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LONG-TERM CARE COVERAGES

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MR. GORDON R. TRAPNELL: Dr. James Knickman received his Ph.D in economics from the Wharton School at the University of Pennsylvania. He is on the faculty of New York University and is currently on leave to serve at SRI International, which used to be Stanford Research, Inc. but is no longer affiliated with the University of Stanford. He has conducted extensive research on the financing of long-term care and has written and spoken extensively on it.

DR. JAMES KNICKMAN: My remarks will focus on some of the important issues in the field of long-term care that are relevant to the development of private insurance instruments.

Long-Term Care: An Emerging Concern

Long-term care is an important emerging concern in society. You read about it in the New York Times; you read about it almost anywhere that you look. It is an emerging concern clearly because our population is aging. It is well publicized that between 1980 and 2000 the number of

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elderly will grow by 18 percent, but even more important is that the elderly population is becoming increasingly "old-old" as opposed to "young-old." In fact, if you look at measures of disability, you can project that the growth in the number of people who have some sort of disability can be expected to grow about 70 percent in the next 20 years. This potential growth in the need for long-term care has those of us who worry about long-term care financing a bit concerned.

Another reason why there is an emerging concern is that the price of expenditures for and use of long-term care have been increasing sharply in recent years. In terms of rates of use, society seems to be relying less on families and friends to deliver basic support services for the elderly and more on formal sources of care. Of course, this leads to greater utilization of formal services and greater budget costs for the delivery of these services. The use of nursing homes was up over 300 percent between 1969 and 1979. Medicaid expenditures on nursing homes was up over 600 percent during those ten years. These expenditures place a tremendous burden on the public sector in terms of Medicaid and on society in general.

Medicaid, in particular, is a large burden for state governments which have been concerned about financing issues in long-term care. Even though we think of Medicaid as a program for the poor, 50 percent or more of Medicaid expenditures in 23 states go to long-term care services. Thus, Medicaid must be seen as much more than a program for the poor; it is beginning to become a program for the aged.

Finally, long-term care is an emerging concern for humanistic reasons. The more people who need to go to nursing homes, the better the realization is about how unsatisfactory nursing homes can be as a place to receive care. Most elderly greatly fear having to be institutionalized, and this leads to the question: "Can we come up with more attractive, more humane, and not incidentally, less expensive strategies for delivering long-term care?"

In a sense this is an important theme of research in this area. Analysis by both government and the private sector focuses on how we can restructure what is going on in long-term care to deliver perhaps more services outside of institutions and to better finance the services in a way that does not rely exclusively on people's own payments and Medicaid.

First, I will talk about what is long-term care, who receives it, who needs it--the what and who of the field. Second, I will talk about how it is financed currently. Finally, I will focus on two technical issues that I think are the most important things to be addressed by the insurance community if you want to get into this market. The other speakers will then go into more detail about these issues.

Defining Long-Term Care

First, what is long term care? Kane and Kane have the classic definition that everybody quotes: "Long-term care is a range of services that addresses the health, personal care, and social needs of

individuals who lack some capacity for self care." This is one of those academic, global definitions, but key in the definition is that long-term care is a different than health care; it involves a lot more than health care. Long-term care includes personal services for people who are not necessarily sick in a classic sense but who are just frail. Long-term care also is a lot more than just institutional care.

Let me review from an insurer's perspective some of the difficulties in defining what long-term care includes. On the institutional side, long-term care includes services delivered in skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). From state to state, unfortunately, the definitions of these services differ and surely the number of them differ. Some states mainly have ICFs, and some states mainly have SNFs. From the federal government's point of view, the key distinction is that an SNF must have 24-hour licensed nursing available and on board, whereas an ICF has less than 24-hour nursing available, but it must have at least some licensed care available. These are the institutional types of care that most likely would be insured. However, there are a series of borderline types of institutional arrangements which you might think of as long-term care or you might think of as just housing.

Domiciliary care homes or personal care homes offer no nursing services, but they offer services like shelter, monitoring, meal preparation, and housekeeping. Offering even fewer services are foster homes, congregate housing, and retirement villages. This represents a continuance on the institutional side going from just a roof over your head to 24-hour nursing services. From an insurance point of view it is difficult to draw the line concerning what is an insurable service as opposed to what is just housing with expanded amenities. This is one of the issues private insurers must address as they explore the market for long-term care insurance.

On the noninstitutional side, you will find another array of possible providers of insured services. The narrowest type of noninstitutional care is home health services. This is where a nurse or some trained medical person goes into a client's home to deliver health-related services. These are the home services that even Medicare covers at least when services are for rehabilitation after an episode. Medicare generally pays for these services when they are aimed at acute care making people better as opposed to just trying to give them custodial ongoing services related to problems of being old.

In addition to home health services, there are personal care services in the home where an attendant, who is not a medical professional, fixes meals, gets the person out of bed, or takes the person for a walk. Another type of noninstitutional service is adult day-care where a frail person, who lives with his or her family, can be brought to a community center during working hours. Finally, there is Meals-on-Wheels, which delivers prepared food to the frail. Thus, even on the noninstitutional side, the insurer is faced with the question: "What is an insurable set of noninstitutional services versus what are things that are convenience oriented?" Again it is a continuum, and the difficult issue is where to draw the line.

One thrust of the home care field is to develop home care that will substitute for nursing homes. This is the type of home care that private insurers definitely ought to include in policies. It should reduce costs and make a policy more attractive to potential beneficiaries.

The second type of home care does not substitute for nursing home care, but does substitute for the support services of family and friends. This second type is what insurers are nervous about, because there is a great deal of potential moral hazard or induced demand. These are important concerns.

Who is in the long-term care population? Nationally about 5 percent of the elderly population are in nursing homes; that is, either in SNFs or ICFs. There are arguments in the field about how many of these people are inappropriately in the nursing home and how many are supposed to be there. In looking at the literature, I am convinced that 5 percent is the right aggregate number. Unfortunately, some of the people in the nursing home right now should not be there, and other people who are not in nursing homes should be. From a planning perspective 5 percent might be right, but we need mechanisms for getting the right 5 percent into the nursing homes.

In terms of the community care population--the noninstitutionalized population needing long-term care--data from the National Health Interview survey, which is a national survey done by the government, suggest that 12.1 percent of the noninstitutionalized elderly population require some support services. The percentage varies from 7 percent for people 65 to 74 years old to 44 percent of people 85 and over. As the elderly population goes from being young-old to old-old, the need for services becomes greater. Most of the 12.1 percent needing care currently receive services delivered by family and friends.

