REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

STUDY OF PUBLIC-PRIVATE PARTNERSHIPS TO ENCOURAGE THE PURCHASE OF LONG-TERM CARE INSURANCE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Study of Public-Private Partnerships to Encourage the Purchase of Long-Term Care Insurance

Executive Summary

Study Origin Two resolutions (House Joint Resolution 688 and Senate Joint Resolution 304) passed in the 1993 General Assembly Session requested the Department of Medical Assistance Services in cooperation with the State Corporation Commission's Bureau of Insurance to study of the advantages of public-private partnerships which other states have implemented to encourage the purchase of long-term care insurance.

Background Recognizing the growing elderly population that will potentially require long-term care services and the increasing costs of these services, several states have explored methods to encourage the purchase of long-term care insurance. At present, most long-term care is paid by public funds, primarily the Medicaid program. Older persons may be unprepared for the expenses of long-term care and need to use the Medicaid program after exhausting personal resources. Some people transfer their assets and deliberately impoverish themselves in order to qualify for Medicaid and preserve their assets for inheritance.

Long-term care insurance accounts for a very small amount of long-term care expenditures. Consumer demand remains low despite improvements in the products and greater availability. A decade ago, long-term care insurance was not even defined as a distinct product in state statutes. In 1987, legislation established long-term care insurance as a specific type of insurance and in 1992, regulations became effective that further defined the intent of the law. At present 40 companies are authorized to sell long-term care insurance products in Virginia. Products available are superior to insurance available even five years ago in terms of useful benefits to the consumer.

In 1988, the Robert Wood Johnson Foundation funded eight states to study public-private partnerships to encourage long-term care insurance and reduce reliance on Medicaid. Four states were funded to develop programs: Connecticut, New York, California, and Indiana. Additionally, Massachusetts has developed a program and Iowa has a program in development. The programs differ in details but all allow Medicaid funding to be used once private insurance has been exhausted without requiring impoverishment. By offering protection of assets as an incentive the states hope to encourage more use of private insurance for long-term care.

Legislation enacted by Congress in August 1993 made the public-private partnerships a less attractive option for states. This study concludes that this model is not a viable alternative for Virginia at this time. Therefore, other methods to encourage purchase of long-term care insurance were also examined and are presented in this report.

Findings and Recommendations

The public-private partnerships, though not a viable option for Virginia at this time, may develop useful models in terms of consumer education and other methods to make long-term care insurance more attractive to purchasers. Therefore, continued monitoring of the programs will be useful.

> **Recommendation 1:** *The Department of Medical Assistance Services should continue to monitor the public-private partnerships established in six other states to encourage the purchase of long-term care insurance, and as appropriate, make recommendations concerning ideas appropriate for implementation in Virginia.*

Tax incentives can include income tax deductions and credits for related expenses like premiums, deductions and co-payments, and exclusion of benefits paid out under an insurance plan. These incentives may be viable methods to encourage the purchase of long-term care insurance, especially among working individuals. The President's proposed health reform plan includes provisions for tax incentives for purchasers of long-term care insurance.

> **Recommendation 2:** *A survey should be conducted to determine whether state tax incentives such as tax credits, deductions or other incentives to encourage the purchase of long-term care insurance by employers, employees or individuals should be implemented in Virginia. Survey results should be provided to the Joint Commission on Health Care in 1994.*

Offering coverage through employer groups makes premiums more affordable and may make purchasing long-term care insurance easier and more attractive. In 1991, 360 employers nationwide offered long-term care insurance including four state governments. A 1993 poll indicated that 65 percent of those surveyed would buy long-term care insurance from an insurance company or through their employer if available.

> **Recommendation 3:** *The Secretary of Administration should consider the feasibility of providing a group long-term care insurance policy option to employees of the Commonwealth. The study should include but not be limited to the costs of such a program, the design of the benefits package to be offered, the projected participation rate, and if appropriate, the projected start date.*

The public still has many misconceptions about long-term care financing. About half believe that Medicare pays for long-term care services. Better informed consumers can make better decisions about their needs and choices regarding long-term care, including long-term care insurance. The Virginia Department for the Aging and the State Corporation Commission's Bureau of Insurance currently provide a range of consumer education services for senior persons. Expanded education efforts could increase the knowledge level of the public and provide assistance when specific information is required.

> **Recommendation 4:** *The Virginia Department for the Aging and the State Corporation Commission's Bureau of Insurance should identify methods to expand consumer education concerning long-term care financing and options available. Programs targeting both older Virginians and younger age groups should be considered.*

STUDY OF PUBLIC-PRIVATE PARTNERSHIPS TO ENCOURAGE THE PURCHASE OF LONG-TERM CARE INSURANCE

Study Mandate

The 1993 General Assembly passed Senate Joint Resolution No. 304 and House Joint Resolution No. 688 requesting the Department of Medical Assistance Services (DMAS), in cooperation with the State Corporation Commission's (SCC) Bureau of Insurance, study public-private partnerships to encourage the purchase of long-term care insurance.

