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FINANCING OF LONG-TERM-CARE COSTS: GOVERNMENT PROPOSALS

Moderator: JOHN C. WILKIN
Panelists: HOWARD BEDLIN*
NELDA MCCALL†
JEANETTE C. TAKAMURA‡
Recorder: JOHN C. WILKIN

- Robert Wood Johnson (RWJ) – public/private partnership
- Hawaii initiative
- American Association of Retired Persons (AARP) position
- Federal initiatives

MR. JOHN C. WILKIN: In 1990, $53 billion were spent on nursing homes, and $28 billion, or 52%, was funded through government programs, mostly the Medicaid program. Twenty-five billion dollars, or 48%, was funded through private sources, of which $0.6 billion, or just over 1%, was from private insurance. Most of the rest was from patient payments. Currently, most nursing home patients must use their own income and assets first, without receiving any aid from third parties until these patients are impoverished. For this reason, many involved in public policy have been examining ways that could increase the funding of long-term care through insurance mechanisms, either by promoting private long-term-care insurance and/or by establishing social insurance programs similar to Medicare. Many would like to see the private insurance market cover a much more substantial portion of costs. But both sales and persistency must increase substantially before private insurance funds a significant portion of total costs. Many would like to see social insurance programs cover a much more substantial portion of costs, but the federal deficit, concern over acute care programs, and the disaster of the Medicare Catastrophic Coverage Act of 1988 all make federal initiatives less likely.

The panel consists of three speakers, all guests of the Society, who have analyzed these issues. Nelda McCall will speak on the Robert Wood Johnson program to promote long-term-care insurance for the elderly; Jeanette Takamura will speak on Hawaii initiatives; and Howard Bedlin will speak on federal legislative proposals, express AARP concerns about the Robert Wood Johnson partnership in Connecticut, and present the AARP position on long-term-care financing insurance standards.

* Mr. Bedlin, not a member of the sponsoring organizations, is Legislative Representative of the American Association of Retired Persons in Washington, District of Columbia.

† Ms. McCall, not a member of the sponsoring organizations, is President of Laguna Research Associates in San Francisco, California.

‡ Ms. Takamura, not a member of the sponsoring organizations, is Director of the Executive Office of Aging at the Office of the Governor in Honolulu, Hawaii.

Nelda McCall has been involved in research and consulting on the cost, delivery, and financing of health care for more than 20 years. She has served as the project director of numerous large-scale evaluations, including assessments of Medicare supplemental insurance, health maintenance organizations, physician reimbursement, mental health coverage, and long-term care. She began her career as a systems analyst with IBM, spent eight years as a research associate in health economics at Palo Alto Medical Foundation/Research Institute, and 12 years as director of the Health Policy Research Program at Stanford Research Institute. She's now president of Laguna Research Associates. She is currently project director of a major Health Care Financing Administration (HCFA) evaluation of Arizona's case-managed Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), and is project director of the evaluation of the Robert Wood Johnson program to promote long-term-care insurance for the elderly.

MS. NELDA MCCALL: We should probably confess that John also is involved in both of those evaluations. He is working with us on the Arizona Health Care Cost Containment System evaluation and the evaluation of the Robert Wood Johnson program to promote long-term-care insurance for the elderly.

The lack of comprehensive insurance to pay for long-term-care expenses is an important social problem today. Policy alternatives under consideration range from the purely public programs that are organized at the federal level, to the purely private approaches based exclusively on private instruments. The Robert Wood Johnson concept attempts to blend public and private insurance in a way that ensures comprehensive financial protection. This approach to long-term-care financing is just beginning its implementation in four states.

As evaluators of the program, our interest is in documenting the process of implementation and in assessing the program's short-term outcomes. In this talk, I am going to focus mainly on the planning phase of the Robert Wood Johnson evaluation, given that the program really has just begun to be implemented. In addition, I will talk a little bit about what will be covered in our evaluation. I need to first remind the audience that I am not speaking as an advocate of the Robert Wood Johnson program, but as the evaluator. As evaluators, our role is to look at the program and to see how well it does. It is an untested program at this point in time.

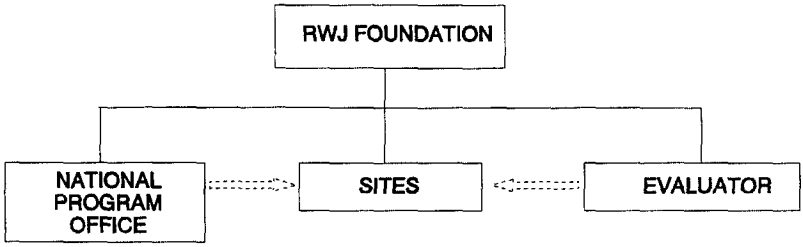
Let me say a few things about the Robert Wood Johnson Foundation and why I decided to fund this program. The Robert Wood Johnson Foundation is the largest foundation solely dedicated to health care. It concentrates on four major activities: (1) assuring access to basic health services, (2) improving the way that services are provided to people with chronic conditions, (3) reducing substance abuse, and (4) helping the nation address the problem of rising health care costs.

There are four goals of this particular Robert Wood Johnson program: (1) avoiding impoverishment among the elderly; (2) covering a full range of home- and community-based services, including case management; (3) designing affordable insurance while providing consumer protection; and (4) learning from state-based experiments whether a national program should be developed. The foundation began its activities on this program officially in August 1987, when the Board of Directors approved funding for

up to eight states to do the necessary groundwork to submit demonstration proposals to the foundation.

Chart 1 shows the structure of a typical Robert Wood Johnson program. The foundation typically funds three kinds of entities: a national program office, which provides administrative support and technical assistance to the sites; the sites themselves (of which there were eight at the beginning of the planning phase, and as we moved to implementation, there are four remaining sites); and an evaluator. In a typical Robert Wood Johnson Foundation program, the demonstration support for the program is separate from the evaluation of the program. The national program office is based at the University of Maryland, and the project director is Mark Meiners. I am going to be talking about the sites in more detail later. Laguna Research Associates, jointly with New York University, is evaluator of the program.

CHART 1
Structure of the Program



The two typical phases in a Robert Wood Johnson program are a planning phase and an implementation phase. The planning phase, for this particular program, was one of the longest planning phases at the foundation. The planning phase is typically a year, sometimes 18 months, during which the foundation provides support to develop a detailed plan and budget for the sites to go to implementation. In this case, there were a number of issues that made the planning phase a lot longer, one of which was that the states were not all awarded grants at the same time. State grants were actually phased in over a year and a half period. A second was difficulties in implementing the program and specifically securing federal participation.

There were eight original planning phase sites. Connecticut and Massachusetts were the first funded sites. They were funded in August 1987, followed by Indiana and Wisconsin, which were funded in January 1988. Next was New Jersey, New York, California, and Oregon, which were funded in January 1989. California, Connecticut, Indiana, and New York are those states that are moving to the implementation phase, since receiving funding from the foundation to implement a program.

