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LONG-TERM CARE (LTC) AND HEALTH CARE REFORM

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The chairperson and members of the American Academy of Actuaries Task Force related to LTC and health care reform will discuss those items being promoted by the administration, other politicians, and others interested in the outcome of health care reform. They will cover the possible effect on private LTC insurers, LTC taxation, and reporting requirements.

MR. HAROLD L. BARNEY: If you've been following the newspapers, you've read about the repositionings by providers, including mergers and joint ventures with large insurance carriers, in anticipation of health care reform. Consulting firms are looking at what roles they're going to fill. Some statistics from Medicare and Medicaid indicate that providers are changing their billing practices. Hospitals are merging together to get ready for health care reform in one form or another.

There are other reactions to the health care reform proposals; one of them is by the American Academy of Actuaries and the Society of Actuaries. They have put together 17 work groups and six task forces, all designed to address actuarial issues in health care reform in recognition of a unique opportunity that comes along about once every generation: an opportunity for us to promote the image of the actuary by contributing something intelligent and nonpartisan to the policy discussion.

Those groups have produced several monographs, which are available from the American Academy of Actuaries. There are monographs on health risk assessment, standard benefits, mandated community rating, actuarial solvency of health plans, actuarial issues involving guaranteed standard benefit packages, budget development, a review of premium estimates, and actuarial issues in designing mental health benefits. There will also soon be one on LTC, and that's what we're here to talk about.

One of the task forces established by the Academy was to look at the LTC aspects of health care reform. That task force is staffed by six people, five of whom are members of the Society and the Academy: there's me, Malcolm and Bart, Eric Stallard, Vince Bodner, and Denny Dewitt, a non-actuary, but a nationally recognized person who was very active in the Reagan Administration in development of LTC policies.

The work group on LTC was charged with identifying issues and discussing the consequences of certain choices that one has to make when including LTC under any health care reform scenario. This is extremely important for some reasons that are not only actuarial, but also socioeconomic and political. LTC is a major social issue because of the aging population. Everybody has seen the demographic charts and the rise in the need for LTC. We have an aging population, and the numbers are growing.

Economically, LTC is eating a larger and larger piece of state budgets for Medicaid. It is having a very dramatic impact on the dollars available for other resources, both from the family's perspective, as well as from the government's. Perhaps most significant are the political ramifications of trying to pass health care reform without LTC. Without it, you don't get the support of the American Association of Retired Persons (AARP). You don't get the support of a number of aging advocacy groups, and you may not get the support of a large segment of the population that is already wearing grey beards and pulling grey hair.

However, on the other side of the coin, putting LTC into health care reform is expensive; a lot of money is involved. If the devil isn't in the details, it's certainly in the out years as the aging population grows. Whatever you put in place today, the demands for it can only increase over time.

Clinton health care reform would offer two areas of great interest to LTC actuaries, and this is what our panelists will be talking about. First, it introduces a public program for home and community-based care (HCBC) designed to extend benefits to people living at home with three or more limitations on activities of daily living (ADL). The HCBC provisions of the Clinton plan amount to essentially a block grant program, not an entitlement program. Second, the Clinton proposal contains a number of provisions related to private insurance that go beyond the HCBC, clarifying some tax issues and various other elements that are of interest to the insurers that are marketing LTC policies. Bart will bring you up to date on some of the public aspects and initiatives of health care reform.

MR. BARTLEY L. MUNSON: I thought I would share some thoughts with you from one of my favorite textbooks, the Murphy Law Books. They list, among other corollaries to Murphy's Law, "The fact that nothing is as easy as it looks;" "Everything takes longer than you think;" "Whenever you set out to do something, something else must be done first;" and "Every solution breeds new problems." I think that's what we're finding in health care reform and specifically in LTC.

LTC is in the public debate sector and treated differently than medical in many ways. Meg Greenfield of *Newsweek* gave in one of her columns what I would say is advice on the need for actuaries in health care reform, especially LTC. It is a column that says only be skeptical and be aware of those out years, which is what Hal mentioned. She says:

> Health care will have its own set of terms that people will invoke without ever bothering to say just how well the proposed one-word solution works, or who will administer it, or whether there's either money or knowledge enough to bring it off. Keeping an eye out for such terms will require some literary skill and so will what I advise as an all points verb alert. I wish you had been paying attention in class instead of staring out the window when they were explaining the subjective mood and the conditional, not to mention the future perfect tense.

