. Of course, almost everyone would prefer to recuperate in the comfort and privacy of their own home as long as possible, so this Plan provides benefits for professional home health care services, as well as adult day care when you require care or assistance at home.

And when an extended nursing home stay is required, AARP's Long Term Care Plan provides valuable benefits for any level of nursing home care in any qualified state-licensed nursing home. **Plus, visits used toward satisfying the home health care and adult day care deductible can be used toward satisfying the 90-day nursing home deductible. And, nursing home deductible days can be used toward satisfying the 45-visit home health care and adult day care deductible.**

Plan Features That Make a Difference

If you are comparing AARP's Long Term Care Plan to any other policies, please consider the following features:

- **GUARANTEED BENEFIT INCREASE** ... The AARP Group Health Insurance Program guarantees to increase your AARP Long Term Care Plan benefits by 5%...compounded annually. There will be no corresponding rate increase as a result of this benefit increase, and it applies to home health care, adult day care and nursing home care benefits.
- **RATE GUARANTEE** ... Your affordable monthly rate is guaranteed not to increase for at least 5 years for any reason.

- NO LENGTHY MEDICAL QUESTIONNAIRES ... Unlike many similar policies on the market, this Plan has no lengthy medical questionnaires. AARP Members and Spouses age 50-79 who are in generally good health and are able to answer "no" to all of the health statements on the Application will be accepted for coverage.

Complete details of the Plans are outlined in the enclosed brochure including the benefits, costs, limitations and exclusions. Please study it carefully. Also, make note of Optional Plan LM, which offers higher benefits at a higher monthly rate.

How to Apply for This Valuable Coverage

To apply, complete all the appropriate areas on the enclosed Application and return it promptly with your first month's payment in the envelope provided. **For the earliest Effective Date, your Application must be received and approved by the date at the top of that form.**

Your Association understands that the high costs of home health care, adult day care, and nursing home care are of great concern to AARP Members. That's why the AARP Group Health Insurance Program developed this valuable coverage. Take advantage of this opportunity to apply for the only long term care insurance approved by your Association. Apply today – Give yourself the security of this important protection.

Sincerely,

Wayne F. Haefer
Director, Membership Division

P.S. Should you have any questions about this coverage, call toll-free 1-800-247-2335 weekdays from 9:00 a.m. to 5:00 p.m., Eastern Time. You can expect superior personal service from the Prudential Service Representatives.

* The 1991 Consumer Guide to Long Term Care Insurance, Health Insurance Association of America. The Home Health Care figure is based on 3 visits per week.

LA8237

AARP's Long Term Care Insurance Plan (Plan LL)

Helps Pay for Home Health Care, Adult Day Care, and Nursing Home Expenses Not Covered by Medicare and Private Insurance Plans.

- **$25.00 - $35.00 per visit** for Home Health Care and Adult Day Care – up to a lifetime maximum of 730 visits.
- **$50.00 per day** for Qualified Nursing Home Confinements – for up to a lifetime maximum of 4 years (1,460 days).
- **Pays for ALL LEVELS** of Nursing Home Care ... Skilled, Intermediate and Custodial.

PLUS These Additional Features

- **Rates are guaranteed** not to increase for at least 5 years for any reason.
- **Guaranteed Benefits Increase:** Per visit and daily benefits are compounded 5% annually – with no corresponding rate increase for this benefit increase.

Please reply before the date on your Application.

AARP Group Health Insurance Program

ThePrudential

The Benefits of the AARP Long Term Care Plan (Plan LL)

Home Health Care and Adult Day Care Visits

How much the Plan Pays the First Year of Coverage:

- **$35.00** for each covered visit by a nurse (RN or LPN) or qualified therapist.
- **$25.00** for each covered visit by a qualified home health aide.
- **$30.00** for each covered adult day care visit.

How Long Benefits Are Paid: Benefits are paid for up to 7 visits per week for a lifetime maximum of 730 visits.

Home Health Care and Adult Day Care Benefit Payments will begin with the 46th covered home health care or adult day care visit in any one benefit period. Any covered nursing home day that counts toward the nursing home deductible during a benefit period may also be counted as a visit toward the 45-visit home health care or adult day care deductible. (See **COVERAGE REQUIREMENTS** section of this brochure.)

Nursing Home Care

How much the Plan Pays the First Year of Coverage:

- **$50.00** for each covered day in a skilled nursing facility.
- **$50.00** for each covered day in an intermediate care facility.
- **$50.00** for each covered day in a custodial care facility.

How Long Benefits Are Paid: Benefits are paid up to 4 years for a lifetime maximum of 1,460 days.

Nursing Home Benefit Payments will begin with the 91st covered day of your confinement in an eligible nursing home in any one benefit period. Any covered home health care or adult day care visit that counts toward the home health care/adult day care deductible during a benefit period may also be counted as a day in satisfying the 90-day nursing home deductible. (See **COVERAGE REQUIREMENTS** section of this brochure.)

*The daily and per visit benefits stated above will increase 5% annually — with no corresponding rate increase to you. This **Guaranteed Benefits Increase** feature will begin one year from the effective date of this insurance.*

PLAN OPTION: AARP's Long Term Care Plan (LM)

If you would like a Plan with the same broad spectrum of coverage as the featured Plan LL, but at higher benefit amounts, you can apply for the Optional AARP Long Term Care Plan, LM. Plan LM pays benefits for the same number of visits and days as Plan LL and it includes the annual 5% Guaranteed Benefits Increase feature. The monthly rates of this Plan are higher than Plan LL.

The first year of coverage benefits for Optional Plan LM are as follows:

- **$50.00** for each covered visit by a nurse (RN or LPN) or qualified therapist.
- **$35.00** for each covered visit by a qualified home health aide.
- **$40.00** for each covered visit to an adult day care facility.
- **$75.00** per day for covered nursing home stays.

The rates for Plan LM are included in the MONTHLY INDIVIDUAL RATES chart. All other provisions, limitations and exclusions described in this Brochure apply to both the featured Plan LL and the Optional Plan LM.

Guaranteed Benefits Increase

Benefits Compounded Annually By 5% For As Long As Coverage Continues

To help offset the steady rise in home health care, adult day care, and nursing home costs, AARP's Long Term Care Plan (LL) contains a valuable feature that automatically increases all your benefits by 5% each year over the preceding year's benefits.

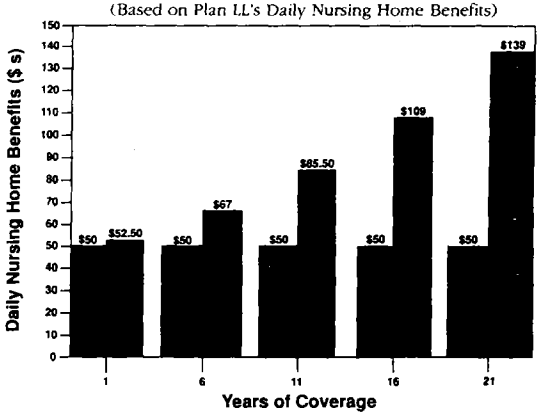
The graph to the right shows how the ***compounding*** *of benefits under Plan LL can result in significant increases over time.*

There is no corresponding increase in your monthly rate for this increase in benefits.

- **COMPOUNDED BENEFITS:** *5% increase over previous years' benefit.*
- **ORIGINAL BENEFIT:** *No inflation protection.*

A Plan for Now and for the Future

(Based on Plan LL's Daily Nursing Home Benefits)



Benefits will increase each year, beginning one year after the effective date of this insurance. Benefit increases will be paid for visits or days of stay that occur on or after the effective date of the increase.

Your Monthly Individual Age Rates (Guaranteed For Five Years)

The monthly rates for Plans LL and LM shown below are based on your individual age as of your insurance effective date. The rate for your spouse, if applying, is determined the same way. Your effective date will be the first of the month following Prudential's receipt and approval of your Application and first month's payment.

PLAN LL and PLAN LM

(Rates are for each person applying for coverage)

Age as of Effective Date	Monthly Rate*		Age as of Effective Date	Monthly Rate*		Age as of Effective Date	Monthly Rate*	
	Plan LL	Plan LM		Plan LL	Plan LM		Plan LL	Plan LM
50	$47	$71	60	$75	$113	70	$134	$201
51	$49	$74	61	$79	$119	71	$143	$215
52	$52	$78	62	$83	$125	72	$153	$230
53	$54	$81	63	$88	$132	73	$163	$245
54	$56	$84	64	$94	$141	74	$174	$261
55	$59	$89	65	$99	$149	75	$186	$279
56	$62	$93	66	$105	$158	76	$197	$296
57	$65	$98	67	$112	$168	77	$209	$314
58	$68	$102	68	$119	$179	78	$222	$333
59	$71	$107	69	$126	$189	79	$234	$351

* Rates for you and your spouse are guaranteed not to increase for at least 5 years for any reason.

Plan Features

Rate Guarantee

You are guaranteed that the rates for these Plans will not increase ... for any reason ... for at least 5 years. After 5 years, your rates can only change if changed for all members of the same class insured under this Plan who reside in your state. Additionally, all rate changes must be approved by AARP.

Benefits Are Paid Directly To You

These benefits will be paid to you regardless of any other insurance you may have. If you prefer, payments can be sent to your health care provider.

Waiver of Premium

If benefits for a nursing home stay had been payable for 90 nursing home days during a benefit period, The Prudential will waive your monthly payment for any month you receive benefits for the remainder of that benefit period.

Continuation Of Coverage

Unless you fail to make your payments when due or reach the Plan's lifetime maximum benefits, you will not lose coverage regardless of the number of claims you make (up to the lifetime maximum benefits). In the event that the Group Policy is terminated and not replaced by another insurance policy providing similar coverage and conditions within 31 days, Prudential, at its option, will provide you with a basis for either maintaining coverage under a group policy or conversion to an individual policy.

Coverage Requirements

To be covered for Home Health Care, Adult Day Care, and/or Nursing Home benefits, the visit or stay must meet the following requirements.

- A "Plan of Treatment" must be developed by your physician, must specify the type and frequency of treatment, and must be recertified at least once within 60 days of the deductible period, and at least once every six months thereafter. A "Plan of Treatment" that includes home health care or adult day care must include a certification that you would require an inpatient stay in a nursing home if the home health care or adult day care were not provided. Or, it must certify that you are unable to perform, without direct human assistance, 2 or more of the Activities of Daily Living (bathing, dressing, toileting, transferring, and eating).
- You must receive services provided by an eligible Adult Day Care Facility or an eligible Home Health Care Agency or be confined in an eligible Nursing Home.
- You or your physician must notify The Prudential of your "Plan of Treatment" by phone or mail at least 7 days before the end of the deductible period.
- The home health care visit must be made by a nurse (RN or LPN), qualified therapist, or qualified home health aide provided by an eligible Home Health Care Agency to you in your home on a visiting basis.
- A qualified home health aide visit or adult day care visit must be of at least 3 hours duration.

Note: A preceding hospital stay is not required for you to collect home health care, adult day care, or nursing home benefits. A preceding nursing home confinement is not necessary for you to collect home health care or adult day care benefits.

Eligibility For The Plan

Members age 50 through 79 who are able to answer "No" to each one of the Health Statements in Section B of the Application are eligible to apply for coverage under the AARP Long Term Care Plans. Spouses may also apply for protection, provided they meet the same requirements.

QUESTIONS & ANSWERS

Q. ***Who is eligible to apply for this new Plan?***

A. **AARP Members (and their spouses) age 50-79 residing in an eligible state** may apply for the new AARP Long Term Care Plan. However, in order to keep the monthly rate affordable for as many members as possible, only those who can answer "No" to each of the Health Statements on the Application form will be accepted under the Plan.

Q. ***Who should not consider the new AARP Long Term Care Plan?***

A. **Individuals who might qualify for state provided Medicaid or Medicaid-type benefits** do not need this Plan and should not apply. This is because the government will pay for most of the benefits provided by this Plan at little or no cost. In addition, individuals should base their ability to pay for the Plan on their projected retirement income. Because this Plan can help to protect your assets, participation in this Plan is recommended only for people with assets of $30,000.00 or more (excluding homes).

Under Federal Law, no new health insurance may be issued to you if it would duplicate any of your current health insurance benefits. To help prevent the possibility of members becoming over-insured, no member may be enrolled in more than one Plan of this type.

Q. ***If I ever do need long term care, it probably won't be for a long time. Why should I apply for this new coverage now?***

A. **Your monthly rates will be less expensive if you apply now,** because your monthly rate is determined by your age at the time your coverage becomes effective. This affordable monthly rate for Plan FO is guaranteed not to change for at least 10 years for any reason. Plan FG rates are guaranteed for at least 5 years. And your state of health at the time you apply will determine whether or not you are accepted. Only those who are in generally good health and can answer "No" to all of the Health Statements on the Application can be accepted. **If your health is good now, it makes sense to apply now.**

Q. ***What kind of coverage does this new Plan provide?***

A. AARP's Long Term Care Plan (FO) provides a total lifetime maximum benefit amount of up to **$150,000.00 in insurance coverage.** First, the Plan pays up to $50.00 to $70.00 for each covered **home visit by nurses, qualified therapists, and qualified home health aides.** Second, this Plan also pays up to $60.00 per visit for covered **care in an adult day care center.** Third, it pays up to $100.00 a day for covered **stays in a nursing home.**

Q. ***What makes this new coverage more flexible?***

A. The new AARP Long Term Care Plan does not have preset limits on the total number of home health care visits, adult day care visits or nursing home days. That means that **you can use part or all of your benefits for the covered service you need the most** – whether it's strictly home health care and adult day care, solely nursing home care, or a combination of all three.

Q. ***Will benefits be paid for a stay in any kind of nursing home?***

A. **Most state-licensed nursing facilities – including skilled nursing facilities, intermediate care facilities, and custodial care facilities – qualify under the Plan.** However, stays in nursing homes outside the United States, homes where there is no charge to you, or facilities that provide residential care or room and board accommodations only, are not covered. See the definitions and exclusions in the brochure for more details.

LL1113

Q. ***Is a nursing home confinement or preceding hospital stay necessary for home health care or adult day care benefits?***

A. **No.** Home health care or adult day care benefits are paid without a prior nursing home confinement or hospital stay. However, your doctor must certify that without home health care or adult day care, your condition would call for treatment in a nursing home. Or, your doctor must certify that you are unable to perform 2 or more Activities of Daily Living. See Coverage Requirements in the enclosed brochure for details.

Q. ***Is a hospital stay required before nursing home benefits are payable?***

A. **No.** A preceding hospital stay is not required. You're eligible for benefits whether you enter a nursing home from your home ... or you enter after a hospital stay. It doesn't matter.

Q. ***Is Alzheimer's disease covered?***

A. **Yes.** Visits or stays due to Alzheimer's disease and similar forms of senility are covered if the disease develops after your coverage effective date. Other mental, nervous, psychotic, or psychoneurotic disorders are not covered.

Q. ***What is Respite Care coverage?***

A. **Respite Care coverage helps pay for covered short-term stays in a nursing home, as well as home health care or adult day care services.** This type of coverage allows family members who provide care at home to take time away from their care-giving responsibilities. Under AARP's new Plan, there is no deductible period for coverage if informal care has been provided for at least 6 months beginning on or after the insurance effective date. Benefits are paid for actual costs up to $50.00 a day.

Q. ***Why are there deductible periods?***

A. **The deductible periods help keep the monthly cost of the Plan more affordable.** Most people can afford the expense of a relatively small number of home health care and adult day care visits or a short-term nursing home stay, but long-term care can lead to severe financial burdens. This Plan is designed to help protect you financially should you be in need of long-term care.

Q. ***Does the Plan offer any type of discount on monthly rates?***

A. **Yes.** You or your spouse will receive a 20% discount on monthly rates when both of you are covered under the new Plan. Upon acceptance, the younger person with coverage – either you or your spouse – will receive a 20% discount on monthly rates. It's an outstanding opportunity to save on your monthly rate.

— IMPORTANT —

If you have any questions about the enclosed Plan(s), please call your Prudential Service Representative toll-free at **1-800-247-2335, any weekday from 9:00 a.m. to 5:00 p.m., Eastern Time.**

For the earliest effective date, your Application must be received and approved by the date at the top of that form.

Chairman THOMAS. With no further questions from—the gentleman from Nevada, Mr. Ensign.

Mr. ENSIGN. Mr. Shreve, most of the members of AARP are lower income or middle income or what percentage thereof?

Mr. SHREVE. With 33 million members we have a pretty heterogeneous group. We have people that are rather affluent. We have people that are not and have to make a decision whether or not they are going to renew for an $8 fee. So we have a full range.

Mr. ENSIGN. Of the people that have bought the long-term care insurance, have you got a general feel on their income levels? Are they in the higher income levels?

Mr. SHREVE. Yes, there is no question about it. The people with higher income are the ones that can afford it. And at the same time they are trying to protect what assets they may have, and it is a calculated risk.

Mr. ENSIGN. Do you feel that these provisions in the tax clarification would benefit some of them in the middle class and not just the upper class because they are starting to do it earlier in their lives when it is a little more affordable?

Mr. SHREVE. Yes, I think it could. I would like to speak not only for our membership but for all older people, and when we talk about all older people, as I mentioned earlier, almost half of them do not have enough income to pay income taxes, therefore they are not going to get any break, regardless of what they do to provide for themselves.

Mr. ENSIGN. Sure. OK. Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Christensen.

Mr. CHRISTENSEN. First, I want to thank the panel for staying here all day and being here for us. And I wanted to thank Mr. Hansen, too. And does The Seniors Coalition, do they sell any product or not? Are there any products that they sell?

Mr. HANSEN. No, we don't, not at this time. We are purely a lobbying organization.

Mr. CHRISTENSEN. Do you see in the future that you might get into that area?

Mr. HANSEN. Well, as a matter of fact after the health care debate, and of course we were opposed to the Clinton plan, we found a lot of people joining our organization and they were saying they wished that we were offering some benefits. So we will look at that.

We know that there is a need out there. And we know that not only are there many wealthy seniors who want this, but there are a number of, you know, middle—moderate meaned seniors who would rather not end up going on the public dole. And this is going to, in the long run, if we offer this type of insurance, and if the country makes it available, we will find many, many people taking advantage of it, I believe.

Mr. CHRISTENSEN. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Christensen.