The foundation envisioned a model that would share responsibility between individuals, private insurers, and the state. To assure that kind of model, one of the major concerns addressed by the states during the planning phase was getting the involvement, the cooperation, and the participation of a number of diverse groups in their communities. This cooperation and participation was absolutely critical to the success of the program. The state program staff had to work with at least three different

agencies in each state and sometimes more; these included agencies involved with aging issues, those involved with the Medicaid program, and departments of insurance. They had to work with insurers, providers, and consumer groups, and because the approach that was put forward in seven of the eight states involved an interaction with the Medicaid program, they needed to work closely with the federal government.

The planning phase activities were in three major areas: defining the specific program features; conducting data analysis to help design and price the products, and calculating the likely effects of those products being in the market on the Medicaid costs for the state; and, setting up the program administration involved in running the program. The model of the partnership that has moved forward is one with a front-end private insurance coverage and a back-end Medicaid coverage. Agreeing to a definition of the insured event is actually a process that's still going on in some of the states. Each state must determine the specific benefit-eligibility requirements that an insurer must use if it wished to be part of the partnership.

In conducting data analysis, some states relied on primary data collection. A number of them did surveys and some linked secondary data (for example they attempted to link their Medicaid data with home-health data and other data bases). Each state used modeling to calculate the fiscal impacts of its programs. In addition, there was a great deal of work that needed to be done to set up the program administration. States needed to think very carefully about the regulations and the data requirements that were going to be part of the program, develop their own internal systems to manage this kind of a program, and develop programs to educate the public.

Several accomplishments resulted from the planning phase, not just within the states that are moving on to implementation, but in the other states as well. The planning activities promoted a great deal of cooperation among the various public sectors (many on the staffs of these agencies had not really had much contact with each other), and between the public and the private sector. The planning activities provided a forum for them to discuss long-term-care issues. Some specific models for public/private partnerships were developed. Improvements in the benefit designs were promoted. People within the communities began to think about what kinds of benefits are important for people to have, and that had an impact on some of the work that has recently been done by the NAIC. As a matter of fact, some of the NAIC analysis of the cost of inflation protection and nonforfeiture benefits was based on the RWJ funded research done in Wisconsin.

Long-term-care databases were developed -- as you all know, one of the big problems with pricing long-term-care insurance products is the lack of utilization data. The planning activities gave eight states the ability to link various data bases and conduct analysis of long-term-care issues. Considerable work on data linkage was done in Connecticut, New York, and Wisconsin. Consumer information was improved as a result of the planning activities, and consumer education programs were developed. Many of the states conducted community forums and were involved in the development of brochures. Consequently, there has been an increased public awareness of the importance of the whole issue of long-term-care financing.

And lastly, there were notable improvements in the long-term-care delivery system infrastructure development. One of the big goals of the foundation was to see case

management and home- and community-based services in the package of benefits offered, and, in many of the states, there were a lot of improvements in infrastructure. In addition, the availability of home- and community-based services were sometimes problems in certain areas, and there was considerable development on that front, specifically, in Indiana, where they had a very limited 2176 waiver program (the program which permits Medicaid to provide home- and community-based services). Indiana expanded that program substantially.

Before I go on to talk about the four states that went forward to the implementation phase, I am going to talk a little bit about the four states that did not move forward. Although there are four reasons, I think there were two main reasons why the states, excluding Oregon, did not move forward. Oregon decided reasonably early on that its approach was not going to include Medicaid back-end protection, and the foundation felt that the approach it was proposing was not the public/private linkage that it wanted to continue funding. Consequently, Oregon dropped out rather early.

The second thing that impacted the states moving forward were the delays in securing federal participation. Because the approach was to go forward with a private-insurance-at-the-front-end, Medicaid-at-the-back-end kind of approach, states needed to get permission from the federal government to alter the Medicaid program.

There were several routes that states could use to try to get this permission. One was to attempt to secure a legislative waiver. A second was to attempt to secure an administrative waiver, and the third was to amend their Medicaid state plan. Early in the process, the decision was made to attempt to get a legislative waiver. Unfortunately, in October 1990, language to permit the waiver was dropped from Congressional consideration during the budget reconciliation process. Resistance to the waiver developed in the Congress which was led by Congressional Representative Henry A. Waxman's office.

At that time, the seven states who were planning to move forward had to regroup and decide how they were going to proceed. Two of them had approaches that were not consistent with a Medicaid plan amendment, which required that services would be provided statewide. The New Jersey approach and the Massachusetts approach were for limited population groups. So, they decided not to move forward. In addition, there were changes in leadership in many of the states and severe budgetary constraints, especially in New Jersey, Massachusetts, and Wisconsin. Changes in leadership often brought a change in the political party. The new leadership did not see this as not something that they necessarily wanted to pursue. In terms of direct political opposition to the program at the state level, our impression as evaluators was that only Massachusetts experienced vocal opposition. In all of the other states (and we did site visits where we talked to consumer groups), the program received bipartisan support and did not have much opposition. Although, as we will hear later, there was opposition at the national level from the AARP.

I am going to talk just a little bit about the partnership in the four states that are moving forward. Table 1 shows some of the characteristics of the program in each state. Some of the information that I am presenting is more firm than other information. For instance, Connecticut's program is pretty definite. Indiana and New York are still in the process of thinking through a number of these issues, and so their

specific requirements are not yet firm. The information presented represents where each state currently thinks it is going. California is further behind Indiana and New York. Connecticut received a Medicaid plan amendment in August 1991. Indiana and New York received their plan amendments early this year. California's plan amendment is still pending federal government approval.

And as you can see from Table 1, there are two major kinds of models of partnership that have been developed. One is the asset-protection model, which is the one that is being put forward by Connecticut, Indiana, and California, where, essentially, an individual purchasing a policy can protect assets up to the amount of the qualified insurance benefits that are paid by the policy. In other words, if a benefit would have qualified for payment under Medicaid and is paid by the policy instead, the individual can protect assets up to the amount that is paid by the policy. So, a person having $100,000 in assets could decide to purchase a policy that paid at least $100,000 in benefits if it was desired to protect those assets. In New York, the program will be requiring a three-year, minimum-coverage plan. There is asset disregard for Medicaid when the insurance expires. Consequently, if a person bought a three-year policy that is certified by the partnership in New York, when the insurance plan has finished paying, they would be able to disregard all their assets in determining their Medicaid eligibility. I should mention that assets do not include income. Income is counted in all of the states. Income is not protected. Income would need to be used to pay for care first, before a beneficiary would be eligible for Medicaid. But a purchaser would be able to protect their assets.

