The Long-Term Care Partnership Program: What Role Will It Play In Broader Long-Term Care Policy?
November 9, 2006

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[START RECORDING]

ED HOWARD: Well, I guess the hush that has come over the room is a sign that we ought to get started, and we're going to do it on time. We have everybody here. We have a good audience and we have a terrific topic. I'm Ed Howard. I'm with the Alliance for Health Reform. On behalf of our chairman, Jay Rockefeller; our vice-chairman, Bill Frist; and our soon-to-be co-chair, Susan Collins; and the other members of the Board of Directors, I want to welcome to this briefing on the Long-Term Care Partnership Program, which is a way for people to use private long-term care insurance to protect at least some of their assets and still qualify for Medicaid coverage of their long-term care expenses. I worked for a long time trying to get it down to a 20-word description, but I may not have succeeded. It's a demonstration program now in just four states, but as a result of one provision in the Deficit Reduction Act of 2005, we're about to find out if it's ready for prime-time across the country.

Our partner in today's program is Robert Wood Johnson Foundation, the country's largest philanthropy devoted to improving health and health care. Part of that mission is reflected in the fact that the Foundation has been involved in the Partnership initiative from the beginning, so we're really doubly pleased to be co-sponsoring the briefing with them, and pleased to have with us David Colby, the Foundation's interim

vice-president for Research and Evaluation. We're going to hear from him in a few minutes on today's topic.

A few logistical items before we launch into that discussion. In your packets, you will find a lot of background information that will be useful to you, including something that is not clearly identified as what it is. It says Chapter Seven on it, but its Chapter Seven of the new sourcebook for journalists that the Alliance, with help from Robert Wood Johnson, actually, has published recently. You'll find the entire text online. We're in the process of translating it into Spanish and you'll be able to access both of those on our Web site, which is allhealth.org. Tomorrow, you can view the webcast of this session on kaisernetwork.org, or download an audio podcast, if you are so inclined, of this session. That's kaisernetwork.org. All of the materials will be there as well in electronic form. In a few days, we'll have a transcript for you that you can use to quote from and remember every precious moment of the briefing. We'll let you know by e-mail when that transcript is available.

One completely unrelated logistical note, some of you were at our briefing last week in Hart [misspelled?] 902, and you may have walked off inadvertently with the topcoat of one of the Alliance staffers, Brendon Rogers [misspelled?]. It's a size 38 black topcoat, in case it doesn't fit quite as well, that's why. If you happen to have left an Albert Nipon size 4

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women’s topcoat in that room, there’s a reason why the one you have is too big. So see Brendon or Nancy Peavey [misspelled?] in the back of the room if you would like to effect an exchange.

Also, one final logistical note, getting back to the program. In your packets, right on top in the left, you’ll find both a green question card that you can use at the appropriate time and a blue evaluation form which we implore you to fill out so that we can take your comments and incorporate them into making these programs better as we go along.

We do have, I think, an extremely capable lineup of speakers to talk about the Long-Term Care Partnership initiative, and I want to get started without further delay. We’re going to lead off today’s discussion with Lisa Alecxih, who is the vice-president of Lewin Group. Most of you are familiar with that health care consulting firm. Her work on a range of long-term care issues, home- and community-based services and financing, among others, is among the most respected in the country. And long ago in her career, when she was very young, she did a lot of key work on the long-term recommendations of the Pepper Commission out of which grew fairly directly, the Alliance for Health Reform. So Lisa is going to undertake the necessary but daunting task of laying out the structure and the functioning of long-term care in 10 minutes. So be careful, you don’t want to wear your hand out

writing your notes so fast. Lisa, thank you very much for being with us today.

LISA ALECXIH: I'll turn this on also. As Ed noted, my task is to give you some background and make sure you're up to speed for the remainder of the discussion. I want to start out with, what is long-term care? It's services and supports needed by people to care for themselves, usually because of a chronic illness, disability or frailty, and they're provided by family and friends, through home- and community-based services and also through institutional care. So there are all kinds of settings and all kinds of people involved.

This graph gives you a sense of the need for long-term care. This is measured by activities of daily living or instrumental activities by age, so you can see as you get older, you are much more likely to need some type of assistance with those types of activities. ADLs are eating, bathing, dressing, transferring, getting in and out of bed, that type of thing. IDLs tend to be money management, more cognitive oriented tasks.

To give you a sense of the cost of long-term care, these are all private pay rates. MetLife Market Survey did their most recent one last year, and so for the nursing home care, the average annual cost is about $74,000, but it ranges. It depends of where you are. In Shreveport, Louisiana, it's only about $42,000 and in Alaska, it's going to run you

$194,000 for a year of care. Assisted living is a slightly lower cost alternative at $35,000 a year, but again, the range is pretty dramatic depending on where you live.

Finally, home care – the range is a little less, but we're also measuring this on a per hour basis. The average is about $19 per hour and this is for services provided by a certified home health agency. There is a lot of care that is provided by people that are hired directly, don't necessarily go through a home health agency, so this represents the higher end of the cost per hour. But again, there is a pretty wide range of the cost of care.

I do want to point out that much of the care that supports seniors is provided on an unpaid basis by their family and friends. So 71-percent of people who require some type of assistance are in the community and that about 67-percent of the total are receiving unpaid support, some in combination with paid support, but a substantial portion – 42-percent - without any assistance with paid supports.

This is a slightly different look and the numbers end up being a little bit different, this is also by age. This includes care that is for post-acute care, so its Medicare post-acute care included in here also. So the paid HCBS ends up being probably more than if you were trying to just focus on long-term chronic management, but it gives you a sense of the use of services by age group and how it increases by age.

How does the paid care get paid for? Unlike health insurance or acute care health, health insurance doesn't play a large role and so that's part of the motivation for the Long-Term Care Insurance Partnership, and these guys will talk about it some more. Long-term care insurance has a small role in the current financing among seniors. Medicare plays a pretty substantial role, but again, that's for that post-acute care and then Medicaid is the primary insurance mechanism, but as we will discuss and most of you know, it requires you basically to spend all of your income and assets in order to qualify. The remainder and a large chunk much more than under acute-care are paid for by family resources.

So just a little bit about the different sources. Medicare covers limited long-term care benefits, primarily post-acute. Home health services are only for people who are home bound and need part-time skilled nursing or therapy services and are under the care of a physician. On average in 2005, people receiving Medicare home health visits received 27 on average. Skilled nursing facility care – to get Medicare coverage, you have to have been in a hospital – so discharge from a hospital to a nursing home, skilled nursing care and you can get coverage for up to 100 days, but actually Medicare only fully pays for the first 20 days. After that, the co-pay becomes pretty substantial and the average length of stay for Medicare nursing home care is about 35 days on average in 2005.

Medicaid is pretty complicated only because every state is different. But there is also in the long-term care part of it, there are pieces that can be covered under the state plan option, which means states aren't required to cover it, but if they do it under the state plan, it's an entitlement for everyone. Or they can do it through a waiver on the home community-based side and still call the waiver even though every state in the country has at least one, if not more waivers. The wavier side is designed to cover care for people who otherwise might have been institutionalized. So 36-percent of Medicaid spending goes to long-term care services, so that's a reason why states are very concerned about what's going on in this area.

As you can see, for older adults and for younger people with physical disabilities, this graph specifically excludes people with mental retardation and developmental disabilities. The proportion of Medicaid spending for home and community based services has been increasing particularly since 2000. In 2000, it was around 14-percent and it's now up to 23-percent, so states have been really looking to shift the locus of care from institutions to home and community based care under Medicaid.

As I mentioned, long-term care insurance plays a limited role in this market. The long-term care insurance market emerged during the 1980s. To-date, 9.2 million policies

have been sold, or actually through 2002 was the most recent year the AHIP data are available, but that doesn't mean that there are that many policies in force, because some of the policies sold or people replacing policies, and other people lapsed. What it results in is about 10-percent of those 50 and older who own a long-term care insurance policy. The reason for that low purchase rate, some of the reasons that have been proposed are the policies are pretty complicated and they're pretty expensive. They can range from about $1,300 to $2,800 at age 65, depending on how much of a policy you want to buy. Consumers generally are not aware, and many assume that Medicare is going to cover their long-term care expenses, so there is also this aspect of not knowing, but also denial of need.