Once again, I thank the panel very much for your willingness to abide until the end.

The first hearing of the Health Subcommittee of the Ways and Means Committee is adjourned.

[Whereupon, at 2:41 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

January 19, 1995

The Honorable Bill Thomas
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman,

I am writing to present the views of the Alzheimer's Association on provisions in the Senior Citizens' Equity Act related to long term care, and ask that this letter be made a part of the record of the Subcommittee's hearing on this issue scheduled for January 20.

The Alzheimer's Association is the national voluntary health agency organized specifically to represent the interests of the 4 million persons with Alzheimer's disease and their 19 million family members. We work through a network of over 200 local Chapters in the 50 states, several thousand support groups and more than 35,000 volunteers. There is no issue more important than long term care for families facing the emotional, financial, and physical devastation of Alzheimer's disease.

The Senior Citizens' Equity Act addresses this issue in two ways: it clarifies the tax code to treat qualified long term care expenses as medical expenses for personal income tax purposes, and it provides favorable tax treatment for long term care insurance.

Tax deductibility of qualified long term care expenses. This is an important clarification of current tax law which the Alzheimer's Association has long supported. Alzheimer's disease is one of the most costly illnesses a family can face. Even when most of the care is provided by the family, yearly out-of-pocket expenses average more than $12,000. If residential care is needed, annual costs easily exceed $30,000. And those costs can add up for 5 to 10 years, sometimes even longer. At best, the tax code is confusing as to whether these costs are deductible as medical expenses. Some taxpayers have claimed such expenses and have won their arguments with the Internal Revenue Service. Others have been discouraged from taking the deductions or have been overruled by the IRS.

The Senior Citizens' Equity Act makes very clear that these expenses are deductible. The language is written specifically to include persons with Alzheimer's disease and the type of care they need:

ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOC. INC.

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- The definition of "chronically ill individual" specifies persons whose disability is due to cognitive impairment (which includes Alzheimer's disease and related dementias).

- "Qualified long term care services" are defined to include maintenance and personal care services as well as diagnostic, preventive, therapeutic, and rehabilitative services.

- "Qualified facility" is defined to include not just nursing homes but other settings that are often more appropriate for Alzheimer care and less costly for the taxpayer, such as assisted living facilities, adult day care, and the person's own home.

We urge enactment of this tax clarification provision as a matter of basic tax fairness. This provision is part of the Contract with America. It was also part of President Clinton's health care proposals last year. There should be no partisan disagreement on this issue.

Tax Treatment of Long Term Care Insurance. The Alzheimer's Association cannot offer the same enthusiastic support for these provisions of the bill before the Subcommittee, for two reasons:

> First, private long term care insurance is an option only for the most well-to-do and the healthiest, those least in need of help. It will do nothing for the millions of American families already shouldering the heavy burden of long term care expenses. Private insurance may have a role in a more comprehensive approach to long term care. But this is not where we should be spending the next tax dollars for long term care.
>
> Second, no tax dollars should be spent at any point to encourage sale or purchase of long term care insurance without strong national standards and enforcement mechanisms to assure that consumers are actually getting meaningful protection.

A good long term care insurance policy is simply not affordable for most people, especially older Americans and younger families with children. The best estimates are that 10% to 20% of older Americans can afford a policy. That would cover about 11% of long term care expenditures and save an estimated 2% of Medicaid nursing home costs. For people over the age of 65, a good policy will cost as much as $3500 to $4000 a year. But median income for insurable persons in this age group is only $12,230; even with assets (other than the house and car) included, average total wealth is only about $24,000. Older Americans already pay an average of 23% of their income for health care (for Medicare cost-sharing, premiums for Medigap policies, prescription drugs, etc.). They simply do not have the money to purchase a long term care insurance policy worth having.

Cost is not the only limiting factor. Regardless of how much money you have, if you have any condition that suggests you may eventually need long term care, you cannot buy a policy. Attached to this testimony is the first page of the application for one of the best long term care insurance policies now on the market. Its "insurability profile" effectively excludes every one of the 14 million Americans with disabilities or functional limitations --

the very people who need, or are most likely to need in the foreseeable future, long term care. (This is not a criticism of the insurance industry. It is the nature of insurance. In a voluntary market, this is the only way a responsible insurer can avoid adverse risk selection.)

Even the most enthusiastic supporters of long term care insurance, insurance companies themselves, concede that at best they may be able to insure 40% of the market. The majority of families will get no benefit from the insurance subsidies you are considering.

For these reasons, the Alzheimer's Association does not believe you should spend the next tax dollars for long term care to subsidize private insurance. But if you are going to do it, at least you must be sure that the policies are worth buying, by specifying uniform national standards for all such policies. The Association would not be enthusiastic about tax considerations for long term care insurance in any event, but we will actively oppose them if you do not include national standards. We would be happy to work with you in developing such standards.

A Typical Family Story. Just this week, we received a telephone call in the Washington office of the Alzheimer's Association from a man in Sun City West, Arizona, Mr. J.C. Whidmont. When we told him about the legislation before the Subcommittee, he encouraged us to share his story with you, to bring home the implications of your actions for real families who are dealing with Alzheimer's disease. Five years ago, Mr. Whidmont considered buying one of the best long term care insurance policies then on the market. The annual cost of the premiums would have been $4000 each for him and his wife. But because Mrs. Whidmont had a lung condition, the company would not issue her a policy. The lung problem has been cured, but in the meantime, Mrs. Whidmont has been diagnosed with Alzheimer's disease, so she is still uninsurable. Nothing you do about long term care insurance will help the Whidmonts.

Mr. Whidmont is now spending $17,000 a year for adult day care to provide therapeutic care for his wife and make it possible to keep her at home with him. None of that cost is deductible for income tax purposes, because Mrs. Whidmont happened to get the wrong disease. The legislation before the Subcommittee would make it possible for Mr. Whidmont to deduct his day care expenses. But Mr. Whidmont is more concerned about the future. He recognizes that, in spite of everything he does, the day may come when he can no longer care for his wife at home. He knows that the cost of good residential care will be at least $30,000 a year, possibly much more. That is when the tax deduction will make the critical difference in his ability to care for his wife.

A Concluding Comment. Tax clarification will help people like Mr. Whidmont who are struggling to pay large long term care bills. But Congress must understand that it is not really an adequate answer to the underlying problem. Even with favorable tax treatment, most families do not have enough income and assets to pay these high costs for any period of time without mortgaging their future and their children's future. Many will still spend their way into poverty and will have no option but to turn to Medicaid for assistance. That system is already under enormous strain and may not withstand the kind of budget cuts Congress is considering this year.

Congress cannot address the long term care problem piecemeal. In the end, you must confront the problem head on and fashion a comprehensive solution that spreads the risk among the entire population. We look forward to the time that we can resume that discussion with you.

Thank you for considering our comments on this legislation. We commend the Subcommittee for addressing the issue of long term care. The Alzheimer's Association is available to work with you to find real solutions for the millions of families who are looking to you for support.

Sincerely,

Stephen McConnell
Senior Vice President,
Public Policy

92001

PLEASE COMPLETE ALL SECTIONS BEFORE SUBMITTING APPLICATION

BENEFIT AMOUNT SELECTIONS			BENEFIT OPTIONS
Daily Maximum $ _____	Benefit Multiplier ☐ 730 ☐ 1460 ☐ 1095 ☐ 2190 ☐ Unlimited	Elimination Period ☐ 0 days ☐ 50 days ☐ 100 days	Inflation Protection ☐ Compound 5% ☐ Equal 5% ☐ None

Premium Payment Method:		Submitted Premium:	Agent Producer Code (Required):
☐ Check ☐ EFT* ☐ American Express® Card* Premium Payment Mode: ☐ Monthly (Check Method not available) ☐ Quarterly ☐ Semi-Annual ☐ Annual	*Be sure to complete the Authorization Form (note: some states restricted)	$ _____	006 _ _ _ _ _ _ _

AMEX *Life Assurance Company*
650 Los Gamos Drive, San Rafael, California 94903

Please Print Clearly

APPLICATION
For Group Insurance

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Name _____
As It Should Appear On Your Certificate

Street Address _____

City _____ State ____ Zip ____

Social Sec. No. ___-__-____

Married? ☐YES ☐NO • If YES, is spouse applying? ☐YES ☐NO

Birthdate _____ Age ____ Sex ☐M ☐F

( ) DAY TELEPHONE ( ) EVENING TELEPHONE

Weight: ____ lbs. Height: ____ ft. ____ in.

For more space, attach a signed and dated sheet with question number and details

YES NO **INSURABILITY PROFILE**

☐ ☐ 1. Are you covered by Medicaid (not Medicare)?

2. Have you had, do you currently have, or have you ever been medically diagnosed as having:

☐ ☐ A. Alzheimer's Disease; Organic Brain Syndrome; Dementia; Chronic Memory Loss; or Senility?

☐ ☐ B. Multiple Sclerosis (MS); Parkinson's Disease; More than One Stroke; Muscular Dystrophy; or ALS (Lou Gehrig's Disease)?

☐ ☐ C. Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or positive HIV test?

☐ ☐ D. Metastatic Cancer (spread from original site/location)?

☐ ☐ 3. Within the past 6 months, have you had: Open Heart Surgery; Back or Spine Surgery?

☐ ☐ 4. Within the past 12 months, have you had a: Stroke; or Transient Ischemic Attack (TIA)?

☐ ☐ 5. Within the past 48 months, have you had Cancer of the: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, Stomach, or Testes?

☐ ☐ 6. A. Do you use a Walker or Wheelchair; Oxygen; Respirator; or Kidney Dialysis?

☐ ☐ B. Do you need the assistance of or supervision by another person in performing any of the following activities: Moving in/out of bed or chair; Bathing; Dressing; Eating; Toileting; Bowel/bladder control; Walking?

If you answered YES to any part of questions #1 through #6, DO NOT SUBMIT THIS APPLICATION. Otherwise, please continue.

☐ ☐ 7. A. Do you have any other accident and sickness or long term care insurance policy or certificate (including health care service contract, health maintenance organization contract) in force or applied for? If YES, give coverage details below.

Company _____ Coverage Type _____ Amount $ _____ per ____

Company _____ Coverage Type _____ Amount $ _____ per ____

B. If you have AMEX Life Nursing Home coverage, please list policy/certificate number(s): _____

☐ ☐ 8. Did you have another long term care insurance policy or certificate in force during the last twelve (12) months?
If so, with which company? _____ If that insurance lapsed, when did it lapse? _____

☐ ☐ 9. Do you intend to replace any of your long term care, medical, or health insurance coverage with this certificate?
If so, name of insurer being replaced: _____
(AGENT: If YES, be sure to fill out Replacement Notice. Leave one copy with applicant; send one copy with application.)

92001

AMERICAN ACADEMY of ACTUARIES

February 7, 1995

Dear: Members of the House Committee on Ways & Means Subcommittee on Health

RE: Analysis of Long-Term Care Provisions in H.R. 8.

The Academy's Long-Term Care Committee (the committee) is pleased that the Health Subcommittee has held a hearing on H.R. 8, which examines long-term care (LTC) financing. This is a timely debate.

Increasing longevity, coupled with relatively lower birth rates, results in an aging population—and a growing challenge for financing LTC. Not only will there be more elderly people utilizing more—and different—services in the future, but the cost burden of these services on each working individual will rise, as the ratio of people using the services to the working-age population increases.

In addition, recent medical breakthroughs have tended to focus on acute illnesses; these discoveries extend life expectancy, but they don't necessarily extend the period of time during which people can continue to live free of limitations on the most basic activities of daily living (ADLs). The result may be two-fold: more people living to reach ages wherein chronic ailments become prevalent, and then living more years with those chronic problems.

Besides demographics, other societal changes compel us to consider possible new approaches to finance LTC. The caregiver support structure in place earlier this century has been altered by higher divorce rates and the greater proportion of women in the paid labor force (who then, as now, provide most of the care for the elderly). Consequently, the people who used to have enough time to provide care for elderly relatives are increasingly unable to do so. In addition, our highly mobile society tends to disperse families geographically, leaving elderly parents far from the offspring who, in the past, may have provided care. The trend toward fewer children per family also reduces the number of offspring available to provide support to elderly parents.

These demographic trends and societal changes support an argument for programs that prefund the cost of LTC, to avoid mortgaging the futures of ensuing generations to support the swelling population of retirees at older ages who lack ready access to family members able to provide care over extended periods of time.

It is generally agreed that LTC is a rapidly growing problem and that it is important to educate the public about the potential magnitude of future costs of LTC to individuals, families, and society as a whole. Further, removing financing barriers, such as an unclear tax treatment, will

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empower individuals to make intelligent decisions to address the problem. Minor changes in tax law today could reduce the need for major policy shifts tomorrow.

Therefore, our committee supports the effort to clarify the tax treatment of private LTC policies. We note that adverse tax treatment is less of a barrier to the design and widespread marketing of LTC policies than is unclear tax treatment. This is true with respect to group policies (sold through employers), as well as individual policies.

Actuarial Implications of H.R. 8

Our committee is pleased to comment on the specifics of H.R. 8 that have actuarial implications, including ADL requirements, the deductibility of LTC insurance premiums based on insured age, the reserve method, the qualified location of care, the use of IRA and 401(k) withdrawals to finance LTC insurance, indexing the cost of living, and the $200 limit on daily benefits.

Activity of Daily Living Requirements

The requirement that individuals must be unable to perform at least two ADLs without substantial assistance from another individual may be too restrictive. Currently, about one-third of ADL-disabled elderly have only one ADL disability. Often what is needed is standby help, supervision, cueing, or other minor assistance. In other cases, the use of special equipment can obviate the need for any personal assistance. The current trend is a movement away from relying solely on personal assistance toward using special equipment, alone, or in combination with, personal assistance. The proposed legislation could inhibit this trend, thereby unintentionally introducing upward cost pressures on LTC.

The proposed legislation defines five categories of ADLs: 1) mobility, 2) dressing, 3) toileting (which includes incontinence) and bathing, 4) transfer, and 5) eating. However, toileting, continence, and bathing should be clearly identified as three distinct ADLs. In particular, toileting and continence should be clarified as two distinct ADLs, not treated as one. This would then yield a total of seven ADLs.

Deductibility of LTC Insurance Premiums Based on Insured Age

H.R. 8 states that the deductibility of "eligible long-term care premiums" will be based on the insured's age, with allowable premiums rising with age. These limitations are based on attained age, even though LTC premiums are generally based on issue age, with level or flat premiums for the life of the insured. This means that the increases in limits as the individual ages will make even very expensive policies fully deductible after less than 10 years, when the age for the next higher limit is attained, but may inhibit purchase of an appropriate benefit at younger ages.

Changing from attained age to issue age may be a problem for younger and older persons. For younger persons, the need for inflation protection and nonforfeiture benefits, with generous LTC benefits, will make the proposed limits too low. For older persons, the cost of LTC insurance will increase dramatically in the 75-to-85-year range. Currently, LTC policies are not issued to individuals above age 80. By setting the limit for those above age 70 to a level appropriate for age 70, the legislation may encourage this practice.

Reserve Method

H.R. 8 would eliminate the inconsistency and the financial difficulty created for LTC insurers by a National Association of Insurance Commissioners' (NAIC) Model Health Statutory Reserve requirement that states that insurers must hold, at a minimum, 1-year preliminary term reserves, while the Internal Revenue Service (IRS) code limits reserves that may be tax deductible by the insurer to those calculated according to the weaker 2-year full preliminary term reserve method.[1] Our committee views changes that will bring consistency between minimum required statutory reserves and reserves recognized by code for tax purposes as appropriate.

Location of Care

The proposed legislation defines qualified care as care received in a "qualified facility." It may be more appropriate to broaden that definition, to include care received in an individual's home if a licensed health care practitioner certifies that the individual meets the eligibility criteria described. One of the purposes of LTC insurance is to enlarge the range of options available to persons in need of LTC—not to restrict options such that they benefit only those who are nursing home certifiable.

IRA and 401(k) Withdrawals to Finance Long-Term Care Insurance

SEC.305(a) and IRC SEC.137 permits LTC premium payments to be made with pre-tax dollars from IRA accounts and 401(k) accounts. This will have the effect of providing a tax deduction up to the full premium amount for the 70% of tax filers who currently do not itemize their deductions. This should make it easier for the elderly and middle-aged to purchase LTC insurance, since the cash buildup inside an IRA or 401(k) should be comparable to that inside an LTC policy purchased at a young age. It is unclear whether this benefit would also apply to 403(b) plans. If it would not apply, it probably should, in order to maintain consistency.

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[1] The LTC Insurance Valuation Methods Task Force, which is a Society of Actuaries group, is currently researching this and other LTC valuation matters and anticipates releasing a report this Spring.

Cost of Living Indexing

The cost of living indexing reference (1)(F)(5) to the medical consumer price index (CPI) should be re-examined. LTC involves more than medical care; it also includes personal services and residential care, whose costs may not be linked to the rate of medical care increases. The Department of Labor publishes a nursing home index that might track LTC costs more closely. However, it would be preferable to create a new index based on a market basket of long-term care services, which would include a mix of medical, nursing, personal care, and residential elements.

$200 Daily Limit

The $200-per-day limit may not be adequate in some states. In Connecticut, parts of New York, northern New Jersey, and parts of Pennsylvania, $250 per day is more typical of the private-pay requirement for nursing home residents.

Conclusion

Our committee has commented on only a few areas. We are prepared to provide further analyses of LTC legislation and to provide some insights into premiums and related benefits. Please direct any questions you may have to Mike Anzick, a health policy analyst in the Academy's Government Information Department. He can be reached at (202) 223-8196.

Long-Term Care Committee
American Academy of Actuaries

STATEMENT OF
MICHAEL F. RODGERS
SENIOR VICE PRESIDENT,
AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING
HEALTH SUBCOMMITTEE

February 3, 1995

The American Association of Homes and Services for the Aging (AAHSA) is a national association representing not-for-profit nursing facilities, housing, assisted living, continuing care retirement communities, health related facilities and community service organizations for the elderly serving over one million elderly persons on a daily basis. Nearly seventy-five percent of AAHSA's 5,000 members are affiliated with religious organizations, while the remaining are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups. Since its founding in 1961, AAHSA has been a leader in the field of nonprofit care and services for the aging.