Specifically, the resolutions directed the agencies to study the advantages of public-private partnerships encouraging the purchase of long-term care insurance which other states have implemented, to analyze the programs in other states, and to address policy questions including: i) who should negotiate nursing home rates used by insurance companies; ii) what eligibility criteria are appropriate; iii) who is the most effective gatekeeper - the state or private care manager, and; iv) what is the appropriate amount of coverage.

I. INTRODUCTION

This report, requested by Senate Joint Resolution 304 and House Joint Resolution 688, reviews the public-private long-term care insurance programs of several states. Due to concern about increasing Medicaid expenditures for long-term care, these states have explored methods for greater use of private resources in providing for long-term care. The intent is to reduce the pressure on public funding and provide an affordable means for individuals to provide for long-term care if needed.

In Virginia, like most of the nation, a growing elderly population in need of long-term care services is putting increasing demand on resources to pay for this care. Public funds have become a major source of funding for nursing home care, the dominant form of long-term care services. In Virginia, Medicaid pays about 60 percent of total nursing home costs. The program's expenditures for nursing home services reached approximately $364 million in fiscal year 1993. Although most Medicaid long-term care recipients are impoverished, some individuals transfer their assets to family members rather than spend them on long-term care, and then qualify for Medicaid coverage These actions place an even greater burden upon the public funds of the Medicaid program,

designed to benefit only the truly indigent.

The public-private partnership programs were examined, as directed by the study resolutions, as a potentially viable model for replication in Virginia. In August 1993, however, passage by Congress of an amendment to Title XIX (Medicaid) made this model much less attractive. This study, therefore, also identifies some alternative methods to encourage greater use of private long-term care insurance in Virginia. Additionally, the policy questions in the study resolutions concerning nursing home rates, coverage and admission criteria to be used in a public-private partnership program are not addressed in this report, as these policy issues no longer have applicability if the program will not become operational.

II. ISSUE OVERVIEW

Long -Term Care Expenditures and Sources of Financing

Concern about financing for long-term care reflects the increase in expenditures in this area and the increasing reliance upon public dollars. Spending for nursing home care nationally increased sixty-fold from 1960 to 1991, from $1.0 billion to almost $59.9 billion. During the same period, funding shifted from private to public sources. In 1960, 80 percent of nursing home care was paid by out-of-pocket payments and 20 percent by third party payors. In 1991, 43 percent of costs were paid out-of-pocket and 57 percent by third party payors, primarily public programs.

Nationally, public funding for nursing home care accounted for $32.3 billion in 1991. Medicaid dollars represented almost half of total nursing home payments (47%), while private insurance represented only about 1 percent.

The following table breaks down national and Virginia spending for nursing home care by sources of funding.

Expenditures by Payment Source

Sources of Funding	U.S. CY 1991 (Expenditures)	VA FY 1990 (Days of Care)
Medicaid	47 %	60 %
Medicare	4 %	2 %
Out-of-Pocket	43 %	35 %
Private Insurance	1 %	3 %
Other Private	2 %	na

Source: Virginia data: Medicaid Asset Transfers and Estate Recovery, Joint Legislative Audit and Review Commission, 1993. National data: Health Care Financing Review, Winter 1992.

Medicaid as the Primary Long-Term Care Payor

Medicaid has developed into the major payor for long-term care services. In Virginia, recipients of long-term care services represent only ten percent of Medicaid recipients, but the cost of their care ($512 million in FY 93) accounts for over half of Medicaid spending.

Medicaid is designed to ensure that indigent individuals have access to necessary health services, including long-term care. Individuals are allowed limited incomes and assets in order to be eligible for the program.

Some individuals receiving Medicaid are already impoverished upon entry to a nursing facility. Additionally, many people entering nursing homes as private pay patients eventually spend their resources to a point of impoverishment and then must rely upon Medicaid to continue their care. Particularly affected are middle income individuals, whose resources initially are too high to qualify for Medicaid yet who may have insufficient funds for an extended period of long-term care. Individuals eventually exhaust their assets on medical care before qualifying for Medicaid, spending intended bequests and potentially reducing the living standards of their dependents.

However, there is evidence that persons who would not otherwise qualify for Medicaid set up trusts or use other transfer mechanisms to divest and protect their assets while qualifying for Medicaid benefits. Recognizing this, Congress recently tightened transfer of assets rules. Other "loopholes" allowing establishment of trusts and other mechanisms for asset protection were also restricted. As noted previously, a major incentive for developing long-term care insurance public-private partnerships has been reducing the incentive for transferring or otherwise protecting assets in order to qualify for Medicaid.

There is no evidence that transfer of assets is an extensive problem in Virginia, according to a Joint Legislative Audit and Review Committee (JLARC) report published in 1993. At the same time, however, anecdotal evidence, including publications and seminars specifically targeting the public, suggests that there is a market for information about such activity. The JLARC report also cautions that this activity may expand in the future.

Issues in Long-Term Care Insurance

Long-term care insurance has been offered nationally for more than a decade. Barriers to the purchase of long-term care insurance identified in the 1980's were a lack of consumer awareness, limited availability of insurance products and problems with the coverage offered by the products. Initial concerns about the products have been

addressed: efforts to improve the policy design, including services covered and length of coverage, have seen some success. (Appendix A provides a summary of state and national efforts to standardize and improve long-term care insurance products.)

