ASSURING DIGNITY IN LONG-TERM CARE FOR THE ELDERLY

SUSAN K. CLAVERIA
Researcher

Report No. 2, 1987

Legislative Reference Bureau
State Capitol
Honolulu, Hawaii

FOREWORD

This report was prepared in response to House Resolution No. 177 which was adopted during the Regular Session of 1986.

Long-term care for the elderly is indeed an issue that must be reckoned with before the close of this decade. The focus of this report, however, is narrow. Long-term care insurance provides an alternative to impoverishment and reliance on public medical assistance primarily for those who may require institutionalization. It is only one of many private financing mechanisms that can help to ease the financial burden of long-term care on the elderly and their families and on the Medicaid program. One mode of financing will not be appropriate for everyone. To provide viable options to Medicaid and to encourage the elderly to plan for their long-term care needs, all financing mechanisms must be considered and promoted by government where feasible.

Three years ago, the Bureau submitted a report on A Home Equity Conversion Program for Hawaii's Elderly Homeowners which similarly examined a financing program which was and is in operation on the mainland, apparently with some success. As with home equity conversion, long-term care insurance cannot be considered as the answer to the elderly's financial problems in the event that long-term care requirements in their old age result in the draining of family assets. It is believed that these mechanisms, as well as others that may be innovated, will work best in a combination tailored to the individual situation of a particular elder and the elder's spouse. However, both reports do indicate that one key to the successful utilization of these and other financing programs is education. Unless the target group truly understands the options available to it, the reception, if these programs are offered, will be much like what was indicated in the surveys done in the home equity conversion study, i.e., "The program is o.k. but it's for somebody else, not me." Thus, it is strongly urged that the government agency with primary responsibility for the target group concerned coordinate educational efforts that will provide meaningful understanding of the various alternatives available to it.

The data presented and the findings and conclusions reached in this report could not have been achieved without the cooperation and assistance of the professionals in the long-term care field. Many individuals were interviewed and later called upon to review the draft of this report for comments and verification of data. The Bureau extends its appreciation to Hiram Tanaka of the Insurance Division of the Department of Commerce and Consumer Affairs; Judith Ooka, Earl Motooka, Masaru Oshiro, Ron Matayoshi, and Randy Chau of the Health Care Administration Division and Lavinia Goto, Wayne Yasutomi, and Alan Matsunami of the Community Long Term Care Services Program of the Department of Social Services and Housing; Renji Goto, Gail Haruki, Marilyn Sealy, and Ross Carswell of the Executive Office on Aging; Herbert Dias and Richard F. Kahle, Jr., of the Department of Taxation; Peter Sybinski, Jamie McCormick, and Robert Ueoka of the Department of Health; Stanley Snodgrass, Richard McCord, and Lynda Johnson of the Healthcare Association of Hawaii (formerly Hospital Association of Hawaii); and James Iwatani and Dawn Terada of the Hawaii Long Term Care Association.

Special acknowledgement is made for the assistance provided by Bernie Tamashiro of the Hawaii Medical Service Association and the input provided by Don Desonier a retired insurance executive who has been volunteering his services to the State to educate the elderly and other interested groups in long-term care insurance.

Samuel B. K. Chang
Director

January 1986

TABLE OF CONTENTS

		Page
	FOREWORD	iii
1.	INTRODUCTION	1
	Conduct of the Study	3
	Organization of Report	3
2.	THE LONG-TERM CARE PROGRAM	4
	What is Long-Term Care?	4
	The Projected Need	7
	The Elderly Population	8
3.	SHORTCOMINGS OF THE CURRENT SYSTEM	10
	Medicare	10
	Medicaid	12
	Private Financing Alternatives	15
4.	LONG-TERM CARE INSURANCE	17
	Definition	17
	Recent Developments in the Field	17
	Basic Elements of a Long-Term Care Insurance Policy	18
	Marketing Problems	22
	The Hawaii Market for Long-Term Care Insurance	22
	Regulating Long-Term Care Insurance	23
5.	THE ROLE OF TAX INCENTIVES	32
	Tax Credits in Hawaii	33
	Pros and Cons of a Tax Credit for Long-Term Care Insurance	34
	Determining Impact on State Revenues	36
	The Proposed Tax Credit for Long-Term Care Insurance	37
6.	CONCLUSIONS AND RECOMMENDATIONS	38
	Findings	38
	Recommendations	42
	FOOTNOTES	51