You're going to get a heavy dose of all these and more—of the "ifs," "assuming thats," "at that point provided thats," "should produces," "all things being equals," and the "will have beens."

She says to us actuaries:

> The best advice is to kick away old assumptions and biases for this debate, be skeptical of everyone, including your own side. Above all, believe that all numbers are provisional and that anything that looks easy is almost certainly fake.

That's a good part of my belief in the health care debate. I wish it weren't, but certainly it is in LTC. LTC is treated differently than medical in the context of what we're to talk about because the premium is not in the LTC premium for the basic plan. So many people, like Hal and others in our profession, have spent a lot of time in trying to figure out whether those premiums were too high or too low. When people ask is it too costly or not, they too often mean those premiums, and the question has nothing to do with LTC.

LTC relates mostly to a special constituency. We tend to forget that it relates to everybody, but it focuses on a special constituency, more so even than the acute care medical expense. The population is not covered much by private insurance, whereas the medical expense certainly is. Both federal and state governments pay for some LTC, and in different ways. The government costs are out of control, as Hal said, and the demographics are a problem.

All of those reasons hit LTC more than acute medical care and are why we don't hear much about LTC in the debate. A recent *Wall Street Journal*, for example, did indeed have four articles on health care reform. In only one of them will you find the phrase *long-term care*. It's just a general passing comment that, "It too is awfully expensive and is going to be a problem for us." It's being subsumed in all those other issues that we hear about and in the articles we read.

Howe's Law states, "Everyone has a scheme that will not work." I think that depicts health care reform on the federal side (and any other side). You've seen these various federal health care reform bills, and all but one have something to say about LTC directly. Not one of them is going to pass. Well, almost none of them. A form of Clinton's bill has finally been voted out of committee, but that's as far as any of the bills have gone.

We indeed tried to do a monograph, which will be out one of these days soon, for the Clinton bill. There are several of us who have worked a bit on it. I want to tell you some things we're trying to address in the monograph that we think, as an Academy work group, are indeed actuarial.

We have five sections in the monograph. The first section is determining eligibility; we think that's fraught with some actuarial issues that I'll mention in a moment. Second, intensity of the services contains things we should examine. Third is cost estimates per se. The work group has met with people in the government to talk about cost estimates and how they came about theirs; not the premiums that we hear all about, but the cost estimates involving LTC. Fourth is the federal funding of the approved state programs. The federal authorities' approving of state programs has major budget implications, and those have not been addressed very much. Fifth, there are also many private insurance issues.

That's our profession's monograph on the Clinton plan. I almost hate to refer to it because there won't be a Clinton plan per se for a long time, if ever. Let me just say a word about those sections to give you a feel for what we think is actuarial in nature in the public sector.

First, under determining eligibility, what would our estimate be for the Clinton plan in 1996? His plan says there will be 3.1 million eligible people in 1996. We aren't saying the estimate is good or bad, but it's clearly a number that the actuaries should take a look at. We should examine the benefit triggers. As Hal said, though it's only home care, it's based on three or more ADLs or cognitive impairment. The reason it's like that is because that's one way to try to keep the cost down, though we don't think it's a very predictable way. You won't have too many people in it if it's three or more ADLs and it's only in the home. If patients fail that many, they shouldn't be there, so there won't be too many, and the cost won't be out of hand. It doesn't seem to be the most proper actuarial chain of logic, and we want to look at that a bit.

Is it right to assume that 85% of those eligible will seek the benefits that they have under the plan? That's the assumption in the Clinton plan pricing. It may or may not be right, but it's certainly the kind of thing that actuaries could poke at.

Second is the intensity of services. For example, we would propose to the government that what we would look at is the reasonableness of the assumption that those in home health care will have 200 visits a year. Is it too high? Too low? What should it be? As those of you who price home health care know, that's a terribly difficult assumption; but it's a terribly important one. How much would be charged per visit? That's underlying the cost estimates the Clinton plan has made, discussed in the third section of the monograph. Also, the authors of the Clinton plan want to cover some nonprovider costs, that is, medical expenses for medical equipment, case management, and so forth. We think actuaries can take a look at that and help them learn about that. How about the controls on informal care? How available will that be to the population who is covered under something like the Clinton plan? Unfortunately, we don't have experience on some of those things either. Olivier's Law tells us that "Experience is something you don't get until just after you need it." It seems to me that that's another applicable law for LTC.