TABLE 1
Structure of the Partnerships

State	Minimum Coverage	Public Coverage	Beneficiary Protection
CA	1 or 2 years	Medicaid/IHSS	Asset protection equal to qualified insurance payments
CT	1 year	Medicaid	Asset protection equal to qualified insurance payments
IN	1 year	Medicaid	Asset protection equal to qualified insurance payments
NY	3 years	Medicaid	Coverage when insurance expires

Table 2 shows the product guidelines for qualified policies in each state. In Connecticut, benefit eligibility must be based on two activities of daily living (ADL) limitations or cognitive impairment. In New York, eligibility is based on the RUG system, or Resource Utilization Groups, which is the New York Medicaid program's method of determining eligibility for long-term-care services. Most of the insured event criteria are based, to some extent, on the kinds of things that are currently used under each state's Medicaid program for nursing home care eligibility. With respect to service coverage, nursing home coverage is required in every state. All states except Connecticut require coverage of home health care. In Connecticut home health coverage is optionally required (that is, an insurance company must provide an option

with home health coverage, but it is not required for every partnership policy). Personal care is also optionally required in Connecticut. In New York, all of those things are required. Indiana is currently thinking of requiring nursing home and home health, but personal care will be optional. California, as I said, is not as far along in firming up the requirements, but the current thinking is that it will require nursing home care, home health care, and personal care.

TABLE 2
Product Guidelines

State	Insured Event	Service coverage		
		NH	HH	PC
CA	2 ADL limitations or cognitive disability	R	R	R
CT	2 ADL limitations or cognitive disability	R	OR	OR
IN	3 of 16 substantial medical conditions or ADL limitations	R	R	O
NY	1 of 11 rugs categories	R	R	R

Table 3 presents minimum benefit product guidelines. Again, let's move to Connecticut first. The minimum benefit for a nursing home is $80 a day, and $40 for home health care. Inflation protection is required, and insurers have three options with respect to inflation protection. Nonforfeiture benefits are not required.

TABLE 3
Product Guidelines

State	Minimum Benefits			
	Nursing Home	Home Health	Inflation Protection	Nonforfeiture
CA	Undecided	Undecided	Required	Comply with NAIC model regulations
CT	$80 per day	$40 per day	Required	Not required
IN	75% of state average per day	50% of nursing home per day	Required	Not required
NY	$100 per day	50% of nursing home per day	Required	Not required

Look at the New York line, which is probably the second most developed in terms of these parameters. They require a minimum benefit of $100 a day for a nursing home, and 50% of the nursing home rate per day for home health. Inflation

protection is required, and it must be 5% compounded annually. Nonforfeiture is not generally required, but it is required if a national long-term-care program becomes enacted. Also, New York is requiring level premiums, unless rate increases are granted by the Department of Insurance.

There are some key program features. The partnership programs require case management, management information systems (MIS) development, and consumer education and marketing. Connecticut and Indiana are proposing doing case management through licensed case management agencies. New York is proposing requiring case management on a service basis, for information and referral. Two face-to-face sessions per year while receiving benefits would be available in approved policies. Considerable MIS development is currently going on, and in addition, all the states have a very large component of their budgets for consumer education and marketing (i.e., brochures, video, volunteers).

Let me quickly give you a preview of some of the things that we are going to be covering in our evaluation. We are going to be looking at the demonstration activities, exactly how the program is implemented and how it operates; insurer participation; the characteristics of policies that are developed under the program; purchasers of policies; consumer satisfaction; insurer performance; use and cost experience of the people who go into benefit; and the impact of the program on the Medicaid costs for the state. The evaluation is for three years. Most of our energy in the three years is going to be spent on the first four issues. We are spending a good deal of energy trying to set up systems that will allow subsequent evaluators to monitor the more long-term kinds of issues. These efforts have included our attempts to develop uniform coding systems and to set up uniform data that will be collected from the state -- especially on use and cost experience and administrative costs.

The foundation program represents a new approach to long-term care, an approach that has not yet been demonstrated, and so it clearly has not been tested. We do not really know if it will be a success or a failure, but I think that it is an important approach that should be considered in the evolving public policy debate.

MR. WILKIN: The next speaker will be Jeanette Takamura, who is the director of the Executive Office on Aging in Hawaii. She has a Ph.D. in social policy from Brandeis University. Jeanette was formerly a faculty member of the University of Hawaii, and she has been a consultant and author on gerontological issues. She has a special interest in long-term care.

MS. JEANETTE C. TAKAMURA: I was actually invited to talk about the Family Hope Program, a program proposed by the state of Hawaii. As I share the information about the Hawaii Family Hope Program, I would really like you to bear in mind that I actually represent a team of five researchers.

The Family Hope Program is a proposal that was developed over a three-year period by the Executive Office on Aging of the Office of the Governor. The Hawaii Family Hope Program is not the sole long-term-care initiative launched by the office. I think what I really need to convey is that the office determined, about five years ago, that long-term care is the single most pressing issue facing our older adult population. Consequently, we have launched a series of initiatives, and these initiatives actually

included addressing such things as a service delivery system, financing, quality of care, etc. The other thing that I would like to mention is that, five years ago, we took 100 people representing all sectors of the community in the state of Hawaii, got them together (many of them had never talked before), and we asked them to actually dedicate themselves to developing a long-term-care plan, again, addressing services, quality of care, and financing. As they did this, they indeed came up with a blueprint that was adopted by the legislature in 1988.

The Hawaii Family Hope Program is, then, one of these initiatives, and there are others that I could mention. One of them is a program that we call Long-Term-Care Choices, which gives money to new entrepreneurs to begin long-term-care businesses. We also have a television program to inform people about long-term care.

Our resident population in the state of Hawaii is definitely aging. If any of you have come to Hawaii, you will know that our over 60 population is growing by leaps and bounds. The population is growing so rapidly that it indeed is becoming a major concern in the state of Hawaii. The older adult population in Hawaii is growing in such dramatic ways that, over the last 10 years, our over 60 population expanded by 52.4%. The general population, meanwhile, grew by some 14%, and the 85-plus population grew astoundingly by 87%. It's very clear to us that we have many elders and many more to come in the years ahead. We expect that with the addition of the baby-boom population, unless we do something, we will be in dire straits.

The Hawaii Family Hope Program actually is a possibility in the state of Hawaii, in part because the state has a universal health access program in place. In fact, in 1974, the state took the very bold step, thanks to the lead of our labor organizations as well as some key legislators, of putting into law the Prepaid Health Care Act. This act enables all people in the state of Hawaii who are employed to enjoy health care coverage. As a result, about 95% of our population is covered for health care and we are not grappling with the question of how we can insure our general population for health care. Rather, we are much more concerned with our older adult population which is clearly growing and which needs assistance with long-term care.

The longevity rate in the state of Hawaii is one of the best in the country, and indeed, one of the best in the world. Our Japanese American and Chinese American women, I am very proud to say, are the longest-living people in the state of Hawaii, and in fact, as a result, are the longest-living people in America. Some of the reasons for longevity can be attributed to lifestyle. I do not want you to think that we lie on the beach all day in Hawaii. If any of you have come to the state, I think, either as consultants or as experts in any way, you know that we will work you to death, right around the clock. The cost of living in Hawaii is extremely high. The cost of housing is even higher and the work ethic is alive and well in the state. Nonetheless, there is a good lifestyle. When I say lifestyle, I am talking about dietary habits and other things. We also must give attention and underscore the important role that having universal health access plays in longevity, or in seeing to it that people live a good long time.