As Mark and others will tell you about the Long-Term Care Partnership polices, long-term care insurance is a sold policy. It's not something that you're going to go online, pick the features and buy it over the Internet. You have to work with somebody to figure out what you're going to buy, what that's going to cost and what will meet your needs. There are limited benefit payouts, not only because there are not that many people who own them, but because the early policies offered limited benefits. They were nursing home only. Now that has totally changed in the market since the 1980s. You buy a daily benefit amount, which may or may not cover the cost

of care and it depends whether you get inflation protection and all sorts of other things that speakers will get into. As I mentioned, people will stop paying their premiums and they will no longer have coverage prior to even accessing the benefit. Partnership policies address some of these policy limitations through the features that are required.

I want to amend the title on this one – it says the majority. It's not the majority. It's a significant amount, but it's not the majority, but out-of-pocket is sort of the remainder of long-term care sources of financing. One point I wanted to make is even people on Medicaid are paying a substantial amount out-of-pocket, because nursing facility residents, basically they spent down to get to Medicaid, but even once they're on Medicaid, they have to devote pretty much all their income except a personal needs allowance, which ranges from about $30 to $100 a month to the cost of their care before Medicaid starts paying for care. There is a significant amount of out-of-pocket coming from people who are on Medicaid. Many states also require cost sharing for home and community based waivers, and another piece of the cost sharing on Medicaid are the Medicaid rules that protect the primary resident while the spouse is alive, as well as protects some of the income. It's caused spousal impoverishment, which I'm not going to go into because I don't have much time.

Risk of needing care, remaining lifetime use of long-

term care by people turning age 65 in 2005. This is a recent article that I worked on with Peter Kemper [misspelled?] and Harriet Kommissar [misspelled?], trying to estimate how much care people need once they turn age 65, and on average, it's three years and most of it again, in the home as evidence by the other things. Basically, the average lifetime per capita at age 65 is $47,000, so if you were turning age 65 today, on average you would expect to pay $47,000, but that includes people who don't use care, as well as the people – the 25-percent who face over $100,000 in expenses. This makes the argument for insurance, basically, is that this is a catastrophic cost, affects a small number of people and is a fairly good risk for insurance for that reason.

Aging baby boomers – you guys have seen this. What it means is that long-term care spending is projected to go pretty high pretty quickly, and that's another motivation for looking for alternatives, trying to encourage private financing options.

The last thing that I wanted to raise was that few Americans plan ahead for their long-term care needs. As I mentioned only 10-percent of those 50 and older have a long-term care policy. Most baby boomers are worried about getting their kids through college, not what their retirement needs are going to be, particularly for long-term care. Women age 40 to 44 today, there are 20-percent who don't have any kids. That

compares to 30 years ago, so the women who are 70 to 74 today, only 10-percent didn't have any kids, so there is going to be a little bit of a dearth, not only because of the baby boom issue, but because people have chosen not to have children and may not have those supports. As I mentioned, two-thirds of Americans are likely to need some type of supported services at age 65, so the DRA provisions encouraged planning for future long-term care needs through an education campaign and individual counseling and then through the Partnership program expansion.

ED HOWARD: Thank you very much, Lisa. That was a tour de force. The article to which Lisa referred with her co-authors Peter Kemper and Harriet Kommissar is in your packets. So you can take a look at that at your leisure.

Now we're going to hear from David Colby. As I mentioned, David is the interim vice-president for Research and Evaluation at the Robert Wood Johnson Foundation. He's held a number of key positions in his more than eight years at the Foundation, including some leadership in both quality and coverage areas. Some of you may know him from his days as a senior staff member at MedPac and one of its predecessors, PPRC. Since RWJ's interest in the Long-Term Care Partnerships was as important in their development as any other factor, we've asked David to explain today for us why the Foundation became interested, what it has learned, what might be in store

from the Foundation's point of view anyway, from this program in the future. David, thanks for being part of this.

DAVID COLBY: Good afternoon, and thank you for the kind words, Ed. I'm delighted to be here today. We're delighted to be able to sponsor this meeting today, but also I'm delighted because this is an area where the Foundation invested a lot over a 20-year period and I think we're starting to come to fruition on it. Mark Meiners, who is going to be speaking after me, was the national program director for the Partnership. We've learned a lot of lessons and I think those will be lessons that will help states implement this program.

I'm going to step back. I'm going to do a little nostalgia tour here for a moment. If you go back to the late 1980s, there was beginning to be a concern about long-term care issues. Alice Rivlin [misspelled?] and Josh Weiner wrote a book called *Who Will Pay?* in the late 1980s and, of course, Ed Howard and the Pepper Commission wrote a long report on this issue. It was sort of a dominant issue at that time. I think Lisa has really walked through most of the things we were concerned with in the 1980s. The 1980s, I think, was more of a preview of what is becoming reality today. We were thinking about what was going to happen, but when the Foundation was first working on this, it was worried about the growth and the elderly, especially the baby boomers aging, and the likelihood as Lisa showed you, the likelihood of having the need for long-

term care services. Actually, the last chart she showed – I will be 100 years old when that last chart pops up their very high. Given my family's history – my grandmother lived to be 102, or two days short of 102, I think I will probably make it to that last chart that you had on the total cost. I will be one of the problems that you all will be dealing with.

The second thing that Lisa had talked about that we had in the 1980s, and that's the long-term care costs that are in state budgets, especially in Medicaid, the impoverishment of the elderly, that is elderly who work hard all their lives and have saved, but some catastrophic event comes along and they no longer have any savings and live out the end of their life very poor. Then the other thing we had at that time period, which we don't have now, we had really a limited private market for long-term care insurance. It was a very young market. It was an undeveloped market at that time period.

The Partnership that was developed by the Foundation really had two principles. One principle was to have the public sector encourage the private market. As we wanted to really develop a private market for long-term care insurance, have people set the rules and have products out there. The second thing is we were talking about having a Partnership in terms of financing long-term care as joint funding where the responsibility would sit both with the private sector, that is both with the elderly and insurance products, and with the

public sector.

We had in terms of program development – this is why I say this goes back 20 years – we made planning grants in 1987 to eight states, California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon and Wisconsin to really look at whether they could develop the Partnership. In 1987-88, four states made planned amendments to their Medicaid programs to adopt a Partnership model. In 1987-'88, we gave grants to the four states to help them try to implement this model and those four states were the ones we have most of our history from; California, Connecticut, Indiana and New York. In '92, the first policies were sold in Connecticut. In '93, the first policies were sold in New York and Indiana. Then we had, really the barrier to the development of this type of product and states adopting this type of product. The OBRA limits – they're discussed in many of your materials. They grandfathered in the original states, but they required new states to recover assets from the states of all persons receiving services from Medicaid, and that virtually stopped the development of this idea in terms of going to other states. '94 – California sold policies and then the real change is the Deficit Reduction Act, which really allows the model to be used in all states.

The program design really has three elements. It's private comprehensive – probably should take out time limited –

but limited long-term care policies, some of them time limited, some are dollar limited. They're comprehensive policies, but they are limited in some way. The second aspect is Medicaid is available for those who exhaust their private long-term care coverage, and it was done it two different ways. It was really addressing the assets rules in Medicaid and spend down. In New York you had what was called total asset protection. If you bought three years of long-term care insurance or six years of home health insurance, or a combination of those, Medicaid would drop the consideration of your assets for eligibility when you exhausted your private long-term care insurance. So Medicaid acted to pick up the cost after you ran out of the private long-term care insurance. In the other states, we really had – when you exhausted benefits, you get a dollar for dollar benefit disregarding your assets in terms of Medicaid eligibility process.