The federal budget, according to the Clinton bill, says that in fiscal year 1996 there will be $4.5 billion available through the program, growing to $38.3 billion in the year 2003. Are those reasonable or unreasonable figures? I don't think the Academy would ever be foolish enough to say a given number is right or wrong, even with using a wide range. It seems that, if anything is actuarial, we ought to be able to bring some insight and help to that; and that's what the work group is going to offer to do through this monograph. Thereafter, it will grow with inflation in the number of eligible people in a state. The states, however, will be free to set benefits. That may leave a state in a little bit of a bind. You have some total dollars that will be allocated by the federal government in some fashion that is not entirely clear. Yet the states can do what they want with the benefit programs. So there is some presumption of a wide federal program average or something that's behind this, and we need to take a look at that. Keep in mind the monograph is not going to have answers. Rather,

it's going to try to identify the things we ought to look at. Actually looking at them is another matter.

Federal funding of the approved state programs is something that we talk about in the fourth section of our monograph. There is some assumed, implicit national plan, as I said. There are some complex formulas for payment to the individual states. How much money will the states get to conduct this program that they're told they should, even without limits on the states and strict guidance? The states have to apply for the approval of their program to the federal government, and it will say, "Yes, you're doing it fine." In spite of the bill's many pages, it's still vague. The formulas to pay the states are complex. It shifts the burden to a federally approved state program that is basically unnamed.

Finally in our monograph is point five, in which we're going to list some of the private insurance issues that the Clinton plan has in it. Malcolm is going to talk about some and give us some thoughts as an actuarial profession about those and other related private insurance issues.

MR. MALCOLM A. CHEUNG: Although things are certainly changing up on Capitol Hill and on the national health care reform scene, I think the overall result so far has been more of the same; and that is there's an utter lack of agreement on what a comprehensive health care reform bill should look like. Part of the dilemma in discussing health care reform is the fact that no one knows what shape this reform is going to take. Some recent examples, such as Medicare Catastrophic that was actually repealed by Congress, seem to suggest that it's going to be the public that will ultimately determine whether or not reform is wanted or what kind of reform will succeed.

Social legislation carries with it the likelihood of sweeping change. It's reminiscent of when Mikhail Gorbachev was presiding over the throes of change in the Soviet Union. There was a joke that was going around Moscow at that time—that Gorbachev told his people that when he first took office they were standing on the edge of a great precipice, and under his leadership they've taken one bold step forward.

The health and LTC reform proposals that are currently being considered may be well-intentioned, but the result may fall somewhat short of the expectations of the legislators, as well as those who have to adhere to the legislation.

Before I address some of the proposed Health Security Act's LTC provisions and before I give you a very brief capsule update on what is happening on Capitol Hill, I just want to take one step back and make a few comments about the current LTC regulatory environment. LTC insurance has been the focus of much attention from state insurance regulators and from federal lawmakers, as well as from consumer advocates and special interest groups. There currently are essentially three policy-making groups shaping LTC regulations. There are state insurance departments, the NAIC, and the federal government, which has more recently entered the scene.

Even though LTC insurance is still relatively new, it's already heavily regulated at the state level. Most states tend to regulate LTC insurance in accordance with model regulations developed by the NAIC. The NAIC first set standards for LTC insurance in

1986 when it developed or produced its first model LTC act and regulation. Since that time, there have been several revised models, and LTC insurance products themselves have undergone very significant changes.

NAIC models can be adopted by states as written or can be used by states as a foundation for separate state regulations and legislation. No state is required to adopt an NAIC model. Most states, however, have chosen to adopt at least some of the provisions currently included in the models. To date, all 50 states do have some form of LTC insurance regulation. Washington, DC is the only jurisdiction in the country that currently has yet to do so.

Historically, the regulation of insurance has been the responsibility of the states. Over the past few years, however, the federal government has expressed growing interest in LTC issues. I think there are several reasons why the federal government is starting to get involved.

First of all, it's the demographic issue that Hal alluded to. With the aging of the population, more and more people are going to start needing LTC services. Currently, only persons who are impoverished qualify for nursing home benefits under Medicaid; so much of this need is not being insured, and people are not being protected from the catastrophic losses that could occur if you need LTC services.