AAHSA has long supported a public and private partnership with a strong role for private insurance as the solution to long-term care coverage in America. AAHSA's position is based on the principle that individuals who can afford to protect themselves against risk of long-term care be given strong incentives to do so, while scarce public resources are preserved for those most in need. We applaud the initial efforts contained within HR 8 of the Contract with America to provide tax incentives for employers to offer and individuals to purchase long term care insurance.

Because of AAHSA's long history and strong commitment to serving the needs of the older population, our interest in long term care insurance products is extensive and long standing. While long term care insurance products have been on the market since 1985, the products that exist today are much more flexible in providing coverage for a range of long term care services in addition to institutional care. The evolution of the long term care insurance product is consistent with the evolution of long term care. At one time, nursing facilities and long term care were synonymous terms and the only environment to receive long term care was within a skilled nursing facility. However, we have moved away from the institutional bias for long term care and now emphasize limited risk, autonomy, and independence for older individuals. Consequently, insurance products have been modified to provide coverage and reimbursement for long term care services other than those provided within an institutional setting, such as home care and care provided by community based services.

We are pleased that the language within HR 8 addresses home care as a long term care option that may be offered by insurers. In addition, we support the use of ability to function based on activities of daily living (ADLs) as the trigger for accessing long term care services. However, AAHSA would like the legislation amended to incorporate the following recommendations:

1. The legislation defines a chronically ill individual as one who has been certified by a licensed health care practitioner as "being unable to perform...at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity,". AAHSA recommends amending this definition by changing the time frame for the inability to perform from 90 days to 60 days to comport more closely with current long term care policies.

2. Include in the "maintenance or personal care services" two additional and instrumental activities of daily living: 1) medication assistance and A) meal preparation. The legislation proposes that inability to perform activities of daily living necessary to live independently as the criteria for triggering coverage. Medication assistance and meal preparation are critical to independent living. While an individual may not require

institutional care for assistance with these activities, the activities are of the type that can and probably should be provided through home care or adult day care.

3. Separate bathing and toileting into separate ADL triggers. These activities should be considered independently because functional impairment in one is not necessarily related to the other.

4. The legislation defines a "qualified facility " as "a nursing, rehabilitative, hospice, or adult care facility (including a hospital, retirement home, nursing home, skilled nursing facility, intermediate care facility or similar institution...or an individual's home if a licensed health care practitioner certifies that without home care the individual would have to be cared for in a facility..." AAHSA recommends adding "assisted living provider" as a qualified facility. Including assisted living in long term care services would further increase the attractiveness of long term care insurance to both the insurance provider and the consumer. Assisted living is a rapidly growing ancillary to the long term care field. Consumers are attracted to assisted living because it permits a flexible lifestyle based upon individual needs and enhances independence and autonomy. Because assisted living programs are designed to meet the specific needs of each individual, it is also a cost effective alternative to home care or nursing facility care. In addition, most states currently regulate assisted living services in order to ensure that providers meet certain level of care standards, thereby guaranteeing a certain level of quality care.

5. Though the current Congress is emphasizing less Federal government and increased state and local control, we feel that minimum federal standards should be developed for long term care insurance. The rationale supporting this recommendation is standardization and consumer protection. Uniform standards could reduce administrative burdens and costs for insurance companies which currently are subject to fifty different sets of state regulations. In addition, uniform standards for long term care insurance products would enhance consumers' understanding of product options, their ability to make prudent purchasing decisions, and enhance consumers' confidence in the product. Finally, uniform regulations would "level the regulatory playing field" and ensure that consumers are protected by the same laws and regulations in every state. Currently tremendous variation exists among states. AAHSA opposes regulations that threaten the growth and evolution of this market either by severely restricting product development and flexibility or pricing products beyond the reach of the average consumer through requirements that constrict the market to unaffordable products.

6. AAHSA supports and encourages expanding the public-private partnerships similar to those currently funded by Robert Wood Johnson Foundation Partnership for Long Term Care. Mark Meiners, Ph.D., National Program Director for this program provided testimony at the Health Subcommittee's hearing on January 20, 1995 detailing the rationale for the program and its attractive features. Individuals need to feel that there is an asset protection advantage in purchasing long term care insurance in order to take advantage of incentives to purchase and feel assured that they will not be impoverished by long term care expenses that would encourage inappropriate transfer of assets to qualify for public long term care benefits. The Partnership for Long Term Care provides further incentive to purchase private long term care insurance and discourages accessing public benefits. Since private/public partnerships for long term care have been available in California, New York, Connecticut and Indiana, there has been a significant increase in the sale of long term care insurance policies. In New York, the State Partnership for Long Term Care has captured more than thirty percent of the long term care insurance market. Connecticut and Indiana have experienced sales trends that are consistent with New York. In Indiana, total sales of long term care policies increased by twenty seven percent within the first six months that the partnership was offered. AAHSA supports the position of the Robert Wood Johnson Foundation Partnership for Long Term Care encouraging the removal of language from the 1993 Omnibus Reconciliation Bill that has held back the growth of these partnerships that currently exist in four states, New York, California, Connecticut and Indiana. Three additional states, Iowa, Illinois and Maryland have launched partnership programs modeled after those of the original Robert Wood Johnson Foundation grantees. Iowa was able to obtain a state plan amendment to qualify for full asset protection as the partnership provides. However, the two other states were unable

to obtain a state plan amendment yet proceeded to implement the partnership plans incorporating the limitations specified in OBRA 1993. Removal of the limitations within OBRA 1993 would encourage further development of and access to partnership plans.

Thank you for the opportunity to present AAHSA's views regarding long term care insurance. Should additional hearings take place or additional information be required, AAHSA is happy to participate and assist the Health Subcommittee of the Ways and Means Committee.

TESTIMONY SUBMITTED FOR THE RECORD

TO THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

HEARING ON HR 8

THE SENIOR CITIZEN'S EQUITY ACT

JANUARY 20, 1995

On Behalf of the Listed Organizations
American Association of University Affiliated Programs
American Network of Community Options and Resources
American Parkinson's Disease Association
American Rehabilitation Association
American Speech-Language-Hearing Association
American Theraputic Recreation Association
National Multiple Sclerosis Society
The Arc
United Cerebral Palsy Associations

Mr. Chairman, we the undersigned organizations appreciate this opportunity to submit the following statement for the record of the hearings on HR 8, The Senior Citizen's Equity Act.

We applaud the committee for its efforts to bring much needed equity to senior citizens after a lifetime of contributing to society. It is appropriate to enable citizens to retire in dignity and comfort and to pursue activities delayed by the need to work and raise families. However, as most Americans, persons with disabilities desire to work and assume all the responsibilities and duties of citizenship in an opportunity society. In order to do so, persons with disabilities must be able to compete on a level playing field. The reality is that faced with the extraordinary cost of disability, persons with disabilities need financial relief from these extraordinary expenses to live independently and be self-sufficient. Therefore we recommend that this bill be renamed the "Senior and Disabled Citizens Equity Act" and the attached amendments be made to the proposed legislation.

A recent Harris poll showed that two-thirds of working age people with disabilities are unemployed. Of this number, 79% want to work. As you may know, individuals with disabilities face significant disincentives in attempting to enter and remain in the workforce. Social Security statistics show that the number of SSDI beneficiaries who successfully return to the workforce is less than one-half of one percent. People with disabilities of all types, including physical, sensory, cognitive, or mental impairments, can experience difficulty in entering or re-entering the work force and can experience substantial costs associated with their disability not encountered by those without disabilities.

We are concerned that HR 8, as it is currently written, relies too heavily on long term care insurance to meet this critical service need for elders and individuals with disabilities. While we do not believe that private insurance will be able to adequately meet the long-term service needs of persons with disabilities of all ages, we recognize that it may help to pay some of the long-term service costs of those persons with disabilities (generally older people) who can afford to purchase and maintain private coverage. Since numerous inadequacies and abuses, including discrimination against people with disabilities, in the long-term care insurance market have been well documented, we believe that private long-term care insurance should not be given preferential tax treatment unless adequate standards are in place to protect consumers from such practices and discrimination.

In order to promote the goal of employment and increased self sufficiency for individuals with disabilities, we recommend changes in Title III to address the cost of long-term services for working persons with disabilities. To do this, we propose a tax credit of one-half of all personal assistance services up to $15,000 for any individual with a disability who is working. We recommend the incorporation of the attached section 303 as part of the Senior and Disabled Citizens Equity Act.

The proposed tax credits and changes in medical care deductions for Personal Assistance will help to offset the extraordinary expenses of living with a disability and assist people with disabilities to enter the workforce by giving them a measure of economic equity with those wage earners amd tax payers who do not need to pay these extraordinary costs.

Personal assistance is defined as one or more persons or devices assisting a person with a disability with tasks which that individual would typically do if they did not have a disability. This includes assistance with such tasks as dressing, bathing, getting in and out of bed or one's wheelchair, toileting (including bowel, bladder and catheter assistance), eating (including feeding), cooking, cleaning house, and on-the-job support. It also includes assistance with cognitive tasks like handling money and planning one's day or fostering communication access through interpreting and reading services.

Individuals with disabilities incur substantial expenses in the conduct of their everyday lives as they try to learn, work, recreate, and live in the community. The cost of personal assistance to enable individuals with severe disabilities to work can be a barrier to employment, as individuals with disabilities often do not earn enough in wages to afford to pay for personal assistance in addition to a rent or mortgage, utilities, food, and related life expenses. Other examples of extraordinary expenses include the cost of accessibility modifications such as a wheelchair lift for a van or hand controls for a car; a wheelchair ramp or alternative signaling device for an accessible home; or medications and medical supplies. There are major expenses for assistive technology, including wheelchairs, hearing aids, guide dogs, computers, augmentative communications devices and the training and maintenance costs of the equipment. Not the least of these extraordinary expenses is for health specialists above and beyond the typical health expenses incurred by the average person. All of these expenses conspire to trap individuals with disabilities in a cycle of poverty and total governmwnt dependency from which most cannot escape without tax assistance to level the economic playing field.

We believe that the inclusion of these amendments would greatly enhance the ability of individuals with disabilities to become and remain contributing members of American society. Encouraging people with disabilities to become tax-payers rather than tax-takers would reduce the out-flows of the SSDI Trust Fund and increase the revenues to both the General Fund and the SSDI Trust Fund. It will also assist them to discharge fully their duties and responsibilities as citizens.

This testimony recommends that several minor enhancements be made to the provisions offering tax incentives for the purchase of long term care insurance. These include expanding the settings in which insurance funded services can be delivered, modifying the definition of chronically ill ill individual to include individuals with disabilities, and expanding the definition of the eating activity of daily living.

Thank you for this opportunity to present testimony for the record. If you have further questions, please contact Tony Young of the American Rehabilitation Association at 202-789-5700 or 1350 I Street, Northwest, Suite 670, Washington, DC 20005.

PROPOSED AMENDMENTS

The Senior Citizens' Equity Act

[recommended amendments are underlined]

1. Rename This The Senior and Disabled Citizens' Equity Act

SECTION 1. SHORT TITLE.
This Act may be cited as the "Senior And Disabled Citizens' Equity Act".

3. TITLE III -- TREATMENT OF LONG TERM CARE AND SERVICES

4. SEC. 301. TREATMENT OF LONG TERM CARE INSURANCE OR PLANS.

(a) General Rule. -- Subpart E of part I of subchapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 818 the following new section:
SEC. 818A. TREATMENT OF LONG TERM CARE INSURANCE OR PLANS.
(c) Qualified Long Term Care Services. -- For purposes of this section --
(1) In General. -- The term 'qualified long term care services' means necessary diagnostic, preventive, therapeutic, and rehabilitative services, and maintenance or personal care services, which --
(A) are required by an individual with a disability or chronic illness at home or in a qualified facility, and

5. AMEND SECTION 818A, (c)(2) to read:

(2) Individual with a Disability or Chronic Illness. --
(A) In General. -- The term 'individual with a disability or chronic illness' means any individual who has been certified by a licensed health care practitioner as --

6. AMEND SECTION 818A, (c) (2)(B)(v) to read:

(B) Activities of Daily Living. -- For purposes of subparagraph (A), each of the following is an activity of daily living:
(v) Eating. ---- The process of acquiring or preparing or getting food from a plate or its equivalent into the mouth.

7. AMEND SECTION 818A, (c)(3) to read:
(3) Qualified Facility. -- The term 'qualified facility' means --
(A) a nursing, rehabilitative, hospice, a comprehensive outpatient rehabilitation facility, or adult day care facility....
(B) an individual's home, including those of two or more individuals choosing to share quarters.

8. SEC. 303 (b) COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

``(a) Allowance of Credit.

``(1) In general.In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable percentage of the personal assistance expenses paid or incurred by the taxpayer during such taxable year.

``(2) Applicable percentage. For purposes of paragraph (1), the term `applicable percentage' means 50 percent reduced (but not below zero) by 10 percentage points for each $5,000 by which the modified adjusted gross income (as defined in section 59B(d)(2)) of the taxpayer for the taxable year exceeds $45,000.

``(b) Limitation.The amount of personal assistance expenses incurred for the benefit of an individual which may be taken into account under subsection (a) for the taxable year shall not exceed the lesser of

``(1) $15,000, or

``(2) such individual's earned income (as defined in section 32(c)(2)of the Internal Revenue Code) for the taxable year. In the case of a joint return, the amount under the preceding sentence shall be determined separately for each spouse.

``(c) Eligible Individual. For purposes of this section, the term `eligible individual' means any individual (other than a nonresident alien) who, by reason of any medically determinable physical, mental, cognitive, or sensory impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, is unable to engage in any substantial gainful activity without personal assistance services appropriate to carry out activities of daily living in or outside of the home. An individual shall not be treated as an eligible individual unless such individual furnishes such proof thereof (in such form and manner, and at such times) as the Secretary may require.

``(d) Other Definitions. For purposes of this section:

``(1) Personal assistance expenses. The term `personal assistance expenses' means expenses for

``(A) personal assistance services appropriate to carry out activities of daily living in or outside the home,

``(B) homemaker/chore services incidental to the provision of such personal assistance services,

``(C) in the case of an individual with a cognitive impairment, assistance with life skills,

``(D) communication services, including, but not limited to, assistance with interpreting, reading, letter writing and the use of communication devices, augmentative communications devices and/or telecommunication devices,

``(E) work-related support services,including, but not limited to, ongoing services to assist an individual in performing work- related functions necessary to obtain and retain work in an integrated work setting, and to fulfill the functions of a job and personal services on the job;

"(F) mobility services in and out of home, including but not limited to, escort and driving,and/ or mobility assistance including on the use of public transportation,

``(G) coordination of services described in this paragraph,

``(H) assistive technology and devises, including assistance with evaluating the needs of an individual in his or her every day environment; purchasing, leasing or obtaining assistive technology devices for use by individuals with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing such devices; coordinating and using other therapies, interventions or services with AT devices (e.g., those associated with existing education/rehabilitation plans or programs); training or technical assistance for an individual with disabilities or where appropriate, the family; and training or technical assistance for personal assistants; , and

``(I) modifications to the principal place of abode of the individual to the extent the expenses for such modifications would (but for subsection (e)(2)) be expenses for medical care (as defined by section 213 of the Internal Revenue Code) of such individual.

``(2) Activities of daily living. The term `activities of daily living' means the activities referred to in section 213(g)(3) of the Internal Revenue Code.

``(e) Special Rules.

``(1) Payments to related persons. Credit shall be allowed under this section for any amount paid by the taxpayer to any person who is related (within the meaning of section 267 or 707(b) of the Internal Revenue Code) to the taxpayer.

``(2) Coordination with medical expense deduction. Any amount taken into account in determining the credit under this section shall not be taken into account in determining the amount of the deduction under section 213 of the Internal Revenue Code.

``(3) Basis reduction. For purposes of this subtitle, if a credit is allowed under this section for any expense with respect to any property, the increase in the basis of such property which would (but for this paragraph) result from such expense shall be reduced by the amount of the credit so allowed.

``(f) Cost-of-Living Adjustment. In the case of any taxable year beginning after 1996, the

$45,000 amount in subsection (a)(2) and the $15,000 amount in subsection (b) shall be increased by an amount equal to

``(1) such dollar amount, multiplied by

``(2) the cost-of-living adjustment determined under section of the Internal Revenue Code for the calendar year in which the taxable year begins by substituting `calendar year 1995' for `calendar year 1992' in subparagraph (B) thereof. If any increase determined under the preceding sentence is not a multiple of $1,000, such increase shall be rounded to the nearest multiple of $1,000."

(b) Technical Amendment. Subsection (a) of section 1016 of the Internal Revenue Code is amended by striking ``and" at the end of paragraph (24), by striking the period at the end of paragraph (25) and inserting ``,and", and by adding at the end thereof the following new paragraph:

``(26) in the case of any property with respect to which a credit has been allowed under section 23 of the Internal Revenue Code, to the extent provided in section 23(e)(3)."

(c) Clerical Amendment.The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 22 the following new item:

``Sec. 23. Cost of personal assistance services required by employed individuals."

(d) Effective Date.The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

TESTIMONY OF THE ASSOCIATION OF HEALTH INSURANCE AGENTS
A CONFERENCE OF
THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

The Association of Health Insurance Agents (AHIA), a conference of The National Association of Life Underwriters (NALU), on behalf of itself and NALU, submits this statement in general support of the proposals relating to the tax treatment of long-term care (LTC) insurance contained in the Senior Citizens Fairness Act, one of the 10 bills that form the "Contract with America." AHIA and NALU believe that the LTC tax rules proposed in this legislation will encourage employers and individuals to purchase LTC coverage. An increase in the level of LTC coverage will in turn promote an increase in private sector responsibility for the care-taking required in extreme old age. It should in turn diminish the pressure on Medicaid and on private citizens to finance the costs of elder care, whether in a nursing home or in a community or private home setting.

AHIA, a conference of NALU, represents over 10,000 professional health insurance agents who specialize in helping individuals and businesses, especially small businesses, find and purchase affordable, adequate health insurance coverage. NALU, a federation of over 1,000 local and state life underwriter associations, represents some 138,000 professional life and health insurance agents all over the country.