Still, the level of insurance purchased is below what experts feel is necessary to ensure protection for those who will need long-term care. Despite product improvements, there is very limited demand from the public. Of those who do purchase polices, most people delay buying policies until their sixties when policies are more expensive and lifetime coverage particularly so. Yet to distribute the risk of long-term care and make insurance premiums more affordable requires greater demand by a younger population than currently exists. More must be done if long-term care insurance is to be a significant factor in the financing of health care for older Virginians.

Several issues seem to influence the public's purchasing behavior regarding long-term care insurance. These factors are discussed below.

Availability of Long-Term Care Insurance

Long-term care insurance has been sold in Virginia since 1987. Prior to 1987, approximately 14 companies in Virginia sold what is now known as long-term care insurance. Virginia was much like the rest of the country; until that time there were few states that even defined "long-term care" as a type of insurance.

Currently, there are approximately 40 companies with long-term care policies approved for sale in Virginia that have complied with Insurance Regulation No. 40. (The State Corporation Commission's Insurance Regulation No. 40, Rules Governing Long-Term Care Insurance, which further defines the statutory requirements mandated by the 1987 law, became effective January 1992.)

The contracts being offered in Virginia at the present time include group contracts, i.e. contracts that can be sold to employers, and individual contracts. One of the group contracts approved for sale, for example, includes coverage for adult day care, home care or home health care, a respite benefit, hospice care and ambulance service. Optional benefits under the product include an annual benefit increase, inflation protection and return of premium on death.

Some of the newer individual contracts offered in Virginia include adult day care, respite benefits, and some non-forfeiture benefits. Most companies offer the insured the option of selecting the daily benefit amount (the amount the policy will pay for each day of long-term care), the number of years that will be covered, and the number of days of long-term care that the insured must receive before the policy begins to pay.

Public Attitudes About Long-Term Care Insurance

Several perceptions must be overcome if private long-term care insurance is to be viable. One, most people do not think they will need long-term care, and two, many think that they are covered under their Medicare or supplemental policies.

In fact, there is a relatively small life-time risk of nursing home admission. About ten percent of the population will eventually need nursing home care, although for the population over age 65 the risk increases to almost 50 percent. However, according to a 1993 poll (Employees Benefits Research Institute - EBRI) only about four percent of those surveyed expected to need long-term care nursing home care, though about one in five respondents thought they would need some kind of long term care.

In the same poll, 45 percent of Americans still incorrectly believed that Medicare pays for long-term care. This compares favorably, however, to almost two-thirds of respondents in 1990 and to 79 percent in 1984 who believed that Medicare would pay for their stay in a nursing home. A 1986 poll of Virginians had similar results - 75 percent thought Medicare provides custodial care..

The EBRI survey also indicated that older and less affluent persons appeared more likely to rely on government programs to fund long-term care if required, while more affluent respondents planned to use insurance or personal savings. Forty-two percent of total respondents said that they would fund services through insurance while 28 percent planned using government programs to pay for the care.

These recent findings suggest increased awareness and acknowledgment by the public of long-term care financing needs. Reduced expectations of government assistance are promising. The survey also suggests that long-term care insurance products have a market. Conclusions about how these attitudes will translate to action, however, must be drawn with caution. Perhaps not surprisingly, the public's attitudes as reflected in surveys to date have not been entirely consistent with its actions.

1993 Federal Health Care Reform Proposal

The impact of the long-term care provisions of the health care reform proposals presented by President Clinton to Congress cannot be overlooked. The plan presented to Congress in September 1993 would create a new federal long-term care program. As drafted, the plan would include standards for private long-term care insurance and tax incentives to encourage its purchase. The plan also would promote community and home based long-term care services. The key provisions relevant to long-term care insurance are summarized below.

Consumer Education

The health reform plan would establish a federal grant program for consumer information, counseling and technical assistance to educate consumers about long-term care insurance. The grants would be available to states and organizations. (This is presumably in addition to federal funding currently being used for this purpose in Virginia.)

Regulation of Long-Term Care Insurance

The Secretary of the Department of Health and Human Services (DHHS) would promulgate federal regulations for long-term care insurance within two years of the enactment of the plan. The regulations would require non-forfeiture benefits, inflation protection and third party notification of pending policy lapse. Eligibility for benefits would be based on a professional and independent functional assessment. Requirements would also be included for continuation and conversion of group policies. Other areas covered by federal regulations would include an appeals process for beneficiaries in each state, timely resolution of consumer complaints, training and certification of agents, and commission limits for agents.

States would be responsible for the implementation and enforcement of the long-term care insurance standards. The states would be required to submit a plan to the Secretary of DHHS within two years of enactment of the health reform legislation. Assuming legislative action is taken by Congress next year, the regulations would be effective by fall 1996.

The system for long-term care insurance regulation described in the proposal is similar to the existing regulation of Medicare supplemental (Medi-gap) insurance. Federal requirements are imposed as a minimum and states must have those requirements in place and enforce them or risk having their insurance regulatory program totally preempted by the federal government. Based on the information provided, the proposed federal regulation of long-term care insurance appears to be similar to the current requirements of the National Association of Insurance Commissioners model legislation.