There are certainly many reasons why we launched the work to put together what we are calling the Family Hope Program. I have gone into great detail and mentioned the longevity rate and the rapid rise in the number of elders in Hawaii. But I must

also mention that Hawaii has a very high percentage of employed women, I think we have one of the highest in the country, attributable, perhaps, to the high cost of living, but also to the fact that many of our immigrants came to Hawaii and began life as workers, and then continued to be engaged in the work force. The rising cost of long-term care must be noted as well. For the people of Hawaii, the average cost of institutional nursing home care is about $45,000 a year, and it is not uncommon to see some people paying up to $70,000 a year to be cared for within a nursing home. I should mention that Hawaii does not have a large supply of nursing home beds or long-term-care services. The bed ratio in the state is only about 14 nursing home beds per every thousand persons 65 years of age and older.

In the state of Hawaii, just as all across the United States, there is a very strong preference among people, and certainly among family members, to retain their elders within their homes and provide them with home care for as long as possible. Because there are so many women in the work force, because of the cost of living, because of the shortage of beds, all of these factors together make long-term care a great challenge in our state. There also are, and all of you know, perhaps even better than I, limitations within the Medicaid program and within private long-term-care insurance policies. We simply do not cover long-term care adequately enough -- not unless you impoverish yourself to become eligible for Medicaid.

There are other reasons why we began to do the work that ultimately led to the Family Hope Program. There was tremendous interest within our legislature, and also a tremendous groundswell of public interest, mostly because many of the people in our state were growing older, and many of them were aggregated in certain key representative districts throughout our state. The federal budget deficit became a factor that we had to consider as well.

I would like to note that our team did not begin with a predetermined notion of the kind of program that the state should adopt. We did not say to ourselves, "What we really ought to do is spend the next three years building a public program." Nor did we say to ourselves that we ought to spend three years putting together a program that uses private long-term-care insurance as a base. Rather, we decided not to presume one or the other or any of a multitude of options as the correct one. We looked at about 112 different financing options, and we compared them. We looked at home equity conversion, the use of dedicated IRAs, and others. And we asked ourselves, which of these would indeed do the best job for the people in the state of Hawaii.

We engaged in numerous discussions with people from across the country who are deemed to be luminaries and experts in the field. Mark Meiners certainly was one, John Wilkin is another, and I certainly can stand here and rattle off quite a number of other individuals. These individuals represented a wide spectrum of ideas, and, I should say, ideologies, and they provided us with very good input. We used them oftentimes to review our work and to provide us with critical feedback. I often purposefully brought in two people who were diametrically opposed in their points of view to look at our work and to critique it. We did not feel that we would do well if we brought in sycophants who simply wanted to visit Waikiki Beach. Rather, we thought it would be important for us to tap people who could attack the program, criticize it, and show us areas that needed to be improved.

In that process, we looked at a spectrum of options. Ultimately, we looked at four options in a great deal of depth. One of them was the option of doing nothing, because we knew that there would be some legislators who would say to us, "This is too complex. It will probably cost too much money. You're asking too much. Why do we have to do anything about long-term care. Families will handle it anyway." We knew that there would be some who would say that the best course of action would be simply to do nothing. We also knew that we had to look very seriously at relying upon private long-term-care insurance. We also entertained the possibility of adopting a general state-funded program that is an entitlement program. Finally, we looked seriously at relying upon a combined public and private approach. We compared these four options, along with the hundred-plus other options.

In the course of the analysis, we made a lot of interesting discoveries. We knew that if we did nothing in the state of Hawaii, the cost of long-term care would continue to be covered first by families, and second by the state and federal shares of the Medicaid program. We realized that private long-term-care insurance does not cover a large number of people, and we could not see it playing a very significant role in the future.

We looked at what would happen if we did nothing in the state. We looked at projections from the present time to the year 2020. We discovered that families would continue to pay a tremendous amount of money out-of-pocket and through the conversion of their assets. The state and the federal government would continue to contribute a large amount of money to keep the Medicaid program going, but it would only pay for those who were at the welfare level or below, not people above the poverty line. Private long-term-care insurance, even when we have projected it out to the year 2020, continues to play a very insignificant role, covering less than 2% of the cost of long-term care in the state of Hawaii. These were points to which we had to pay attention. We looked at what would happen if we maintained the status quo, only to discover that by the year 2020, with inflation built in, families would face nursing home care costs averaging $200,000 per year per person. I am talking about the baby-boom generation who would have to save this amount of money. Family cash outlays would increase more than 1,100%, and family asset expenditures would increase by almost 1,000%. The state's share of the Medicaid program would increase by 1,300%, or 13 times. We looked at the consequences for the federal government and discovered that the federal Medicaid outlay for Hawaii would rise by 14 times or 1,400% between 1991 and the year 2020. We also considered what would happen in the service sector, and we heard from private providers that they were not thrilled by the prospect of continuing to rely on Medicaid and state subsidies. While Hawaii still has a budget that is pretty much in the black, we do not expect that we will be able to keep pace with our growing elderly population.

Another point that we considered was the incentives that would exist to develop the necessary work force. We found that, if we continue things as they are, there will be inadequate incentives to actually encourage people to provide long-term care and aging services. Other consequences of doing nothing will be that the impetus for cost containment will remain the same, and the impetus for quality assurance will also be limited.

The consequences of doing nothing will be significant for caregivers, who will have to give up financial assets, time from work, retirement benefits, and other resources. This will have the greatest effect on women, because the vast majority of caregivers are women. Work force productivity also will be compromised. Finally, we will still be faced with competing state priorities, with no reassurances that we can somehow deal with long-term care in any better way. Family assets and cash resources will continue to be the primary source of funding.

I would like to spend a few minutes talking about the methodology that we used. We used a micro-simulation analysis to generate projections all the way through the year 2020 and beyond. The micro-simulation analysis was based on the Brookings-Lewin Intermediate Care Facility (ICF) model. I think some of you may be very familiar with it. What we did, which was a little different from many of the other states who have subsequently used the Brookings model is that we went into the gut of the entire simulation model and disaggregated it. We wanted to know what was in every single cell, what parameters existed for every one. We wanted to be sure that our simulation runs would replicate or would give us a real picture of Hawaii, as opposed to Michigan or Wisconsin or California, or some other state. It took us about nine months to check all the parameters, and to adjust them so that, in fact, we had a model that really was applicable to Hawaii. In addition to making adjustments to the parameters, we enhanced the model by including seven very technical modifications which permitted us to do some complex runs and to look at a complex insurance environment. We also worked very closely with our actuaries to get some actuarial projections.

I noted earlier that we called in outside experts to critically review our work. We had a long-term-care financing advisory board that was mandated by the legislature and appointed by the governor. The board took about five months to go tediously through every piece of our work. They examined our assumptions, and judged whether our projections were too generous or too conservative. They were asked to determine whether we should, as a state, embark upon the pursuit of a long-term-care financing program. The financing advisory board completed its work in about February of this year, and concluded that we ought to go ahead and have the state think seriously about enacting a public program.