Commonly, the need for services is measured in terms of what are called "activity of daily living problems" of which there are two types. Instrumental activities of daily living problems are home management problems, and they usually include four things: shopping, preparing meals, doing household chores, and handling money. The presence of these problems generally is measured by surveys on a self-reported basis. The other, more serious type of daily living problem, involves a physical limitation. There are seven of these that surveys tend to measure: walking, going outside, bathing, dressing, using the toilet, eating, and getting in and out of bed.

Clearly there are ranges of these problems, and service needs can vary tremendously depending on whether one needs help shopping or handling money or getting in and out of bed and going to the toilet. It also becomes clear when you look at the numbers that the large majority of people who are frail are in the community and not in nursing homes. In addition, it becomes clear that the need for long-term care is not rare. By the time most elderly pass away, they experience some time in their life when they are frail. Thus, long-term care insurance would be a product that most people would benefit from at some point. This feature makes some members of the insurance industry see this product as similar to life insurance rather than health insurance.

The Current Financing System

In 1982, Americans spent $30 billion on long-term care; $27 billion of that was on institutional care. In the case of nursing home expenditures, just 0.8 percent was paid for by private insurance. Many elderly think that Medicare is going to take care of their nursing home needs. Medicare, however, pays just 1.7 percent of nursing home expenses. Medicare pays for limited amounts of rehabilitative types of services.

Responsibility for the bulk of expenditures on long-term care is split half and half between out-of-pocket expenses by the elderly and the Medicaid program. Out-of-pocket expenses represent 43 percent of nursing home costs, and the Medicaid program covers 50 percent. The residual is paid by other federal government programs, including the Veterans Administration system, and county and city programs.

Unfortunately, the way the financing system works in most states is that the elderly start off using out-of-pocket funds until they become impoverished or until they figure out how to give their assets away to their children and then they qualify for Medicaid. This is a rather unattractive social approach for financing long-term care. We force the vulnerable, frail population to go through the humiliating process of impoverishment, and then we say the public sector will pay for it. We rely heavily on the Medicaid program, but most state governments and taxpayers resent this burden and are continually attempting to limit their liabilities.

Let me explain also that Medicaid is the biggest competition for private insurers. In New York, 90 percent of nursing home expenses are paid by Medicaid. In California, 65 percent are paid by Medicaid. This suggests that it is not only the lower income part of the elderly who are spending down and becoming eligible for Medicaid. The great bulk of people needing nursing home care in the big generous states are spending down or getting rid of their assets and being covered by Medicaid. Medicaid represents a rather wide "safety net."

All of the surveys done by the American Association of Retired Persons indicate that the elderly hate this financing system. The elderly do not want to rely on Medicaid. They do not like going through the spend down process, but they see it as the only viable option since widespread private financing is not available.

Let me make two contradictory remarks to end this part of my talk. The first point is a word of caution to insurers. I am afraid that the elderly and the taxpayers see long-term care insurance as a magic cure that is going to make the cost of long-term care go away. This is a real concern of mine because when you ask people if they would like private insurance, everybody says yes. Then when you ask if they are willing to pay $1,500 a year for private insurance, everybody says no. People seem to think this insurance should cost $100 or $200; it is not understood that in many states annual nursing home expenses per elderly are over $1,500. When you add administrative expenses and

coverage for home care services, long-term care insurance is expensive, and society needs to think about where the premiums should come from.

My second remark contradicts this discouraging tone. From a planning perspective, the insurance industry should be optimistic that the environment for long-term care insurance will improve, simply because society desperately needs mechanisms for spreading risks for this need. The problem is so severe that a solution must be made feasible. Eventually, people will have to recognize that the costs for long-term care will not go away. Then the fact that many elderly could afford premiums if they started at a younger age will lead to a larger market for financing instruments that pool the large financial risks associated with the need for long-term care. It will become more apparent, also, that, unless people have the option to purchase insurance, it is unreasonable for society to ask any elderly person to pay $30,000 a year to be in a nursing home. Many people here would try to figure out ways of diverting their assets if faced with that type of bill and could rationalize this behavior on the grounds that society should provide better mechanisms for spreading the risks of long-term care costs.

Two Technical Issues to Resolve

Two technical issues also need to be resolved to make the market for long-term care insurance grow. The first technical problem is that most people want coverage for care; they do not want insurance that covers only nursing home care. A common attitude is: "Why should I pay money to insure something I don't ever want to happen to me, especially since my family would more likely send me to a nursing home if I have insurance coverage?"

The problem with home care coverage, of course, is induced demand or moral hazard. It is what the Washington bureaucrats call the "woodwork" effect: if you cover a service like home care, people who did not use the service in the past come out of the woodwork wanting service. If you look at the 12.1 percent of the elderly who have needs for services, 72 percent currently rely exclusively on informal sources of care, that is family and friends. Another 16 percent rely partly on family and friends and partly on formal services. If you market an insurance product, you have to be concerned about the high percentage of people who are getting services informally now and who could start to ask for them formally.

Is home care an insurable event? If you say no, I am afraid the market will be small for private insurance. If you say yes, I continue to fear the market will be small unless induced demand for home care is kept from increasing premium levels. The creative need here is to come up with policies that include some home care--maybe not all home care--but that also include sharp incentives for limiting the use of these services.

The second technical issue that must be resolved is how to define the insurable event in the case of long-term care coverage. How do you know when people need long-term care services and should receive payments for them? There are two models that can be used. One is a

health insurance model, where you cover types of services and you require a physician or some other health provider to certify the need for these services. This approach could lead to large amounts of moral hazard. The other approach is a disability model where you insure some level of disability and you either make cash payments or service-related payments that are tied to your level of disability. This is a more interesting way to go for various reasons, but this approach does require objective, "nongameable" methods for measuring disability. The activities of daily living indicators are not sophisticated enough measures of disability because people could misrepresent their problems if payments are based on their self-reported problems. Improvements in technology for assessing disability are needed to help the insurance industry.

Conclusion

In closing, let me make these requests to the insurance industry as you design products in this area. I ask you to design products for the elderly that give them as much flexibility as possible. The elderly population is heterogeneous in terms of needs, living arrangements, and so on. The more flexibility you can give them the better, from a social point of view. Second, try to provide design products that maintain strong incentives for informal supports. It would be disastrous, if by the year 2020, there is little informal provision of services.

Please recognize the need for public/private partnerships in this field. The insurance company should be certified or licensed to deliver covered services. Insurers need to work with state governments to improve the regulatory environment for long-term care and, perhaps most importantly, to overcome the problem that the cost of this product is high and a large proportion of elderly are going to need some sort of public sector subsidies to purchase private insurance. Rather than a public system for the poor and a private system for the nonpoor, we should consider a privately managed long-term care insurance system with public subsidies where necessary.