Page

Exhibits

1. Number of Nursing Home Beds in the State of Hawai'i and Its Counties, February 1986 6

2. Summary of Medicare Coverage 11

3. Comparison of Insurance Policies Available in Hawaii 24

4. Estimates of Revenue Impact 45

5. Department of Taxation's Revenue Impact Estimate 47

Appendices

A. House Resolution No. 177, H.D. 1 56

B. Summary of NAIC Issues & Recommendations 60

C. Colorado House Bill No. 1158, 1986 66

D. California Assembly Bill No. 4231 70

E. Consumer Guide 73

F. Long-Term Care Insurance Model Act 85

Chapter 1

INTRODUCTION

"I feel so blue sometimes when I can't see the end of the road".[1] These are the words of a man who was considered "well-off" but who expects his life savings to run out in five years because he is paying over $3,000 a month for his wife's care in a nursing home. Upon discovering that his wife's debilitating illness would necessitate placement in a nursing home, the options available to this man were either to: (1) divorce his wife so she could qualify for medical assistance under the state Medicaid program, or (2) pay the nursing home bills until their life savings are depleted and then turn to Medicaid. The man chose not to divorce his wife.

Many elderly persons throughout the country are faced with similarly dreadful circumstances because there is a widespread misconception that Medicare will pay for all their post retirement health needs, including nursing home care.[2] This misconception is often accompanied by the prevalent "it won't happen to me" attitude. Hence, most elderly persons are totally unprepared when long-term care, especially in an institution, is required. They eventually must impoverish themselves before they can qualify for public medical assistance to finance their long-term care needs. A 1974 study by the Congressional Budget Office found that only one-half of the Medicaid nursing home patients were not initially poor by state definitions but were forced to spend down.[3]

The American pursuit of "wellness" which encourages a lifestyle of physical fitness, good nutritional habits, and stress management has resulted in healthier individuals who live longer. The increase in the life expectancy of Americans coupled with the coming of age of the "baby boomers" has resulted in startling population projections which reveal that the over 65 age group is the fastest growing segment. Despite the improved health status of the elderly today, health deviations continue to be a reality. The normal aging process contributes to the slowing-down of physical processes, especially in individuals who are over 70 years old, and is accompanied by gradual sensory losses. Heart disease, arthritis, and chronic rheumatism are leading causes of disability followed by senility, impairments of the lower extremities and hips, and hypertensive disease.[4] Often, people are faced with chronic illness for the first time in their old age. To complicate matters, advances in medical science and technology in successfully prolonging life effectively increases the need for long-term care.

Large numbers of elderly with serious conditions are able to remain in the community for care because they receive informal care and support from relatives and friends. These persons are vulnerable to institutionalization more from changes in marital status and living arrangements than from changes in their health status.[5] It is estimated that for every nursing home patient there are three people with equal impairment who are receiving care in the community.[6] Sociological trends, however, make it difficult to presume that future generations will continue to care for their impaired elderly at home. More working women, later marriages, fewer or no children, more divorces, and more geographical mobility, ultimately mean less available direct

family support for the elderly in the future who will require long-term care. Moreover, with the increased life expectancy, some of the very old functionally impaired elderly may have children who themselves are functionally impaired elderly and unable to provide home care for their parents.

The financing of long-term care has become a major, if not the, health issue of this decade because it has a tremendous impact on both the federal and state budgets. According to the U.S. Department of Health and Human Services, government spending under the Medicaid program accounted for 41.8 per cent of nursing home care while 51.4 per cent was paid by patients and their families and only one per cent was paid through private insurance.[7] Medicaid is supposed to be the payor of last resort; however, as there are few alternative financing sources, it has become a primary payor. While the government's share has been steadily declining over the past six years, the projected future growth in the elderly population and the concomitant need for long-term care services are causing much uncertainty among policymakers as to the capability of existing long-term care financing mechanisms in meeting future needs.