A second reason the federal government is starting to get more interested in LTC insurance is soaring Medicaid costs. The Health Care Finance Administration (HCFA) currently estimates, as of 1993, total Medicaid costs of $140 billion. A good proportion of that $140 billion is for nursing home and HCBC services. In an age of very high and soaring Medicaid costs, we at John Hancock think it makes sense for both federal and state governments to encourage a healthy, growing, and private LTC insurance market.

Currently, LTC products vary widely, and there is growing support even among insurers for some sort of minimum federal standards. This would serve as a seal of approval for LTC products, and it would make our lives somewhat easier when we are trying to install an employer-sponsored plan at an employer that has employees and retirees scattered throughout the country. Right now, administratively it's just very, very difficult because of all the filing we have to do and the regulations that vary state by state.

There's also a growing consumer interest in the product. The activities of groups such as AARP, the NAIC, Consumers Union, and major employers that have started to offer LTC plans have generally increased the awareness of the need for LTC insurance.

LTC costs can be very devastating to individuals and their families. LTC has been identified as probably the most likely catastrophic illness facing Americans today. Many middle class elderly people become essentially impoverished by the cost of LTC and find themselves ultimately on Medicaid, which is a social program designed for the poor. In 1991, nursing home care cost approximately $60 billion in this country, and that bill was paid almost entirely either out-of-pocket by the elderly or by Medicaid.

The federal government is sending a message to the NAIC and to the states to the extent that there has been a lot of press about abusive sales practices by LTC sales agents and large rate increases imposed on very elderly people very soon after issue. I think the federal government essentially is saying that, if the states and the NAIC cannot regulate this coverage, then the federal government will have to step in to do so.

In October 1993, President Clinton unveiled the American Health Security Act to Congress. I think it's very important to keep in mind that the proposed act is geared overwhelmingly to acute health care needs, not to chronic illness and disability, which are the very conditions that LTC services are designed to cover.

The President's proposal includes five major reforms of the public and private LTC system. First, as Bart already mentioned, it establishes a new HCBC services program for individuals with severe disabilities. Second, it improves Medicaid coverage for institutional LTC services, essentially increasing the monthly living allowance from $50 to $70, and increasing the allowable asset retention from $2,000 to $12,000. Third, it includes standards that we think encourage the development of high-quality, private LTC insurance products; and it also includes provisions for tax incentives to encourage people to buy these products and to encourage employers to sponsor LTC insurance programs for their employees and retirees. The fourth reform is that it includes tax incentives that are designed to help individuals with disabilities who work. Essentially, they would be able to receive a tax credit equal to 50% of what they spend on personal care services, with an annual cap of $15,000. Fifth, it includes funds for a demonstration program that would, we hope, pave the way toward greater integration between acute and LTC services.

We at John Hancock, and I think the industry in general, feel that these recommendations constitute an important first step in addressing the problem of LTC in America. The recommendations also make it very clear that in the area of LTC financing both the public and the private sectors have very important roles to play jointly. However, I think the industry also feels that these recommendations do not constitute adequate coverage of LTC for a vast majority of Americans. In fact, the recommendations could even create some problems by leaving people with the impression that the federal government will cover all or most of an individual's LTC needs.

I'd like to make a few comments about the HCBC program, the tax incentives, and the federal insurance standards that have been included in the President's proposal. These are the provisions that have the greatest potential impact on the private LTC insurance industry.

First of all, the HCBC program is the most costly and I think controversial of the LTC provisions. The benefits provided would be relatively modest in the scheme of things in that only certain home care services would be covered. But the cost to the federal government is not modest. It's almost $60 billion over the first five years of the program and, as Bart mentioned, around $38 billion in fiscal year 2003. This program would provide benefits for HCBC services to all individuals with severe disabilities without regard to age, income, geographic area, nature of disability, or residential setting. An individual, however, that resides in an institution, be it a nursing home or a hospital, would not be eligible for program benefits.

I think it's critical for the public to understand that this program is not a full-service entitlement program and that individuals would still continue to bear significant responsibilities for financing HCBC and home care. First of all, although the states are entitled to federal funding for qualifying plans, they have to operate at funding levels that will not realize full allotment of the funds until the year 2002. Even when they get the full allotment, it's not clear whether or not the funds that this proposal would earmark for that program would be sufficient to provide the coverage that I think the act intends to be provided.