Tax Incentives Will Encourage Individual/Employer Assumption of Responsibility for Risks Associated with Cost of Care during Extreme Old Age

Americans in all income classes and from all political persuasions share a concern about what will happen to their parents and/or to themselves if and when they get old enough that they can no longer care for themselves. The cost of nursing home care–or in-home custodial care–is extremely expensive. Estimates range from $24,000 to $36,000 and higher per year. The issues facing the "sandwich generation"–those middle-aged babyboomers facing the need to provide custodial care for both aging parents and very young children–are well-documented and at the front of the minds of most Americans. In fact, it is this very prevalence of concern that inspired the authors of the "Contract with America" to include proposed legislation that will help address these concerns. The tax incentives that will help make LTC more available because it will become more affordable are generally present in the "Senior Citizens Fairness Act." AHIA and NALU support this committee's efforts to enact these provisions.

Generally, the tax incentives contained in this legislation would treat LTC insurance as health and accident insurance. Among these provisions is one that includes LTC in the IRC Section 106 rule that premiums (or contributions to a separate fund) paid by employers are not included in the taxable incomes of the employees receiving the coverage. Presumably, the authors of this legislation also intended for employers who provide LTC coverage to their employees (for their own benefit or for the benefit of their parents) to also be able to deduct the cost of that coverage as an ordinary and usual business expense. However, this needs to be clarified in final legislative language because of the rule in the Internal Revenue Code that otherwise deductible business expenses that have the effect of deferring compensation are not currently deductible. Because LTC can arguably be characterized as a form of deferred compensation because it provides a future benefit (as opposed to protection against a current risk), there needs to be clarification that employer-paid LTC premiums are in fact deductible, regardless of LTC's characterization as a present or future benefit.

In addition, the legislation needs to be clarified to be sure that employers can provide LTC coverage that protects against the cost of parents' needing care, as well as spouses and children. The crux of the LTC issue is concern about aging parents, as well as about one's own personal old age. It is very important to allow employer-provided LTC coverage to include parents as well as selves and children in the group being protected.

The Senior Citizens Fairness Act also includes rules that allow individuals to deduct the cost of LTC coverage as a medical expense, within the rules of IRC Section 213 (i.e., medical expenses are deductible to the extent they exceed 7.5% of adjusted gross income). Another provision in the legislation would allow individuals to receive benefits payable under an LTC policy on a tax-free basis, at least to the extent that the benefits do not exceed $200/day. NALU and AHIA believe that these provisions are important considerations in

making the decision to purchase LTC coverage an affordable one. Tax-free benefits and the ability to deduct the cost of the coverage--at least to the extent that it exceeds 7.5% of AGI--will encourage people to assume their own individual responsibility to plan for the costs of their own extreme old age.

The combination of rules contained in this legislation--treatment of LTC as health and accident insurance for tax purposes; the excludability of the value of employer-provided LTC from employee taxable income; the tax-free treatment of benefits payable by LTC policies; and the deductibility by individuals of LTC premiums within the rules of Section 213--will, when combined with the needed clarification that employers can deduct the cost of their employees' LTC coverage and that employees can claim parents as dependents for purposes of employer-provided LTC, significantly enhance the overall level of LTC coverage. When LTC is treated as other employer-provided benefits, employers will look seriously at adding LTC coverage to their benefits packages. It is a benefit which addresses a real concern among many employees, and will be viewed by many employers as a cost-effective way to attract and retain quality workforces. However, parity in tax treatment of LTC as an employee benefit with other employee benefits (like health insurance, life insurance, retirement plans, etc.--all of which have similar tax rules) is crucial to acceptance of LTC as an employee benefit. And as with most, if not all, insurance benefits, coverage tends to be less expensive and broader in scope if it is group as opposed to individual, and if it's available at younger as opposed to older ages.

For those individuals whose employers do not choose to offer LTC coverage, the individual tax rules--tax-free benefits, deductibility of premiums within the rules of Section 213--will encourage them to purchase the needed coverage on their own. And for both employers and individuals, the addition of one more tax rule that is generally available to most employer-provided benefit choices would be to allow inclusion of LTC coverage in Section 125 cafeteria plans. Cafeteria plans are an increasingly popular mechanism among both employers and employees for tailoring the most cost-effective benefits package. Because cafeteria plans involve salary reduction, employers have much more flexibility in offering choices of available benefits for the same total amount of compensation (salary and cost of benefits). Because of the options, employees can choose to accept only those benefits they really want; they can have (taxable) cash compensation instead of benefits they don't select.

LTC, because it can be characterized as providing a future benefit as opposed to protecting against a current risk, has been argued as qualifying as deferred compensation. There is a rule against including deferred compensation in cafeteria plans. Thus, in order to include LTC coverage in a cafeteria plan, the law would have to be clarified to make it an allowable cafeteria plan benefit. NALU and AHIA urge you do this. Availability of LTC through a cafeteria plan will substantially increase availability of funding when and if prospective insureds need nursing home (or in-home) care. NALU and AHIA strongly urge that the LTC tax provisions be amended to include a provision that makes LTC an allowable cafeteria plan benefit.

"Contract" Legislation Is Largely Silent on Standards; That Is Appropriate Because the States and NAIC Are the Appropriate Forum for Development, Implementation of LTC Insurance Policy Standards

LTC is not a new issue confronting this committee, or Congress. LTC insurance has been the subject of Congressional attempts to write Federal underwriting and marketing standards as well as the subject of a debate over whether to grant it status, for tax purposes, as a benefit or as health and accident insurance. "Contract" legislation is largely silent as to LTC insurance standards. With one exception (a requirement that to qualify for tax advantages, the policy must pay no more than $200/day in benefits, indexed), there are no standards set out in this bill. NALU and AHIA believe that this approach is appropriate.

The associations do in fact support standards to be applied to LTC insurance. However, we believe that the States are the appropriate forum for development and

implementation of policy design and marketing requirements. The National Association of Insurance Commissioners (NAIC) has a long history of developing LTC policy standards (both as to product design and as to marketing practices). NAIC then makes available to the States its model laws and regulations. This process includes input from consumers, insurers, legislators and regulators. NALU and AHIA are active in the process. Where appropriate, we support the NAIC model laws and regulations and where appropriate we encourage NAIC and, if necessary, the individual states to make appropriate modifications. This is exactly the process in place for LTC standards. The associations are working closely with NAIC and the States to modify the existing package of LTC standards.

We believe that the long-term care needs of individuals are best served by the flexibility that is available by regulating LTC coverage at the State level. Costs of long-term care vary dramatically among the States. Options for long-term care, in terms of facilities and services, also vary dramatically. State-financed options vary. In short, there is so much variation in the factors that make up the package of LTC standards that it is appropriate that those standards be established at the State level. To the degree uniformity is needed or desirable, it generally develops because of uniform or near-uniform adoption of NAIC standards. But development of those standards at the NAIC level allows for variations among the several States as the circumstances in those States dictate.

Again, NALU and AHIA strongly support continuation of State regulation of all insurance, including long-term care insurance. And that means that standards--which are near-universally agreed to as necessary--should be developed by the NAIC and implemented by the individual States. Accordingly, we support the "Contract's" absence of a standards package in its provisions.

The one exception to this statement is the requirement that LTC policies pay no more than $200/day in order to qualify for the tax treatment set out in the legislation. Because the $200 is indexed, AHIA and NALU believe that it is a benefits level that is acceptable, albeit low enough that some policies currently on the market would exceed that ceiling. However, to the extent that benefits up to $200/day (indexed) remain tax-advantaged, the associations are prepared to support the provision. AHIA and NALU urge, however, that clarifying language be added to the legislation to make sure that only excess benefits become taxable, not the basic $200/day worth of benefits. This is particularly important for high-cost metropolitan areas where many LTC policies' limits are already higher than the $200/day base. To disqualify the entire policy would be most unfair; disqualification of excess benefits should suffice.

On a related subject, while the $200/day benefit limit is marginally acceptable as long as it's indexed and as long as only the excess benefits become subject to tax, it is also important to make clear that reimbursement policies as well as per diem policies qualify for the tax rules contained in the "Contract" legislation. The choice of reimbursement (the policy pays direct nursing home or in home custodial care costs) or per diem (the policy pays the beneficiary as result of the beneficiary incurring nursing home or in home custodial care costs) should be a matter of personal choice, not tax policy. Either policy form can be "right" for some prospective insureds and "wrong" for others. The tax code, so long as the value of the policies' benefits are treated equally, should not distinguish between the two policy forms.

Summary: AHIA and NALU Generally Support "Contract's" Proposed Tax Rules for LTC Insurance

In summary, AHIA and NALU generally support the "Contract's" LTC tax provisions. The associations believe that employers should be able to pay for and deduct the cost of LTC coverage for their employees. We believe that employees should be able to cover their parents as dependents for purposes of LTC coverage. We believe that LTC should be an allowable cafeteria plan benefit. We support making employer-provided LTC excludable from employees' taxable incomes. We support making individually-purchased LTC premiums deductible within the rules of IRC Section 213, and we support making LTC

benefits tax-free to beneficiaries. This package of tax rules will, we believe, encourage businesses and individuals to purchase LTC coverage. To the extent that the level of LTC coverage increases, the level of personal assumption of the responsibility to plan for one's old age will also increase. This in turn will reduce pressure on the Federal government and on the Federal budget to provide for citizens who need custodial nursing or in home care during those years when they become too old to care for themselves.

In short, AHIA and NALU believe that the package of LTC rules proposed in the "Senior Citizens Fairness Act"–as improved by the modifications proposed in the foregoing statement (clarification of employer deductibility, allowance of LTC as a cafeteria plan benefit, clarification that only excess benefits would be taxable, and clarification that per diem and reimbursement type policies will be treated equally)–is good tax policy and good social policy. We support the provisions, and your efforts to enact them into law.

Publisher of Consumer Reports

January 19, 1995

The Honorable Bill Archer
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515-4307

Dear Chairman Archer:

The Ways and Means Committee is considering H.R. 8, a proposal to provide people age 59 1/2 or older with tax incentives to purchase private long-term care insurance. **We urge you to oppose H.R. 8 in its present form.** Even though it may sound appealing at first blush, it has two serious problems. First, it does not address the very serious deficiencies in these private policies. Second, it favors higher income consumers at the expense of middle-income consumers. Furthermore, the bill would cost American families over $1 billion during the first five years.

Consumers buy private long-term care insurance in order to provide their family with economic security against financial devastation that can result from costly long-term care bills. Tax incentives alone -- without increased consumer protections -- will result in many disappointed families who will not achieve this economic security because the policy sold to their loved one fails to provide the expected benefits. This is a very inefficient use of tax dollars.

The private long-term care insurance market is one in which the average consumer can not make informed, responsible choices for his or her family's economic security. In June 1991, Consumer Reports found widespread agent abuses and numerous loopholes that deny coverage to consumers when they really need it. Consumers need to be protected so they can more effectively make choices in this market. Numerous bills that would solve these problems were introduced in the 102nd and 103rd Congresses, often with bipartisan support.

We do not believe that providing tax incentives for the purchase of long-term care insurance is a responsible way to spend tax dollars. If you retain the tax incentives, we urge you to finance them through a tax that would be paid by high-income consumers, the principal beneficiaries. Otherwise, the tax burden falls on the middle class. We recommend that you consider a tax credit rather than a tax deduction, so that middle class taxpayers in lower tax brackets benefit as much as taxpayers in higher tax brackets.

Enclosed is a more detailed analysis of H.R. 8. Thank you for considering our views.

Sincerely,

Gail Shearer
Director, Health Policy Analysis
Washington Office

Washington Office
1666 Connecticut Avenue, Suite 310 • Washington, D.C. 20009-1039 • (202) 462-6262

ANALYSIS OF H.R. 8
CONSUMERS UNION

H.R. 8 has two serious problems. First, it does not address the very serious deficiencies in these private long-term care insurance policies. Second, it favors higher income consumers at the expense of middle-income consumers. The bill would cost American families over $1 billion during the first five years.

THE PRIVATE LONG-TERM CARE INSURANCE MARKET HARMS CONSUMERS.

Consumer Reports has issued several reports about the many flaws in the private long-term care insurance market. We believe that it would be extremely irresponsible for Congress to encourage consumers to buy a product that will fail to provide their family with economic security. Unless the legislation includes badly needed federal consumer protection standards, then the result is likely to be the purchase of defective policies by thousands -- possibly even millions -- of consumers.

Among the traps awaiting unwary consumers (as reported in **Consumer Reports**, June 1991) are:

Agent abuses. Not one of the 15 agents whose sales pitch our reporter monitored properly explained the policies' benefits, restrictions, and policy limitations. Some actually lied.

Large rate increases. Premiums are not guaranteed over the life of the policy. Consumers may face the possibility of stiff premium increases in the future.

Fine print and loopholes. Agents and companies' sales materials often fail to reveal policies' limitations and restrictions. Consumers may believe, for example, that any nursing home stay will be covered, when in fact the definition of "nursing home" limits the coverage to a fraction of nursing homes.

Impossibility of comparison shopping. Benefits, terminology and definitions vary so greatly from policy to policy that consumers cannot make informed purchasing decisions. The long-term care insurance market currently flunks the "kitchen table test": it is virtually impossible for a prospective purchaser to sit down at his or her kitchen table and make a rational comparison of policies. The choices and variations from policy-to-policy are too complicated.

Inadequate inflation coverage. Most policies lacked built-in coverage of inflation. Without inflation coverage, policies may be nearly worthless by the time they are needed.

Dropped coverage. What happens if you drop your policy? Few policies have so-called "nonforfeiture benefits" which return to policyholders some of their equity if they drop their coverage.

STRONG CONSUMER PROTECTION PROVISIONS ARE NEEDED.

We believe that this market can be made better for consumers.[1] Congress should follow the excellent model it developed (with strong bipartisan support) in 1990, when it enacted reform of the medigap market. This market shared many of the same imperfections as the long-term care insurance market. Some of the specific reforms that are needed include:

Built-in inflation coverage: Inflation protection should be built-in to all long-term care insurance policies. Without inflation protection, a long-term care policy provides only illusory coverage. Many consumers face a shock several years in the future, when they discover that their policy will pay only a small percentage of their long-term care costs.

Premium stability: We believe that long-term care premiums should be fixed, so that families know the future price at the time the purchase the policy. (In insurance parlance, policies would be "noncancelable.") Without fixed premiums, consumers are asked to purchase a policy without knowing its price. Consumers are better able to make a rational and efficient decision if they know up-front the price of the product. It is unfair to sell a consumer a policy and then later increase the price after the consumer is locked-in to the policy. Requiring all insurers to have fixed premiums will provide a "level-playing field" for all. The present system rewards companies who deceptively underprice their policies initially. It encourages companies to find ways to "game the system."

Simplifying shopping decisions. Policy terms (e.g., "skilled nursing facility," "licensed nursing facility," "custodial care," "home health care benefit," "inflation benefit," "nonforfeiture benefit," and other terms) should be the same from one policy to another. Regulators should work toward standardizing benefit packages -- modeled on the successful standardizing of the medigap market. Perhaps we should start with voluntary standard benefits.

Protections for consumers who drop their policy. All policies should be required to include a standard nonforfeiture benefit. This will help protect the 60 percent of policyholders that insurers expect to drop their policy within 10 years.

Protection against unscrupulous agents. The commission structure should be modified so that agents do not have a financial incentive to make a sale that does not meet the long-range needs of the purchasers. Senior health insurance counseling programs should be fully funded in all 50 states to provide consumers with an objective source of counsel about their long-term care insurance needs.

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[1]It is important to keep in mind, however, that the private market will never protect consumers who can not afford a policy or are too sick to qualify for a policy. Consumers Union supports financing long-term care through a largely public program. Until this is achieved, we support improved regulation of the private market.

IMPROVED OVERSIGHT OF PRIVATE LONG-TERM CARE INSURANCE HAS RECEIVED BIPARTISAN SUPPORT IN THE PAST AND SHOULD BE INCLUDED IN H.R.8.

Numerous bills that address consumers' needs for long-term care consumer protections were introduced in both the 102nd and 103rd Congress.[2] Congressman Wyden's bill H.R. 1916 (102nd Congress), which included comprehensive requirements, had bipartisan support. In 1992, Senators Kennedy and Hatch succeeded in reporting S.2131, "Long-Term Care Insurance Improvement and Accountability Act" out of the Labor and Human Resources Committee. S.2131 would have offered substantial protections to all purchasers of long-term care insurance.

Many health reform bills that were introduced in the 103rd Congress included strong provisions to improve the long-term care insurance market. For example, the Chafee/Thomas bills (S. 1770/H.R. 3704) would have linked beneficial tax treatment to meeting minimum consumer protection standards, incorporating many of the requirements that are in the National Association of Insurance Commissioner's long-term care insurance model. The Administration bill would have standardized policy format and terminology, prohibited false and misleading representations, regulated premium increases, and provided for an independent professional assessment of the need for long-term care.

THE PROPOSED TAX EXPENDITURE IS SUBSTANTIAL, INEFFICIENT AND WOULD PENALIZE THE MIDDLE CLASS.

Under H.R. 8, many purchasers of long-term care insurance would be eligible for a tax deduction or other tax incentives. In light of the country's limited health care resources, we do not believe that millions of new dollars should be spent each year on a tax incentive to encourage the purchase of long-term care insurance. Few low-income consumers can afford to buy a long-term care policy. We have several equity concerns about this proposed new tax expenditure which is estimated to result in over one billion dollars of lost revenues during the first five years. First, how would this new tax expenditure be financed? We believe that it would be inequitable to finance a new tax incentive that will be used predominantly by high-income consumers through increased taxes (or reduced benefits) for low- or moderate- income consumers. We urge you to explore revenue sources other than cuts in Medicare, cuts in

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[2]Bills introduced in the 102nd Congress include: S. 1693 (Senator Bentsen); S. 2141 (Senator Kennedy); S. 846 (Senator Pryor); H.R. 2378 (Cong. Bruce); H.R. 3830 (Cong. Stark); H.R. 1916 (Cong. Wyden). In 1992, Consumers Union issued a report (Analysis of Long-Term Care Insurance Proposals) that outlined consumer protections needed in long-term care insurance market, and compared the bills that had been introduced in the 102nd Congress. We would be happy to provide you with a copy of this report.

Medicaid, and general revenues. Ideally, the incidence for the increased taxes would fall on relatively high income consumers, since they are the beneficiaries of this policy. One possible source could be increased estate taxes.