There is a nationwide effort toward the development of methods of financing formal long-term care services, institutional as well as noninstitutional, aimed at averting devastating financial losses for those who have labored most of their earlier years to build a nest egg and would not qualify for public medical assistance. With the Reagan Administration's clear signals of intent to curb federal government spending in Medicaid,[8] state governments have a great incentive to develop private alternatives to finance long-term needs and this issue is gaining in priority on state agendas.

Among the most frequently mentioned private financing alternatives is long-term care insurance. Long-term care insurance is regarded by its advocates as the best way to avoid the impoverishment of the middle and upper-middle income elderly and to relieve the public Medicaid burden. Long-term care insurance offers to many a hope of assuring dignity in long-term care for the elderly.

House Resolution No. 177 which was adopted by the House of Representatives during the 1986 legislative session is part of the Hawaii Legislature's effort to assist the elderly in planning for possible long-term care needs.[9] (See Appendix A for text of Resolution.) The Legislature considered legislation (H.B. No. 1925-86 and S.B. No. 2479-86, S.D. 1) proposing a tax credit up to twice the premium paid for long-term care insurance. Concerned about the potential revenue loss, the House of Representatives felt a study was necessary before any action could be taken on a tax credit.[10] The Resolution requests the Legislative Reference Bureau (hereinafter Bureau) to study the benefits and impact of long-term care insurance and the feasibility of providing a tax credit for long-term care insurance premiums as an incentive for people to purchase such insurance.

Conduct of the Study

As provided in House Resolution No. 177, the scope of the study has been limited to the feasibility of implementing a tax credit for premiums paid for long-term care insurance policies. The study focuses on the issue of whether or not long-term care insurance will indeed relieve the dependency on the Medicaid program and save dollars for the State. The specific objectives of the study were to:

(1) Determine the impact and benefits of long-term care insurance.

(2) Determine the impact and benefits of a tax credit for long-term care insurance premiums.

(3) Assess the desirable elements to be included in long-term care policies to qualify for a tax credit.

(4) Determine the impact on the state budget.

To accomplish these objectives, the Bureau conducted a review of recent literature in the areas of long-term care, Medicare and Medicaid reimbursements, Hawaii tax credits, and elderly population projections. Administrators of government agencies as well as the private sector were interviewed to provide the Bureau with an understanding of the breadth of the long-term care financing problem in Hawaii. An obstacle immediately encountered in this study was the unavailability of compiled statistical and demographic data from which profiles of the nursing home patients and Medicaid clients could be developed and assumptions on the impact of insurance could be drawn. Cooperation was solicited from the Department of Social Services and Housing, the Insurance Commissioner, the Hawaii Long-term Care Association, and the Hospital Association to obtain the sketchy data presented in this report. Inquiries were also made of selected states to ascertain the status of their proposed tax incentive proposals for long-term care insurance. Sample policies of long-term care insurance obtained through the local insurance industry were comparatively studied.

Organization of Report

Chapter 2 provides background on the current long-term care situation in Hawaii and the projected need for long-term care. Chapter 3 discusses the shortcomings of the current financing mechanisms. Long-term care insurance, as an alternative method of financing long-term care, is discussed in Chapter 4 and Chapter 5 explores the use of a tax credit as an incentive to purchase long-term care insurance. The Bureau's conclusions and recommendations are reported in Chapter 6.

Chapter 2

THE LONG-TERM CARE PROBLEM

What is Long-Term Care?

For the purposes of this report, "long-term care" refers to the provision of services to functionally-impaired elderly who are not capable of self-care. Long-term care may be delivered on a continuing or intermittent basis in institutional settings, such as a hospital or a nursing home, or in noninstitutional settings, such as the family home. Unfortunately, long-term care has been synonymous with nursing home care because nursing home expenses account for a major portion of public expenditures for long-term care.[1] The goal of long-term care is to provide a continuum of care to achieve maximum functional independence of the functionally-impaired.