MR. TRAPNELL: Now that Dr. Knickman has introduced some of the institutions and the nature of the patients, I will point out some of the issues that need to be resolved in order to offer practical insurance policies that will protect people against the hazard of needing the services.

- The first basic requirement of any insurance policy is to identify a specific market. There are many markets in the long-term care field.

- Next you have to identify the products that are going to be offered and specify them in detail. You need to define the insurable event.

When a patient who is using one of these services is in the payment category, the moral hazard is a major problem, and it certainly seems to be here with so much informal care that can be converted into paid

care. You have to have the means at hand to control utilization or at least to collect enough premium to pay for it.

You need to develop underwriting techniques that are different from those existing for life insurance and the traditional ones used in health insurance. These new techniques must select groups of people who will utilize care moderately enough so it is practical to insure them. The techniques must be predictable enough to be able to set adequate premium rates in advance. They also must be homogeneous in the sense that, if there is a large subgrowth with a much lower readily identifiable cost within that group, you can prevent another insurer from offering a policy that targets them and removes them from your pool causing your rate to be too low.

You need appropriate regulation. Although the situation has improved greatly over the last couple of years with most states now recognizing that a long-term care policy is not a Medigap insurance policy and not requiring you to cover the hospital deductible and coinsurance payments in Medicare, there are still some significant problems in regulation like getting interest earnings on reserves free of taxation which requires the state to recognize the need for the reserves that would need to be set up.

There is also a major data problem. The main sources of available data come from national surveys and other public sources like the Medicaid program which are not applicable to any insured population that any company is likely to assemble. The remedy may be to offer insurance policies on an experimental and limited basis in order to gather the data necessary to proceed further.

Let me comment about some of the many markets that are within this field. The most obvious market is the already old and frail, by which I mean mostly people over age 80 but also in their 70s going through the period of retirement in which they are active and able to enjoy life and starting to reach the period in which they become more aware of their limitations and what the future holds for them.

The experience so far has been that people are mostly interested in buying nursing home insurance when they get into their late 70s. It is extremely difficult to get their attention directed toward their potential need for this at an earlier age. The last thing they want to think about is going to a nursing home when they are in their 50s and 60s. It's much like the difficulty of persuading any employee under age 40 that they may retire someday and that the pension is worth money to them. This seems to be projected even further into the age span. The lack of publicity and the lack of generally available information to promote the need for these services and the nature of the aging process seem to reinforce the difficulty in persuading people that there's a real need.

The experience so far seems to indicate that long-term care insurance needs to be sold, as opposed to being something that people identify that they're going to need. It may be necessary to approach them with

agents, as opposed to many of the marketing methods that are now being used especially for persons over age 65.

One of the biggest problems appears to be the conviction that someone else, somehow, is going to take care of this need, and these people won't have to face it. It's like selling life insurance has always been; people don't want to die, therefore, they don't want to buy life insurance.

The general impression is that Medicare pays for a large proportion of nursing home services and that Medigap policies pay for nursing home services, of course, stemming from the coverage in Medicare and most Medigap policies of acute care for convalescing after a hospital episode. The other market for which a much more technically sound and appealing product can be designed is persons who are approaching retirement or who are in their early retirement years, especially at age 65 when Medicare begins. To be able to couple a product like this to the Medicare supplement policies, giving a more substantive benefit, is an appealing notion. So far I am not aware of anyone who is able to market a product like that in any volume.

This product lends itself to free funding. Some paraliels can be made between long-term care benefits and annuity benefits. The insurance industry found that it was almost impossible to sell pure annuities. In fact, people who bought pure annuities were regarded as such unusual people that special mortality tables were developed to account for the low mortality experienced under pure annuities.

The standards in the industry were cash refund annuities and ten-year certain and continuous, of course. Now the standards have moved to joint survivorhoods required to be the standard retirement benefit for couples. Parallels in the long-term care field would suggest that products which ought to be viable in this market are ones that accumulate funds over working years and continue to mount in interest over the years during which long-term care usage is low, the 60s and the 70s, to be available to pay for these benefits using accumulated funds with the unused funds being available for posterity. One of the major motivations that would lead to purchasing long-term care insurance is to protect assets to pass on to the next generation.

Other markets enticing to insurers are any natural groups with a common interest, other than purchasing insurance, leading to membership in the group. For example, retirement communities would be an appealing target where you have a naturally defined population, all in the retirement years, all of whom eventually will be subject to this risk and who frequently have the facilities on-site. Other groups are unions, retired teachers associations, public employment groups, and of course, one of the most interesting groups beginning to market long-term care policies on a pilot basis is the American Association of Retired Persons. Other targets that do not look particularly enticing at the moment but that would make natural purchasers for the services would be the employers who have funded the health insurance and retirement programs for most of the rest of the population.

Using the parallel with how hospital surgical coverage got started, the simplest product is to cover nursing home services on an indemnity basis. These may be skilled care only, convalescent care, or custodial care if the stay began as a convalescent stay. Many of the policies now on the market pay only for posthospital confinement which turned into custodial care. The benefits can be offered without prior hospitalization.

There are the problems of whether to cover mental and nervous conditions as well as other causes. When you get into mental and nervous conditions, it is difficult to determine whether the persons really need to be there. A high proportion of people in nursing homes are there because they're confused some of the time, most of the time, or all of the time, and it is difficult to determine within this group, those that do and that don't meet insurance definitions.

Moving into the home care field requires a great expansion in the definitions of coverage, the terms of coverage, and the circumstances under which you pay. The definitions used by researchers, the activities of daily living, have been effective for research purposes when no money was changing hands over whether somebody was found to be in need or found to be able to transport himself. When you are designing insurance policies, you need definitions that are more robust. For example, homebound has been a much more effective definition in the insurance field because you can always investigate suspicious cases and see if indeed they are staying home or leaving home only with assistance.

The definition of the insurance event is a particularly difficult aspect of these insurance policies. The phenomenon alluded to earlier is that, among the people who are not in nursing homes, are people who are more disabled than people who are in the nursing homes and that, among the population that appears to have acute need of help, only a small proportion is now receiving paid help. This leads to the need to manage the services that are being offered with an active intervention by the insurer in who receives the services and which services they receive.

Mr. Dennis Kodner has developed a mechanism for managing the needs of the care of the individuals who are enrolled in their social health maintenance organizations (SHMOs), which is one answer to all of the problems that I have enumerated in the design and execution of insurance for long-term care.

Mr. Kodner is a general director of Elder Plan Inc., an SHMO in Brooklyn, New York. He has an extensive background in long-term care and became interested in finding a viable way of obtaining private financing for long-term care. He has published extensively, lectured on long-term care policies and on the elements of SHMOs, and is currently an Assistant Professor of Health Policy and Medicine in the Division of Geriatrics at Cornell University Medical College. Elder Plan is owned and operated by the Metropolitan Jewish Geriatric Center, a 1,000-bed, voluntary, nonprofit, long-term-care institution in Brooklyn, New York.