A second equity concern is that the structure -- use of tax deductions instead of tax credits -- provides a larger benefit to high- income purchasers than to low-income purchasers. A 70- year-old purchaser of a $2,500 policy would get a $375 tax benefit if he or she is in the 15 percent tax bracket, while a 70-year-old purchaser in the 33 percent tax bracket would get a tax benefit of $825 for the purchase of the same policy.[3] Unfortunately, the this public policy approach will barely make a dent in solving the nation's long-term care crisis.[4]

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[3]This example applies to employer-paid policies. H.R. 8 provides a strong incentive for small "companies" to be established by people searching for a low-cost way of funding long-term care insurance.

[4]See, for example, Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance, by Joshua M. Wiener, Laurel Hixon Illston, and Raymond J. Hanley, The Brookings Institution, 1995.

TESTIMONY OF GREG SCANDLEN
COUNCIL FOR AFFORDABLE HEALTH INSURANCE

The Council for Affordable Health Insurance (CAHI) is pleased to submit written testimony on the tax incentives for long term care insurance contained in HR 8, The Senior Citizens' Equity Act. CAHI is an organization of insurance companies and individuals who are vitally involved with our health care financing system and its ability to serve all segments of our population.

We are convinced the best approach to the problems in our health care system is to maximize the individual's freedom of choice and to promote a robust competitive market. We support a program which uses the concepts which have always been the strength of our country -- individual freedom and responsibility; a free market for goods, services, and ideas; a robust competitive environment; and government involvement designed to protect those who are incapable of caring for their own needs.

We believe the best way for more Americans to finance their long term care needs is through the purchase of private long term care insurance, rather than through reliance upon government programs. In order to encourage individuals to plan for their retirement needs and purchase private long term care insurance, changes need to be made to our federal tax policy.

CAHI commends the House Ways and Means Subcommittee on Health for recognizing the importance of promoting private sector solutions in financing long term care. HR 8 is an important step in formulating appropriate tax policy in the treatment of long term care insurance. However, in order to reach the majority of American taxpayers, CAHI's proposal on the tax treatment of long term care differs in some respects with HR 8. Our specific recommendations follow.

The Need for Private Sector Solutions to Long Term Care Financing

The American population is aging, and especially as baby boomers reach retirement, the long term care needs of the nation will increase substantially. Currently, about 13 percent of the population is 65 and older. A recent Census Bureau report finds that more than 20 percent of the nation will be over age 65 in the year 2050.

However, individuals are not planning for their long term care needs. A 1994 Lou Harris and Associates poll asked adults aged 65 and over how they would pay for nursing home or home care. Almost half of those polled (48%) did not know how they would pay. Only 13% responded that insurance would pay, while 15% said they would rely on the government to pay the costs.

At present, Medicaid is the primary financing mechanism for nursing home care. In 1993, 74% of nursing home patient days were paid for by Medicaid. Medicaid recently edged out higher education to become the second largest program in states' budgets (following K-12 education).

This undue reliance on government programs is clearly not sustainable. Precious dollars that would otherwise finance health care for the poor are instead paying for the long term care expenses of people with the ability to purchase private long term care insurance. It is estimated that 20-25 percent of persons aged 65 or older who enter a nursing home as a private pay patient eventually "spend down" and are ultimately covered by Medicaid. All individuals who spend down to Medicaid, whether before they enter a nursing home or after, use about 50 percent of total Medicaid nursing home dollars.

Tax Clarification of Long Term Care Insurance

At present, under the current tax code, there is no clear statement as to the deductibility of long term care insurance premiums, whether paid by an individual or an employer. Nor is there a clear statement about how long term care benefits should be treated. This lack of clarity creates an impediment to the purchase of private long term care insurance and an undue reliance on government welfare and entitlement programs, such as Medicaid.

CAHI applauds the Senior Citizens' Equity Act for recognizing the need to clarify the tax treatment of long term care insurance. However, the goal of long term care tax policy should be to provide significant incentives for the purchase of long term care insurance to the broadest spectrum and largest number of Americans. We believe this necessitates treating long term care insurance differently than other forms of accident and health insurance. Merely treating long term care expenditures as a medical expense does not provide the appropriate incentive to the broad spectrum of individuals because it is limited to those who itemize and take advantage of medical expense deductions. In 1992, less than 5 percent of individuals filing tax returns itemized and claimed a medical expense deduction.

In contrast to HR 8, CAHI proposes that all taxpayers be able to deduct premiums for long term care insurance; the deduction should not be subject to a floor of 7.5% of adjusted gross income (AGI), nor limited to taxpayers who itemize.

In order to actualize real savings in the Medicaid program, the tax incentive must encourage individuals who would not otherwise purchase private long term care insurance to do so. It must not only be a benefit to those who would purchase it anyway. Crafting the tax treatment as CAHI proposes will achieve this end, and provide an appropriate tax incentive to individuals of all income levels.

Additionally, CAHI believes that benefits paid under a long term care policy should not be included as income to the recipient. HR 8 limits the amount of long term care benefits that can be excluded from gross income to $200 per day. We oppose setting such an artificial limit because it does not take into account the long term nature of when benefits are received under a long term care insurance policy, nor changes in the long term care delivery system. For example, the $200 per day limit may not be sufficient when individuals receive benefits under their long term care insurance policy 20 years hence.

Moreover, the $200 per day limitation guards against a problem with other health insurance -- over-insurance -- that does not exist in the long term care insurance market. The nature of long term care involves built-in barriers that discourage over-utilization. The reality of being in a nursing home, including the resultant loss of freedom, is an example. Indeed, moving into a nursing home is the choice of last resort for individuals and families.

In addition, long term care insurance is a "premium sensitive" product, with the average annual premium for 65 year olds commensurate with their premiums for a Medicare supplement policy. It is more common for purchasers to "underinsure" to save premium. This is accomplished through lower daily benefits or longer deductibles or elimination periods, or combinations of both, which subject consumers to out of pocket liability and therefore, personal responsibility for exposure to service costs.

As mentioned above, employer contributions for long term care insurance should be deductible as a business expense. It is important to encourage employers to offer group long term care insurance for several reasons. First, the long term care insurance would become effective earlier and at a younger age. This would result in prefunding the insurance risk, thus resulting in lower annual costs to the covered person. In addition, increased market penetration by all ages is needed to effectively reduce Medicaid outlays by protecting against asset spend down.

Additional Comments on HR 8

In addition to the tax treatment of long term care insurance premiums and benefits, CAHI would like to comment on the following aspects of The Senior Citizens' Equity Act.

Eligibility for Favorable Tax Treatment. Regulation of long term care insurance is under the purview of the states, and the existing framework of state regulation is working very well. The states have actively engaged in the oversight of the long term care insurance product, and have enacted ample and adequate consumer protections.

There is a movement to mandate extensive federal benefit standards for long term care policies in order for those policies to receive favorable tax treatment. CAHI believes that it is unnecessary -- indeed, inappropriate -- for the federal government to either usurp the states' ability to regulate insurance within their borders, or to add another layer of regulation on top of what is currently in place. Simply put, state regulation of long term care insurance is not "broken"; therefore, the process does not need to be fixed by the federal government.

Therefore, we consider it appropriate that HR 8 not contain benefit standards. The Subcommittee is right to leave this responsibility in the hands of the states, to be dealt with under their statutory and regulatory authority.

Insurance Company Reserves. HR 8 conforms the tax treatment of long term care reserves with the statutory reserving requirements. We enthusiastically support this provision, which CAHI believes will ultimately reduce the cost of long term care insurance.

Activities of Daily Living. HR 8 defines a chronically ill individual in terms of the inability to perform two of the specified activities of daily living (ADLs). In response, we restate our position on the regulation of long term care insurance: it is the purview of the states, not the federal government. The National Association of Insurance Commissioners (NAIC) is currently addressing this issue, and the states will have the opportunity to adopt those portions of the NAIC's model which they feel are appropriate. We maintain that it is unnecessary for HR 8 to address ADLs, and request that this provision be deleted from the bill.

IRA Withdrawals. CAHI agrees with the provision to allow tax free withdrawals from Individual Retirement Accounts for the purpose of purchasing long term care insurance. We would also note that Medical Savings Accounts, if enacted by the 104th Congress, would serve as an important financing vehicle for private long term care insurance premiums.

Grandfather Clause. We support the bill's provision to grandfather all existing policies which met the long term care insurance requirements of the state in which the policy was issued at the time the policy was issued. Without such a provision, there would be the potential for widespread dislocation in the long term care insurance market. Moreover, individuals who had taken the responsibility and purchased long term care insurance would be punished for their foresight, a result that should not occur.

Parents. There are many instances where children purchase a long term care insurance policy for their parent. In these cases, the family member that pays the premium should be given the tax deduction. HR 8 does not address this issue; we encourage the Subcommittee to add language in this regard.

Medicare Duplication

CAHI would also like to take this opportunity to ask the Subcommittee for further technical corrections to OBRA 1990. Since the passage of OBRA 1990, it has generally been a violation of Federal law to sell to a Medicare beneficiary:

1. a health insurance policy with the knowledge that the policy duplicates health benefits (Medicare, Medicaid or other health insurance coverage) to which the individual is otherwise entitled; or

2. a standardized Medigap plan to a person who already has a Medigap policy.

The 103rd Congress enacted HR 5252, which was signed into law October 31, 1994. HR 5252 retains the prohibition against selling a Medigap policy to a Medicaid recipient. Further, an exception was created for certain policies which duplicate Medicare or other health coverage. Such a policy MAY be sold if the policy pays its benefits without regard to other coverage the individual might have. Further, if Medicare is duplicated by the

policy, a disclosure of the extent to which the policy duplicates Medicare must be given to the consumer.

Under the terms of HR 5252, Congress gave the NAIC the opportunity to establish standards to be incorporated by reference as Federal requirements. The NAIC, in developing its standards, has defined the word "duplicates" in terms of the service received; if the individual receives a medical or hospital service, and that service is covered to any extent by both Medicare and private insurance, duplication exists. The fact that there may be no "duplication" at the benefit level does not change this fact.

This approach has led to a result which we believe was not intended by Congress; Home Health Care, Long Term Care and other health insurance policies which coordinate their benefits with Medicare (and therefore are less expensive to purchase and help to avoid overinsurance) may not be sold to a Medicare beneficiary. These policies meet the definition of a policy which "duplicates" but fall outside the statutory exception.

CAHI believes that this unintended result must be reversed by the 104th Congress. This could most easily be accomplished by enactment of a statutory definition of "duplication." Policies meeting the following would be considered as not duplicating Medicare: (1) health insurance policies (including long term care) that pay without regard to Medicare, or (2) health insurance policies (including long term care) that coordinate with Medicare.

Conclusion

America's increasing long term care needs necessitate immediate policy changes to encourage individuals and families to take personal responsibility to plan for future long term care needs. As a first step, the Council for Affordable Health Insurance believes the federal government should act quickly to clarify the tax treatment of long term care insurance premiums and benefits.

However tax clarification is only the beginning of the process. Even with an affordable long term care insurance product and favorable tax treatment, individuals will not purchase a private long term care insurance policy if they continue to believe that Medicare will pay for their long term care needs. An aggressive public education program to attack this misconception is essential. Government, both federal and state, must be responsible for accurately informing and educating the public regarding actual coverage available for long term care.

The Council for Affordable Health Insurance applauds the Subcommittee for promoting private sector solutions to long term care financing. We would be pleased to assist Members of Congress in crafting proposals to accomplish this goal. In particular, CAHI's Senior Issues Committee, composed of actuaries and insurance industry representatives who are experts in long term care financing, is available to aid the Subcommittee in developing the most appropriate tax policy for long term care. Thank you for the opportunity to provide our comments on HR 8.

TESTIMONY OF SARAH SNIDER
EMPLOYEE BENEFIT RESEARCH INSTITUTE

Introduction

The Employee Benefit Research Institute (EBRI) is pleased to submit for the committee record the enclosed statement regarding the long-term care insurance provisions contained in the Senior Citizens' Equity Act (H.R. 8). EBRI is a nonprofit, nonpartisan, public policy research organization based in Washington, DC.

EBRI has been committed, since its founding in 1978, to the accurate statistical analysis of economic security issues. Through our research we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions.

Among the general population, recognition that neither Medicare nor most private insurance plans cover long-term care has come slowly. Retirees and workers have only begun to understand their exposure to the risk of needing costly community or institutional long-term care, as an increasing number have faced the necessity of caring for a parent, spouse, or child needing chronic (and often increasing) personal care assistance.

Demographic trends ensure that the proportion of individuals requiring formal paid care will increase in years to come. Increased life expectancy, reduced fertility rates, and the aging of the baby boom generation mean that the proportion of people at greater risk of needing long-term care relative to the proportion who can provide physical and financial assistance will increase dramatically over the next several decades. In addition, more two worker families and single workers and increased mobility among family members mean that there will be fewer individuals available to provide care on an informal basis to friends and family.

Current Sources of Financing

Under the current system of financing long-term care, most financing for care comes from individual out-of-pocket expenditures or Medicaid, with Medicare and private insurance accounting for only a small proportion of total expenditures. Long-term care includes services provided by paid and nonpaid caregivers in institutional, home, and community settings. Because the majority of functionally dependent individuals receive long-term care on an informal basis from friends and family,[1] it is difficult to measure the total expenditures on this care. However, according to the U.S. Health Care Financing Administration (HCFA), nursing home expenditures totaled $69.6 billion in 1993, of which 33 percent was financed through consumer out-of-pocket payments. Most of the remainder was financed through the Medicaid program (52 percent), with Medicare accounting for 9 percent, other public and private programs accounting for 4 percent, and private insurance paying for 2 percent.

While private insurance now finances only a small portion of long-term care needs, as an increasing number of individuals recognize the possibility of needing long-term care and the costs associated with such care, private initiatives to provide for this need have grown, through both individually purchased and employment-based plans. By the end of 1992, a total of 2.9 million private-sector insurance policies had been sold, up from 815 thousand in 1987.[2] These policies included individual, group association, Continuing Care Retirement Communities (CCRC), employer-sponsored and accelerated death benefits specifically for long-term care. While the majority of these plans were sold to individuals or through group associations, employment-based plans accounted for a significant proportion of this growth (increasing from 20,000 policies sold and 2 employers offering long-term care insurance in 1987 to 350,000 policies sold and 506 employers offering long-

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[1]U.S. Bipartisan Commission on Comprehensive Health Care, *A Call for Action* (Washington DC: U.S. Government Printing Office, 1990).

[2]Susan Coronel, "Long-Term Care Insurance in 1992," *Policy and Research Findings* (Washington DC: Health Insurance Association of America, February 1994).

term care insurance in 1992). The average age of buyers of employer-sponsored plans in 1992 was 42, compared with 68 for purchasers of individual and group association policies. Furthermore, recognition that many states are currently suffering from serious budget deficits and have been forced to make changes to Medicaid that may threaten beneficiaries' access to quality care has led many leaders to regard long-term care insurance as a potential alternative to Medicaid.

The design of private insurance policies being sold has also changed dramatically in recent years. Long-term care insurance policies have become less restrictive as they have evolved, and many of today's policies have additional provisions that make them more valuable to individuals than earlier policies. For example, several insurers now offer policies that adjust the benefit for inflation. Many policies also now include a provision that allows policyholders to stop paying premiums after a specified number of days. One type of nonforfeiture provision continues coverage at a reduced benefit level if a minimum number of payments has been made. Another type allows partial recovery of premiums paid. While policyholders may value these provisions, policies with such features cost more. However, these and other innovations give an indication of how much the private long-term care insurance market has evolved since its emergence in the early 1980s.

ISSUES

Despite growth and significant changes with regard to private-sector long-term care insurance plans since the early and mid 1980s, no clear policy with regard to long-term care currently exists in the United States. While the private-sector market is likely to continue to grow and develop despite the ambiguities and obstacles that exist in the current system, it is unlikely that the goals of adequate coverage, universal access, affordability, and high quality care will be met without a more coherent strategy, including clarifications in policy objectives and in the regulatory environment, toward long-term care in the United States.

At present, long-term care needs are met through both public- and private-sector initiatives in the United States. Medicaid, Medicare, private-sector long-term care insurance, and private out-of-pocket payments (including reliance on family and friends) are all mechanisms used to meet individuals' long-term care needs. Recent proposals call for strengthening both public- and private-sector mechanisms through which individuals can gain access to the financing of long-term care. Some proposals advocate a public-sector solution, some a private-sector solution, and some advocate initiatives that would bolster the current public/private-sector mix. One such proposal is that contained in the Senior Citizens' Equity Act (H.R. 8) which would, among other things, encourage the growth of long-term care insurance contracts by stipulating that these contracts be treated as accident or health insurance contracts for tax purposes. The bill would also allow for the exclusion from gross income amounts withdrawn from individual retirement plans or 401(k) plans for the purchase of long-term care insurance.

The Taxation of Long-Term Care Insurance

Theoretically, long-term care insurance is an item for which individuals with assets to protect should be willing to pay. Furthermore, since people of any age may potentially need long-term care services, their assets could be at risk at any time. While the chances of having extended long-term care needs are small, the costs of such a need are extremely high. However, for a variety of reasons, only a small proportion of those who can afford long-term care insurance have actually purchased it. For those individuals who have no assets they wish to protect or who believe they will never require formal care (perhaps because they have a large family), long-term care insurance may never be worth the price. However, others may lack information on the probability of needing such care, may mistakenly believe that they are already

covered by Medicare or health insurance, or may be dissatisfied or mistrustful of policies that are currently available.

The tax code currently does not explicitly recognize long-term care. Therefore, the tax treatment of long-term care insurance premiums and benefits is ambiguous. Ambiguity surrounding long-term care insurance tax treatment might be an impediment to the market for long-term care insurance—particularly employer-based group insurance.