Tax Treatment of Long-Term Care Insurance Premiums

The proposal would amend a number of Internal Revenue Code provisions. The tax changes would include allowing benefit amounts paid for long-term care services or as cash payments to be excluded as taxable income and allowing the cost of long-term care insurance policies to be included as an itemized medical expense deduction. The proposal would also allow employer paid long-term care insurance premiums to be treated as deductions for employers and excluded from taxable income for employees.

Federal tax changes would represent a significantly greater incentive than state tax credits because of the higher federal taxation rate. The proposed tax incentives in the

program may well act to entice more employers and individuals to purchase or offer coverage.

The implementation of these proposals would greatly reshape the current long-term care insurance market. If many of the features relating to long-term care insurance are enacted into law, the future of and perhaps the need for programs like the public-private partnerships will be altered.

III. PUBLIC-PRIVATE LONG-TERM CARE INSURANCE PARTNERSHIPS IN OTHER STATES

Two policy goals are typically sought in long-term care public-private partnerships: to give individuals a means to provide for long-term care while still preserving some assets, and to reduce or at least contain the growth of Medicaid expenditures.

The most ambitious of public-private partnerships for long-term care insurance are those identified with their grantor, the Robert Wood Johnson Foundation Public-Private Long-Term Care Insurance Partnerships. In 1988, the Robert Wood Johnson Foundation provided planning grants to eight states to explore the feasibility of public-private partnerships to encourage the use of long-term care insurance and to establish demonstration pilot projects. Four states have or are in the process of implementing such programs: Connecticut, New York, Indiana, and California. California and Indiana plan to adopt an approach similar to Connecticut's, described below. Massachusetts has also implemented a program using a somewhat different model (not under the auspices of the Robert Wood Johnson program).

A key feature of the programs is to encourage the purchase of long-term care insurance by allowing individuals to qualify for Medicaid while retaining assets above the level normally allowed, once the benefits of a state approved long-term care policy have been exhausted. The partnerships provide individuals with an alternative to transferring assets to avoid Medicaid spend-down requirements. Presumably, by offering an alternative way to protect assets, the incentive to transfer assets or manipulate the system is reduced. The partnership programs are seen particularly as a method to encourage middle class individuals to purchase long-term care insurance. For many, a long-term care policy may be viewed as too expensive to be attractive unless the incentives provided through the partnerships are added.

Development of the partnerships has often been a lengthy process and has required cooperative efforts between a number of parties, including state insurance regulatory agencies, state agencies responsible for planning and providing long-term care

services, and private insurance and long-term care providers. State legislation regarding insurance products allowed under the program and waivers from the federal Health Care Financing Administration (HCFA) which administers the Medicaid program have also been required to make the programs operational.

New York

The New York state legislature authorized the long-term insurance public-private program in 1989. The program received HCFA approval in February 1992 and began selling policies at the end of 1992. New York's program emphasizes length of private insurance coverage rather than the amount of coverage purchased. Participants purchase state approved private long-term care policies covering three years of nursing home care or six years of home care, or a combination of the two. One day of nursing home care is considered equivalent to two days of home care. In return, the individual is guaranteed qualification for Medicaid with assets protected if additional care beyond that time is required.

A unique feature of New York's program is that it allows all assets to be kept if a qualified policy is purchased, in the event that the private benefits are exhausted and Medicaid coverage begins. Income must still be applied to the cost of care (this is consistent with federal Medicaid requirements).

Supporters say the program puts long-term care insurance within reach of the middle class. New York's Medicaid program estimates that an annual income of at least $20,000 is necessary to afford the policies. Critics charge however, that the program is still out of reach for people with limited incomes who cannot afford the premiums and must spend down their assets to qualify for Medicaid.

Connecticut

Connecticut's program, which is the model also followed by California and Indiana, provides "dollar for dollar" protection of assets. For every dollar of private long-term care insurance benefits paid out, a dollar of assets is protected. Consumers can purchase varying levels of coverage, choosing the amount of protection that is needed and affordable. Policies are available to cover relatively short periods of care - for example, one year - and therefore moderate assets, making the products more affordable while still offering some asset protection. As in New York, income must be applied to the costs of long-term care.

The Connecticut program received HCFA approval in August 1991 and qualified long-term care policies were being marketed by April 1992. California and Indiana's programs are expected to begin at the end of 1993 or the beginning of 1994.

Massachusetts

The Massachusetts program, recently established, uses a different approach. Purchase of long-term care insurance allows a person's home to be exempted from consideration when determing assets for Medicaid eligibility, if the long-term care insurance benefits have been exhausted.

The programs in effect have been operational only a short period and sufficient experience for evaluation is not yet available. It is interesting, however, that New York's program appears to be creating more demand among purchasers than the Connecticut program. Experts at the Robert Wood Johnson program suggest that the simplicity of New York's program and the generosity of benefits may enhance its marketability. New York also has, proportionately, one of the largest elderly populations in the nation and relatively high costs for long-term care services.