There were four public programs at which we looked. One was a mandatory, comprehensive program that offers long-term-care coverage for life, covering both home- and community-based care as well as nursing home care. This program proposes to pay 80% of the cost of long-term care, up to a maximum daily rate for nursing home care and for home- and community-based care, at a cost of about 0.6% of modified adjusted gross income. The program would cover 550,000 persons.

There were three other options that the financing advisory board examined. One was a mandatory front-end program, another was a mandatory back-end program, and finally, the third was a voluntary group approach. After looking at the consequences of covering a small group of people versus 550,000 individuals, the financing advisory board, comprising of members from the private sector and as well as the public sector, and advocates from within the community, concluded that the mandatory comprehensive option should be pursued.

I could talk a lot more about each of these options, but in the interest of time, I am only going to briefly describe the Hawaii Family Hope Program. The program will be overseen by a board of trustees. There will be a long-term-care fund. The board, as proposed by our office, will include members from the public, including those with insurance-management backgrounds, investment portfolio-management backgrounds, long-term-care backgrounds, and senior citizen advocates (because of legislative interest); and, we felt that it would be important to include the directors of various state departments as ex officio members. With the Family Hope Program in place, it will be possible to contain the state Medicaid budget as well as, interestingly, the federal Medicaid budget for the state of Hawaii. We will be able to stimulate the service sector, because there will be a steady source of reimbursement. We will be better able to pursue the development of the necessary work force.

We are very interested in stimulating private long-term-care insurance opportunities. I mentioned earlier that the plan will cover 80% of the cost of care. And that remaining 20% which would be a copayment, will afford the long-term-care insurance industry the opportunity to develop supplemental policies. In addition, the program calls for a vesting of benefit levels based on participation in the program. As you participate in the program, you acquire more and more coverage until you are 100% vested.

We also see some additional impetus for quality assurance and cost containment through the program. To restate some of these points in another way, we view the net gains to the state, and the net gains to the families in our state, to, in general, be very favorable.

I must repeat that possibly the only reason we can consider a program such as this, even though there are so many other compelling reasons, is that in 1974 Hawaii enacted the Prepaid Health Care Act.

I would be most happy to take questions, once our third panelist has finished with his presentation, and I certainly thank you for the opportunity to share the Family Hope Program with you.

MR. WILKIN: Our last speaker will be Howard Bedlin. Howard has been a health care legislative representative for the American Association of Retired Persons for over five years. At AARP, Howard is primarily responsible for issues concerning long-term and post-acute health care, and the Medicaid program. After working on health issues at the Johns Hopkins Medical Center and the U.S. General Accounting Office, (GAO), Howard went on to become the counsel for public policy at the American Association of Homes for the Aging, and deputy director of government affairs at the National Association for Homecare. He received his law degree and master's degree in public policy from the University of Maryland.

MR. HOWARD BEDLIN: I bring greetings from Washington, D.C., not so affectionately but probably well-deservedly referred to these days as the Disneyland of the East, or my favorite, the National Zoo, particularly in an election year. First, I am going to talk about some of the concerns that AARP has with the public/private partnerships, and then go on to discuss what is happening on Capitol Hill on long-term-care issues.

The AARP is on record as opposing the RWJ public/private partnerships. This was a difficult position to take, because, generally, we like to see states innovating. State experimentation can provide extremely important information for federal policy. For example, we have been very supportive of the efforts in Hawaii and those in Washington state as well. But in our view, the public/private partnership is similar to a lot of other very complex proposals in the health care area in that the devil is in the details. At first glance, the partnerships seem good. But once you start to scratch the surface, you expose some pretty serious faults. Our concerns are divided primarily into general public policy and consumer protection.

First, many analysts at AARP, consultants to AARP, and those in the Department of Health and Human Services estimate that these partnerships are going to cost Medicaid additional dollars, despite the claims of many of the partnership supporters who say that it will be budget neutral, or maybe even save money. State legislatures were also told that the program would not cost money, and that was part of the reason the partnerships got through pretty easily at the state legislative level. Many believe that these partnerships will ultimately cost money, and we are concerned about the implications that these increased Medicaid costs may have for persons who are currently eligible for Medicaid, those that the program was specifically designed to protect. Particularly during times of budget crunches and state cutbacks in Medicaid, that is a very serious concern.

Second, I think it is disingenuous to refer to these as demonstration projects. Generally, demonstration projects are three to five, maybe 10 years. They hopefully do provide some very good information, in theory, for federal policy. But I do think that the RWJ partnerships probably will take 15 or 20 years before we really have the kind of data that would be helpful in constructing federal policy. People must hold on to long-term-care insurance policies for many years before they are likely to go into claim status. A typical person may buy a policy around age 65 or 70 and will generally not file a claim until over age 80. We do not see any valuable information coming out of this for about 15 or 20 years.

Third, I think there is the potential for an institutional bias. There is already a real institutional bias in both public and private programs, and we are concerned that the partnership program may exacerbate this bias. People need to understand that for a partnership policy to protect their assets from the cost of long-term-care services, they basically have to jump through two hoops. First, the qualified insurance policy has to cover the service used by an individual, and second, it must also be a service that Medicaid would cover. Medicaid does a much better job covering institutional care than it does home- and community-based care, and the same can be said for private insurance policies, as shown by available data. We are concerned that people will only receive asset protection for an institutional stay, and therefore may opt to enter a nursing home even when it is more appropriate to use home-care service.

That leads to some of the consumer protection issues. The second Medicaid hoop is a major concern. There is no guarantee that the services that Medicaid is covering are going to be covered when the policyholders go into claim status and that the services will be eligible for asset protection. Rather, asset protection is based upon whatever Medicaid covers when you go into claim status. I would be willing to

wager that the Medicaid program, 10, 15 or 20 years from now, is going to look significantly different, if it exists at all. We have serious concerns about that.

I was pleased that the issue of income was mentioned, because it also is a major concern. The partnership marketing materials do not really reflect this as clearly as we would like. While there are asset disregards, the Medicaid income eligibility criteria are not affected at all. This is something that consumers need to understand. It is a very complex area, not surprisingly. Consumers may believe that if they enroll in this program, it is going to be easier to get Medicaid. That might not be the case, and likely will not be with regard to income. There is a correlation among older people between income and assets. Those that have a lot of income tend to have a lot of assets, and the assets that are protected are going to be generating income, which, in turn, is likely to keep people off of Medicaid. A great deal more needs to be done with regard to informing consumers exactly how this is going to be working. Another concern is that the partnership program is not portable. An individual in the program who moves to another state loses the protection.

Finally, we have concerns about some of the qualified policy benefit design standards. Connecticut deserves a great deal of credit for a lot of the work that they did in this area, with regard to home- and community-based care, inflation protection, and care management. We are not as confident that the other states are going to be quite as good. Our concerns are similar to those that we have with the current NAIC model laws and regulations, as well as the federal legislative proposals on regulating long-term care. We are hoping that the standards that are put into place in these states are dynamic, and open to amendment later. As we see the NAIC models developing, we would like to see more progress on mandatory nonforfeiture values, and I will get into that in a minute. We would like to see something on premium stabilization, although it is understandably a very controversial and complicated issue. We do not want to move quickly in that area. A great deal more evaluation and analysis needs to be done before we move on that front. We would like to see something on policy upgrades, another area that NAIC is interested in, and I hope that the states will look at it as well.