Proponents of changing the tax code argue that the ambiguity concerning long-term care leads to questions not only about how to treat long-term care expenses but also about the treatment of long-term care insurance. If long-term care were deemed to be medical, long-term care insurance premiums paid by an employer on behalf of an employee would be tax deductible to the employer and would not have to be included in the employee's gross income. In addition, the benefits received when a long-term care insurance claim is filed (whether under an individual or employer-sponsored policy) would not be included as taxable income to the beneficiary. However, since long-term care has not been thus defined, most employers have avoided the problem altogether either by not sponsoring a long-term care policy or by offering coverage on an employee-pay-all basis. Individuals purchasing long-term care insurance either on an individual basis or as part of an employer-based plan use after-tax dollars, which has been assumed to guarantee them tax-free claims payments consistent with general rules of insurance taxation. The assumption that long-term care premiums must be included in the taxable income of employees may impede the development of the group long-term care insurance market because employers may assume that other forms of compensation that are tax preferred (e.g., health insurance and pensions) will be more valuable to most employees. In addition, employers may refrain from offering long-term care insurance out of concern that their interpretation of the tax treatment will be contrary to an eventual ruling. A misinterpretation could require the payment of back taxes or result in uncertainty regarding the recovery of past surplus tax payments.

The provision in the Senior Citizens' Equity Act to treat long-term care insurance the same as accident and health insurance for purposes of taxation would mean that premiums paid by an employer on behalf of an employee would not have to be included in the employee's gross income and that benefits received when a long-term care insurance claim is filed would not be included as taxable income to the beneficiary.

If long-term care insurance were to receive the same tax treatment as accident and health insurance, employees receiving employer-sponsored long-term care insurance benefits would receive the same tax-exempt premium payments and nontaxation of interest on accumulating plan deposits that are characteristic of qualified pension plans. The benefits paid to them would also be tax exempt, similar to those paid by health plans. To date, the only other tax-preferred prefunding (prefunding without immediate taxation of interest) of health benefits is through a separate account in a tax-qualified pension plan (a 401(h) account). However, these accounts have not been widely used in the past because of various limitations.

Conclusion

Tax policy is often used to promote specific social and economic goals. The proposed policies for the tax treatment of long-term care can be evaluated in terms of their tax burden versus their social benefit (keeping in mind who bears the burden and who benefits). Tax policies can also be evaluated in terms of the public long-term care expenditures associated with the policy relative to the expenditures that would accrue without it. For example, a proposal to treat long-term care insurance the same as health insurance for tax purposes has an associated tax expenditure (and burden), and its adoption would subsidize those who purchase individual or receive employer-sponsored long-term care insurance. Furthermore, it might encourage the substitution of formal for informal or more efficient sources of care unless the policies pay benefits according to a disability model (i.e., disability triggers

payment as opposed to specific services). However, such a proposal may also further certain social and economic goals, including increased risk pooling, preservation of assets, and potential reduction in Medicaid expenditures for those who are not poor. Quantification and comparison of the costs versus the benefits of such a policy need to be carefully considered to develop appropriate public policy.

The committee faces a difficult challenge as they confront the complexities of this issue. EBRI stands ready to assist the committee in its efforts.

Equitable Life & Casualty
INSURANCE COMPANY
3 Triad Center, Suite 200
Salt Lake City, Utah 84180-1202

E. Rod Ross
President

TO: House Committee on Ways and Means
Subcommittee on Health

DATE: February 2, 1995

RE: Tax Treatment of Long Term Care Insurance under HR8, The Senior Citizens' Equity Act

Dear Mr. Chairman and Members of the Subcommittee on Health:

My name is Rod Ross and I am President of Equitable Life & Casualty Insurance Company.

Equitable Life & Casualty is a life, accident and health insurer domiciled in Salt Lake City, Utah. We are one of the oldest writers of Long Term Care (LTC) insurance in America.

We are especially pleased that the Senior Citizens' Equity Act, as part of the Republican leadership initiative under the Contract with America, is receiving attention this early in the 104th Congress. This proposal ends a long period of uncertainty regarding tax treatment of LTC insurance for insurers and consumers. Moreover, it establishes sound public policy in the face of a looming health care crisis.

The need to incorporate incentives for expanding private sector financing of long term care is well documented and has been presented to this Subcommittee through prior testimony. It need not be repeated by us.

We believe two questions need to be answered in formulating the most appropriate tax clarification for LTC insurance under HR8:

1. Should the tax clarification of LTC insurance apply to the broadest spectrum of taxpayers?

2. Does the federal government need to gain oversight over LTC insurance products?

The Need to Appeal to All Taxpayers

HR8 proposes to treat the deductibility of LTC insurance premiums as accident and health insurance, subject to the floor of 7.5% of adjusted gross income. We have seen other proposals identical to HR8 in this regard. We believe this "incentive" to be limited in application and value to the great majority of potential consumers.

Prior proposals which provided tax deductibility of LTC insurance as accident and health insurance were seen as benefiting only that small portion of the population who could afford it anyway without the deduction. This tax incentive should not be a vehicle only for the wealthy. Nor should it be limited to those taxpayers who itemize deductions.

The incentive to purchase private LTC insurance should appeal to taxpayers of all income levels. A straight line deduction accomplishes this result. It sends the right message--that personal responsibility for anticipating future contingencies is rewarded; that government should not be the financier of services for people capable of taking care of themselves. The proper incentive is a win/win proposition for individuals, for strained Medicaid budgets and a more significant private sector role in financing long term care.

The Recognition of State Authority

We have seen prior proposals which grant tax clarification of LTC insurance conditioned upon a base of federal minimum standards. We believe this linkage is unnecessary for several reasons:

a) The majority of states have existing standards defining LTC insurance, requiring prior approval of products;

b) States without specific LTC standards require prior approval of products under accident and health insurance standards; and

c) Insurance products marketed primarily to individuals age 65 and older receive more intensive scrutiny at the state level.

The federal tax treatment of accident and sickness and disability insurance is provided without mandating product design or specifications. Early on, the states deliberately considered specific minimum requirements for LTC insurance to ward off the occurrence of abuses and practices which regulators encountered in Medigap insurance.

We speak from firsthand experience when we tell you that the regulatory scrutiny of the states is alive and well in LTC insurance. Our latest product reimburses expenses incurred for home and community based services under a plan of care developed between the insured, the family and a care coordinator. The approval process for this product in the states was detailed; and the product was not approved in all states. Suffice it to say, state regulation over LTC insurance is more than adequate.

There is simply no need for an additional layer of federal oversight. Precedent in tax clarification of other health insurance exists to negate its necessity as well. At a point when the federal government has signaled strong support for the return of power to the states, to dictate standards to those now on the front line of regulatory oversight and consumer protection is a step backward.

Summary

In summary, we advocate a straight line deduction for taxpayers' premiums for LTC insurance. Additionally, we propose HR8 eliminate federal minimum standards and defer to the states in determining what is a LTC insurance contract.

We appreciate this opportunity to present our position regarding the tax treatment of LTC insurance under HR8, The Senior Citizens' Equity Act. Additionally, we offer our assistance in crafting acceptable proposals which promote a more active role in private sector financing of long term care.

Sincerely,

E. Rod Ross
President

STATEMENT OF LINCOLN NATIONAL CORPORATION, LINCOLN NATIONAL LIFE INSURANCE COMPANY, AND FIRST PENN-PACIFIC LIFE INSURANCE COMPANY ON THE SENIOR CITIZENS EQUITY ACT, H.R. 8

For hearings held before
The Subcommittee on Health of
The Committee on Ways and Means
on January 20, 1995

Lincoln National Corporation and Lincoln National Life Insurance Company, of Fort Wayne, Indiana, and First Penn-Pacific Life Insurance Company, of Oakbrook Terrace, Illinois (the "Lincoln National Companies") submit this statement for inclusion in the record of the hearings held by the Subcommittee on Health of the Committee on Ways and Means on January 20, 1995 concerning the Senior Citizens Equity Act, H.R. 8. The Lincoln National Companies are pleased to express their strong support for the provisions of the Senior Citizens Equity Act that provide clarifications for the tax treatment of accelerated death benefits and long-term care insurance.

We consider the Senior Citizens Equity Act well framed in providing tax clarifications for accelerated death benefits and long-term care insurance, and we compliment the drafters on both their willingness to step forward in this area and their foresight in so doing. H.R. 8 makes much-needed clarifications in the tax law, and is quite timely in view of the substantial and rising interest in "living benefits" provided through life insurance contracts. This fact, coupled with the importance of facilitating efficient funding for the often great costs of long-term care and terminal illness, make enactment of these tax clarifications both important and necessary.

There are two types of "living benefits" addressed by H.R. 8 that are increasingly offered in connection with life insurance contracts: (1) accelerated death benefits, usually provided by a rider on a life insurance contract which accelerates payment of the contract's death benefit when the insured becomes chronically ill (including the "long-term care acceleration rider") or when he or she becomes terminally ill (the "terminal illness rider"), and (2) so-called "non-acceleration" long-term care benefits, provided under a rider which pays long-term care benefits when the insured becomes chronically ill but which does not affect the values, including the death benefit, of a related life insurance contract (sometimes referred to as a "stand-alone" long-term care rider).

H.R. 8 addresses accelerated death benefits in section 306 of the bill, while non-acceleration long-term care benefits offered in connection with life insurance contracts are addressed in section 301 of the bill (specifically in proposed section 818A(d) of the Internal Revenue Code). H.R. 8 also addresses long-term care insurance offered independent of any life insurance contract in sections 301-303 of the bill. This statement focuses on the tax clarifications made for life insurance rider products, although we support the tax clarifications which H.R. 8 provides for long-term care insurance generally.

Accelerated Death Benefits

In General. Since the late-1980s, many life insurance companies have begun offering accelerated death benefits in connection with their life insurance contracts. The purpose of accelerated death benefits is to allow chronically and terminally ill policyholders to receive the full value of their contracts prior to death, not just their cash surrender values, to help them manage the added financial burdens occasioned by their illness.

People primarily purchase life insurance for income protection, to provide for a surviving spouse or children in the event of the insured's premature death. As individuals reach older ages, their need for income protection becomes less impor-

tant. But, at such times, the built-up value of the life insurance contract may be used to address other insurance needs that are then arising -- the risk that an illness will place substantial financial burdens on the family. Accelerated death benefit riders provide access to the "entire" value of a life insurance contract (including its pure insurance element) to pay long-term care or terminal illness costs. These riders thus substantially complement an individual's insurance protection after retirement, recognizing that one of the greatest risks, or emergencies, that individuals can face at this time is the financial crisis that arises upon an insured's chronic or final illness.

Accelerated death benefits constitute an important addition to the benefits offered under life insurance contracts. If they were not available, a chronically or terminally ill individual would likely be faced with poor financial options -- either avoiding life-time expenses to the extent possible or cashing in his or her life insurance contract to cover expenses. If forced to surrender the contract, the individual would lose the pure insurance element of the contract (the excess of the contract's death benefit over the cash surrender value). Under an accelerated death benefit rider, however, both the pure insurance element and the cash surrender value are available to provide benefits.

Long-Term Care Acceleration Riders. Under a long-term care acceleration rider, accelerated death benefits are paid to chronically ill individuals in the same circumstances as under stand-alone long-term care insurance contracts. When benefits are paid under the rider, however, there is a dollar-for-dollar reduction in the death benefit of the related life insurance contract -- the rider "accelerates" payment of the death benefit. Benefit payments under such a rider are made periodically, either in reimbursement of actual long-term care expenses incurred (subject to limits set forth in the rider) or as a stated percentage of the life insurance death benefit.

Terminal Illness Riders. Under a terminal illness accelerated death benefit rider, benefits are paid upon establishment of the insured's terminal illness (when the insured's life expectancy is 12 months or less). Most riders pay the benefits in a lump sum rather than on a periodic basis, although it is not uncommon for some portion of the life insurance death benefit to remain after the accelerated death benefit payment. For example, a rider might provide that 50 percent of the death benefit may be paid out as an accelerated death benefit, with the remainder to be paid out to the beneficiary when the insured dies.

Methods of Purchase for Long-Term Care Acceleration Riders and Terminal Illness Riders. There are several methods by which insurance companies are compensated in connection with accelerated death benefits, but, in all cases, the cost is only the time value of money cost associated with paying the death benefit prior to death. In the case of long-term care acceleration riders, the cost is typically assessed through stated charges imposed prior to the chronic illness, e.g., through a monthly rider charge. Therefore, in contrast with terminal illness riders, discussed next, the full undiscounted death benefit can be paid out as benefits under a long-term care acceleration rider.

In the case of accelerated death benefits payable under terminal illness riders, there are two mechanisms by which the cost is typically assessed: (1) through the so-called "lien method" or (2) in the form of a "back-end" discount. Under the lien method, the accelerated death benefit is paid out in the form of a loan: the loan is secured by a lien against the death benefit payable under the related life insurance contract, and interest accrues on this loan. Insurers generally require that some portion of the death benefit remain unencumbered by the lien after the accelerated death benefit payment is made, so that

interest can be offset against this amount upon death. When terminal illness accelerated death benefits are paid out through the discount method, the accelerated death benefit payment typically will represent 85 percent to 90 percent of the death benefit extinguished by the payment. The 10 percent to 15 percent difference represents the interest cost of paying the death benefit early.

As indicated above, for all accelerated death benefits, the insurance company need only charge for the time value of money cost associated with paying the death benefit prior to death. As a result, accelerated death benefits represent an inexpensive way for policyholders to acquire insurance protection against the costs associated with chronic or terminal illness. The low incremental cost of these benefits, together with the wide-spread current ownership of cash value life insurance, provides a large number of people with the ability to acquire these beneficial insurance coverages.

"Non-Acceleration" Long-Term Care Insurance Riders

We also strongly support the tax clarifications provided by the Senior Citizens Equity Act for "stand-alone" long-term care insurance. These tax clarifications are provided in sections 301-303 of the bill, and address both long-term care insurance benefits offered in connection with a life insurance contract and those offered independent of any life insurance contract. In the former case, it is our understanding that proposed section 818A(d), which addresses long-term care benefits offered under life insurance contracts, was included in the long-term care portion of H.R. 8 to address "non-acceleration" long-term care rider benefits, i.e., long-term care insurance riders which do not accelerate payment of the underlying life insurance contract's death benefit.

An example of a non-acceleration long-term care rider is the so-called "extension rider," which pays long-term care benefits only after a long-term care acceleration rider has paid out the entirety of the underlying life insurance contract's death benefit. Another example of a non-acceleration long-term care rider would be one similar to that described in IRS Private Letter Ruling 9106050 (November 16, 1990) which operated as an independent long-term care insurance contract attached to a life insurance contract.

The Proposed Legislation

We are very pleased that the Senior Citizens Equity Act contains provisions which clarify the tax treatment of accelerated death benefits and long-term care insurance. These clarifications are especially timely given that use of living benefits under life insurance contracts has flourished in recent years. With these clarifications, life insurance policyholders will be able to utilize their contracts in an efficient manner to assist them in dealing with the potentially devastating costs associated with chronic and terminal illness.

There are several minor technical changes, however, that we would recommend for improvement of the bill. We believe that the recommendations, set forth in the attached appendix, will help assure that the bill achieves its goals.

Conclusion

Accelerated death benefits and long-term care insurance provide an efficient and effective way for individuals to achieve some "piece of mind" in regards to the potentially devastating cost of chronic or terminal illness. Thus, it is entirely appropriate that favorable clarifications in the tax status of such benefits be provided at this time, to remove any unintended disincentive that may exist because of the current tax uncertainty.

APPENDIX

SUGGESTED TECHNICAL MODIFICATIONS TO THE ACCELERATED DEATH BENEFIT AND LONG-TERM CARE PROVISIONS OF H.R. 8

Matters Relating to the Section 7702 Definition of Life Insurance

Treatment of Rider Charges. When accelerated death benefit or long-term care rider charges are made against a life insurance contract's cash value to fund the rider, there may not be a corresponding reduction in "premiums paid" for the life insurance contract, within the meaning of section 7702(f)(1) of the Code, and this may prevent the life insurance contract from being able to mature on its promised benefits. This problem has been addressed in prior bills by providing for an increase in the guideline premium limitation under section 7702(c)(2) in any case where such charges do not reduce "premiums paid." (See proposed section 7702B(d)(3) in section 7402 of S. 2357, 103d Cong., 2d Sess.)

As an alternative to legislative language, we note that a specific grant of regulatory authority exists in section 7702(f)(1), under which "premiums paid" can be reduced by "amounts received with respect to [a life insurance contract] which are specified in regulations." If this approach is to be taken, it would be very helpful for this Committee's report to indicate that the Treasury Department should exercise its regulatory authority under section 7702(f)(1) in respect of accelerated death benefit and long-term care rider charges.

Application of the Section 7702(f)(7) Adjustment Rule. A related problem regarding "premiums paid" arises when payments of accelerated death benefits result in the application of the section 7702(f)(7) adjustment rule. Long-term care acceleration riders generally make periodic payments, so that the death benefit may be reduced by a relatively modest amount each month. In addition, while terminal illness riders can pay out all of the death benefit, many pay out only a portion of the death benefit, leaving some life insurance so that the beneficiary will receive a death benefit on the insured's death. Thus, under either type of rider, the life insurance contract, with a reduced death benefit, may remain after accelerated death benefits are paid, and this necessitates application of the section 7702(f)(7) adjustment rule under current law. This adjustment rule will often produce extremely harsh results in such circumstances -- adjustments may cause a life insurance contract to collapse either when or within a short time after accelerated death benefits commence. This is because the adjustment rule will reduce the guideline premium limitation, but the payment of accelerated death benefits (and any consequent reduction of the life insurance contract's cash value) apparently will not reduce "premiums paid."

We believe it would be appropriate to create a statutory rule to address how the section 7702(f)(7) adjustment rule should apply upon the payment of accelerated death benefits, and we would be pleased to provide any technical assistance that the Committee may require in this regard. Alternatively, this problem could be substantially ameliorated if the Treasury Department were to issue regulations indicating that "premiums paid" is reduced by any payments of accelerated death benefits, to the extent such payments reduce the cash value of the life insurance contract. If this approach is to be taken, it would be very helpful for this Committee's report to indicate that the Treasury Department should exercise its existing regulatory authority under section 7702(f)(1) to this effect.