I regard Mr. Kodner as one of the real pioneers in insuring long-term care in a program.

MR. DENNIS KODNER: I've been asked to talk about managed-care solutions in dealing with people who need long-term care and insurance coverage and use, as an example, the SHMO model that we and three other organizations throughout the country are trying to implement and get experience with.

For your information, one of the three other organizations is Kaiser Portland. Kaiser is the largest health maintenance organization (HMO) in the country, and the Kaiser Portland entity in Kaiser has been experimenting with Medicare supplemental products in their HMO for several years which led to the enactment of the Tax Equity and Fiscal Responsibility Act of 1974 legislation for Medicare HMO coverage. As a result, Kaiser became interested in how it could include a long-term care wrapper for people in HMOs and that's what drew it into the SHMO demonstration.

Another site in this demonstration sponsored by the federal and state governments is something called SCAN Health Plan in Long Beach, California. SCAN, prior to developing the HMO for this demonstration, was a community-based social service agency which had limited contact with the health care system. It was serving very frail people and was struck with the fact that only public funds, primarily from Medicaid, covered the catastrophic costs of long-term care.

Parenthetically, you have Group Health, Inc. which is a large consumer-oriented HMO with 700,000 members in the Minneapolis-St. Paul metropolitan area, and the Ebenezier Society which is a large voluntary nonprofit long-term care institution. On one hand, Group Health had been interested in finding better ways to serve the members who were aging as well as to find a way of keeping pace with the market in competition for elders in the metropolitan Minneapolis area. On the other hand, the Ebenezier Society had been experimenting with ways to get people out of the nursing homes into the community setting and to prevent people from coming into the nursing home. Thus, their interests merged, and they developed something called Seniors Plus, which is a partnership which operates with the HMO license of Group Health, Inc.

Elder Plan is a subsidiary of the Metropolitan Jewish Geriatric Center which is a large, multilevel long-term health care facility. For the last ten years, we've been trying to find ways of keeping people out. We have come to the conclusion that at least 30 percent of all elders in nursing homes don't need to be there. They are there because of the way the system is organized and because of the way the system finances their long-term care. In fact, there is a good way to introduce the concept of form follows financing.

What people get in the health care system, particularly for people who need long-term care--the elderly--has more to do with the card that they carry in their pocket than what their needs actually are. Medicare, on the one hand, provides an extensive coverage for medical

benefits (hospital and doctor care). It only pays limited service to long-term care, and that's for short-term restorative care after a hospital stay.

Medicaid, on the other hand, offers a much broader coverage of long-term care whether it be in a nursing home or a home care setting. New York state, for example, uses 80 percent of the country's entire Medicaid home care budget. That's how effective New York has been in maximizing federal funding through Medicaid.

If you don't find a way to divest yourself of the resources that you've built up all your life, if you do not find a way of somehow avoiding the state attaching to your property, you are in effect in spend down, and you come into Medicaid and are entitled to services. But as compared to the system which finances acute care, hospital, and doctor care, virtually most of the care for long-term care is covered through public sources, mostly through Medicaid. That's in direct contrast to the acute care side where, in fact, private financing is a large source of financing. So form follows financing is a fundamental principle or concept that we have to address in finding ways to restructure the system.

As a result of the way in which financing has been developed on the long-term care side--this predominant public financing scheme--we have overmedicalization of the health care system for the elderly. Why do doctors make determinations as to whether, in some states under Medicaid, for example, people have to go into a nursing home? What do doctors know about long-term care? We know that the event precipitating the institutionalization of an elder, i.e., placement in a nursing home, has little to do with some medical event and has much to do with the burden a family perceives about caring for an elder.

Eighty percent of all the care provided to older people when they are impaired is provided by the families, not by the government, as the government would want you to think. Families have the burden of caring for impaired elder people. We know that after the second hospitalization, the willingness of the family to care for an elderly person reduces by 50 percent. Even if the person is hospitalized for a minor condition, the straw that breaks the camel's back is when someone becomes senile, has dementia, or has incontinence. The family can't take it anymore and by default, with great guilt, makes a decision to institutionalize the elder.

The form follows financing concept also enters into this artificial separation for acute and long-term care. When we talk about long-term care, and some of the insurance companies are looking at free-standing long-term care insurance products, there is an intricate relationship, even though it's not the most important relationship, between acute and long-term care. We do not know how acute care has an impact on the needs for long-term care all the time. We do know that for people with a disability, their disability can have an impact on medical condition as well. If a person does not live in a safe, supportive environment and because they have an unsteady gait and they fall, obviously that results in a medical problem.

So the challenge is not merely finding a way to finance long-term care but a way of reforming the way in which health care is provided to old people. It is institutionally biased, in that 30 percent of people in nursing homes probably would not need to be there if there were services in the community, but they're not paid for because of the form follows financing issue. It's fragmented and uncoordinated. I'm tired of hearing that the acute-care system is fragmented and uncoordinated. It's nothing like the kind of fragmentation that exists in long-term care because the complexity of long-term care needs are such that it is not only the traditional things that you think of as health care. It is also what we call social care, what people in Europe call "home health services" *not* "*home help services*"; *things that help people in their activities* of daily living--grooming, shopping, meal preparation, toileting --fundamental things that have nothing to do with medicine per se.

Also, there's an issue of not recognizing the family's involvement. Any kind of a product that's developed, whether it be public or private, has to recognize that the family decides to institutionalize. You are bucking up not only against the insured's decision but also someone else who is not insured, and you are going to have to find a way to deal with that in some creative way.

There are a number of ways to develop risk-pooling options. There are two categories and we sit in one category. One category is the individual *risk-pooling option of developing some kind of free-standing* long-term care insurance product. There are a number of ways to do that and a number of populations that you can approach in marketing it.

The second category is managed-care systems. Continuing care retirement communities (CCRCs) are the oldest risk-based managed-care systems which try to pool risk, particularly for people who have many varying needs, but also for long-term care. We have SHMOs, the TEFRA HMO, and the HMO under Medicare which has the potential to expand its benefits, e.g., you might want to develop, instead of a free-standing product, a long-term wrapper for managed-care systems. It is an entirely different approach in selling policies on the street or *selling policies on a group basis. This is creating a long-term care* insurance mechanism to wrap around an existing prepaid managed health care system for a well-defined group, or at least a group where the system knows what the health care needs are and is able to manage them and perhaps can extend this managing capability to older people who are members of their plan.