Cost savings to Medicaid from the public-private partnership programs are projected to be very modest. Additionally, the states suggest that any savings to the Medicaid programs will not be available until the programs have been in effect for a long period of time. Connecticut, for example, has projected that savings will not occur until the second decade of the program's operation.

OBRA 1993 Amendments to Title XIX (Medicaid)

Enactment by Congress of Section 13612(A) of the Omnibus Budget Reconcilation Act of 1993 (OBRA 93) limited the attractiveness of the long-term care insurance public-private partnerships. This Section, passed in August 1993, requires state Medicaid programs to attempt to recover from the estate of an individual the costs of long-term care services provided under Medicaid. The provision specifically requires that assets disregarded (protected) during Medicaid eligibility determinations in connection with long-term care insurance, i.e. those assets protected through the partnerships, be recovered. Therefore, asset protection will apply only during the individual's lifetime but not after death.

This removes the major incentive of the partnerships - the desire to retain assets to pass on to heirs - and significantly reduces their potential effectiveness as an alternative to transferring assets to avoid Medicaid spend-down requirements. Among reasons cited for this legislation were the lack of information demonstrating program effectiveness and concerns about promoting the use of Medicaid by the non-impoverished.

The amendment exempted the six states that had federal approval for the partnerships as of May 14, 1993. Those six states are California, Connecticut, Indiana, Massachusetts, New York and Iowa.

IV. OTHER APPROACHES TO ENCOURAGE PURCHASE OF PRIVATE LONG-TERM CARE INSURANCE

Policy approaches that may increase individuals' interest in long-term care insurance, in addition to the public-private long-term care insurance partnerships described above, include:

- Tax incentives to encourage insurance purchase or savings;
- Encouraging employers to offer group long-term care insurance plans to employees;
- Educating the public so that consumers can make informed decisions.

1. Tax incentives to encourage the purchase of long-term care insurance or savings

Tax incentives can target either purchasers or insurers. The use of tax incentives to encourage the purchase of long-term care insurance, as well as to induce insurers to market long-term insurance, was considered in the late 1980's when long-term care insurance was developing. As the availability of products is now less of a problem than when first explored, this discussion addresses only tax incentives focused on increasing buyer participation.

Tax incentives for long-term care insurance purchasers can include income tax deductions or credits for long-term care expenses including co-payments, deductibles and premiums and exclusions for benefits paid out by the insurance plan.

The federal government explored tax incentives when it studied long-term care insurance in 1986 and 1987. At that time, the task force studying the issue stopped short of recommending tax incentives because it felt that reductions in the use of public resources might not offset the tax revenue lost.

Tax incentives may be a viable option to encourage individuals to purchase long-term care insurance. Tax incentives may be limited in scope, however, due to the lower tax liability of many long-term care insurance policy purchasers and/or beneficiaries, most of whom are older and in lower tax brackets. For this reason, tax incentives may be a more useful approach for targeting younger, working purchasers. Also, as noted previously, state tax credits or deductions tend to be relatively insignificant, making federal taxes a more likely target. The proposed federal health reform plan discussed earlier includes tax incentives for long-term care insurance.

Individual medical accounts (IMAs) similar to individual retirement accounts (IRAs) have also been proposed as a method to encourage saving for long-term care costs. Rather than encouraging the purchase of long-term care insurance, they would provide tax breaks for money reserved for medical expenses, including long-term care. Several limitations have been noted, however. Even prior to changes in tax laws reducing their deductibility, IRAs experienced limited use by the public. Additionally, IMAs are expected to have even less appeal because use is limited to medical costs, preventing application to other purposes. Finally, it is likely that many individuals might find their protection levels still inadequate if faced by major long-term care or medical costs.

2. Encourage group long-term care coverage through employers

An alternative means of promoting long-term care insurance is making it available through employers. Offering the coverage through employers, i.e. as a group policy, typically makes it more affordable due to the reduced administrative costs per insured. Group coverage also helps to introduce the concept to younger persons, and through workplace benefit education and payroll deductions may make it more attractive.

Program designs vary. For example, an employer may offer voluntary group coverage for employees and their dependents and may include optional continued coverage during retirement or through integration of long-term care insurance with the existing system of pensions and retirement benefits. Employers may contribute the premium as an employee benefit; alternatively, a program may be partially or entirely employee-funded similar to disability insurance policies offered by many government and private employers.

A number of employers and states offer long-term care insurance to their employees. In a recent report, the Health Insurance Association of America (HIAA) estimated that as of December 1991, 360 employers offered long-term care insurance. An estimated 202,500 individuals were enrolled in employer-sponsored plans, representing a growth of over 50 percent over the previous year. Included were four state governments (Alaska, Illinois, Maryland, and Nevada) as well as Blue Cross and Blue Shield of Virginia and Blue Cross and Blue Shield of the National Capital Area.

The HIAA report states that most (98 percent) of all employer-sponsored long-term care policies were sold to employees with an average age 39 to 56 years, from which the HIAA computed a weighted average age of 43 years. The weighted monthly premium in the groups was estimated at $22.33 or $267.96 per year. The table below shows the premiums for various ages. The HIAA estimated that participation rates ranged from 0.3 percent to 9.9 percent for plans totally funded by the employee.