The third part of this is states really regulated these products and they regulated in ways they don't regulate some other insurance or they didn't regulate as much other insurance. Most insurance regulations are about solvency of the company. This really broadened out to define what was the event that would trigger your getting long-term care insurance and Lisa mentioned ADLs, ADLs were used as the event and cognitive impairments were used as the event, but they defined what an event was to trigger your getting health insurance or

getting long-term care insurance. They added some case management approaches. They broke down the barriers between institutional care and home health care, and they also prevented lapses, unintentional lapses in payments for coverage, and for those of you who have elderly parents, my parents have long-term care insurance at age 89, and my mother wrote the check to pay it. She wrote out the number correctly. She put the number correctly, but when she wrote the script of the number, she forget the cents, so she owed a little more for her policy than she actually paid, because that's the legally binding part of a check. Of course, then that triggered the insurance company in sending me and sending my parents a notification that this had happened. So they knew something had happened. I had gotten information so I could my mother and say, "You didn't pay your amount. What happened?" My mother is enough with it that she really knew exactly what happened. She said, "I didn't write out the number correctly." These are part of the regulations.

What kind of lessons? These are top-line lessons. I think the most important lesson of this program and the experiment the Foundation conducted was we could actually implement this idea. This was an idea out there that nobody had implemented before. It took us a little time, but it was a collaborative approach between states and insurers and it really broadened the protection for the middle-class elderly

Americans. We saw high quality products being produced. Mark is going to talk a little bit about the next one. We saved state expenditures. States report on their websites for this program – the expenditure savings.

On the disappointing side we didn't sell as many policies in the early stages of this, or not as many policies were sold as we really expected. There is an AARP memo in your packet that gives you some of the latest numbers. The numbers start to click up after about '99. It was pretty slow before '99 and then it starts to develop more, but in some ways it was a slight disappointment. Also, while the products were purchased by what most of us call middle class elderly, amongst that group it really was the more educated, the wealthier who were producing it. It's still not the – I'm not talking about the wealthy people, but amongst middle class, it was a wealthier slice of the middle class that were producing it.

Then the last lesson is insurance agents are crucial for this product. The Foundation had this dream, and it was a field of dreams kind of thing. They thought you make a good product, you get it out there, it's cheaper than the other products, people will want to sell it and people will want to buy it. This was a case where the Chicago Shoeless Joe and Chicago Black Sox didn't show up, and neither did the agents in the beginning. We really had to concentrate how do get the agents who were selling these products involved in the process,

and that was something we really learned from the beginning.

Now, where are we going? Where is the Foundation going on this? As we mentioned, the DRA allows the expansion of this approach. It's a fairly complex approach to implement. I don't think it's a simple approach to implement and there are a lot of policy decisions, but our Board of Trustees felt that it was important to help spread this idea, which we had invested in from the late 1980s to the 1990s. We have developed a program that will roll out — trustees voted on this in late October, the program will roll out in the new year. It will involve the Center for Health Care Strategies, which is a group that works with Medicaid programs. It will involve Mark Meiners, who has really been the champion of this idea and will participate as a faculty and consultant in this. We will have Seed Grants for 10 states next year to help them plan the idea and work on the idea. Then we will provide technical assistance because we have a lot of expertise in this. Technical assistance around what are the specs for contracting with long-term care insurance partners? What are the best practices in marketing? What are the standards for coverage, inflation protection, et cetera? Eventually we'll develop a tool kit that all the stake holders can use under this program.

I think it's important — the Foundation felt that we had planted the seed for this idea and that we should follow up and help the states develop it in the future, so this is what's

coming next year. Thank you very much.

ED HOWARD: All right, thank you very much, David. Very essential background – this thing has been around and people have been looking at it for a very long time. One of those people, as David mentioned, is our next panelist, Mark Meiners. He is director of George Mason University Center for Health Policy Research. He is an economist. One of those knowledgeable people in the country on the subject of private long-term care insurance most relevant to our discussion today. As David mentioned, Mark has been the leader of the Partnership's initiative at the Foundation since it started back in '87. Who better to help us look under the hood, if you will, of these Partnerships, understand better how they've been functioning where they already exist, and what the response by states to the enactment of this new legislation has been, and what we might look for in the coming months and years? Mark.

MARK MEINERS PH.D.: Great, thanks, Ed. It is a pleasure to be here. Is this on?

ED HOWARD: Tell you what – why don't you move over and try that one.

MARK MEINERS PH.D.: Is this one on? Okay. Well, I'll be in front of this one. It's always great to come to the hill. Springtime in November, right? It is a pleasure to be here today to talk about this program and as you can see from the title of this session, it goes to the heart of what I think

we really do want to focus on for those of us who have worked on this for many years. That is – what is the role that long-term care partnerships can play in the broader long-term care policy reform and debate? That's where I was coming from in being interested in this in the first place. I did a lot of work – actually when I was still a fed for – then it was called the National Center for Health Services Research, just figuring out why there wasn't a market for long-term care in the early '80s. That led to actually helping to develop a market. Then the next question for me and for those of us who wanted to take it a step further was – how could we really make sure this new idea, this long-term care insurance that still is such a small portion of the market could actually be relevant to public policy. What I mean by that is really acting as a way to help avoid impoverishment and needing to depend on the Medicaid program. That's what led us to thinking about how we could work with states. We're very interested in inactive [misspelled?] and trying to help the long-term care insurance market to think about how to help that market to actually be relevant to middle and modest income people. That's where the Partnership stepped in.

Then of course, we had that situation that David has referred to where there were some restrictions put on, roughly around the time get had gotten it going in 1993 that allowed the four states that had gone through – we actually had a 50-

percent batting average. Half the states who went through the planning process went to implement and right at that time there were some restrictions put on replication so we went from maybe 20 more states being interested in replicating this idea to just being able go forward with those four states. That situation pretty much went from 1993 to just this year, when the Deficit Reduction Act actually turned it on its head.

So I'm going to try and start from there while I'm also giving you a little bit of the background, because it's all extremely relevant for where we go forward. This is an idea that's been successful in a fashion at some level, so to speak, and certainly in the four states we've viewed it as a success for the reasons David gave, but without it being able to go nationwide and be much more widely available. It isn't as successful as it needs to be. It isn't really solving the public policy problem, so how do we get there is what I want to think about with you today.

To get there we need to step back and say, "What did DRA do?" One thing it did was remove the restrictions on Partnership replication so that other states could adopt this idea and I'll talk a little bit about under what circumstances because that's going to be important, and then it actually had authorized a clearinghouse of information to help consumers know more about long-term care, long-term care financing, long-term care insurance, et cetera, really understand this risk

that people really are to a great extent unfortunately in denial. So some definite carrots in the DRA, but along with those carrots are the sticks, and there is always been a sense that you need carrots and sticks in this area because Medicaid is out there. Well, there are the carrots, sorry.

I'm so used to doing my own computer. I remember one of these before where one of your presenters was well into his slides before – anyway, I won't go into that.

So we have the sticks and we have them up there. The fact that now the look back period for Medicaid is longer, there are some provisions that people can't hide resources in annuities, and actually one of the most significant things perhaps is if people have significant home equity, they are not going to be eligible for Medicaid. So Congress felt there was a need to really tighten up the eligibility criteria. That's not a new idea, but what is new is the combination of the carrots and sticks, because these things have never been that effective without really giving people a reasonable shot at how to prepare for this risk. When the rubber hits the road, these are always hard to implement and especially hard if you look at the situation and say, "Gee, how could this person have prepared?" That's why Congress came out with something like support for the Partnership in the context of these tightening up on the Medicaid program.