There are four levels of care that encompass the full spectrum of long-term care services: (1) acute care, (2) skilled nursing care, (3) intermediate care, and (4) custodial care. As used in this report, acute care refers to care provided when a person is admitted to a hospital due to illness or injury and requires medical treatment that can only be provided in a hospital. If the patient's condition stabilizes and the patient still requires continued and daily nursing care as prescribed by a physician, the patient is at the skilled nursing level. At the intermediate care level the patient is required by a physician to obtain continued and regular nursing care but at a less intense program of medical care and treatment than that received in skilled nursing care. Custodial care refers to personal care services, such as bathing, grooming, and feeding, that a patient in the skilled nursing or intermediate care levels will require in addition to the medical and rehabilitative treatment. Custodial care is the type of care many assume is provided by relatives and friends when a person remains at home for long-term care. This report focuses on the skilled nursing, intermediate care, and custodial care levels since long-term care insurance policies are primarily concerned with care beyond the acute care level. It should be noted that although custodial care is not formally recognized as a separate level of care among long-term care professionals in Hawaii, the Bureau has employed this term in this report to provide a clearer picture of the scope of long-term care insurance coverage.

Institutional Care - Skilled nursing care and intermediate care are usually delivered in skilled nursing facilities and intermediate care facilities that are free-standing or distinct parts of a hospital that are licensed by the Department of Health for the provision of skilled nursing care, intermediate care, or both.[2] The Board of Examiners of Nursing Home Administrators handles the licensure of all administrators of such facilities.[3]

The number of facilities and beds permitted to operate in the State is controlled by the State Health Planning and Development Agency.[4] The State Health Planning and Development Agency is responsible for determining statewide needs for health services and facilities and approving any construction, expansion, conversion, alteration, and development of health care services and facilities according to such identified needs. There are a

total of 2,769 long-term care beds in operation at 33 facilities, although the facility count approved by the State Health Planning and Development Agency is 38 and the approved bed count is 3,383. Of the 33 long-term care facilities, 17 are free standing and 16 are distinct parts of hospitals. Long-term care at facilities that are part of hospitals are usually more expensive than free-standing facilities because other ancillary services are provided. (See Exhibit 1 for listing of long-term care facilities approved by the State Health Planning and Development Agency.) All of Hawaii's long-term care facilities are Medicare certified and only one intermediate care facility is not a Medicaid participant.[5]

Of the 33 facilities, 12 belong to the County/State Hospitals Division of the Department of Health. These publicly operated facilities have a total of 630 long-term care beds in operation (152 skilled nursing; 187 intermediate care; 274 skilled nursing/intermediate care; 17 acute/long-term care). Most of the patients in the County/State Hospitals Division are at the intermediate care level and it is estimated that about 90-93 per cent of the intermediate care patients are Medicaid recipients.[6]

The 17 privately operated facilities together have a total of 2,074 long-term care beds in operation (463 skilled nursing; 829 intermediate care; 782 skilled nursing/intermediate care).[7] Most of the patients are at the intermediate care level and it is estimated that well over 60 per cent of the patients are receiving Medicaid assistance.[8]

Custodial care is also delivered in institutions known as care homes. Care homes are licensed and regulated by the Department of Health.[9] Family care homes are occupied by a single family with no more than four unrelated adults who need assistance. Residential care homes have five or more unrelated residents who range in dependency from ambulatory to wheelchair bound. Finally, adult boarding homes provide minimal maintenance and protective care for one to four adults unrelated to the operator who need supervision and assistance with daily living activities.[10]

Noninstitutional Care - Skilled nursing care and intermediate care are also delivered in a patient's home where medical treatment services are furnished by providers who make home visits. There are no hard statistics that can tell us how many persons receiving long-term care in the community are at the skilled nursing and intermediate care levels except for those who are involved in the community-based programs discussed below. Since it is costly for a family to obtain professional medical or therapeutic services on a daily basis, it can be assumed that either very few of those receiving home care are at the skilled nursing or intermediate care levels, or that those who are at such level of care are not receiving adequate care.