Average Annual Premiums for Employer-Sponsored Long-Term Care Plan at Selected Ages

Age	Annual Premium Amount
30	$ 108.99
40	$ 183.21
50	$ 340.66
65	$ 884.17
79/80	$3808.82

For plans typically providing $80 per day nursing home care, $40 per day home health care, a 90-day deductible, and five years of nursing home coverage.
Source: Health Insurance Association of America, 1992

A 1993 public opinion poll conducted by the EBRI indicated that 65 percent of the American people would purchase long-term care insurance from an insurance company or through their employer if it was available. Of respondents saying that they would purchase a policy, the median amount they would pay annually for a policy was $500. The level of coverage that premium amount would provide would depend upon the insured's age and the type of coverage. Based upon the premiums noted in the table above, that amount could potentially provide long-term care protection adequate for a younger population enrolled through a group but may be too low to purchase sufficient care for an older population.

The Commonwealth of Virginia could make long-term care coverage available as an optional benefit. This would serve several purposes: reduce the risk of adverse selection because of the size of the group (although it potentially could still occur through a voluntary program); increase awareness and knowledge about long-term care financing issues among a large and relatively young population; introduce a younger age cohort into the risk-pool, presumably reducing costs and premiums; and serve as a demonstration that could be evaluated and, if successful, replicated by private businesses.

3. Expand consumer education concerning the risks of needing long-term care, and coverage options and cost

There is a continuing need to educate the public about the need for long-term care and the funding for that care. As noted previously, many people still mistakenly believe that the government currently pays for long-term care.

Education is aimed toward creating a well informed public. Educated consumers are more able to make good decisions about their needs and the options available. Inaccurate information noted among consumers includes mistaken beliefs that Medicare or Medi-gap policies will cover all necessary care; underestimating the risk of needing long-term care and the costs of such care; and lack of knowledge of public policy

changes (such as just occurred with Medicaid transfer of assets rules) which alter financing for services.

Virginia has increased consumer education regarding long-term care insurance since products first became available. Some of the increased education is the result of the state's 1987 legislation, which defined long-term care insurance and provided statutory requirements regarding insurers and products. Among its provisions, the law requires the delivery of a consumer's guide to long-term care insurance purchasers. The guide is also widely distributed by the SCC's Bureau of Insurance, the Department for the Aging and the local Area Offices on Aging The SCC's Bureau of Insurance additionally provides consumer education for senior citizens that focuses on long-term care insurance as well as Medicare supplemental insurance (Medi-gap policies) and other insurance concerns of seniors.

Additionally, federal funds have been made available to the states for operation of consumer insurance counseling programs. In Virginia, the Virginia Insurance Counseling and Advocacy Project (VICAP) began operations in 1993. The program is administered by the Department for the Aging in cooperation with the Bureau of Insurance. Volunteers are trained throughout the state to provide information on insurance concerns for older individuals including Medicare coverage, Medi-gap policies, public benefits, and long-term care insurance. The volunteers provide one-on-one counseling and are available at designated locations in most areas of the state.

Educational efforts of this type will continue to increase the awareness of the public and to assist them when they need long-term care coverage or services. The expansion of the existing VICAP program or development of similar projects could reach more consumers. Programs that will also target a younger population could ensure better knowledge of the lifetime need for and financing of long-term care, much as retirement planning is now targeted to a younger population to allow time to plan for future needs and accumulate resources.

V. CONCLUSIONS AND RECOMMENDATIONS

Long-term care financed through private insurance reduces the need for the public sector to subsidize long-term care and provides individuals with a way to provide for future long-term care if needed. Long-term care insurance will not be the sole solution to long-term care financing or to Medicaid cost escalation, however. Even optimistic projections suggest that a small proportion of long-term care that would be financed by Medicaid would be covered instead through insurance. The elderly at greatest risk of disability are likely to have limited resources and insurance premiums are likely to be unaffordable. Those with resources are not likely to be users for at least a decade. So any

offset to Medicaid expenditures are not likely to be realized within at least the next ten years.

For policies to capture a large enough pool to be widely affordable, purchasers in their forties and fifties or even younger are necessary. However, the long period between premium payment and receipt of benefits puts the purchaser at risk regarding adequate coverage. Also, until more predictability is available about the financing and delivery of long-term care services, individuals may be reluctant to purchase insurance that may not be needed or may be inadequate.

Still, it is probable that individuals increasingly will be called upon to provide funding for long-term care for themselves and family members. For many Virginians, long-term care insurance could provide adequate financing and protect their assets and resources. The recommendations below may help create options for individuals seeking long-term care insurance as one method to ensure security regarding potential long-term care needs.

Recommendation 1:

The Department of Medical Assistance Services should continue to monitor the public-private partnerships established in six other states to encourage the purchase of long-term care insurance, and as appropriate, make recommendations concerning ideas appropriate for implementation in Virginia.