Now, let's take a little bit of a step back. We've

already talk about the Partnership. I want to share with you the features from my perspective that are really important. What we're trying to get at is really create a situation where we were balancing what was always a very tricky tradeoff between improved quality, so the benefits are decent and the fact that anytime you do that it's a rare thing you increase the quality in something that you don't increase the cost. We wanted to create a situation where people could still get high quality products and have confidence in them and still feel like it was affordable. We ended strategizing to do that in a way that would provide people extra asset protection and created a variety of different models, dollar for dollar, total asset. Actually, what came out of that were some combo models, where people could have dollar-for-dollar up to a point, and then maybe get total asset protection if they bought a certain higher level of insurance. There was uniform reporting and consumer educational campaigns that really help bolster consumer confidence and our ability to track what we were doing. Those were all some real positives that we felt from this program.

What's going to come out of the Deficit Reduction? Actually – one of the things that it emphasizes, is that of the various approaches that we came up with, the one that they saw, rightfully so, that can be replicated nationwide and across the states is this dollar-for-dollar idea. This schematic gives

you a little bit of sense of how it works. You can have a situation where if somebody had assets of $100,000 and bought insurance that paid out $100,000, they could essentially avoid spend down and protect that $100,000 while they were gaining some access to Medicaid benefits, so they would have extra resources at their disposal.

The other two examples on this slide indicated a situation where somebody actually had more assets than they bought insurance to protect, which indicates that they would have to have some spend down, but their spend down would be limited. So if you were in the choose to save mindset and you saved a larger amount than you would actually protected assets, you would still would have some spend down, but this kind of Partnership approach would allow your spend down to be limited so that you could have some protection from impoverishment while you were still getting assistance from the public program. That's the heart and soul of the idea that is that you are creating an incentive for people to buy some coverage where they wouldn't have otherwise had an incentive.

Lisa mentioned, for example, that most people are going to use an average of three years. You can imagine the target market that we're shooting for might be people that don't have assets that would cover them for three years. So at that point, they're going to say, "Long-term care insurance is not for me. I'm going to end up having to spend through it

anyhow." This approach actually makes it relevant to a wider swath of the population and that's what we were going for, so this could be an idea that could be presented to all populations who had some resources to protect, not just high end, even high end middle class.

Some of the positives that we see that can come from it, because it is a strategy that really from the simulations we did is basically cost effective and can produce some savings, it's an efficient subsidy. These trade-offs really come out only at the end. There are no up front payments, no premium subsidies for this strategy. It is a strategy that only kicks in where you can begin to have people contribute to the savings while some few people might actually be using the benefits where they wouldn't be using them before, I can get into that a little bit more. But basically, it's a very efficient – on a present value basis for those economists in the room – it's an efficient way to give people a way – an incentive – to buy this coverage.

I won't go through all of these, insurance, particularly this helps avoid gaming and helps people avoid impoverishment as I mentioned. The one I want to emphasize here is that in an interesting way, because we're always involved in a political process in these ideas because people come at this from different perspectives, it has a way to mitigate some of the concerns about means testing programs.

That is, any of us in this room who may never think we're going to be on Medicaid, if you bought a Partnership policy, you nonetheless would have a stake in it. It being a decent program for those it was meant for. This was a goal that we had. We wanted to have something that was helping to preserve Medicaid resources for those who really needed them and give people who could plan for long-term care an option so that they wouldn't be looking to Medicaid as their long-term care insurer and do that as much as possible. We feel it creates a dynamic where there is a constituency for Medicaid even amongst people who hopefully will never, ever rely on it.

Now of course, we ran into some difficulties. Any time you try and change the world in essence, you're going to run into some challenges. They're targeting issues. Insurers oftentimes basically will encourage people to buy this because Medicaid was not a program that you should rely on, and not as high a quality program, so it was a way to encourage people to buy. This idea – selling it in a somewhat different way that created a situation where distributional channels were not geared up necessarily to view this and to understand it for what it was. It wasn't just the mainstream private insurance product, it was a little bit different and those nuances needed to be learned that created some sort of a challenge to us that are out there. Then insurers also face the state-by-state filing burden and the fact that there was really no reciprocity

between the states when we had gotten started, actually a reciprocity agreement was developed that I'll touch on a little bit more, because it's a model for the reciprocity that the DRA does call for. But the idea that you could have your insurance protection in the state where you were, but that special asset protection if you move from New York to Florida that didn't have such a program, you wouldn't get the special asset protection, so that was viewed by some as a barrier. Then of course, the fact that the Medicaid program, whatever that was at the end, there was some unevenness across the states. So those were all things that made it a message that had to be crafted carefully and was a challenge to the traditional insurance market.

Now, what does the National Partnership do? I'm going to run through these quickly. First of all it grandfathered the four Partnership states as they are. That was important to them. They put a lot of time and effort into it and certainly some of the ways they do things are not what was ensconced in the provisions of the DRA. The dollar-for-dollars I mentioned is the approach that is encouraged by the DRA. Policies have to be tax qualified. They have to follow the NAIC guideline, the Model 2000 Act. They do need to be inflation protected but only in a fashion – compound up to age 61, some level of inflation protection, 61 to 76, and then after that no inflation protection. Our states all wanted to have compound

inflation protection be required across the board. That's something we can talk about.

There is a strong sense that there should be some training – special training about Partnership policies because they're a little bit different. There is a need for uniform data set to help monitor it. Then there are provisions in there, again we should talk about in the discussion that basically are interesting and potentially controversial. No special Partnership policy features can be mandated except for the ones that I've just gone through. What that means is that states really aren't in a position to do things that are unusually different for the Partnership policies from the non-Partnership market, and in some sense that really creates some good things and some bad things. It creates a situation where Partnership and non-Partnership are pretty much going to be similar except for things like inflation protection, which simplifies the decision making and keeps those policies up to date, but it does begin to get in the way of states being creative about other things that they would like in their Partnership policies that they wouldn't necessarily require in the non—Partnership. They're not going to be allowed to create that dynamic.

There are a couple of provisions that are being worked on as we speak. The idea that reciprocity arrangements are going to be guidance for how reciprocity arrangement could be

structured or going to be worked on by the Department of Health and Human Services, and the Department of Health and Human Services has some special reporting requirements around the effect that it's having on Medicare and Medicaid expenditures as well as the relationship between long-term care and Medicaid.

Now we have gotten to this stage in part because what the insurers found was that the Partnership policies actually were acting as a catalyst. The markets for long-term care insurance, both Partnership and non-Partnership grew faster in the Partnership states than in the non-Partnership states, and that helped create some of the political dynamic that led to the passage of the DRA. Some of the lessons learned – we've touched on these and can talk about them more. One of the important ones is trying to keep it simple as much as possible, and also having comparability between Partnership and non-Partnership policies. The other thing is that we have gotten some preliminary results that the states have estimated, a little bit in back of the envelope doing survey work and some of the results of who has purchased it. We estimate in fact, in the three dollar-for-dollar states, there has been savings on the order of $20 million so far, so at least it's going in the direction of what we had simulated.

I'll talk a little bit more about the dynamic of the cost effectiveness. Basically that slide indicates that the

incentive is there to try to get more people into the market, yet relatively few of them are actually going to ever need to use the benefit and use up their Medicaid so that they would have to get the special asset protection. That's really what creates the cost effectiveness. In your slides, you are going to see some updates of where we are with respect to state plan amendments and some of the other states that are considering that. The key things here are that coming up in this next year we're going to get the guidance out of the Department of Health and Human Services on the reciprocity and the reporting requirements. At that stage it's going to be much more comfortable for states to move forward. With that, I'll end.

ED HOWARD: Thank you so much, Mark. Our final speaker is Bonnie Burns. She is the training and policy specialist at California Health Advocates, a non-profit group that looks after the health and long-term care interests of older Californians. She pursues this goal so well that she serves as a consumer representative on the National Association of Insurance Commissioners, and she is here to help us recognize some of the issues that the Partnership initiative presents that can affect whether consumers actually get the most value from their policies. Bonnie, thanks for coming so long a distance to talk to our audience and explain some of these connections.

BONNIE BURNS: Thank you, Ed. It's nice to be here.