As Bart already mentioned, there is a lot of work that we, as actuaries, need to do to review the assumptions and the cost estimates that those assumptions generate with respect to the cost of this program. It's not required that a state spend all of the money that would be allocated to it. This means that not all the money might be available for individuals who actually need the coverage.

On top of all that, if you make more than 150% of the poverty line, you're expected to make not insignificant copayments of between 10% and 25% of the cost of home care services, depending in your income level. In fact, I think it's been estimated that 60% of the cost of this new program would be directed towards individuals that make more than 200% of the poverty level. Although most of these individuals are by no means wealthy, they may have significant assets, and they may have the ability to purchase private, LTC insurance on their own.

It's an inequitable use of public funds to spend so much on people who might be able to meet their own needs through private insurance. A better use of limited tax dollars would be to focus on those individuals who cannot obtain coverage on their own, either because they can't afford it or because they wouldn't pass initial underwriting and therefore might not be insurable. Even if this home care program were adopted by Congress and implemented, I think private insurers would still have a major role in providing this protection to the populace. They can essentially develop comprehensive plans that supplement the benefits provided by the federal program, although that would be extremely complex administratively, because you would be carving out or supplementing benefits that can vary significantly from state to state. The bill as proposed would leave the specifics as to what benefits are provided up to the states. So you'll have a tremendous amount of variation from state to state.

At John Hancock we've already received a number of requests from some of our larger group clients asking about what the impact of this proposed act would be on their plans. Essentially we tell them that we have to maintain the value of the program to the insureds. For instance, if we have a typical employer plan with a 90-day elimination period, a five-year benefit period, and our standard benefit trigger, to offset the value of the home care program that's proposed here, we would probably have to liberalize the benefit period from five to ten years or reduce the elimination period from 90 days to 60 days.

We've also talked about providing prospective rate reductions for existing insureds, as well as providing temporary rate holidays where you don't have to pay premium for the next year or 18 months, or however long. It affects not only new customers that we may bring on, but also existing customers as well.

Overall, we're generally encouraged by the provisions in the Clinton proposal that clarify the tax status of LTC products and would implement federal standards for LTC products. Both of these approaches would encourage a very strong public/private partnership in financing LTC.

Looking at some of the proposed tax changes, individuals would be able to exclude from taxable income any amounts paid for services or amounts paid as a cash payment under a qualified LTC policy. The proposed daily maximum benefit that would be excludable is $150 per day, and that would be indexed with inflation. We think that the $150 is probably not a reasonable maximum for a number of large metropolitan areas where the average cost of even home care can exceed $200 or $250.

Furthermore, the premium cost of qualified LTC policies could be included as an itemized medical expense deduction on individuals' federal income tax returns. That would be subject to the 7.5% floor that currently applies to medical deductions. The definition of medical expenses would be broadened to include expenses for qualified LTC services. Employer-paid premiums for qualified LTC policies would be treated as business deductions for the employers, as well as excluded from taxable income to the employees. The act prohibits the use of cafeteria plans under Section 125 for LTC policies. You can't pay on a pretax basis. I understand that the act would actually prohibit the use of cafeteria plans for pretax payment of medical plan premiums as well.

One tax issue not addressed by the Health Security Act that we think should be is one relating to deductible tax reserves. The NAIC model regulation on minimum reserves for individual and group health contracts requires that minimum contract reserves for LTC insurance be calculated using a one-year, preliminary-term methodology. However, if you look at the Internal Revenue Code, specifically Sections 807 and 816, it implies that, in order for companies to deduct reserves for both noncancelable and guaranteed renewable health insurance, you would have to use a two-year, preliminary-term method.

There would be a substantial positive effect on private LTC insurance if the tax reserving method is brought in line with the one-year standard set by the NAIC. Under the current inconsistency between the minimum statutory reserves recommended by the NAIC and deductible tax reserves, there's a very high level of nondeductible reserves, and this contributes to a very high tax rate that needs to be reflected in our pricing.