Modification of "No Material Change" Transition Rule

The transition rule in section 307(d) of H.R. 8 is intended to prevent the addition of a long-term care or accelerated death benefit rider to a life insurance contract from constituting a modification or material change of the contract. Under this rule, adding such a rider would not disrupt any "grandfathering" that exists with respect to a life insurance contract, nor would it

subject the contract to a change in its limitations under the technical rules of sections 101(f)(2)(E), 7702(f)(7), and 7702A(c)(3). Thus, if a life insurance contract is currently governed by a set of rules under prior law, e.g., it is a section 101(f) flexible premium life insurance contract, the addition of a rider would not, in and of itself, cause the contract to become subject to a new set of rules. Further, if the contract is already governed by current law, e.g., section 7702A, the addition of a rider would not trigger a section 7702A(c)(3) material change.

As currently drafted, however, the rule does not appear to accomplish this purpose fully and unambiguously. We therefore recommend that the following changes be made:

- The rule currently appears to be limited to "determining whether section 7702 or section 7702A" of the Code "applies to any contract." This might be interpreted as limiting application of the rule to older, grandfathered contracts, denying its relief to recently or newly issued contracts. To clarify that this is not intended, the phrases "determining whether" and "applies to any contract" should be deleted.

- The rule currently has no application to terminal illness riders -- only long-term care riders are expressly covered -- and fails to mention section 101(f) contracts. The rule should be changed to cover the omitted riders and contracts.

- The rule currently appears only to address the addition of riders. The rule should be expanded to include the conformance of an existing rider to any of the Act's requirements, e.g., those of proposed section 818A(b) or (c).

Thus, we respectfully suggest that the transition rule be modified to read as follows (deleted language is stricken, new language is underscored):

> (d) Issuance of Certain Riders Permitted.-- For purposes of ~~determining whether~~ sections 101(f), 7702 or 7702A of the Internal Revenue Code of 1986~~ applies to any contract~~, the issuance, whether before, on, or after December 31, 1995, of a rider on a life insurance contract providing long-term care insurance or accelerated death benefit coverage, or the conformance of such a rider to the requirements of this Act, shall not be treated as a modification or material change of such contract.

Long-Term Care Acceleration and "Non-Acceleration" Riders

It is our understanding that the treatment of long-term care benefits under H.R. 8 has been bifurcated, so that benefits from "non-acceleration" long-term care riders are addressed in section 301 of the bill (in proposed section 818A(d) of the Code) and benefits from long-term care acceleration riders are addressed in section 306 of the bill (in proposed section 101(g)(1)(B) of the Code). We believe it is entirely appropriate to address these benefits in the manner done in H.R. 8, given the operation of long-term care acceleration riders. Also, proposed section 818A(d) is necessary given the existence of products such as the extension rider. To alleviate any potential confusion arising from this bifurcated treatment, it would be helpful if this Committee's report, in addressing the accelerated death benefit provisions of H.R. 8, included the following language:

> The treatment of benefits from long-term care insurance riders to life insurance contracts that accelerate the life insurance death benefit is addressed in the accelerated death benefit provisions of the Act. In contrast, the treatment of benefits from other long-term care insurance riders is addressed in the long-term care insurance provisions of the Act.

TESTIMONY OF JENNIFER WARREN
MARKMAN COMPANY

Sharing the Responsibility In Long Term Care

With the Republican's Contract With America, a new opportunity exists to finally create a policy that will have multiple economic and social benefits. The introduction of tax incentives for long term care insurance will have far-reaching repercussions. Long term care costs bore by the public sector amounted to $108 billion in 1993. Medicaid pays for a good portion of our nation's long term care tab by default. Due to Medicaid's role in long term care, people have come to use this system for purposes which were not intended by the taxpayers. Many have stopped planning responsibly knowing that the government will pickup the bill.

About the Long Term Care Market
America is about the face a demographic-induced economic challenge which must be dealt with now in order to maintain fiscal responsibility. In the US, we spent approximately $108 billion in 1993; the government paid for about 65 percent of the total expenditures. The 32 million Americans aged 65 and over will double to 65 million by the year 2030. The $108 billion long term care figure does not even include acute care spending supported by Medicare. Long term care expenditures have been growing steadily and rapidly. Home health care spending alone will grow at a rate of 12% per annum between 1991-1996; other research indicates a 14.6 % growth rate.

What Should Be Done
A few facts will start the analysis in the proper direction. Medicaid spent $42 billion, mostly for the elderly, on long term care in 1993. It is estimated that 25% to 50% of beneficiaries receiving Medicaid long term care involved some form of divestiture or "spending down" to qualify for Medicaid. Medicare has also entered the long term care arena by discharging beneficiaries sooner from hospitals and there being the need for ongoing care. This has created an area called "post-acute care" which grew at a rate of 37% between 1988- 1991, the amounts being $4.7 billion to $12.2 billion respectively. Post-acute care is comprised of home health care and skilled nursing facilities, both "long term care" providers. Hence, Medicare now pays for small, but growing percent of long term care type services though its intended for acute care needs.

What should be done:

• Provide tax incentives for long term care insurance. Long term care is an additional insurance expense for the elderly just like Medicare Supplement insurance. Since the taxpayers would be partially relieved for some of the elderly's LTC costs by them planning for their own needs, a tax incentive would create a better environment for coverage like the premise of our employer-provided insurance system.

• Stop producing regulation that obstructs the private market for long term care

insurance. The industry is being constantly barraged by a bureaucracy that would ultimately like a public LTC system. Many insurer's have left the market due to perpetual, ongoing regulation. This regulation is causing policies to become more expensive and prohibitive to the middle class who very much needs to purchase the insurance so that taxpayers don't inadvertently pay for their LTC.

These are easily implemented, symbolic gestures that the government can and should initiate. With the focus once again on less government and fiscal responsibility, some honesty about the way things are in our health care and tax system is due. The country of Chile had a bankrupt public pension system; the government allowed the public to choose between contributing to a private scheme or a public scheme. The net result is that most Chileans now contribute to their own private pension and the savings rate for the country as a whole has risen. If you let people do for themselves what they know is right, mostly they will. The obstacle here in long term care is a lack of understanding of what has happened in a system supported by people in government who do not believe in individual's ability to provide for themselves. They have helped create dependence.

Future Market Development

Long term care in its entirety has grown not only from demographics, increased willingness to use health care services and a wealthier, healthier society but from the "deep pockets" of the government. Aside from eligibility restrictions for Medicare and Medicaid to control expenditures, our government simply writes blank checks year after year for long term care. Having some better accountability via the private market which must provide an acceptable service with an acceptable return on investment in order to perpetuate itself is a desired counterbalance to the bloated public arm in long term care financing. The gatekeepers of the public sector are not strong enough with the proper incentives to motivate efficiency and innovation that will be needed to support our aging population with its greater need for health care services.

Tax incentives, as provided in the Contract With America, are a beginning to encourage the further development of a private long term care market. Programs like Medicaid that were designed for the indigent should remain as the safety net they were intended to be. It is simply one more step that needs to be taken by Americans to provide for themselves once again.

TESTIMONY OF VAL J. HALAMANDARIS
NATIONAL ASSOCIATION FOR HOME CARE

The National Association for Home Care (NAHC) represents the nation's home care providers -- including home health agencies, home care aide organizations, and hospices -- and the individuals they serve. NAHC is committed to assuring the availability of humane, cost-effective, high quality home care services to all individuals who require them. Toward this end, NAHC believes that America must do better at ensuring access to high quality home care and hospice in both the acute and long-term care setting. These vital services provide millions of individuals -- the aged, infirm, disabled, and children -- the ability to receive care in the settings that allow them the highest level of satisfaction, independence, and dignity -- in their homes.

The Senior Citizens' Equity Act acknowledges the growing long-term care need in the U.S. Long-term care is one of the most devastating problems America faces today. Estimates indicate that between 9 and 11 million Americans of all ages require long-term care because of chronic illness or disability that render them helpless to perform basic tasks of daily living without assistance. This number could double by the year 2030 to more than 19 million. The need for long-term care is expected to increase substantially as a result of several factors: the burgeoning growth of the elderly population; increased usage of high technology and new medical breakthroughs that may extend the lives of more mentally retarded, developmentally disabled and physically disabled persons; increased survivorship of low birthright children; greater longevity for children with terminal chronic illness, and earlier detection of chronic health problems; and the growth of the number of persons with AIDS.

Spending for long-term care is currently estimated at $57.8 billion. Yet neither Medicare nor private insurance provides adequate protection against the costs of long-tern care. Many families exhaust their emotional and financial resources providing and purchasing long-term care. A million Americans a year are impoverished trying to meet the cost of long-term care left uncovered by insurance. Only the most wealthy of Americans are insulated from the potential financial devastation. The rest can have their lifetime savings wiped out in a matter of months paying for long-term care.

Long-term home care improves the quality of life because it is more humane. It reinforces and supplements the care provided by family members and friends and maintains the recipient's dignity and independence, qualities that are all too often lost in even the best institutions.

Long-term home care services can also be cost-effective. New York State's experience with its Nursing Home Without Walls program is that the great majority of clients who would otherwise need to be placed in a nursing home can be cared for at home for a much lower cost.

Medicaid waiver programs have increasingly relied on home care services as a way to reduce states' long-term care costs. For example, New Mexico's waiver program for people with AIDS estimates a savings of $1,100 a month for patients who use home care rather than skilled nursing facility care. The average patient plan of care costs $1,000 a month for home care compared to $2,100 a month for skilled nursing facility care, according to the program director. Moreover, New Mexico reports that only about 47 percent of patients receiving waiver services are hospitalized in a given year, compared to 70 percent of those not under waiver.

The National Governors' Association (NGA) has recognized the importance of home care services and in a resolution adopted in 1992 stressed the importance of making home- and community-based services a key component of all long-term care policies and programs. NGA recommended elimination of the current institutional bias in public programs for long-term care in favor of home care as a more preferred and cost-effective method of care.

The National Association for Home Care applauds the Committee's commitment to making long-term home care more accessible for the millions of Americans with chronic disabilities. This crucial component of the Contract with America will help make the promise of long-term home care a reality for the young, the elderly, and all disabled Americans. Home care has a long and distinguished history of caring for individuals of all ages in the setting they like best -- in their own homes where they can maintain their dignity, their independence, and their individuality.

Very few individuals can afford to pay for long-term care at home or in a nursing home out of their own pockets, and yet neither Medicare nor private insurance cover those services to any great degree. Private long-term care insurance policies first appeared on the market nearly 17 years ago, but have grown dramatically in the past several years. Between 1987 and 1991, companies offering policies increased from 75 to more than 130. Although the proliferation of policies has created competition among insurers to significantly improve their products, problems remain in even the most improved policies.

Regulation of the private long-term care insurance market is left up to the states and the National Association of Insurance Commissioners (NAIC) has recommended model laws and regulations. Nearly all states have adopted the NAIC model act, but only 28 states have issued regulations, only 14 require any form of inflation protection, and only 12 have issued home care coverage standards.

Ongoing problems with high lapse rates, coupled with persistent reports about abusive sales tactics, has fueled concern over the ability of states to regulate the private long-term care insurance market to ensure the sale of high quality products and protect consumers from fraud and abuse.

NAHC supports Congressional action to create favorable tax incentives to promote the purchase of long-term care insurance that meet federally established minimum standards by those who can afford it. Tax incentives are especially needed to foster development of long-term care insurance through employer based plans and vested retirement funds. Employment based plans could be more attractive and affordable and extend coverage to the largest number of people. Congress should clarify whether tax exempt status applies to long-term care insurance reserves held by insurers and to the investment earnings credited to them.

Present restrictions on buying long-term care insurance through cafeteria plans and flexible spending accounts should be removed. In addition, individuals should be allowed, before and after retirement, to use money accumulated in pension plans, individual retirement accounts, and life insurance policies for long-term home care needs without penalties or loss of tax deductions. In the alternative, Congress should allow tax deductions for individuals who establish individual medical accounts devoted to long-term care needs.

The Senior Citizens' Equity Act would address two of these issues. Section 302 would allow employers to provide employees with tax free long-term care insurance and to permit exclusion for benefits provided under long-term care insurance. This provision could help promote the growth of the group market for younger purchasers and should be extended to employees who purchase the policies for their parents.

Section 305 of the Act would permit tax free distributions from IRAs and 401(k) plans to purchase long-term care insurance. NAHC supports this provision as well.

Probably the provision in the Act that may be most valuable to individuals in need of long-term care and their families is Section 303(a) which would treat qualified long-term care services as medical care for purposes of the medical expense deduction currently allowed when such expenses are in excess of 7.5 percent of adjusted gross income. This benefit would not be limited to those who purchase private long-term care insurance and would help all families burdened with out of pocket long-term care expenses.

This proposal could even help to delay nursing home placement and help individuals avoid having to spend down their life savings in order to qualify for Medicaid nursing home coverage.

However, tax incentives for the purchase of long-term care insurance must be accompanied by aggressive minimum standards and consumer protections for long-term care insurance. Policies should not be sold, and certainly should not be given preferential tax treatment, that do not meet strict federal consumer protection standards. Only in this way will Congress ensure that individual purchasers are guaranteed a high quality product that will provide them with the measure of protection they expect when purchasing long-term care insurance. Federal tax incentives should not be available for the purchase of inferior policies that offer only hollow promises.

Just as Congress, in 1990, established federal minimum standards for the sale of Medicare supplemental insurance (Medigap) policies, so should Congress establish minimum federal standards for the sale of long-term care insurance policies. These standards should, at a minimum, specify coverage standards for home care and hospice services, require inflation protection and nonforfeiture benefits, and regulate sales practices.

Probably the greatest coverage failing with private long-term care insurance today is the inadequate coverage that most of these policies provide for long-term home care -- undoubtedly the benefit most purchasers prefer over nursing home care. Private policies provide very poor coverage for long-term home care needs. Some companies limit home care coverage by requiring prior nursing home care, paying only a small fraction of the nursing home benefit, covering only medically necessary services, and excluding coverage for home care aide services. Mandatory federal minimum standards for home care coverage can help address this failing, and help make private long-term care insurance policies more attractive to consumers.

State attempts to regulate the private long-term care insurance market have had only limited success. In the absence of federal regulation, it is up to consumers to carefully sort through the myriad policies, riders and features to find an affordable reliable plan. The choices are complex and the figures easily manipulated. Only by mandating federal standards for long-term care insurance will all consumers be protected. Regulation of the market will foster confidence among consumers that private long-term care insurance constitutes a viable option for their protection from large out of pocket expenses in the event that they may need long-term care services.

While NAHC supports tax incentives to purchase long-term care insurance policies, we believe that the Senior Citizen's Equity Act, by restricting use of home care benefits only to cases where they would prevent institutionalization, would severely and unnecessarily hinder a policyholder's choice of health delivery systems.

Home care has long been recognized as an appropriate and cost-effective method for delivery of acute care, as well as long-term care services. Home care has been a mandatory benefit under Medicare since its inception. In addition, federal requirements for health maintenance organizations have, since 1973, mandated the provision of home health services "without limitation as to time or cost." Under employer-sponsored plans, home care is widely available. A survey by the Health Insurance Association of America found that 83-89% of insured employees had coverage for home health services.

Limiting the home health benefit as an alternative to institutionalization could become an administrative quagmire that would restrict access to appropriate in-home care for patients who are not able to prove to their health plans' satisfaction that without home care services they would be institutionalized. Patients should be entitled to receive health services in the most appropriate and least restrictive setting -- be it in the home, skilled nursing facility, hospital or some other setting.

It is the responsibility of the physician to weigh the alternative delivery methods and choose the most appropriate course of treatment.

Moreover, limiting home health benefits to coverage only as an alternative to inpatient treatment would exclude coverage of many patients who clearly need in-home services but do not require an institutional level of services. For example, it is often appropriate to provide monthly catheter changes for patients with multiple sclerosis or other neurological disorders in their homes because of the problems of transporting them by van or ambulance to a medical facility. Moreover, there are other home care patients for whom institutionalization is unnecessary such as blind insulin dependent diabetics, ventilator dependent children, patients with mild strokes, acute infections, chronic asthma or those needing outpatient surgery and control medications.

For the reasons stated above, we urge you to amend the Senior Citizens Equity Act to allow preferential tax treatment for long-term care insurance policies that cover home care without regard to whether institutionalization would occur without this care.

Inadequate access to long-term home care is one of the most devastating problems facing America. Although private long-term care insurance will not be a total solution for financing long-term care, it can help protect some people against large out of pocket expenses. It gives some individuals the opportunity to retain choices and develop a flexible, planned response to a potentially ruinous event that will confront many people over 65 as well as many disabled people under 65.

Thank you for your interest in this important area and for the opportunity to present our views for consideration by the Committee.

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TESTIMONY OF SPENCER A. LEHMANN, RHU
NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

SUBCOMMITTEE ON HEALTH

Dear Mr. Chairman, Mr. Stark, Members of the Committee:

I thank you for the opportunity to give testimony on behalf of the **National Association of Health Underwriters (NAHU)** regarding the Senior Citizens' Equity Act and to specifically address long term care insurance tax deductibility issues, long term care insurance minimum standards and agent educational requirements.

My name is Spencer Lehmann. I am advisor to the **National Association of Health Underwriters (NAHU)** on senior health care issues and served on the Board of Trustees as chairman of the Health Insurance Training Council. I am past president of the Washington State Association of Health Underwriters and a member of the Washington State Insurance Commissioner's advisory committee. I have 27 years of experience in the insurance business and am principal in Lehmann-Wood Associates, an agency in Bellevue, Washington, specializing in group and individual long term care insurance. I am also author of a monthly column on long term care for the *Health Insurance Underwriter*, **NAHU's** national monthly magazine.

With more than 13,000 members, **NAHU** is the largest and only independent association representing professional insurance benefit advisors specializing in health insurance in the U.S.

The National Association of Health Underwriters appreciates this opportunity to submit testimony regarding the Senior Citizens' Equity Act. We would like to specifically address long term care insurance tax deductibility issues, long term care insurance minimum standards, and long term care insurance agent educational requirements.

Prefacing our specific comments we offer the following for consideration: The subject of long term care is not a concern exclusive to the senior population. Long term care affects citizens of all ages. Recent studies have shown that the possibility of needing long term care can be as great as one chance in four for those who are under 79 years of age, and one chance in two for those who are 80 years of age and older. The results of a study published in the New England Journal of Medicine in May 1992 revealed that of those Americans who turned 65 in 1990, 43% will live in a nursing facility at least once during their lifetime. Many who are under the age of 65 experience medical trauma and chronic disability due to accidents or illness and will undergo long term care in both rehabilitative and custodial settings.