When I woke up this morning, I thought I must be in California with all the sunshine and warm weather. We do have a Partnership in California. We had just prior to the beginning of the Partnership program, done a massive overhaul of our state regulations in regards to long-term care insurance. Consumers who buy these products in any state need high quality, reliable products with no surprises, and because long-term care insurance is state regulated, in many ways it depends on the state a person lives in as to the quality of the product that they're going to get in that state. They need understandable disclosure documents. They need to know in a clear way how these policies relate to the state Medicaid program, and that can't be left up to individual agents to explain. They need well-trained agents, as two of the speakers have already noted, agents are key to this, but they are accustomed to selling against Medicaid. That's the whole reason for buying a long-term care insurance policy is that so that you won't use Medicaid. It requires a shift in thinking to understand the connection between the program and the private insurance policy, and it requires an agent to understand how all of that works, how a state recovery works and they can't be left to their own devices to explain that to people. There needs to be strong state oversight of a Partnership program because many of the people who are buying these policies are sometimes at the lower end of the moderate

income and need to be protected from buying products that they won't be able to keep in the future.

We need to take the time to do this right. It isn't just amending a state plan. It means that the insurance department and the state Medicaid director need to understand each others field of expertise. Medicaid directors need to understand how long-term care policies work, what they cover, because often long-term care insurance covers benefits that are not available through the state Medicaid program. The Department of Insurance needs to understand Medicaid and how that relates to the products that they're regulating. They both need to understand and agree on the programs operation. They need to look at a process for training agents and a process for verifying that the agents are understanding the state Partnership program that is specifically required in the DRA.

State agencies need to establish clear rules for the agent participation in the program, for the training and verification and for the operational rules that the program is going to operate under, under the dual responsibilities of two different state agencies. They need to develop mandatory standardized explanations and disclosures. You can't leave these kinds of explanations up to agents, as important as they are to the process. Eligibility for state Medicaid programs varies from state to another. Asset protection and a state

recovery rules vary from one state to another. Agents often sell in more than one state, especially when they're located near state borders. To have agents selling a Partnership program, they're going to need to understand how these operate in more than one state if they are selling in more than one state. They may even need to know that in order to explain to a person what happens if they leave the state they bought a Partnership policy in.

The products have to meet high standards. This is an opportunity for some states who have lower standards, or who have standards that they would like to increase, to increase the requirements for all policies sold in their state, not just the Partnership programs. There are some things left out of the DRA, as they were left out of the HIPA legislation when they created the test qualify program is based on the NAIC Model Act and Regulation. They didn't, in fact, require everything that was in the Model Act and Regulation in '93. They left out many provisions when they adopted the federally tax-qualified policies, and the same thing happened in DRA. Some of the things that were left out are the rate stability requirements in the NAIC Model Regulation. That is a very important provision of the NAIC Model because it increases the requirements that companies have to meet when they file for an initial rate to sell a long-term care policy that may, in fact, protect people from later rate increases.

Pricing practices are really important here, because there have been rate increases, and for some people massive rate increases. The worst combination is to have a tax-qualified policy that provides asset protection for a person but doesn't control the rates. Later, if a person isn't able to keep that policy, they have gotten the tax benefits of having had it. The companies have gotten the tax benefits of having sold it. They've had the asset protection in place while the policy was in force, but then when they need benefits, they don't have it. Having the pricing practices controlled as they are through the NAIC Model at a minimum, should've been included in the DRA and wasn't. There has been a recent market consolidation with more than a dozen companies leaving the market. The reason that they've done so in part is because the profitability of the policies has been less than expected.

The agent training is absolutely crucial to this. As many people know the agents are going to be selling this and they need, for the protection of the consumers to have good training. In the Partnership states today, two of them require eight hours, two of them require seven. The Deficit Reduction Act, however, only requires that the Medicaid agency provide the technical assistance to the Insurance Department to ensure that agents receive the training and demonstrate the understanding of the policies and public benefits. That places

a burden on the state Insurance Department to make sure that this happens. However, the Model Act draft amendments, which have not yet been adopted, have adopted some changes here requiring a one time training of eight hours. I might add here that some of the people who do the training for long-term care insurance in the states were appalled at a minimum of the eight hour requirement because many of them feel this can't be done in less than 12 or 16 hours, but there is a one time training requirement of eight hours with four hours required every 24 months for agents who are going to be selling long-term care insurance. That, of course, is only applicable once the NAIC adopts that requirement in states that also adopt that same requirement. There are specific elements of training required in the NAIC Model Act, and I've listed some of them here.

We made sure in those requirements to preclude the producers using sales and marketing information or company specific products as part of the training. The Model Act does, however, delegate the responsibility and the proof of this training to the insurers and requires the insurers to verify that agents have taken the training and that they understand it. I'm not sure that that satisfies the requirements of the DRA, and lets the insurance commissioners off the hook by delegating this to the insurance companies.

Asset protection standards are really important here because they need to cover all of the benefits that are being

covered in a policy. Assisted living is one example here. Many states don't cover assisted living under their state Medicaid program. So the question will be, for many state Medicaid directors, will be whether they will allow asset protection for an assisted living benefit. We had that discussion in our state, by the way, when we were going through the process of starting up the Partnership program. Asset protection and reciprocity are absolutely critical to the Partnership program because people move, and the average age of purchasers has been moving down because of the group sales. Many younger people are buying these products and they are not likely to retire in the state that they live in when they bought these products. Many older people are forced to move when they need long-term care to be closer to their families, so portability is really crucial here.

Inflation protection – there is a big discussion going on in the industry about whether the DRA allows for what they call periodic increases, and some call future purchase options because it's cheaper to price a future purchase option than it is the built-in compounded inflation protection. So many of the companies prefer the future purchase option knowing that over time, fewer people will be able to take advantage of it, because it also increases the cost of their premium each time it's offered, and most companies include a limited amount of time that you can turn down a future purchase option before

that option is completely eliminated. There is a discussion going on within the industry about that very thing right now.

The questions are will a Partnership save Medicaid dollars? It looks like in the Partnership states that exist today, that may in fact, be the case. That may not be the case in the future, depending on how some states organize a Partnership program. Consumers are going to want to know whether they're going to be able to get those benefits and that promise access to protection later, and some of that will depend on how the rate regulation is handled within states. Companies will want to know whether the Partnership policies will stimulate sales, many of them believe that it will, but of course the industry is always looking for the next best thing to distinguish their products from someone else's products. Again, agents are crucial to this process. They need to convert from selling against Medicaid to selling with Medicaid and then they also need to understand the whole issue of Medicaid and how that works with the policies that they are selling.

I put in two pages of resources for you aside from what you already have in your packet and the one that I want to talk about for a moment is the database on rate increases. California passed a law requiring all companies who had sold long-term care insurance in California at any time since 1990 to annually contribute data about rate increases that they have

had on their long-term care policies, not just in California, but in any state in which they sold a long-term care policy. The California Department of Insurance has almost a national database on rate increases, which is interesting reading to see how some companies have dealt with this issue, because there are some companies who have never had rate increases on their long-term care business over several decades and there are others who have had numerous and massive cumulative rate increases over short periods of time.

This last page, of course, talks a little bit about some of the consumer materials that are available and where you can find them. Then on the AARP Public Policy Institute report that I did on the problem of trying to compare long-term care and policies with each other. Thank you.

ED HOWARD: Thank you very much, Bonnie. Provocative stuff. We're now at the question point. There are microphones you can use that people are already going to. There are green question cards that you can fill out and raise your hand, but can I exercise a prerogative of the guy with the microphone and ask a question that occurred to me as Bonnie was talking. You referred to the lower than expected profitability. This is not necessarily your question or it might be Mark's or anyone else who would like to chime in. Mark's slide shows that of the 200,000 policies that have been sold, only 119 have gotten to the full benefits that are provided by the policies. How much

more profitability can anybody expect?

BONNIE BURNS: There are a number of studies out there down by actuarial groups that point to the low profitability of long-term care insurance in general. Not being an actuary, I can't comment on those particular figures, but certainly some of the companies have left the marketplace with that explanation.