There are six fundamental elements of the SHMO model. The SHMO clearly has two antecedents: (1) the HMO part of SHMO; (2) for the last 10 or 15 years, there have been robust research and demonstration projects supported by the federal government which have tried to demonstrate the value of developing community-based long-term care as an alternative to nursing home care or as a forestaller to institutionalization.

The SHMO represents a merger of the technology that has developed over 50 years with HMOs on a prepaid capitation, on the one hand, and

the experience we have developed over the last 10 to 15 years with community long-term care programs. HMOs have taught us that managed care is an identifiable way of containing the risk of delivering services to an identifiable population through an organized delivery system. It merges insurance with the concept of management of care. That is important because the elements of the model I am going to describe and the community-based long-term care systems experience has clearly shown that not all elders belong in nursing homes.

There is a technology called case management which can be used to assess people's needs and to determine whether they belong in the matrix of long-term care services and can act as an effective tool of gatekeeping and make sure that people's needs are matched with appropriate services. You'll immediately recognize a lot of these six elements from the HMO field.

First, there is broad eligibility. When we talk about the people who join the SHMO, we're talking about Medicare beneficiaries age 65 or older living in a particular community--people who do not have end-stage renal disease. It's a voluntary enrollment. We're looking for a representative mix of people in the community. We're not marketing the long-term care products; we're marketing a product which includes acute care benefits, preventive health care benefits, and long-term care benefits.

We think there are numerous problems with trying to market just a long-term care benefit, and if you do try to offer a free-standing long-term care product to people, there's going to be a great potential for adverse selection and moral hazard. One of the ways to cut down is to offer it as part of a much more comprehensive benefit package which attempts by the pricing, the benefit package, and the marketing strategy to say, "This is a total health plan for you, the older person." It has all kinds of services, not just long-term care. It's also clear that people who need long-term care will find you anyway, but that clearly marketing a health product which has all the benefits, including long- term care, is preferential to marketing just a long-term care product.

Second, it's a single provider. Just as an HMO, there is a single entity which integrates all the acute and chronic care benefits.

Third, there are comprehensive benefits, although there are some limitations even on the long-term care side. We have all the Medicare A and B benefits plus prescription drugs, eyeglasses, hearing aids, dentures, case management, preventive services, medical transportation, and long-term care. The long-term care benefit is one which we would consider shallow compared to what we know the needs are for someone who genuinely needs long-term care support and gets it from government sources. In our case, it's $6,500 per year, and that's subject to certain copayments. In the case of Kaiser, it's $12,000 a year. We don't say we are a long-term policy because we're not a long-term care policy and because we have the same problems of actuarially estimating what the needs and costs of these particular long-term care benefits are, no less the acute care benefits for a population like this.

LONG-TERM CARE COVERAGES

We know that we are gradually expanding the depth of coverage for long-term care. It is more than Medicare A and B, and it is much more of an enriched package than Medicare supplemental policies. We have developed in the case of our demonstration, although this need not be so for a SHMO-like HMO, plans that are developing around the country. We have a new underwriting formula on the Medicare side. We have funds-pooling for the SHMO. Medicare puts in money, the private premiums, copayments, and another source of revenue, and we enroll duly eligible people--people who have Medicare and Medicaid at the same time.

The basis of the Medicare contribution to the plan is something called the adjusted average per capita cost (AAPCC) which is the average amount of money Medicare estimates it would cost if they were to pay out the A and B benefits in the particular county in which the member resides. So it's the average amount of money Medicare estimates it would be paying if the person joined our plan. It would be paying on a fee-for-service basis. The TEFRA HMOs, the Medicare HMOs that are now operating, and the nonsocial HMOs get 95 percent of the AAPCC. The government takes off 5 percent from the top, and the difference between what it costs the plan to provide the basic A and B benefits and the 95 percent of the average Medicare prospective payment on a monthly basis is what the plan, in effect, uses to provide additional benefits. Obviously, the more additional benefits you provide, the more rich you appear, and the more people you hope will join. That's good for the plan as well. In our case, we are 100 percent of the average amount Medicare pays out.

In addition, this AAPCC formula has a variety of underwriting characteristics. There is one underwriting factor in the AAPCC called "nursing home" or "institutionalized," i.e., right now Medicare pays HMOs --it's a perverse incentive--more if the person wasn't in a nursing home than if the person was in a nursing home.

Under our plan, obviously, we're trying to keep people out of nursing homes, but we want to get paid as much as if they were in a nursing home if they qualified. So the government permits us to certify the person as eligible for a nursing home, and we get paid as though they are in a nursing home, but we can use those additional funds to provide home care services, all within this 100 percent of the AAPCC.

As far as provider risk, Lloyds of London wouldn't sell us reinsurance. Three or four years ago we tried to get reinsurance, but nobody wanted to reinsure us. The existing HMOs which provide acute care services have no trouble extending their reinsurance coverage for the enrollees of this plan. Those organizations which were neither HMOs nor had an existing history of organized delivery services couldn't get reinsurance for the acute care benefits, and they certainly couldn't get reinsurance for long-term care. Just trying to explain to people what long-term care meant was tiring. As a result, we were fortunate that we convinced HCFA and the state of New York, and in the case of the other sites, their states, that the government had to become the reinsurer.

We have a graduated assumption of risk which, in effect, says that each of the sites have negotiated with the government, because we have pooling, as Medicare and Medicaid, an amount which we can absorb in the first 18 months. Above that, Medicare or Medicaid would share proportionally, because they have part of the revenues in the risk, any excess expenses above this first risk corridor.

Savings work the same way. In our case, we have a mere $150,000 risk exposure in the first 18 months, which is small given the potential of this project and the size of its budget. Above that, Medicare pays roughly 80 percent; Medicaid and the state of New York pay 20 percent. If we were to make a profit, we get the first $150,000, and Medicare and Medicaid would share in the profit. If we made a profit, they said they wouldn't even know how to get the money from us; it would probably require an act of Congress, but I don't think we're worried about profit at this point.

The idea of taking small experimental steps, the risk and uncertainty involved in this demonstration even though it's a managed-care process as opposed to the kind of private product that people would be exposed to in the long-term care area are all extremely important notions. Even managed-care systems have to take these small steps, and even then we have a problem with getting protection and the government has to step in.

How do SHMOs protect themselves? There are a variety of ways. I am going to focus in on case management, but I want to give you a list of the ways. First is the selection risk. We have no health screening, but we do have queuing in the high risk category. Each of the sites have the option of queuing on enrollment, which means we have done a synthetic estimate of the distribution of disability in our service area. We have up-front estimates of how many people might be severely impaired, how many people might be moderately impaired, how many people are well, able-bodied, fully independent, and functioning.