Recommendation 2:

A survey should be conducted to determine whether state tax incentives such as tax credits, deductions or other incentives to encourage the purchase of long-term care insurance by employers, employees, or individuals should be implemented in the Commonwealth. Survey results should be provided to the Joint Commission on Health Care in 1994.

Recommendation 3:

The Secretary of Administration should consider the feasibility of providing a group long-term care insurance policy option to employees of the Commonwealth. The study should include but not be limited to the costs of such a program, the designs of the benefit package(s) to be offered, the projected participation rate, and, if appropriate, the projected start date.

Recommendation 4:

The Virginia Department for the Aging and the State Corporation Commission's Bureau of Insurance should identify methods to expand consumer education concerning long-term care financing and options available. Programs targeting both older Virginians and younger age groups should be considered.

APPENDIX A

Virginia's Long-Term Care Insurance Law and Regulations

Long-term care insurance has been sold in Virginia since 1987. Prior to 1987, approximately 14 companies sold what is now know as long-term care insurance in this state. Virginia was much like the rest of the country with regard to long-term care insurance. Until that time there were few states that even defined "long-term care" as a type of insurance. Long-term care itself includes an array of services that are provided to individuals with a need for assistance that is vital to the well-being of an individual for an extended period of time.

Benefit design at that time was a particular point of concern from a consumer protection and regulatory standpoint. The policies that were offered varied with regard to the type of care covered (skilled, intermediate or custodial care). The majority of the policies limited coverage to skilled care, although the newer contracts being filed included custodial care.

Reflecting this concern about the adequacy of long-term care insurance products, a study was conducted by the State Corporation Commission's Bureau of Insurance and the Department of Medical Assistance Services in 1986. As a result of the study, in 1987 legislation was enacted that defined long-term care as a type of insurance, and recognized the distinct nature of the products that differentiated them from accident and sickness insurance.* Policies that were to be marketed or offered as long-term care insurance would have to comply with the requirements of the long-term care chapter in the *Code.*

The law also contained limits on prior institutionalization requirements, pre-existing conditions, and disclosure requirements. It required insurers to offer insureds the right to return the contract within the first 10 days and receive a full refund if an individual contract, and within the first 30 days if a direct response product. Additionally, it mandated that a consumer's guide be delivered to purchasers of long-term care insurance by the insurer.

The State Corporation Commission's Insurance Regulation No. 40, Rules Governing Long-Term Care Insurance, which further defines the statutory requirements mandated by the 1987 law, became effective January 1992. Currently, there are approximately 40 companies with long-term care policies approved for sale in Virginia that have complied with Insurance Regulation No. 40.

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* Long-term care insurance was defined in the law as:

"any insurance policy primarily advertised, marketed, offered or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary, diagnostic, preventative, therapeutic, rehabilitative, maintenance, personal care, mental health or substance abuse services, provided in a setting other than an acute care unit of a hospital."
(*Code of Virginia,* Section 38.2-5200)

National Guidelines Regarding Long-Term Care Insurance

The National Association of Insurance Commissioners (NAIC) is the organization of state regulators of insurance that work together to provide a forum for the exchange of ideas and to assist in the formulation of uniform policy. The NAIC began studying long-term care insurance in 1985. After extensive study, model legislation was adopted by the NAIC in December of 1986 and a model regulation was adopted in 1988.

The model act and regulation have been revised considerably over the past seven years. The majority of the changes have been viewed as consumer protection features that have made the product more attractive to consumers. The current features, also included in the Virginia regulation, are standards for marketing, reporting requirements, a prohibition of post-claims underwriting, the required offer of inflation protection, a requirement that recommended purchases be appropriate, and a prohibition against pre-existing conditions or probationary periods in replacement of a long-term care policy with a new long-term care policy.

The most recent change to the NAIC model law was made in July 1993, when it was revised to require the inclusion of non-forfeiture benefits in the contracts. This revision had been considered over a period of time. Those supporting the change see it as providing further consumer protection. Long-term care contracts are ideally designed to be purchased when the insured is in the 40-50 age range. Premiums at that time are commonly lower because they will build over a longer period of time. However, the average purchaser in 1991 was 69 years old according to information from the Health Insurance Association of America (HIAA). Those supporting the mandatory inclusion of non-forfeiture benefits believe that the current lapse rates (policyholders who cease paying premiums prior to utilizing the coverage and coverage expires) are sufficiently high that insurers should provide something to the policyholder who has paid premiums over a number of years.

As of 1991, there were 135 companies nationally selling long-term care insurance. Seventy-five companies were selling contracts that met the minimum requirements of the NAIC model act. Fifteen companies account for 80 percent of the national market based on 1991 sales, according to the HIAA. The policies offered by those fifteen insurers cover both nursing home and home health care. Thirteen of the contracts will cover adult day care and six include a respite benefit. None of those plans use a prior hospital stay or use of a higher level of care as an eligibility requirement. Thirteen of the fifteen companies offer coverage up to an unlimited lifetime nursing home maximum. All of the plans could be sold to individuals over the age of 80. Prior to the NAIC's requirements, ten of these plans offered a non-forfeiture benefit to insureds.