MARK MEINERS, PH.D.: This slide I showed, those are the numbers which actually exhausted benefits, but the principle is the same. The number who buy, the expectation is a relatively small number are actually going to go into benefit. So that's part of it, and I think that's what you would see in any case. If you saw the number of people who purchased the policy versus those who use it, you would see a much smaller percentage. The other thing is that it is a unique product in a sense that you have to have a long time frame, so even though it's now maybe 20 years old, you are buying this for people – people buy this in their 50s and use it in their 80s. A significant part of any particular body of purchasers is going to not be in benefit as this point.

BONNIE BURNS: Ed, there is an emerging experience in the industry on long-term care insurance benefits, particularly in the area of cognitive impairment. I hear the industry saying that they are getting about half of the claims for cognitive impairment as the trigger, which is not what they had

expected. That may simply be part of the dynamics of people living longer and developing conditions that have a cognitive impairment factor.

LISA ALECXIH: The other piece of it is long-term care insurance is a complicated policy to price and one of the components of pricing is estimating how many people are not going to go into benefit, drop their policy before they go into benefit. The fact of the matter is people are not lapsing their policies at the rate that some companies assumed. So instead of paying in for 10 years, or however long they pay in for, then never going into benefit claim and having that money available, people are keeping their policies going into benefit claim and drawing against the policies at a greater rate than insurance companies anticipated.

MARK MEINERS, PH.D.: Which is a good thing to keep your policies.

LISA ALECXIH: Yes.

ED HOWARD: All right. We have number of people lined up at the microphone, so I would urge you if you are contemplating writing a card that you think about going back to a microphone because you might not get it read. We'd ask you to identify yourself as you ask the question.

JOCELYN MOORE: Jocelyn Moore with Senator Rockefeller's office. I certainly would like to thank all the panelists for being here for what has been a very lively

discussion. I'd like to explore the issue of savings to Medicaid as many of you are aware. Senator Rockefeller has some very interesting thoughts about that, and I know that much has been said about the policies and the intent to really target folks who would spend down to Medicaid but the Government Accountability office, and I know they are represented here today so I certainly would invite them to comment, their research indicates that the purchases of Partnership policies in the four states actually have assets around $350,000. So we're talking about very wealthy or relatively wealthy individuals who are purchasing the policies. I'd like to explore the savings standpoint from that perspective.

Also I'd like for the panelists to talk about whether or not the purchasers of the policies would have otherwise spent down to Medicaid, because I think when we're looking at savings, if these are folks who would not otherwise have been on Medicaid in the first place, I think one could argue that there aren't really savings to the Medicaid program.

Then the third thing I'd like the panelists to comment on in terms of savings - and Mark, you mentioned this a little bit - when we look at the four states, California, Indiana, Connecticut and New York, individuals in those states tend to be relatively wealthy. So when you look at the policies and implementation in a state, like West Virginia, do we anticipate

that they would actually save money, because those folks probably will exhaust and go on to Medicaid? Thank you.

ED HOWARD: Mark, do you want to start?

MARK MEINERS, PH.D.: Sure, I'll try. There is a lot in there. People who buy enough insurance that they don't have to go on Medicaid, whether it's prompted by Partnership or non-Partnership, that's a good thing. In some sense, you can think if they would have conserved those resources, wouldn't have transferred their assets, maybe it's a wash. So you take them out of the equation, whatever the incentive is. What the Partnership is designed to do is to try to help people who are really more at risk of ending up on Medicaid and those might be people who either would game the system and that could be well to do people, but it can be people along the wealth spectrum. I personally think that when people "game," the system, it's when their backs are to the wall. So one way to avoid that is to make sure that people of middle and modest income for sure, who don't have the resources, are preparing for this risk with insurance, and this is a way to make it meaningful to them. To the extent that they have insurance between themselves and Medicaid, it's going to delay or maybe totally forestall the transition of Medicaid. That's the target population and that's what it's designed to really get to.

The people who are well-to-do – and Jocelyn, you are right – if you look at the data, you're going to see in all of

the states for a variety of reasons, there are people who are buying fair amounts of insurance who get Partnership protection and that's also possible under the DRA. To a great extent that protection is never going to have to kick in, so it's not like it's going to cost Medicaid anything by having provided that commitment to those people because they're going to have the assets and income to cover their risk. That's what we're finding. There are people who have the insurance who even when they go into benefit often times will have assets that sometimes exceed what was protected for them or will have income that will exceed or be enough to pay so that they won't ever have to be on Medicaid. So those people, in that sense, are out of the equation. The reason in terms of our design, and we debated this in the early stages, it was decided at some point that that we didn't need to worry about those folks because they weren't going to be accessing Medicaid and we didn't need to create an artificial distinction in the marketing process by saying this is just for middle-income people and higher-income people couldn't access it. It's a long answer, but in general, those people who aren't really going to be putting any pressure on the Medicaid system one way or another.

BONNIE BURNS: Could I add to that for just a moment? When we designed our program in California, we limited the coverage to five years because we were targeting the people in

the middle, the people whom we thought were most at risk of spending their assets if they needed long-term care services and who had enough income to be able to afford the premiums. We were later forced to add lifetime coverage as an option because the agents demanded something that they could sell in competition with what was in the private market. When you're dealing with agents and private insurance, those are the kinds of dynamics that you get. Agents want something to sell that competes with other products. You sometimes are forced to accept things that you wouldn't otherwise have done in a Partnership policy or product.

MARK MEINERS, PH.D.: Just one other sidebar to your question and I think it's important, and that is I think we felt and feel that it's really important that they're be the equivalent of one- and two-year policies offered out there in the market for this to work, and that's not required anyplace at this stage. In fact, you can buy stuff online, long-term care quote is a way to do that, you can actually get three quotes. It's kind of interesting. Anyhow, there is a sidebar, if you do that, I don't think at least in Virginia, you're not going to see a one-year policy. That is a concern that states want to keep an eye out for that there are policies that are sold in that equivalent of one- or two-year framework, certainly three years is okay, but what we're going for, that's an important target market. So those options are out there for

people, and that is not as an enticing sale for an agent because the commission is lower on that level of coverage and that's one of the things that when I talk about needing to work on the distribution channel, that's an important area that we need to keep an eye on.

COLETTE IZMARROS [MISSPELLED?]: Colette Izmarros with Senator Grassley's Finance Committee staff. I just want to follow up on some of the comments about compound annual inflation protection. The Senate bill actually before we had gotten to conference had a requirement of a 5-percent compound annual inflation protection on all of the policies sold under the Long-Term Care Partnerships, and during negotiations with the House, which didn't have a requirement for inflation protection, we ended up with a bifurcated system that was put into the statute, but Bonnie, you mentioned that some of the insurers are having conversations about what actually qualifies or is compound annual inflation protection. And I think that my boss would view the statute as being abundantly clear with respect to what compound annual inflation protection is, and I just would point out that during deliberations on the bill, prior to going to conference, they were very concerned about compound annual inflation protection. So if there is a true belief that future purchase option actually is compound inflation protection, then they actually shouldn't have been worried about it, but that's a whole other thing. I think he

has made clear, and has Chairman Barton to the administration what was meant by the statute which, again, we think is very clear. I guess I would like to ask Bonnie or any other member of the panel to discuss the difference between the two and why it's so important. I think you touched on the fact that over time the value of the benefit package erodes, the premiums go up, but if you can touch on how compound works relative to future purchase option, I think that would be helpful for folks. Thanks.