By the way, the majority of the elderly are not senile; they're not disabled. But we have queuing, which means on a first-come first-served basis, based upon answers to certain questions on an application form, we enroll people. Then, when we fill the queue for that month, they are put on the waiting list and are told we cannot enroll them. Initially in our brochures, we indicate we have a limited capacity to serve everybody. We do not see much lying on the application yet, but we have limited experience, and we carefully monitor how a person might say they're well, get in, and end up all of a sudden severely impaired. We're clearly concerned, but that's one way of protecting against selection risk. It's also sold as part of an acute care benefit package as I mentioned before.

There are five utilization controls. One is incentives of the provider as insurer. Then there's case management. Another is work with informal care givers--the need to work with families and other individuals to insure that if they are providing a level of support to the elder, they will continue to provide the support even though insurance or coverage through the plan is available. The government is afraid to expand

Medicare to make it a long-term care entitlement because we know that, for every person in a nursing home, there are two to three other people in the community who are as impaired and who could meet the same admission criteria. The fear is that, if they were to offer a benefit under a public program as an entitlement, the people would come out of the woodwork and say "It is my birthright to get long-term care."

It's interesting because one of the Senate Committees on the Aged found that the Vietnamese boat people coming to this country never knew about long-term care, they just knew about surviving from day-to-day. One of the first things the boat people discovered was that part of becoming an American was learning about nursing homes and where to put their elders.

This is incredible. Obviously the need to work with the family is important. If you have a free-standing product, as the insurer does, this notion of a close contact not only in case management but also in working with families obviously does not exist, and you should reconsider it.

Putting copayments on institutional services in the long-term care benefit and making it less expensive or no cost for home care is a way of stimulating people to move in the direction of less costly services in the community. Limits on the chronic care benefit is a way of controlling utilization as well. When you have a limit on the dollar amount of a benefit, there is an amount of bargaining that goes on between the case manager, the family, and the elder about how they're going to stretch the benefit so that there is a maximum amount of support over time. They can preserve what the family and friends do but also provide the formal care and the overall coordination of the plan. As people pass the midpoint of their coverage, there is a tremendous scramble to provide more hours of support in the home.

For protection from inflation and actuarial errors, we can always increase the premium, but we're in a market where Medigap policies are our competition, even though they are not offering what we are offering. We sense we're much higher than they are because we have problems in marketing what we have to offer.

You might have heard about case management. I read a number of magazines for insurance people and the term medical case management is becoming vogue. I'm disturbed by that because the insurance companies or others offering these services are talking about claims management, utilization review, preadmission screening, and the more traditional medical gatekeeping function, not the case management I'm talking about. It's important in terms of medical gatekeeping that you not rely on doctors because that's how you got into the trouble with the health insurance industry in the first place. For those of you who know this, you have moved to HMOs because you know you can't trust the physicians to make those decisions if they're not in an organized delivery system with incentives in place.

Take it from me, I teach geriatricians: clearly, doctors know nothing about long-term care. They are just as confused about what long-term

care is as you are. Even geriatricians trained in long-term care medicine still have some strange notions about elderly people and what their needs are. Case management has nothing to do with these but incorporates these tools into something which is much more encompassing.

There are four elements of case management. First, case management is a comprehensive assessment of an individual's condition in order to determine what services or resources, both formal and informal, are needed; what benefits you will cover; what support is available from family and friends; and what degree of reassessment is needed. It's not a claims review, medical director, utilization review, or preadmission screening, although these are tools that are used. It is something much more; it is a clinical process.

Second, a care plan is developed which specifies how much, where, and by whom the required resource would be most appropriately and cost effectively delivered to meet the individual's identified needs. It is translating what the sense of this person's needs are into a concrete list of services, the volume of services, and the provider of services so that the insurer or plan knows what they are going to be paying for. It is a basis that authorizations are to be issued upon, a basis of getting data about what needs are, and what costs are from a plan's point of view.

Third, case management entails a referral of the individual to providers in order to carry out the care plan and also the provision of ongoing coordination of multiple and often diverse services. The criteria used in referring people into the system may be informal. You can use a provider in the community who has a Medicare or Medicaid certification or is licensed by the state. It can be much more strict in that you have a preferred provider organization (PPO) arrangement; you can use only the providers who are affiliated with the insurance company through a plan or agreement to provide services on some formal basis. It can also be done on the basis of limitations on frequency or quantity of care.

Fourth, case management also entails ongoing monitoring to assess progress, to assure services are delivered, and to determine what else is required. All of these things are subjective, and that is what is so scary to not only insurance companies when they begin to understand the ramifications of case management but also to those of us who have managed care. We struggle on a daily basis with these things. We do not have a good, concrete understanding of the things that we must target to determine who needs long-term care. We look at activities of daily living, instrumental activities of daily living, family support, which we think is as important as anything else, environmental conditions, the member, and medical reports for those being cared for on the medical side. It's still a clinical decision.

In Elder Plan and the other sites, we have a research consortium which is trying to develop baseline information which will enable us to distill some of the clinical decision making into detailed guidelines which can be computerized and which can give some reasonable expectations to the managers of the plan as to the fact that rational resource allocation

decisions are being made. Right now it's a clinical, open-ended process, and I, as a manager, actually sit in at case management meetings with nurses and social workers who are the specific case managers and voice my opinion. That's an unusual position to be in with independent, autonomous health professionals who have titles of managers and take them seriously. It's clear that we do not have all of the details that we need to know to target this population.

The need to work with families is extremely important. Some families are willing to continue to provide the care they are providing. Some families want to give up the kind of support they are providing because their elder is a member of the plan and they feel as if they've already done their share. That presents a major problem to us, but we seem to have been effective in retaining the kind of support that people are receiving.

To give you a sense of where we are in the plan having to do with case management, we are in Brooklyn where we serve seven zip codes out of 36. There are 82,000 people over the age of 65 within a mile of where we are. This is not what we call "rural America," and clearly this indicates that there's a market. There is no HMO competition of any consequence. Health Insurance Plan of Greater New York is there. Blue Cross/Blue Shield, the supplemental insurer, is competition from our perspective.

Why are we finding it so hard to sign up members? We are underenrolled at this point. We underestimated when we developed our market strategy. We did the focus groups and the market surveys and began to believe these numbers, which I now think was a big mistake. But I think what we really underestimated was that we need to sell the people to join the plan. The assumption was that we can mount a sophisticated, slick, not nonprofit approach to this market like many Medigap insurers. We would sell through the mail; we don't have Lorne Greene, but we have other well-known spokespeople including the mayor of New York. We had a press conference, and we got 5,000 phone calls in three days when the mayor said he liked Elder Plan. He didn't even charge a fee.