We've already done some pricing analysis, and we've estimated that some of our group products actually have an effective tax rate approaching 80% of pretax profits. The high tax rate is not driven entirely by the one-year/two-year discrepancy—the high applicable federal rate (AFR) discount rate that you use for tax reserves as compared to the relatively low statutory discount rate contributes significantly to it. We think eliminating this one-year/two-year discrepancy would significantly improve the situation and would result in LTC products that have somewhat lower premiums.

Let's take a look now at the federal insurance standards that are proposed under Clinton's bill. We share the desire of policymakers and consumers for strong

consumer protection laws for the LTC insurance. Regulation that sets product standards and encourages consumers to purchase quality LTC insurance products makes sense, especially if your objective is to keep the number of people who have to rely on public programs like Medicaid to a minimum.

It's not clear that each of the elements in the President's proposal would be in the consumer's best interest. While the standards in the proposed act seem to be reasonable, there are a few that cause some concern for private insurers and in the work group's opinion need to be reviewed.

For instance, the President's proposal leaves many of the provisions dealing with federal standards for LTC insurance up to the discretion of the Secretary of Health and Human Services, as well as the newly formed National LTC Advisory Council. We believe that the legislation should be as specific as possible just to minimize the opportunities for unintended interpretations of the act by the Secretary or by the Council.

The President's proposal also permits states to apply standards that exceed whatever federal standards are included in the law and prohibits insurers from selling policies in a state that does not have in place an approved LTC enforcement program so that these standards can be monitored. This would compound the complexity of the regulatory process. By prohibiting insurers from selling policies in a state that doesn't have an approved enforcement program, you're essentially penalizing insurers and consumers for what are violations of federal law and regulations on the part of the state.

The Health Security Act also requires an independent assessment of benefit eligibility by a qualified, independent assessor that's selected by the insured. That poses some major problems for private insurers in this market. I think we're all in favor of a strong claim appeals process; however, it's the insurer or the organization affiliated with the insurer that is contractually obligated to manage an individual's LTC needs. Transferring that claim adjudication function to an outside third party not only exposes the carrier to possibly unintended claim liabilities, but it also makes it very difficult for actuaries to estimate the claim costs accurately. If you don't have uniform claim certification standards or procedures, it will be very difficult to refine your claim cost estimates.

The President's bill also requires the mandated inclusion of nonforfeiture benefits, which are extremely expensive benefits. The most recent minimum nonforfeiture benefit scale that was proposed by the NAIC would, at some issue ages, more than double the cost of an LTC insurance product. Essentially, people will be paying more for the nonforfeiture benefit than they would for the basic underlying coverage. That's an unreasonable premium relationship. It will discourage many, especially younger, people where the impact is greatest, from considering buying LTC insurance. I think we do want to encourage people to buy it when they're young and when their premiums are relatively low. Most insurers do, however, support the offer of a nonforfeiture benefit rather than the mandatory inclusion of such a benefit.

With respect to rate stabilization, Clinton's bill would permit the Secretary of Health and Human Services to develop guidelines for rate caps and limitations on rate

increases. Although I think we all want consumers to be protected against unwarranted rate increases or inappropriate rates at issue, we think the most effective way of providing that protection would be a thorough actuarial review up-front of initial rates or of rate increase requests. It doesn't seem appropriate to impose somewhat arbitrary and maybe unreasonable rating restrictions on carriers.

The rate stabilization principles that were voted on in the last NAIC meeting are a four-year rate guarantee up-front; no more than a 25% rate increase over any four-year period under age 65; between age 65 and 80 no more than a 15% rate increase over any five years; and over age 80 no more than 10% over any five-year period. Those are tough guidelines, but we think they're workable and they're reasonable. One impact of those guidelines is going to be higher capital requirements, higher risk charges, and consequently higher premiums for purchasers of LTC insurance.

Let me give you a quick update on what we see happening in Washington. What are the prospects for health care reform moving forward in a form similar to what the President has proposed? Even before Mr. Rostenkowski (D-IL) had to step down as Chairperson of the Ways and Means Committee, we thought the prospects for health care reform, and the Health Security Act in particular, looked dim. Right now, there are five Congressional committees working on some version of health care reform.

I'd like to just focus on some of the more recent activity of the five Congressional committees. In the House, there is Ways and Means under Representative Sam Gibbons (D-FL); Energy and Commerce under Representative John D. Dingell (D-MI); Education and Labor under Representative William D. Ford (D-MI). In the Senate, there are two committees: Labor and Human Relations under Senator Edward M. Kennedy (D-MA) and Senator Daniel P. (Pat) Moynihan's (D-NY) Finance Committee.