The number of long-term care insurance policies purchased nationally as of December 1991 was 2.4 million, compared to 815,000 in 1987. Virginia figures are not available and are assumed for this report to be comparable for population size.

APPENDIX B

GENERAL ASSEMBLY OF VIRGINIA--1993 SESSION

HOUSE JOINT RESOLUTION NO. 688

Requesting the Department of Medical Assistance Services in cooperation with the State Corporation Commission's Bureau of Insurance to study public-private partnerships which encourage the purchase of long-term care insurance.

Agreed to by the House of Delegates, February 25, 1993
Agreed to by the Senate, February 23, 1993

WHEREAS, consistent with a national trend, the Commonwealth's population is aging; and

WHEREAS, over the next decade, the Commonwealth's elderly population will increase four times as rapidly as the general population; and

WHEREAS, the need for extended services and care for individuals is generally inherent to longevity; and

WHEREAS, the financing of long-term care for services required to manage chronic conditions or to compensate for limited ability affects not only individuals but also the Commonwealth in its role as service provider; and

WHEREAS, long-term care expenditures represented 56 percent of the Commonwealth's Medicaid expenditures in FY 1991 and are expected to grow annually by nine percent if current trends continue; and

WHEREAS, studies by the Commonwealth's Department of Medical Assistance Services indicate that approximately one in five people needing long-term care will begin as private pay patients in nursing homes but will eventually spend down and become Medicaid recipients; and

WHEREAS, 43 percent of these individuals will, in fact, spend down within the first six months of their stay, and 64 percent will spend down during their first year; and

WHEREAS, the Joint Commission on Health Care, established by the 1992 General Assembly is to study, report, and offer recommendations on health care issues within the Commonwealth, including long-term care; and

WHEREAS, the joint commission has agreed to explore all public and private partnership opportunities in enhancing and providing long-term care services, including long-term care insurance; and

WHEREAS, studies in other states initiating long-term care partnerships with the private sector indicate a great possibility of savings in Medicaid programs; and

WHEREAS, such experiments in the financing of long-term care could benefit the Commonwealth, as well as her citizens; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Medical Assistance Services in cooperation with the State Corporation Commission's Bureau of Insurance be requested to study the advantages of public-private partnerships which other states have implemented to encourage the purchase of private long-term care insurance.

The study shall include but not be limited to an analysis of programs in other states and shall address such policy questions as (i) who should negotiate nursing home rates used by insurance companies; (ii) what eligibility criteria are appropriate; (iii) who is the more effective gatekeeper, the state or a private care manager; and (iv) what is the appropriate amount of coverage.

The Department of Medical Assistance Services and the State Corporation Commission's Bureau of Insurance shall submit their findings and recommendations to the Joint Commission on Health Care by September 1993 and to the Governor and the 1994 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 304

Requesting the Department of Medical Assistance Services in cooperation with the Bureau of Insurance to study public-private partnerships which encourage the purchase of long-term care insurance.

Agreed to by the Senate, February 22, 1993
Agreed to by the House of Delegates, February 18, 1993

WHEREAS, consistent with a national trend, the Commonwealth's population is aging; and

WHEREAS, over the next decade, the Commonwealth's elderly population will increase four times as rapidly as the general population; and

WHEREAS, the need for extended services and care for individuals is generally inherent to longevity; and

WHEREAS, the financing of long-term care for services required to manage chronic conditions or to compensate for limited ability affects not only individuals but also the Commonwealth in its role as service provider; and

WHEREAS, long-term care expenditures represented 56 percent of the Commonwealth's Medicaid expenditures in FY 1991 and are expected to grow annually by nine percent if current trends continue; and

WHEREAS, studies by the Commonwealth's Department of Medical Assistance Services indicate that approximately one in five people needing long-term care will begin as private pay patients in nursing homes but will eventually spend down and become Medicaid recipients; and

WHEREAS, 43 percent of these individuals will, in fact, spend down within the first six months of their stay, and 64 percent will spend down during their first year; and

WHEREAS, the Joint Commission on Health Care, established by the 1992 General Assembly is to study, report, and offer recommendations on health care issues within the Commonwealth, including long-term care; and

WHEREAS, the Joint Commission has agreed to explore all public-private partnership opportunities in enhancing and providing long-term care services, including long-term care insurance; and

WHEREAS, studies in other states initiating long-term care partnerships with the private sector indicate a great possibility of savings in Medicaid programs; and

WHEREAS, such experiments in the financing of long-term care could benefit the Commonwealth, as well as her citizens; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Medical Assistance Services in cooperation with the Bureau of Insurance be requested to study the advantages of public-private partnerships which other states have implemented to encourage the purchase of private long-term care insurance. The study shall include but not be limited to an analysis of programs in other states and shall address such policy questions as (i) who should negotiate nursing home rates used by insurance companies; (ii) what eligibility criteria are appropriate; (iii) who is the most effective gatekeeper - the state or a private care manager; and (iv) what is the appropriate amount of coverage.

The Department of Medical Assistance Services and the Bureau of Insurance shall submit their findings and recommendations to the Joint Commission on Health Care by September 1993, and to the Governor and the 1994 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.