The problem is that we have 10,000 or 11,000 responses to mailings in the last three months, but we have a difficulty in conversion. The answer is that we don't have a sales force. We totally underestimated the need to close a deal. We didn't close the deal; we didn't even accept a check.

One of the members of my board is Art Libson who is the Chairman of a Long-Term Care Task Force of the Health Insurance Association of America with Equitable. He didn't realize we weren't accepting checks. We were afraid to take the check because we had a queuing system, and we said it would create bad word of mouth if we were to accept an application with a check and then find out that we have no room for this person and then return the check. But we were wrong, because it's better to send the check back and have one irate person than not to convert thousands of people who indicated an interest in our product but who we didn't contact.

In our perspective we are convinced that there is a big market; it is perhaps a unique market in terms of the competition, but the sales issue for us is the biggest issue. We also have some preliminary experience over six or eight months with the long-term care piece. We are doing better with the long-term care side than we are doing on the acute care side, but we expected that. We were never an HMO, and we never had experience in managing acute care. We won't know for another 14 or 18 months, but at least on a micro-level with brief experience, there seems to be something positive happening in the sense that we have some severly impaired people who we would have predicted would have gotten into a nursing home in the fee-for-service system, with families who are agitating for the nursing home care, and we've kept them at bay. We actually have little nursing home use, and we know how long we can keep them at bay which might haunt us later.

To summarize, whether it is an SHMO the insurer is interested in, or whether it is developing long-term care wraparounds for HMOs, or whether it is developing free-standing products that you are going to try to market in conjunction with large HMOs which have a number of elderly people (Group Health Cooperative in Washington is a good example of that approach), even if you develop a long-term care product and sell it on the street, you have to deal with the issue of case management. If you are going to provide a legitimate comprehensive form of protection against the catastrophic cost of long-term care, you are going to have to find a way of providing both home care and long-term care. The only way to do that is to have case management. Case management, in effect, is a crucible for any kind of private long-term care product you are going to develop.

MR. TRAPNELL: Our last speaker is the pioneer among actuaries in developing long-term care insurance. You might say that he is the actuary who didn't say "no" when about seven or eight years ago somebody in his organization brought him the outlandish proposition of insuring long-term care. In addition to all of the problems that have been brought out by the previous speakers, there is the natural skepticism of any insurance organization in getting involved in a field that seems so completely open to moral hazard, antiselection, and so on.

At the time, Mr. Hersh Markusfeld was in a senior actuarial position with the Fireman's Fund Insurance Company in California. He's held various actuarial and senior management positions there over the last ten years. He is currently leaving the insurance field and is now president of AccuMed Systems, a firm that analyzes health claims data and tells you whether you are using providers efficiently and what you need to do to have improved performance in the future.

The Fireman's Fund introduced a genuine long-term care policy around 1973 or 1974, over ten years ago, while the rest of us just assumed that insuring long-term care services was impossible.

MR. HERSH MARKUSFELD: I would like to talk briefly about some overall market and risk factors that impact long-term care insurance coverages and describe some of the experience we've had at Fireman's Fund in test-marketing this product for ten years. At this point, the

company just now is moving out of the test-marketing stage. We have about $8 million in premium, about 12,000 insureds, and ten years of experience, and we still are uncertain of where we would have wanted to go with this product. That's how long it takes to get any kind of accurate guage on the combination of exponentially rising term insurance costs and on a product that is subjective and qualitative in nature.

On some of the marketing and risk factors for long-term care coverage, it looks like a combination of good news and bad news for the insurance industry. The good news is it's a tremendous marketing opportunity. There is a large growing unmet need.

Just to touch on some of the numbers, the over age 65 population currently is 11 percent of the population. Projections made by the government are that over the next 20 years it will go from 11 percent to about 12.5 percent. Then between the years 2010 and 2030, the over 65 group will jump from about 12 percent of the population to about 18 percent of the population. That is the baby boom group and the post-World War II group going from under 65 to over 65.

With the over 85 group, the costs rise in an exponential curve with age and with the needs of care, not necessarily acute care but some form of care. Today the over age 85 population is about 2.7 million. Within 15 years, by the year 2000, that will go from 2.7 million to about 5 million; it is nearly a 100 percent increase in the size of the group. With the demands for various forms of care, whether they are institutional, home or otherwise, there are estimates that well over 50 percent of this group will need some form of ongoing personal care. That might be provided by family or institutionally, but it is not a medical problem.

The costs of institutional care are high. Typically $20,000 to $50,000 a year is the range of costs going into an intermediate or skilled nursing home. Currently Medicaid pays only about 50 percent of the total cost, that's roughly about $17 billion a year now. One interesting fact is that where private funds pay for about 40-43 percent of the cost, they are now typically exhausted within one year for two-thirds of the elderly who enter institutions. In other words, they have either spent down before they go in, or they haven't. But nationwide more than two-thirds of the people within one year have exhausted their funds. So they are then in a situation where the government is paying, which is an inhumane, humiliating, and incorrect way of doing things. Right now, only about 100,000 people have private insurance coverage. Fireman's Fund has about 12,000 of those policies, and various small companies have the others. The good news is this bleak picture of this tremendous unmet need. There is a market and a need for private insurers.

There are some problems for the private sector. One key is that the private sector is tremendously lacking in adequate data for either pricing or reserves. This is tremendously complicated, but costs go up exponentially, where from the buyer standpoint, it only makes sense to get a product that has level premiums or is prepaid and paid up at

some early age. That could be done reasonably economically, but it is not being done. The elderly generally have the impression that it is covered under Medicare, and they generally have a rude surprise when they find out that it is not. They are facing this problem typically at ages 75 or over.

There have been so many changes recently in the private health care delivery system that the data are largely irrelevant and are difficult to get at.

There isn't a strong perceived need for long-term care insurance, and on an individual basis, there are tremendously high costs of selling and administering the product and then trying to ward off the large anti-selection potential you get whenever you have a product without a strong perceived need and a low buying propensity.

The liabilities are by nature long term. When you sell the coverage, the problem of trying to design a pilot program is that it takes five to ten years to begin to have any idea how it's doing because of the cost curve, the subjective nature of the risk, and the inadequacy of data.

Finally, the market need is for a guaranteed renewable or noncancelable policy; but issuing a policy like that would increase tremendously the risk for insurers. Up to now none of them have done it. I believe Aetna has just introduced a guaranteed renewable policy. I think that is admirable and if I were them I'd be scared.

This is one final strong negative. The state regulatory environment has been difficult. It's not uniform and rightfully so. The states are cautious about any form of insurance marketed to the elderly, partly because so many of them have been real rip-offs.