The House Ways and Means Committee under Sam Gibbons' new leadership just recently released a health reform bill for consideration. At this point, the details of the Gibbons' mark are still somewhat sketchy, but it appears to include both federal insurance standards for LTC, as well as tax clarification. It also includes funds for HCBC benefits similar to the program that the Clinton bill proposes. However, the funding for this program is significantly lower than what Clinton originally proposed. As a comparison, the $38.3 billion for fiscal year 2003 under Clinton's bill is only about $13 billion under Gibbons' bill.

The House Energy and Commerce Committee under Dingell has been unable to produce a bill. Its members have been paralyzed because they have representatives of both extremes of health care reform debate, and they just have not been able to reach any sort of consensus to come up with a single bill.

The House Education and Labor Committee has an extremely liberal membership and some commentators are talking about the bill that they're working on as Clinton "heavy" because it's even more costly than the original Clinton proposal. Its deliberations haven't attracted a lot of attention because its members' views apparently are fairly extreme and very unlikely to be adopted by the Congress.

The Senate Labor and Human Relations Committee under Kennedy completed the markup process recently. The Kennedy bill includes tax incentives and insurance standards similar to the Clinton bill. It includes Clinton's home care program, and it also includes a provision for a voluntary, individual-pay-all nursing home program that its authors call Life Care. This would be a guaranteed issue, voluntary program with individuals being able to purchase coverage only during open enrollment periods that are ten years apart. I haven't seen too much of the details of this particular proposed program, but it's not clear to me whether the adverse selection would be controlled sufficiently by this ten-year open enrollment period to make such a program financially viable.

With Rostenkowski's indictment, we think the committee to watch is the Senate Finance Committee. It's a somewhat more conservative committee than Kennedy's, and it's probably somewhat more representative of Congressional intent on this issue. This is a very high-powered committee, and it includes Senators Robert Dole (R-KS), Robert Packwood (R-OR), and Moynihan, as well as the majority leader, Senator George J. Mitchell (D-ME). An outline of the chairperson's markup for that committee was released recently. Although the LTC provisions seem consistent with what Clinton had originally proposed, the expectation is that those provisions, through the markup process, will be watered down.

It does seem likely that there's going to be major change with respect to the President's proposed Health Security Act, including the sections that deal with LTC. In particular, the home care program, due to its high cost, probably will not survive as the bill moves through Congress. It's probably much more likely that federal action will include establishment of federal insurance standards and possibly clarification of certain tax issues. Our contacts in Washington believe that, whatever federal standards are developed, they're going to be basically consistent with the provisions currently included in the NAIC model act and regulation. I think it's safe to say that Congress is moving ahead fairly cautiously on this whole issue. There's also an outside possibility that LTC issues, because they're clearly secondary to reform of the acute care system, may not be addressed at all in what ultimately emerges from Congress later this year. We do know that the political horse trading hasn't begun in earnest yet. Our only advice to people who are interested in the ultimate outcome is essentially, stay tuned.

MR. ROBERT L. WHITNEY: If Malcolm could expand on why he thinks rate caps are workable, particularly from an individual insurance point of view, I'd appreciate it.

MR. CHEUNG: When we were going through this process with the NAIC, we were trying to read the political tea leaves. It was clear that the NAIC was intent on implementing some form of rate stabilization. When we came up with this proposal, it appeared that what the NAIC was intent on imposing on the industry was noncancelable LTC insurance—no ability to raise rates at any time.

We felt that, politically, we needed to accede to something that, although onerous, was reasonable and workable. It's not just John Hancock. A number of other carriers also looked into this. If the NAIC was going to do something, we certainly didn't want it to be noncancelable. What we did end up with leaves us with some

latitude, although we're concerned about what the impact will be on required surplus as well as on the rates.

MR. MUNSON: I agree that it's not unreasonable, having sat through a couple years of meetings and fights over rate stabilization with the regulators, to think that we need some rules. The ones that were adopted by the NAIC in plenary session are messy because they're complicated. They're an attempted compromise from the one extreme—noncancelable—to others that, in the minds of the regulators and the consumer groups and many insurers who talk to them, left no protection to aging policyholders at all. There are many rate increases that are happening in some states, and it's to an especially protected class. It's hard to tell the regulators they don't need some protection on this. We've argued for a better process of filing approval by the states.