BONNIE BURNS: I'd like to address that because I feel very strongly about 5-percent compounded. It does two things. It increases the daily benefit amount each year on a compounded basis, but it also increases the maximum amount of asset protection that a person has in the same way. With younger people who are considering long-term care insurance, one of the points that we made is that if you are younger, you may be able to buy a two-year policy that covers $100,000 worth of assets, because over time, that asset protection will grow to meet the assets that you have that are greater than that. They also need to keep in mind that assets sometimes grow as well, so that compounded feature is really important. It's priced at the beginning of the policy. You know what kind of a policy you can afford, and the inflation protection is built in at the front end and the price is part of that. The future purchase option means that periodically, usually every three years, the

company will send you a notice and say, “Here is the amount of increase that you are able to buy with no health underwriting, and here is the price for that inflation protected daily benefit amount.” When people are younger and still having income coming in through work, they’re more likely to buy that increased inflation protection. Later, when they retire and have less income, and the prices go up as they get older, they’re less likely to take advantage of those offers, which leaves them with not just a static benefit of a particular daily amount, but one that decreases every year in contrast to the increase in the inflated cost of care.

ED HOWARD: Go ahead, Mark.

MARK MEINERS PH.D.: Just a comment on this. It’s a tough issue, but I think states that have done these programs felt very strongly from a standpoint of protecting the states and the consumer. Compound inflation protection and 5-percent rate is what they preferred across the board. I know that what it does, the extremes are no inflation protection, compound inflation protection at five-percent probably at least adds 50-percent to the price, but that’s the issue. You can sell something easier that’s 50-percent less, right? But, a couple of things I would say, again, the consumer could well spend through their resources if it’s not inflation protected appropriately — number one. I think more importantly, I don’t know about more importantly, but equally important, if we’re

going to launch this program in a lot of states across the country and have it be successful, as I said on the one side, simpler has to be better. So I don't think it's wise to get bogged down in these nuances that are so hard to follow. I think a good rule of thumb is the compound inflation. I think that helps protect the state and the consumers, and I think insurers have been able to sell that product and I'm really hoping that we don't get bogged down in that kind of debate.

ED HOWARD: If there is anyone here from the administration that would like to make a prediction on whether the response to Senator Grassley and Senator Baucus' letter will be forthcoming, and the content thereof, we'd love to hear it. It doesn't have to be right now, if you need to work on it. Yes, John?

JOHN GREENE: John Greene with the National Association of Health Underwriters representing the agent groups. I'm going to just address the agent training issue. To say that carriers and NAHU have been working closely together for almost a year now to develop a training program for the states, meaning carriers are responsible for the agent training. That there is no vacuum for states to have to fill. I know that Minnesota has been under the impression that they had to fill that void and I just wanted to do it in this public forum to say that agent training is coming, be ready in January – and it will be a self-study program and there will be worksite later

on in February and in mid-spring or so, we should have an online version. There is a one-year grace period, of course. We want to get this out as soon as we can, but like everybody else, we were waiting NAIC modeling language which our training complies with. Thanks.

ED HOWARD: Yes?

DANIEL THOMAS: My name is Daniel Thomas. I'm a former employee of the Health Insurance Association of America, which everybody at the panel I'm sure knows about. That organization no longer exists. It was merged into another organization. The audience also needs to know that that organization worked on long-term care insurance and I was part of the initial group that started to talk about standards for long-term care insurance. I think the panel did an excellent job of identifying the problems. One of the funny things is as I sat here, I discovered that apparently I am the wealthy group of society, because you're throwing some figures out here for assets and income. I'm a simple guy, so some of the stuff doesn't make sense when one talks about it to me, when one talks about the affluent society.

Nevertheless, I also have two long-term care insurance policies. One was through the Health Insurance Association of America with no escalator clause. That policy that I bought I quickly discovered would not, which would have protected me adequately with long-term care insurance, I quickly discovered

that within about five years of my purchasing, that was inadequate. So I bought another health insurance policy, not getting rid of the other. [Inaudible] and that one had an escalator clause. I then had the opportunity to transfer my policy to another policy through the Health Insurance Association of America and was able to have an escalator clause. Oh, wonderful. So I just knew that I was well protected. Now when I heard you talk about the expenses for long-term care insurance right now – and by the way, I only changed this about three years ago – I'm inadequately covered. Now there is something wrong. What's apparently not being taken into account is the fact that as people in your position set these standards, the long-term care providers are saying, "Hey, we have a source of income here and it's not exclusively Medicaid." Therefore, their costs are going up a heck of a lot faster than any 5-percent. If you look at cost for health care in general, 5-percent is far less, and most companies or people experience in terms of the escalation of premium of cost. Escalation of cost of services, so I just want to say that you did an excellent job, but this inflation factor is grossly underestimated. Thank you very much.

ED HOWARD: Provocative, and who would like to address it. How about you, Mark?

MARK MEINERS, PH.D.: I think that really captures the discussion. You go where from where some people are saying,

“Oh, none,” and others are saying, “Five-percent is not enough.” The reality is that we all have experienced inflation so we know the cost of care is going to increase whether it’s five-percent or more than that is something that is less certain. A lot of what we do in this area preparing for the risk in a reasonable fashion is about what we can hope to do and that’s where, personally, I think the 5-percent number comes in on over the past probably 10 years. It has not been too bad, but when we first started with that number, it was right where we said it was. It was behind, so that is a way to capture that thought process about the importance of inflation protection and how to do it in a straight forward reasonable fashion.

ED HOWARD: Could we get some sense of how long-term care costs have gone up relative to the five-percent as opposed to the health care costs that were in double digits and are now edging down to the high single digits. Is long-term care going up as fast as health care in this period of low inflation in general? $70,000 is an awful lot.

BONNIE BURNS: That might depend on which service you are asking about.

ED HOWARD: How about nursing homes?

BONNIE BURNS: I don’t know the answer to that, and I am anticipating that assisted living is the one that will go up as more people are willing to go into an assisted living

arrangement than they are to go into a nursing home.

BOB ROSENBLATT: Bob Rosenblatt, freelance writer. I'd like to ask the panel to discuss in some more detail one of the penalties of DRA, which is you can't get on Medicaid if your house is worth more than $500,000 or $750,000, no matter how poor you are. First question is where is there an estimate, if there is one by CRS or by one of the committees, as to how many people this would affect in each state?

Then as a former newspaper reporter, let me ask you to address a few hypotheticals. Will insurance agents call on elderly widows and say, "Buy this policy or you will lose your home?" If they don't buy the policy, will newspapers and television stations be interviewing crying widows who have just sold their home to pay for their nursing home bills? The third hypothetical – the penalty does not apply if the adult child or spouse is in the home. What's to prevent the baby boomers' son or daughter of someone who is 90 from saying, "I live in mom's house, therefore we don't have to count that as an asset." If that happens, will state be sending inspectors to knock on the door to see if the adult child is legitimately living in mom's home?

LISA ALECXIH: I want to start with that in terms of the 13th slide that I had. Today's elderly, the median net worth is $110,000 total. That's both home equity and financial assets, and $25,000 of that are the financial assets, so that

leaves $75,000, $85,000 median home equity. So the $500,000 in San Mateo County where 50-percent of the homes have a $750,000 or more homes, yes, may be a problem. But the vast majority of the country, this is not going to be an issue for the current elderly. It may become more of an issue as people age and as the value of homes continue to increase. Who knows? We're in a bubble – I don't know, but for the vast majority of the current elderly, this is not an issue. In terms of your stories of crying widows and inspectors knocking on your door, that's going to be up to the states, and I doubt it's going to happen a whole lot.

BONNIE BURNS: I'd like to tell you what I've seen in California, and I expect it's not unlike what other high cost residential states have seen. That is that it's the home equity conversion folks that are convincing people that they need that product because they have a house worth quite a bit of money in most parts of California. In order to protect the amount above $500,000 – that's what I'm anticipating. We already have pretty active home equity conversion sales force in California. Many of the folks who sell those products convince people that they can use some of that money to pay for a long-term care policy too.

MARK MEINERS, PH.D.: I think to be fair on this issue, it came about because people who have that kind of home equity have resources at their disposal. They may be house-rich,

cash-poor, so in some ways, when you are talking about Medicaid reform and needing to have resources to pay the long-term care bill, then the idea is that those resources should be on the table and not excluded. That's, I think where Congress was coming from, and I think just allowing states to up it from $500,000 to $750,000 for example, allows for some variability for states like California or other places where the housing market is very high. And yes, home equity conversion is one of those options out there that folks are trying to stimulate more of an interest in.