I'd like to touch on a little of what Fireman's Fund has done over the last ten years. We characterized our work essentially as a market test and a successful market test. Fireman's Fund, in late 1974, identified a market and a market need that we thought would have long-term potential and some real social worth to begin to develop as a pilot project. Basically, the target market would be the affluent and relatively healthy elderly group with an estate protection need. This was sold as an estate protection policy for people who did not want to spend down to qualify for Medicaid.

Our first policy was sold in December, 1974. We went at the market cautiously and slowly. We sold face-to-face through a single broker-administrator with a salaried agency force in California. Our largest concern, frankly, was that even though we had the right by state to raise rates, we wanted to be absolutely certain we were not going to have to do that to this particular group. We felt that the negative public relations attached to it long term would be destructive for the company. We attacked it on a market test as if it were a noncancelable, guaranteed rate policy, even though we did not take that legal risk. Our intent was to offer a quality product, meaningful benefits, and minimal limitations and exclusions and to keep the underwriting and claims administration as simple as possible.

Based on slow initial sales and preliminary experience, in 1978 and again in 1982, we modified the policy fairly dramatically. This is more than an eight-year period that we were going at a market test, and basically the changes made at that time that we considered critical to the success of the policy were changing rates slowed by age so that we sharply increased rates at the higher ages and dropped them at the lower ages on an attained-age level-pricing basis. In other words, we had level premiums from age of entry. But where we initially had a fairly steep slope, we made it steeper, by age.

We were offering the product for sale up to age 85, and we stopped offering it past age 80. Actually, we still offer it at age 80 and 81 if a spouse were insured for the same or a higher amount and was below age 80. But we found that, whatever maximum age we offered the policy at, the agency-sold products concentrated the buying at the oldest ages and the reason was that the highest perceived need was at the oldest ages.

We included a questionnaire that had to be answered by the insured's personal physician. All these measures were taken to ward off what looked to us like slowly but steadily increasing claims, which even if we stopped selling this block of business, would go well through the acceptable loss ratios by premium for the coverage. We also offered a low daily benefit initially. I think it was $40. We're presently up to $70, but in reference to keeping the cost below the true cost of care, as a form of coinsurance or an incentive against institutionalization, we still consider it important to overpay the cost or to not pay fully the cost of actually being in a nursing home.

Annual cost by age 60 to 64 for a product with a 20-day elimination period, four-year maximum is about $540 a year. That premium goes up to $1,044 at age 75 and $1,400 a year at age 80. These are level premiums by entry age. We offer two products, a 20- and a 100-day elimination period. The 100-day elimination period is roughly 75 percent of those premiums. The cost goes up even on a level entry-age basis. It doubles between age 65 and age 80. If you offer beyond age 80, depending on how you underwrote and marketed the product, it would go up much higher than that.

Firemen's Fund is a four-year maximum benefit 20- to 100-day elimination period offer to age 80. It is level premiums, but the premiums are waived after 90 days of confinement to a nursing home. The premiums are waived for the rest of that coverage. Another good feature is that the policy becomes paid up after 18 consecutive months of nursing home confinements. Then whether you stay in or get out, it is a paid up policy for the rest of your life. The single most important feature of the product is that it provides full benefits for custodial care. That is limited to care where the initial care follows three or more days of hospitalization, and is due to a covered injury or illness, with a doctor certification of need. If you went into the hospital initially within a period of time, then entered a nursing facility and, if you were covered initially, you're covered ongoing, including custodial care. This is important because we think it is one of the real marketplace needs.

We also offered a home convalescent benefit which was at the 50 percent level of whatever benefit was bought, which was limited, but which was meant as a valuable incentive to get out of the nursing home. If you had been in for 180 days, you qualified for up to 180 days of home nursing care benefit, meaning you would get 50 percent benefit if you got out and went home, irrespective of what costs you were then incurring. The only exclusions were for confinement in hospitals, veterans' administrations or federal institutions, suicide, and--one important exclusion--mental and nervous condition without demonstrable organic illness. In other words, Alzeheimer's disease and related types of incapacities are questionably covered. The treatment we have taken on the claim side is to cover anything like it.

The policy is conditionally renewable, meaning that the company has the right to cancel the policy or raise rates state to state. Our strong intent was never to invoke that right. That was our reason for going so cautiously at this market. We would have been able to expand much faster and go at it much stronger if we were willing to take the approach that if we needed money later, we would go try to get it.

Fireman's Fund experience with the product over this ten-year period is that currently they have about $8 million of annual premium. That is about 12,000 covered lives with an average annual premium of $650 a life. It is sold on an individual basis, face-to-face. Commissions and administrative fees are high. They average about 35 percent. The product has been profitable, particularly after the changes made in 1978 and 1982.

The company is now expanding from its original market in California to additional states including Arizona, Oregon, Texas, and Florida--the heavy retirement sunbelt states. The consideration has been a combination of how it's distributed and the state regulatory environment.

In regard to competition, for the first ten years Fireman's Fund was one of the first carriers to sell the product. There had been about 20 small companies offering it regionally and usually excluding custodial care. Total penetration of the market up to now is only about 100,000 people. The competitive situation is changing fast. Companies beginning to market the product are Prudential marketing to the XXX group. Aetna has announced a product that I think is patterned after the Fireman's Fund product, but it is guaranteed renewable, which is a big plus. Mutual of Omaha is marketing a product. Some of the big carriers are going to begin to penetrate this market. There is a real need out there.

The legislative environment is that many states have proposals for mandating coverages, most of which would make our product not viable for us as an insurer. The NAIC has a long-term care test for us, due to come out on a report for a model bill in the spring of 1988. The National Academy of Sciences has formed a committee to study long-term care issues and report on changes requires for financing of delivery at the federal level. That is due to come out before the Presidential elections in 1988. One of the people at Fireman's Fund on the planning

group which is involved with the National Academy of Sciences says that it appears to strongly favor an expanded federal role in this area.

I perceive the current situation as a real national disgrace. The situation is going to get dramatically worse over the next 10 to 30 years as this group, the elderly-old, doubles in size. The present situation is one which the federal government does not want to cover under Medicare. The states are taking defensive measures trying to protect their own Medicaid cost base, so they often are insisting on spend down now to cover the spouse (the spouse must now be below the poverty level as well as the institutionalized person to qualify for Medicaid). The states and the federal government are fighting over the issue, with the elderly being the victims.

This is a product that needs to be prefunded and tied in with other coverages. The problem, though, that private industry faces is that if the federal government produces a long-term solution, how can we persuade people to set money aside to pay for it? I was delighted to hear about the experiment with SHMO. It is the right role for federal and private cooperation, and I believe that the federal government will be forced to come up with a long-term solution that will include prefunding under Medicare.

I do think the private insurance industry has a combination of short-term opportunity and real social opportunity for doing something in the mean time.