Long term care insurance first became available in the early 1970's and has evolved exponentially since it was first introduced. The vast majority of policies now being offered contain very liberal benefit triggers. Most require that the claimant meet one of the three criteria in order to be eligible for benefits: medical necessity; the inability to perform two or more of the activities of daily living (ADL's), most commonly defined as eating, dressing, transferring, bathing, toileting, and continence; and cognitive development. We no longer find unrealistic gatekeeping hurdles such as a three-day prior hospital requirement, nor entry to nursing facilities at a level of care higher than custodial, unlike Medicare.

The need for long term care as an integral component in health care delivery continues to grow as our society ages, lives longer, and endeavors to contain escalating health care costs. Funding for long term care delivery is available from only three primary sources; personal income and assets, Medicaid, and private long term care insurance. Unless a private long term care insurance policy is already in place, once personal assets have been exhausted Medicaid becomes the only viable funding source for the long term care patient. In the 1988 study performed by the Long Term Care Task Force of Health and Human Services, under the auspices of Dr. Otis Bowen, private long term care insurance was found to be the most cost effective method of funding long term care. That is still the case today.

We have been embroiled in health care reform debate for several years. One outcome of that debate has been the recognition that long term care funding carries too high a price to be included in any government program as another entitlement whose cost would be borne by the already overburdened US taxpayer. It has become equally clear that we must now promote health care reform legislation that will encourage a philosophy of individual responsibility, and not

"societal welfare-ism." To that end, preferential tax treatment of long term care insurance premiums is imperative. Additionally, all states should be encouraged to establish long term care public/private partnerships, such as the Connecticut Partnership. Further, a floor of long term care insurance minimum standards should be recommended for all states, and educational programs should be developed for all agents and home office personnel involved in marketing long term care insurance.

The National Association of Health Underwriters suggests that regarding:

1. **Tax issues**: all premiums paid for long term care insurance should be tax deductible. Employer contributions to long term care insurance premiums should be tax deductible to the employer. Policy benefits for long term care should be tax free, and long term care expenses should be viewed as a deductible medical expense.

2. **Individual responsibility incentives**: public/private long term care partnerships, such as those established in Connecticut, New York, California, Indiana, Illinois, and Maryland should be encouraged in all states. The asset protections afforded by these partnerships serve as model incentives for the states to promote to their citizens in an effort to encourage their citizens to purchase long term care insurance and not have to access Medicaid. The discriminatory provision in the "Waxman Amendment" in OBRA 93 relating to the public/private partnerships and addressing estate recovery after the death of the "well spouse" should be repealed. Individual responsibility needs to be encouraged and the public/private partnerships offer a viable means of achieving that goal.

3. **Consumer protection**: Minimum standards should be enacted by all states regarding long term care insurance policy components. It is critical that these standards meet the test of protecting the consumer without infringing on the consumers' right to choice, and not inhibiting policy benefit innovation. Certain components of the NAIC Long Term Care Insurance Model would protect the consumer to the extreme, deny the consumer choice, and drive the cost of long term care insurance up so dramatically that many would not be able to find affordable coverage. Examples of these onerous components are mandated non-forfeiture benefits and rate stabilization.

4. **Educational requirements**: Insurers should establish long term care insurance education programs for agents. In states requiring continuing education, agents marketing long term care should have to meet a minimum number of credits in long term care insurance. States not presently requiring continuing education should be encouraged to do so.

5. **Additional consumer protections we suggest**: Federal standards should be developed requiring that licensing forms. policy forms, disclosure forms, replacement forms, medical authorization forms, and claim forms be uniform. Further, all physicians, medical clinics, labs, hospitals and all other health care deliverers and providers should be required to accept the standardized forms. Implementation of standardized forms is a needed component in cost containment and will help reduce consumer confusion.

The National Association of Health Underwriters applauds the efforts of the sponsors of the Senior Citizens' Equity Act for recognizing the need to develop incentives to encourage the growth of the private long term care insurance market, and to encourage the citizens of our country to be individually and socially responsible. A commitment by the public and private

sectors to work together in an effort to develop strong and responsible long term care financing solutions is imperative to the future financial strength of our country, and its citizens.

The National Association of Health Underwriters would like to serve as a resource for, and stands ready to assist in any way that it can, the members of Congress and the Administration as we move forward in developing solutions to the important problems in long term care financing that face us today.

We thank you for this opportunity to contribute our remarks.

GEORGE ROSS FISHER, M. D.
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Long-Term Care Tax Clarification

(Testimony Submitted to Committee on Ways and Means, Health Subcommittee, Congressman Bill Thomas, Chairman)

George Ross Fisher, MD
Trustee for Philadelphia, Pennsylvania Medical Society

In response to your public invitation for testimony on this important subject, I submit the following simple suggestion, which I believe would make an important contribution.

Retired persons can be generally divided into the group younger than roughly age 80, who are vigorous and active, and those over roughly age 80 who are often or mostly infirm and needful of assistance. Members of both groups are concerned about limited finances.

Many voluntary organizations and organized retirement communities are composed of members of both groups. That is, some are passing through each stage of retired life. The thought has occurred to many such organizations that the younger group might volunteer to help the older ones, looking forward to the day when they would be needful themselves.

Unfortunately, the Internal Revenue Service has taken a position that such activity is equivalent to in-kind income, subject to income tax. While voluntarism will always be a vigorous part of the character of most Americans, nevertheless the IRS policy has a chilling effect on the incentives to do a little more. It is particularly chilling to more organized concepts of accumulating service credits or transferable vouchers. Many seniors might want to perform volunteer work in a location different from the location where they might later receive some benefit themselves. And some forms of volunteer effort are less attractive than others, so that availability may not match the actual need, unless some more organized recognition were made possible .

Mr. Chairman, I will not further embroider on this idea, whose consequences seem self-evident. I hope your subcommittee can consider it.

TESTIMONY OF
CONGRESSMAN CHRISTOPHER SHAYS

BEFORE THE
HOUSE WAYS AND MEANS COMMITTEE

Chairman Archer, Congressman Gibbons, and members of the Committee, thank you for providing me the opportunity to testify before your committee to discuss the five bills within the Contract With America that are under the committee's jurisdiction. This is an important part of moving the contract forward. I would like to take this opportunity to share my views with you on these five proposals.

I. THE AMERICAN DREAM RESTORATION ACT

H.R. 6, the American Dream Restoration Act, of which I am a cosponsor, will help restore economic viability to the American family, and promote greater individual savings.

As you know, the bill provides a tax credit of up to $500 per child for families with incomes under $250,000. Phase out of the credit would begin at $200,000, with full phase out at $250,000.

The legislation also provides tax credits to individual affected by the marriage penalty, which occurs when a married couple pays more as a couple than they would as individuals.

Finally, the legislation creates a new type of Individual Retirement Account (IRA) which would permit individuals with any income level to contribute up to $2,000 per year ($4,000 for married couples) into a new IRA, called the American Dream Savings Account (ADSA). These new accounts differ from conventional IRAs in that individuals would pay income tax on contributions to the accounts, but would be able to make withdrawals tax free. Current IRA participants would be allowed a two-year window to roll over existing IRAs into an ADSA.

I strongly support these provisions. As you may know, the Republican Budget Alternative for fiscal year 1995 (FY 95), written by the Republicans on the Budget Committee, included provisions providing for expanded IRAs and a $500 tax credit per child. Our alternative budget not only provided for greater deficit reduction in FY 95 than the President's budget but also paid for the tax incentives. It is equally important that the tax provisions in H.R. 6 and all the tax provisions within the Contract With America be paid for. Tax provisions will not help if ultimately they contribute to the federal budget deficits.

II. THE JOB CREATION AND WAGE ENHANCEMENT ACT

H.R. 9 is an effort to do just what its title states -- help create jobs and enhance the wages of American workers.

Small business continues to be the job creator in our economy, but federal taxes and regulations have stifled small business creation. While the United States and the Soviet Union were fighting the Cold War, our trading partners in Europe and Asia have been fighting an economic war. It is essential that we provide ways to help businesses advance in the global market. This bill is an effort to create a better environment for growth in what has become a very competitive global economy.

I support the tax provisions in H.R. 9, which include: cutting the capital gains tax; increasing capital investment depreciation; raising the estate tax exemption; providing greater expensing on equipment for small businesses; and restoring the deduction for individuals who work out of their homes.

One of the ways we can help businesses is by reducing the burden of

taxes. As you know, the bill provides a 50 percent capital gains tax rate cut and prospectively indexes capital gains to account for inflation. It will reduce the current tax rate from 39.6 percent to 19.8 percent. It also allows those who lose money on the sale of their home the ability to deduct the loss from their taxable income.

The neutral cost recovery system allows businesses to depreciate the original cost over the life of the equipment, plus inflation, plus 3.5 percent each year. This provides the opportunity for businesses to deduct the true value of this investment by factoring in the effect of inflation.

Accordingly, businesses that invest less than $200,000 in depreciable property each year will be able to receive an immediate $25,000 deduction on the purchase of new equipment, which represents an increase of $7,500.

Also included in the bill is an increase in the exemption of the estate tax from $600,000 to $750,000. The increase in the exemption is phased in beginning at $700,000 in 1996 and increasing $25,000 over the next two years.

H.R. 9 also clarifies current regulations concerning the deduction of home office expenses by allowing those who perform essential administrative and managerial duties of the business in their homes to take these costs as a business deduction.

Under the Taxpayer Debt Buy-down provision, taxpayers could designate up to 10 percent of their taxes to reduce the federal debt. Congress would be required to reduce government spending by the amount in the Public Debt Reduction Fund or mandatory sequestration would take effect. The Congressional Budget Office (CBO) has calculated that if all taxpayers checked off the maximum level of 10 percent, and Congress was then forced to make the reductions in spending necessary to comply, the federal budget deficits would be eliminated by the year 2000. While I cosponsored the Taxpayer Debt By-down last Congress when it was introduced as a separate bill by Congressman Bob Walker of Pennsylvania, I believe this provision of H.R. 9 should not be included if the balanced budget amendment is ultimately ratified.

The Taxpayers Debt Buy-down provision is a tool to force Congress to reduce our annual federal budget deficits, but in my opinion, the constitutional amendment is a far stronger tool. I believe it might be ultimately harmful to our economy if both the Taxpayer Debt Buy-down and the balanced budget amendment were in place.

While I support many of the provisions in this bill, I have concerns with Title IX: Private Property Rights Protections and Compensation. As you know, under this provision private property owners would be compensated by the Federal Government if the use of their property is limited as a result of actions taken by the Federal Government.

I agree private property owners should be protected from undue financial harm caused by an overzealous federal government. But the Fifth Amendment of the Constitution provides this protection and the courts have, in most cases, been an appropriate forum to address these issues.

Title IX raises several questions that I would like to share with you. One question I have is related to retroactivity. I am unclear as to whether people would be able to receive compensation for property depreciation as a result of a regulation that is already in place. If this is the case, it seems the bill would open up the possibility for people to apply for compensation above and beyond what was paid for the property.

It is also unclear whether H.R. 9 would apply to potential loss of property value, or just actual loss. For example, suppose an individual planned to build an apartment complex on a piece of property, but then found out that an endangered species lived on the land. It is not clear to me if property owners would be compensated for the potential increased revenue that might have

been gained had the apartment complex been built. It seems it would be difficult to determine the amount of compensation due a property owner under this type of scenario.

Another issue raised by the bill's provisions is that of direct versus indirect loss of property value. Most property value is in some way linked to other nearby property. If a wetlands regulation meant that an amusement park couldn't be built in a particular community, I am unclear whether a neighboring property owner could receive compensation because his plans to develop the land based on the development of the neighboring amusement park were no longer economically viable.

I recognize that regulations sometimes result in decreased property value, but they also can result in increased property value. The federal government does not expect to be compensated for such "givings," and it seems to me this understanding should be a part of the debate on "takings."

Clearly, compensation under this bill could be extraordinarily expensive. By requiring agencies to use their own appropriations to fund the compensation, the intent seems to encourage agencies to loosen regulations. But we, as lawmakers, must hold ourselves accountable for making good laws that make sense. If we feel a law does not make sense, we should change it.

Finally, I wish to express my concern about how this law might affect our environment. Our nation's environmental laws and regulations were created to protect the health, lives and safety of American citizens. In addition, they aim to preserve and protect our natural resources for future generations to use and enjoy. This lofty goal should not be taken lightly and we must take responsibility for achieving and maintaining it. Environmental laws and regulations need to be debated, and at the end of that debate some laws might need to be strengthened, and others weakened. But they should be assessed based on the merits, and not on the broad ramifications that could result if Title IX of H.R. 9 became law.

My staff and I have spoken with many people and organizations who have brought up these and other questions regarding possible scenarios under which people could be compensated under Title IX.

These concerns, among others, lead me to believe that the issue of federal takings is best left up to the courts. Every claim will be different, and should be decided on a case-by-case basis, not on a sweeping law open to wide interpretation.

If we decide that Congress, not the courts, is that best forum for deciding the issue of "takings," I hope some changes will be made to the pending legislation. I support raising the percentage of property loss meriting compensation. In addition, I hope that any "takings" legislation passed by Congress is more narrow in scope, so the ambiguities such as the ones I have outlined are made clear.

III. THE FAMILY REINFORCEMENT ACT

I would also like to thank you for allowing me to testify on H.R. 11, I am proud to be a cosponsor of this important legislation.

The Family Reinforcement Act, of which I am a cosponsor, offers tax relief for an already overburdened middle class by providing credits in two areas which have previously been overlooked. The $500 per person eldercare credit will give needed assistance to families who are caring for the elderly, and the $5,000 credit for adoption expenses will help find new homes for displaced children.

Another area which needs strengthening is child support enforcement. H.R. 11 includes provisions that help prevent non-custodial parents from turning their backs on their children. Given the fact that child support payments often determine whether a family remains financially stable or is reduced to poverty, it is imperative our government actively and vigorously enforce child support regulations.

A third provision of the Family Reinforcement Act which I believe is extremely important is the increase in sentences for sexual offenses against children. I am glad the bill also provides for a minimum three year sentence for anyone who forces children into prostitution, a provision I strongly support. It is about time criminals who commit such horrific acts on our children begin to pay for their crimes.

It is my hope the passage of H.R. 11 will be a major step in ensuring that the interests and needs of our children are protected. This bill will offer a better, brighter future for the families of our great nation.

IV. THE SENIOR CITIZENS EQUITY ACT

I would like to express my support for the provisions of the Senior Citizens' Equity Act which would raise the earnings limitation on older Americans, and commend the Ways and Means Committee for acting so promptly in the 104th Congress to correct this injustice.

I believe Social Security recipients who want to continue working should be able to earn outside income without being penalized. Senior citizens, like any other group of Americans, have a right to work to achieve financial independence without being penalized by the federal government.

Unfortunately, that is not currently the case. The earnings test imposed on senior citizens, taxing their Social Security benefits if they earn more than a certain amount, is an unfair punishment for those who wish to stay productive and contribute to our economy.

Persons aged 65 to 69 can receive full benefits as long as they earn no more than $11,160 in outside income. Benefits under this category are reduced $1 for every $3 earned above this amount. For those citizens 70 years old or older there is no earnings test.

The Senior Citizens Fairness Act, of which I am a cosponsor, would phase in an increase of the earnings limit over five years, raising it to $15,000 in 1996, $19,000 in 1997, $23,000 in 1998, $27,000 in 1999 and $30,000 in 2000.

Support for this change is strong, both from the public and here in Congress. We cannot afford to ignore the experience and professionalism older Americans bring to our workforce. In addition, these older Americans will be working longer and paying more taxes.

The earnings test, developed during a depressed economic environment, was designed to drive workers out of scarce jobs. Its repeal is long past due as a recognition of the changing needs of businesses struggling to find qualified workers and remain competitive.

V. THE PERSONAL RESPONSIBILITY ACT

As this committee knows all too well, many welfare recipients view employment as a threat to their standard of living. We have created a culture of dependency where getting a job may actually result in a decreased income. This must end. We must change the welfare state so that people are encouraged to work and save in an effort to become self-sufficient.

In a perfect world, certain provisions of H.R. 4, the Personal Responsibility Act, could be seen as outdated, but unfortunately we do not live in a perfect world. When you have 12 year-olds having babies, 14 year-olds selling drugs, 15 year-olds killing each other, 18 year-olds who can't even read their own diplomas, and 30 year olds who have never held a job, you see that measures such as orphanages and foster homes must be considered as possible solutions in reforming the existing welfare system.

We also need to encourage our young people to focus on moral living. Government legislates immorality when it encourages our children to have babies out of wedlock rather than in wedlock and doesn't hold the fathers accountable.

H.R. 4 contains provisions, which I support, that reform our welfare system and provide greater control to the states in the use of federal welfare funds.

The legislation will terminate Aid to Families with Dependent Children (AFDC) payments to unwed mothers under age 18 and their children, while allowing the states to have the option to extend payments between the ages of 18-20. The savings from these programs will then be given to the states in the form of block grants. These block grants may be used to establish orphanages or group homes for unwed mothers. Also H.R. 4 requires paternity to be established to receive full benefits.

The Personal Responsibility Act also will eliminate welfare benefits to legal permanent residents. I support placing this limitation on federal assistance programs because it will preserve the original intent of social service programs -- to protect citizens of our country -- and discourage immigrants who come to the United States intending to apply for benefits.

There is one element of H.R. 4, however, that gravely concerns me. I am opposed to any provision that would silence health professionals from advising their clients about abortion services. I believe the government has no business interfering in the relationship between a doctor and their patient. The "gag rule" denies all women, especially those less fortunate, information about the full range of available medical options. This could cause them to make uninformed decisions and deprive them of needed medical services. I have always voted against the "gag rule provision" and will do so again should this language remain in H.R. 4.

A fifth provision of the Personal Responsibility Act is the consolidation of 10 nutrition programs such as food stamps, Supplemental Nutrition for Women, Infants and Children (WIC), and the school lunch and breakfast program into 1 block grant. I support this idea because I believe each state and town should be able to decide where it can best use the money. For some it may be in the schools, while others may desire to utilize the moneys to strengthen the food stamp program. I also believe competition is important and only those programs which truly need the funding will receive them under this proposal.

Thank you for your consideration of this testimony.

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