That leads me to what is happening on the Hill. There are essentially three kinds of legislative proposals concerning long-term care. One kind sets federal standards for private long-term-care insurance policies. Many of these proposals are linked to clarification of tax issues. A second kind makes incremental Medicare benefit improvements, generally bringing back those catastrophic coverage improvements that had been repealed. The third kind proposes comprehensive programs intended to cover the long-term care needs of the whole population.

With regard to the first area, it is not surprising that in times of tight budgets when there is little money to spend, people in the federal government want to regulate, because it does not cost much money, at least to the federal government. There is a great deal of consensus on Capitol Hill that long-term-care insurance needs uniform federal standards, partly because the states have been slow in adopting the NAIC Model Act and Regulations. This has been highlighted by studies conducted recently by the General Accounting Office, the Office of Technology Assessment, as well as one that we contracted for recently by Project Hope. The findings were extremely consistent.

Therefore, there are about six bills right now that would create federal standards, three on the House side, three on the Senate side and all are pretty similar. On the House side, Fortney (Pete) Stark has introduced H.R.3830, Ron Wyden introduced H.R.1916, and Terry Bruce (who was defeated in the primary and will not be around next year) introduced H.R.2378. On the Senate side, David Pryor introduced S.846, Edward M. Kennedy introduced S.2141, and Lloyd Bentsen introduced S.1693. For the most part, all of these bills would require that every state adopt at least what is currently in the NAIC Model Act and Regulations, but with some additions. For example, most of them require, or mandate, both inflation protection and nonforfeiture values. The Bentsen bill does not do this. The Pryor bill adopts the position that AARP endorses, which is a mandatory offer of an inflation-protection option, but mandatory nonforfeiture benefits in all polices. Most of the bills have some kind of rate-stabilization provision, generally requiring a public hearing or public comment before premium increases are approved. The Stark bill basically has a noncancelable provision for people over 75 years of age. The Kennedy bill limits increases for people over 75 to 10% annually. Many of the bills have some limitations on agent commissions in the first year.

The tax clarification issues are quite interesting. Pete Stark's bill places an excise tax on companies that do not meet the policy standards, whereas, instead of using the stick, the Bentsen bill and others use a carrot. In other words, policies that meet the qualifying standards are eligible for tax clarification or tax breaks. A lot of other bills, too numerous to mention, also would address these tax issues. Probably most prominent among them is Willis D. Gradison's, bill. He is the ranking minority member of the Ways and Means Health Subcommittee. Others are from Senator Arlen Specter, Congressional Representative Matthew J. Rinaldo and John J. Rhodes, and many others. Generally, they deal with a whole host of issues: allowing long-term-care expenses to be deducted as a medical expense; development of individual medical accounts, treatment of reserves; favorable tax treatment for accelerated death benefits for life policies (this is probably the one on that list that has the best chance of being enacted some time in the next year or two); and as tax credits, in some instances.

Unfortunately, the effects of these bills have not been costed out. We are concerned about the potential revenues foregone. No one has done any distributional analysis to determine who would benefit from the changes. We at AARP are withholding our support for any of these bills until we see some analysis.

Whether any of these bills might be enacted is a tough question. It depends upon what other bills exist as vehicles to which the long-term-care bills can be attached. The two most likely would be a modest health care reform bill or a tax bill. As you know, the earlier tax bills were designed to be vetoed, as they were very partisan proposals. There are questions now as to whether or not a second tax bill will be introduced. Maybe that will be a vehicle. Another possibility is a bill addressing private standards for small group insurance. As you may know, Mr. Rostenkowski and Mr. Bentsen have proposals on small group reform. If the acute care insurance reforms move forward, many may try to attach the long-term-care insurance reforms to them. It is hard to predict what may happen this year, though, because it is an election year. The Democratic Congress may be reluctant to join hands with the Republican Administration and move forward together to enact anything. Rather, it

seems as if the Congress is more likely to enact something that will not be looked upon favorably by the administration, and then use a Presidential veto as a campaign issue. Unfortunately, I am not particularly optimistic that any of these bills will move forward.

With regard to nonforfeiture benefits, AARP believes they should be mandated, and we are advocating this view both at the NAIC and on the Hill. A primary reason for our position is that all of the aggregate data available from the General Accounting Office, the Health Insurance Association of America (HIAA), and from the Energy and Commerce Committee shows that there is a significant lapsing risk to consumers. Certainly we need better data. We would love to see the reasons for lapse. That is something that cries out for additional clarification.

I would like to quote the statement that the president of the Actuarial Research Corporation, Gordon Trapnell, made in testimony. He says, "At issue age 55, with a 5% annual lapse rate (which is the lowest he has seen in any actuarial memoranda other than his own), the insurer is assuming that of those who are actually confined to a nursing home, less than one out of five will keep the policy long enough to be insured when they are admitted." One out of five is actually institutionalized. The proportions are better at later issue ages: 28% at issue age 65 and 37% at issue age 75. That illustrates a big concern: many people who buy long-term-care policies are never going to see the benefits.

We also are concerned that if companies were only required to offer consumers a policy with a nonforfeiture benefit (as opposed to requiring nonforfeiture benefits on all policies), it would be extremely difficult for consumers to make an informed decision. Whether to buy a long-term-care policy is already a complex enough decision. The poor record of agents as reflected in investigations by NBC News, the Consumers Union, and the House Committee on Aging does not inspire a great deal of confidence that agents are going to accurately portray the risk to consumers.

We also are concerned about future premium increases. It is something that nobody has a good handle on at this point. If premium increases result from utilization being higher than anticipated, nonforfeiture values become even more important. The big question, of course, is cost. If nonforfeiture benefits are mandated, how much is it going to cost consumers? In our view, it need not be prohibitively expensive, particularly if cash values are not provided.

One type of nonforfeiture benefit that we and many others are particularly interested in, which was developed by Bart Munson of William Mercer, is the notion of a shortened benefit period. This would essentially be specifically designed for long-term-care insurance, as opposed to a life product. Under the shortened benefit period the insured would get the full daily benefit amount, which is similar to extended term, and would be covered for life, which is one of the nice things about reduced paid-up; however, the lifetime maximum benefit would be shortened. I think that it combines those very desirable features and we are hoping that NAIC will look favorably upon it.