MS. MARY ANN BROWN: Malcolm, I'd just like to support and applaud your efforts on the tax reform and the tax reserves. Certainly that's a penalty we have to get changed in order to continue with this. Bart, I'd like to ask a question would your working group consider experience from other countries as something to put forward to the U.S. government or on your working group recommendations?

I have some experience with the German plan, and it has just mandated that every person of working age is required to either buy private LTC insurance or buy it from the government. The government has mandated the premiums. This is from age 19 up. Germany's demographics are worse than our country's. It has recognized, through a lot of study research, what's been happening in our country, that it's going to be very necessary to prefund this. If we don't do something now, it's going to be an intergenerational conflict later. I was just wondering if you'd be interested in some of that information.

MR. MUNSON: We'd be happy to learn from other countries. We've been told by somebody behind the scenes on Clinton's task force on this subject for the last year or two that it's kind of a chuckle that we think other countries have it solved, yet they're coming over here and talking to Clinton's LTC task force, pleading, "Help us to continue to solve ours."

MR. BARNEY: Unless I'm mistaken, I think Germany is a single-payer system to begin with. We've got quite a ways to go to get to that point in this country.

MS. BROWN: For private people who can afford it, there is supplemental insurance.

MR. BARNEY: They have a two-tier system. Of course, a lot of what health care reform is about in this country, and a lot of the debate, is how to avoid creating a two-tiered system. That's a policy question, not an actuarial system, I think.

MS. BROWN: I was not suggesting a two-tiered system at all; that's just how Germany has addressed it.

MR. BARNEY: I think the committee should be aware of what's working and what's not working in other countries, and certainly should be willing to share that.

Just to put this quickly in perspective, the estimates that I last saw are $996 billion will be spent on health care this year in 1994. I think it's important to note that this comes from some of the cost estimates work group studies that the Academy did. The federal government already controls two thirds when you consider Medicare, Medicaid, Veterans Administration, and several other programs. The effective spending is therefore about $320 billion this year. Of that, you're talking about adding $38 billion of LTC entitlement or block grant programs on top of what's already there. That was the federal dollars, and the federal matching is somewhere between 73% and 95% of the total LTC program.

You're actually adding a lot to expenditures, but I thought it was interesting to note that the LTC piece, when measured not against total expenditures under health care reform but only against the effective spending under health care reform, is a very substantial piece. The only larger, single piece is approximately $56 billion that would be added to the system as a result of adding coverage for the uninsured. Then your second biggest piece in this plan is LTC in and of itself.

MR. ANDREW J. HERMAN: My question is, under the proposed Health Security Act, what would become of today's Medicare Home Health Program?

MR. MUNSON: I think it gets partially integrated. That's a half answer maybe, but I think the very poor continue under Medicaid. Many will pick up the new home health care benefit under the new state programs, if the state chooses to cover deeply enough to them. I don't recall the specifics of it.

MR. CHEUNG: I think there's something similar to a maintenance of effort provision—that if a state is currently providing home care services under Medicaid to an individual, under this new program the state would have to essentially maintain at least that level of coverage. You might have some states trying to shift people from Medicaid to this program, because as Hal just mentioned, the matching percentages between 73% and 95% are much higher generally than what you would get under Medicaid. You might have states actually trying to get reimbursement under this program versus Medicaid, but they're supposed to be providing at least equivalent benefits. Individuals are not supposed to lose any benefits.

MR. MUNSON: The variation among the states on that is huge. New York has a very large percentage of the home care paid out of Medicaid, far more, I believe, than any other state and probably more than almost all other states combined. It varies greatly about what's already being done on home health care out of Medicaid because of waivers and individual programs.

MR. BARNEY: Some of you may remember Pogo, who might have looked at health care reform, and said, "I find myself surrounded by insurmountable opportunity." This health care reform is a tremendous opportunity for all of us to have something to say and perhaps to have full employment. Using Malcolm's story of Gorbachev, as he stood on the precipice, I hope that we, instead of allowing Congress to move one giant step forward from that precipice, help steer it in a direction that is a little safer path to take. That is the primary charge of all of the work groups.