The bottom line is if you write your story as a horror story, have it be on the side of encouraging people to prepare for this risk, because fundamentally that's the stick part of the carrot and the stick issue. People need to think about preparing for this risk. Need to think if they have home equity it's not just to sit there to transfer to someone else. It needs to be there for the rainy day, or we won't be able to afford some of those costs that Lisa was indicating were going to be there in the future.

ED HOWARD: Just to clarify – is the $500,000 or $750,000 limit applicable to Partnership policies, so that even if people buy the Partnership policy with the premise that they will be able to access Medicaid benefits, they won't be able to access Medicaid benefits. Is that right?

MARK MEINERS, PH.D.: The four states that Partnership

policies exist in are working to try to create language that makes the asset protection over and above what's normally protected, which is pretty much when you talk about spousal impoverishment or any of the other murky details of eligibility is the way the Partnership works. It's over and above things that are already available to people who are on Medicaid. What CMS will do in that regard – I don't think from that standpoint that they have ruled in favor of Partnership assets being allowed to do that. So it may come into a hardship kind of special situation to be decided by states and at the point of application.

ED HOWARD: Bonnie.

BONNIE BURNS: I think that's a very important point, because I think the guidance that has already been issued makes that pretty clear that the $500,000 is the limit, and that the current Partnership programs – that would not affect those programs, your asset protection and those programs would not apply to that $500,000. That does raise the question of buying something that you think protects your assets, only to find out later, that it doesn't protect a particular asset.

ED HOWARD: Yes, ma'am.

STEPHANIE HALL: Hi, I'm Stephanie Hall. I'm with the state of Maryland and we are now proceeding on to develop a Long-Term Care Partnership Program and my question is somewhat in the nature of yours, Mr. Howard. These are technical

questions, so I may just leave them here and I'll leave you with my green card, but I think that both the Medicaid divisions in the states and probably the insurance administrations need some technical assistance on some things, similar to the question that was just asked. The things that we've been working on, how does a disability type policy fit into this? Because my understanding is that the current four Partnerships have set amounts that are paid, and the disability type, where you simply get a total amount of money because you need a criteria of disability are very popular now and we would like to see those apply. Of course, the place that is most scary would be Medicaid.

We also wonder how we can assure that people who take the Partnerships, but because of their specific kinds of care they need don't exhaust those benefits, and therefore need assistance even sometimes before they can fully exhaust the benefits, because of the nature of their disability.

The last thing we're struggling with, since we're in the development and we're publicly announcing this, what do agents do? Of course, I'm with the state so I would like the agents to disclose to people that they are selling to now, that this is something that may be there. Not because the person should wait, but because people should have full disclosure, that this is a form of policy that is coming up. I know time is getting short, so I may just leave my green card with my e-

mail up there with – those are probably about 26 or 30 questions Marilyn has.

ED HOWARD: We'll collect them and we'll be happy to make sure that all of our panelists get them. If any of the panelists would like to take on any of them directly right now.

MARK MEINERS PH.D.: Well, I could probably do them fairly quickly. You're right, Stephanie, disability policies under the current Partnerships were avoided, meaning that's pretty much where benefits get paid out. If you have your activities of daily living, you can get a cash benefit. It's kind of appealing because it gives you a lot of flexibility. The current states didn't particularly allow that for reasons I can get into, but I think going forward they will be allowed because some of those restrictions – unless a state says they won't allow them, in which case they wouldn't be allowed in the non-Partnership, and that's one of those things that will trigger significant controversy in a state.

So that's the way it would work. If Marilyn said, "We aren't going to allow those in Partnership," they would have to say the same things in non-Partnership and you would have the likes of UNUM and others who have done well with those being pretty much against the Partnership. That's one of the things that's in there.

In terms of exhausting – the way the dollar-for-dollar model has worked, basically you begin to accumulate asset

protection as soon as the benefits start spending out, and there is this situation conceivably where your insurance could still be in force and you're being used, at which point you have also been using some of your assets. They cross at some point so that you would begin to have protected assets while your insurance policy was still in force and still paying out. It doesn't require that it has to be exhausted, so that's one of those fail safe things that were built in the model as it exists in the dollar-for-dollar states. So at least those two I can deal with.

ED HOWARD: We have just a couple of minutes remaining. We have a question or so on a card that we figured we better get in front of our panelists. Let me just ask before I do that ask you while you're listening to the last Q&A, pull out those blue evaluation forms and fill them out for us. The question which is one of two on this card and is labeled by the writer as the more important, "Why do Partnership policies need to resemble other long-term care insurance products?" Since obviously they have different benefits, and go beyond those policies?

MARK MEINERS PH.D.: The experience that we had was that when they didn't – because Partnership basically was a niche product, the non-Partnership would add the newest features, bells and whistles, et cetera, and the Partnership wasn't updated. It created a situation where Partnership

really couldn't compete, so there was a sense around the time of HIPA and the tax qualified policies to try to get policies as much as possible on an even playing field so that the agents and people buying the policies would see that the major differences between Partnership and non-Partnership might be the mandatory inflation protection and the reporting requirements, so there wasn't a big Partnership, non-Partnership distinction. That was the origins of that. The current Partnership states feel that's important to the success of their programs. That has, in some sense, been codified with this other provision that I was mentioning about to Stephanie from Maryland. It now works the other way too, so states can't go in and make the Partnership policies real special in certain ways without making sure that that is also for non-Partnership policies. What that means is that some of – Bonnie was mentioning this and I think it's an important point, that if you have a state, for example, and the state wants to use the Partnership to upgrade the whole industry, it can do that and the industry will have to go along with that upgrade. They will have to play. This is a Partnership after all, states want something, and insurers want something. They need to agree, otherwise you won't have insurers play. So it's a fairly subtle, but important issue to have comparability between the two.

BONNIE BURNS: Now what we saw in California, for the

most part, we saw it a lot before we required agent training. There was about a five-year period when the Partnership was available, but the agents weren't required to take training. During that time, we saw the agents using the Partnership to sell against. They were comparing a Partnership policy that had built in 5-percent inflation protection with a policy from the same company that didn't, and selling the cheaper policy to people. That was in era both before we required agent training and before 5-percent compounded was so often available. We've seen less of that over time, but that again goes to the issue of agents understanding these products and understanding the difference, if there is one, between the Partnership policies and the policies that are available in the private market. It gets particularly difficult when you have a company selling both a Partnership product and products that are not Partnership, making it much more difficult for people to understand the differences between the two.

MARK MEINERS PH.D.: One other comment on this. I would say, over the course of when the Partnership emerged, long-term care insurance, particularly by the big players, has really improved dramatically. To a large extent a lot of the features that are in the NAIC expectations are there in the best policies, the highest selling policies. So what the state requires and what the insurers do are different. Many insurers will exceed what's actually required in their states. I guess

that’s a way of saying I think, for the most part, it’s less of an issue today, though it’s worth being diligent on in terms of what the state expects, but not all insurers are the same. But for the most part I would say the products have improved dramatically and have a lot of terrific features.

ED HOWARD: I should remind you that in furtherance of the premise that Mark just articulated that all insurance is not the same, you should check out Bonnie Burns’ database and see what’s happened in the way of rate increases in the last 15 years across different companies before you either buy or advise others to buy a particular long-term care insurance product.

We’ve come to the end of our time. This is a tough issue to wrestle with. It’s a really important aspect of the policy debate about long-term care and I want to thank you for staying with this discussion. I want to thank our panel for an extremely articulate setting forth of the different aspects of this initiative. Thanks to the Robert Wood Johnson Foundation for allowing us to do this and for its long-term interest in this long-term care issue, and I ask you to join me in thanking our panel for this discussion. I have a hunch that we’ll be talking about long-term care in the next couple of years some more, and please fill out those blue evaluation forms and thanks for coming.

[END RECORDING]