A quick summary of some other bills: One would reenact some of the provisions that were repealed in the catastrophic Medicare bill, such as elimination of the three-day prior hospitalization requirement for skilled nursing facility (SNF) care in the Medicare

program. This is something that providers of nursing home care are really pushing very hard. A House bill that would do this has over 200 sponsors. One bill has been introduced by Pete Stark, another one on the Senate side by Senator John Breaux of Louisiana. The problem is, the Congressional Budget Office (CBO) has estimated that it would cost somewhere in the ballpark of about $500 million annually, so I do not know if it is going to move anywhere. Those bills also include clarification of the intermittent care requirement and other liberalizations for the Medicare home health benefit. Instead of only two or three weeks of daily care, beneficiaries could get about 38 days of daily care -- again, this is something that was in the catastrophic Medicare legislation. Senator Bentsen has a bill that includes those, plus reduces the SNF Medicare coinsurance amount, which is pretty outrageous, in my view. From the 21st to the 100th day, it is over $80 a day, which, in about one-fifth of nursing facilities, is higher than the cost of care. AARP would like to see copayments closer to about 20% of the cost, which is what a coinsurance amount is supposed to be. We are hoping that idea might move forward.

Senator Bill Bradley introduced a bill that provides a respite care benefit. Senator Carl M. Levin has introduced a companion bill on the House side, which creates a new Title 21 to the Social Security Act. This Title would provide for up to $2,400 per calendar year per beneficiary who needs help with three out of five ADLs. The problem we have with it is that it is means tested. No one with over $75,000 in income is eligible to receive the benefit. A problem with all of these provisions, however, is that none of them have provided any financing. Everybody is afraid to talk about raising taxes, so perhaps we should not take many of these very seriously.

Finally, there are the rather broad social insurance proposals that had a lot of momentum back in 1988 and 1989, but don't now. Hopefully, tomorrow or the next day, we will see renewed interest, because the Pepper Commission recommendations may finally see the light, in terms of a legislative proposal. We understand that Majority Leader George Mitchell and Senator John D. Rockefeller on the Senate side, and Henry A. Waxman and Majority Leader Richard A. Gephardt on the House side, are going to introduce the long-term-care provisions of the Pepper Commission proposals. These would provide home care benefits to those failing three out of five ADLs with 20% coinsurance. Nursing homes would be covered for the first six months, followed by some income and asset protection similar to what is currently in place to prevent spousal impoverishment in Medicaid, but it would also be available for single individuals. The cost is about $45 billion. My understanding is the House provision will include financing and the Senate provision will not. We should see those in the next few days, and it will be interesting to see how they are received. We are hoping that there will be renewed interest in long-term care.

There are a lot of other proposals on the House side. Pete Stark has one. Edward Roybal, who is going to retire, but is the current Chairman of the Aging Committee, has a proposal that combines acute and long-term care. Mary Rose Oakar has a similar one. Marty Russo, who had a Canadian-style acute care program, also included some long-term-care coverage, but we are not going to be seeing him next year either. On the Senate side, Paul Simon had a bill. Brock Adams, another one who is going to be leaving (a lot of folks are not going to be around next year) has a home-care social insurance proposal. And another interesting bill was recently introduced by Senators Tom Daschle and Harrison Wofford from Pennsylvania, that

would form commissions to essentially structure both acute and long-term-care coverage.

I am going to give you a quick synopsis of what AARP is doing on the broad issue of health care reform. Our volunteers and our members make policy at AARP. They meet annually in January, about 40 of them, and determine what positions the Association is going to take. This past January, they approved a draft proposal, and I want to emphasize that it is a draft proposal, on health care reform, including long-term care, that we are going to be taking to our membership and the public throughout this year to obtain feedback for reconsideration next January. When they meet again, probably to make some modifications, we may have an AARP proposal. On the acute care side, the proposal attempts to blend the play-or-pay single payer and private sector proposals, hopefully taking the best elements of each of those. On the long-term care side, it is a social insurance proposal that provides nursing home coverage with a maximum 35% copayment with low-income protections. Home care benefits are provided for those needing help with two out of five ADLs, with a 20% copay.

We do see an important role for private insurance to play in filling those copayments and providing services that are not covered by the public program. We include financing in our proposal, which is going to make it very controversial. We essentially give our members two options for the bulk of the financing, either a value-added tax or an income tax. The total cost would be about $100 billion annually. Other sources of financing include about five billion from corporate income taxes, about five billion from estate and gift taxes, and a little bit from alcohol and tobacco taxes as well. We are in the process of taking this draft proposal to our members, getting feedback, and looking at it again next year.

Concerning this whole area of health care reform, I think Mr. Rostenkowski was correct in saying that a lot of it is going to depend on what happens in November. If we see a Democrat in the White House, I think that we are likely to see some comprehensive health care reform during the next Congressional session. If the current administration returns, I think, legislation will continue to be, to some degree, stalemated, with Congress and the White House trying to find some areas of agreement. A lot of moderate Republicans would now like to move on insurance reform and managed care proposals. The difficult part is going to be the financing. No matter what is done, even with the president's proposals, is costs money, and nobody wants to talk about how to pay for new proposals. All the public opinion polls I have seen have shown that the American public thinks that they can get health care and not have to pay for it. They think that we can cut fraud and abuse, administrative costs and waste, and adopt a Canadian-style heath care proposal, and do it without any pain. People who understand health care financing and are honest about it know that this is impossible and it is not going to happen. Part of the reason the AARP proposal contains financing provisions and states the proposal would cost $100 billion a year is to try to educate people that, providing coverage of long-term care and taking care of people without insurance means taxpayers will have to pay for it. That is going to be very difficult for a lot of people to accept. It will be a very interesting few years. I think we can all agree that we need to contain costs, and there is a lot we can do on that front, and a lot that consumers and industry and others can work on together.

MR. KENNETH R. SMITH: I am a consultant in Detroit. I did not quite follow the $190-a-year premium for the Hawaii program. Is that for all residents of the state, or just people over a certain age?

MS. TAKAMURA: The premium is actually 0.6% of modified adjusted gross income. It is applicable to all bona fide residents. These are people who pay income taxes in the state of Hawaii. We are not interested in helping people in other states cover their long-term-care needs.

MR. JUAN N. KELLY: I am a consultant in Atlanta. I want to follow up with Jeanette on that question. It occurs to me that the Family Hope Program is open to all kinds of abuse and antiselection that the Prepaid Health Care Act does not have. I would also note that Hawaii has pioneered by going its own way, by fighting ERISA preemptions since 1974. Along those lines, in terms of philosophy, where are you headed?

MS. TAKAMURA: Perhaps what I should have said earlier is that this is not limited to people who are elderly. This actually would cover all people who have some kind of income. When you have a mandatory program of this sort, and you build in a lot of preventive programs, which Hawaii already has, and add in its Prepaid Health Care Act, you have a healthier population. I think there is a chance of seeing abuses relative to people who will come in to the state needing long-term care. There are other things that I did not have time to mention that we built into the program to be sure that we are not expending unnecessarily for people's self-identified needs.

MR. JAY P. BOEKHOFF: I am with Reden and Anders, and my question is about Hawaii also. Regarding the vesting, and the role of private insurance, it would seem like the vesting would have the role of making the private insurance obsolete, which may not be in the public interest.

MS. TAKAMURA: Private insurance has a role in providing supplemental insurance up front, before a person is 100% vested. Then, yes, at some point, that individual will not need to have the up-front supplemental piece. But even after you are 100% vested, the benefit is a maximum of 80% of the cost up to a maximum daily benefit. So, that means that there is a supplemental piece in the back end as well.

MR. ROBERT YEE: Mr. Bedlin raised three consumer protection issues regarding the RWJ partnerships: the two eligibility requirements (Medicaid and the insurance policy), the potential for changes in Medicaid coverage, and the problem of portability of the coverage. I am neutral to the Connecticut partnership program, but in defense of the partnership, I believe these three issues have been addressed in the regulations. Maybe Nelda could answer that, I am not quite sure.

MS. MCCALL: Yes. A lot of the issues that Howard talked about are very legitimate consumer protection issues. But, our evaluation of the Connecticut partnership and of the other states is that they are cognizant of these issues and are very sensitive to ensuring that these concerns are addressed. Although I completely agree with your concern about consumer protection, and having information available about exactly what is covered and what is not covered, Connecticut has attempted to do this and I have no reason to believe the other states will be different. All of the discussions we

have had with them have indicated that they are concerned about those issues and are going to be doing something about them.

I would like to make two other points of clarification with respect to Howard's comment. One has to do with the neutral-cost assumption. We have not looked at those data as part of the evaluation, but one has to acknowledge that the question is really whose model do you want to use? There are many people on one side using one set of assumptions about what is going to happen in the future who come up with one set of conclusions, and there are people on the other side who come up with a different set of conclusions. In a situation where we really do not know what is going to happen, I think it is appropriate to try some of these things, and to see what happens.

Regarding the second issue that you raised that these are not demonstration projects, I will respond that some of them are demonstration projects, and some of them are not. Indiana, for instance, is a program, not a demonstration project, and because they have gotten a Medicaid plan amendment for federal support, they do not need to be demonstration projects. They can be real state programs. With respect to Medicaid coverage, I think that the partnership program has had, at least to this point, a positive impact on the state Medicaid program's willingness to expand its own home- and community based services. The foundation has looked favorably on states who are providing home- and community-based services and case management in their Medicaid programs as part of their public/private partnership. So, while I think that many of your issues present some concerns, they are concerns to which people really have been very sensitive.

MR. BEDLIN: A lot of the concerns that we expressed are things that can be incorporated into the program, quite frankly. We are working with people in Connecticut now, for example, to have the marketing materials reflect some of the concerns. What I have seen so far does not really talk much about meeting Medicaid's income requirements, or the service also having to be covered by Medicaid. It is buried in the fine print, as best as I can ascertain. With regard to cost neutrality, you are absolutely right. It is all very sensitive to the assumptions that you make. However, we have been trying to get the data from Connecticut, without much success. And if anyone knows how we might be able to at least see what assumptions they are making, that would be very helpful.

With regard to demonstration projects, part of my concern is that these partnerships have been sold to a lot of policymakers as demonstrations and experiments, etc. I do think a lot of people acknowledge it, but that was one of the purposes articulated in how they got off the ground. I agree with you, absolutely, and we are very pleased that the partnerships have, I think, helped to expand Medicaid coverage for home- and community-based care. As a matter of fact, I have heard that the continued success of these partnerships has helped in lobbying against Medicaid cuts in home- and community-based care in the state, which I think is great, but we do have a lot of concerns about the future given what is happening in New York. They are looking to cut back on Medicaid home-care benefits right now. I think it was not in their budget, but it was on the table. And it will be back next year, I am sure. Connecticut is also having real serious budget problems. Our concern is down the road. You can fix it by just saying, whatever services are in place now are what will receive the

asset protection later, but the states have not been willing to do that. A lot of our concerns can be addressed by amendments and could be improved, so, again, I hope that it is a dynamic process.

MR. YEE: One quick question for Jeanette. My understanding is the contribution rate is not projected to change. Is this a pay-as-you-go program?

MS. TAKAMURA: It is projected to change. We actually have projections all the way through 2020 or thereabouts. The 0.6% would be for three years, and then it moves up a little for another three years, and then up a little more for another three years, and it ends up in the year 2002 at about 1.4%.

MS. MCCALL: If anybody is interested in an article that summarizes the RWJ program that appeared in *Health Affairs* by James Knickman, Ellen Bauer and I, you can write to me.

MR. DAVID M. CAMPBELL: I am with the Hartford Insurance Group. Some comments, mainly in relation to the Robert Wood Johnson program, and echoing some of Howard's comments. One of the concerns that I have, at least in Connecticut right now, is that both the brochures coming from the Department on Aging and the materials coming from some of the insurance companies offering the product basically give the impression that if you buy a $50,000 policy, you are going to have $50,000 of asset protection, whether you ever use the benefits or not. I think one of the biggest weaknesses is the fact that, as Howard said, everything gets buried in the fine print, and people do not really know what it is that they are buying.

In terms of the nonforfeiture benefits, though I disagree with having it mandated, I am happy to see that some other people besides our company are trying to advocate the type of nonforfeiture benefit that is sort of a bank account idea, not reduced paid-up, not extended term, but includes the best of both worlds. So you do not have a noncancelable benefit, you do not have a meaningless benefit of $15 a day, and you are not limited to receiving the benefit prior to age 70, when you are probably not going to get benefits anyway. So, I am happy to see that other people are on record advocating that type of idea.

MR. FRANK E. KNORR: I am from Duncanson and Holt. I have a question for Howard. As I understand it, the members of the AARP are offered long-term-care insurance through a group plan. Does this group plan mandate nonforfeiture benefits? If not, is that a decision by the carrier, or is it a decision of the AARP? And if it does, how are sales going for the policies with nonforfeiture?

MR. BEDLIN: As I recall, we are currently offering three products through Prudential, one of which has nonforfeiture. It kicks in after 10 years. I do want to say that the benefit design issues are dealt with in one department of AARP, and the public policy positions are developed in another department at AARP, and we consult with one another, but they are very much separate. We do have a volunteer board who works very closely with the staff and with the people at Prudential on benefit design issues. And I can not tell you about how sales are going. Jay, you might know more about that, I do not.

MR. BOEKOFF: I think, in general, the plans that have the higher premium levels are more difficult to market through the mail, and so they have not been selling as well as some of the plans, say, with built-in inflation protection. Although they're desirable, they have not sold as well as the plans without inflation protection.

MR. BEDLIN: Actually, that is a good example of the information that we use to develop our public policy positions. A couple years ago, we only offered one policy, which had compounded inflation protection, and it was expensive, and it did not sell. That helped to influence our public policy view that we do not think that inflation should be mandatory. We were very pleased last year with the NAIC provisions on disclosure for inflation. We do think that, for example, someone who is 75 years old and decides to be buy a $100 policy, without inflation, is making a rational decision, even if his next-door neighbor may be getting an $80 policy with inflation. Even if you do not have inflation, you are still going to get something. If you lapse, you are not going to get anything. Inflation protection is pretty expensive, as reflected by data we have seen.