Two experimental programs, the Nursing Home Without Walls program and the Queen's Medical Center Community Care Program, which are administered by the Community Long Term Care Services program of the Department of Social Services and Housing, seek to divert more people from institutionalized care by providing medical and support social services to patients receiving care at home and to their families.[11] These programs were made possible under a federal act which authorized the Secretary of Health and Human Services to grant waivers to states permitting Medicaid reimbursement of home

EXHIBIT 1

Number of Nursing Home Beds in the State of Hawai'i and Its Counties, February 1986

	Facility Type**	SNF	ICF	Combined SNF/ICF	Acute/LTC Swing	In Operation (Approved)
City & County of Honolulu (O'ahu)						
(Aloha)*	33	--	--	-- (120)*	--	-- (120)*
Ann Pearl	33	--	86	--	--	86
Arcadia	21	60	--	--	--	60
(Beach Front Manor)*	33	--	-- (40)*	--	--	-- (40)*
Beverly Manor	33	--	--	108	--	108
Convalescent Center	33	--	--	182	--	182
Crawford's	33	--	68	--	--	68
Hale Ho Aloha	33	--	73	--	--	73
Hale Malamalama	33	--	31	--	--	31
Hale Nani	33	--	--	232	--	232
Hawai'i Select Care*	33	--	--	92	--	92
Island Nursing	33	--	--	42	--	42
Kahanaloa	21	--	--	42	--	42
Kahuku	23	11	--	--	4	15
(Kaiser)*	23	-- (55)*	--	--	--	-- (55)*
Kuakini	23	50	100	--	--	150
Leahi	12	92	38	-- (44)*	--	130(174)*
Leeward	33	--	50(78)*	--	--	50(128)*
(Life Care Services)*	33	--	--	-- (60)*	--	-- (60)*
Maluhia	12	--	--	150(8)*	--	150(158)*
Maunalani	23	101	--	--	--	101
Nuuanu Hale	33	75	--	--	--	75
(O'ahu Care)	33	--	-- (82)*	--	--	-- (82)*
(Ohana Kupuna)*	33	--	--	-- (135)*	--	-- (135)*
St. Francis	21	52	--	--	--	52
Wahiawa	23	--	--	93	--	93
TOTAL OAHU - 20 (25)*		441(496)*	446(646)*	950(1309)*	4	1841(2455)*
Hawai'i County						
Life Care Center	33	--	240	--	--	240
Hilo Hospital	12	36	72	--	--	108
Honokaa	12	8	--	--	--	8
Ka'u	12	8	--	--	--	8
Kohala	12	2	16	--	--	18
Kona	12	--	--	22	--	22
TOTAL HAWAI'I COUNTY - 6		54	328	22	0	404
Maui County						
Maui Island						
Hale Makua	23	120	124	--	--	244
Kula	12	--	--	94	--	94
Lana'i Island						
Lana'i Hospital	12	--	--	8	--	8
Moloka'i Island						
Moloka'i Hospital	23	--	--	14	--	14
TOTAL MAUI COUNTY - 4		120	124	116	--	360
Kaua'i County						
Kaua'i Veterans	12	6	--	--	11	17
Mahelona	12	--	61	--	6	67
C.N. Wilcox	23	--	--	80	--	80
TOTAL KAUA'I COUNTY - 3		6	61	80	17***	164
STATE TOTAL - 33(38)*		621(676)*	959(1159)*	1168(1527)*	21	2769(3383)*

*( )Total number when approved beds are in operation.

**CODE: 12 = government, non-federal, state
21 = nongovernment, not-for-profit, church operated
23 = nongovernment, not-for-profit, other
33 = investor owned (for profit) corporation
42 = government, federal, army

SOURCE: SHPDA Inventory, February 1986

FROM: Health Services and Facilities Plan for the State of Hawaii, 1986, Table 11.

***Correct number inserted; original table displayed 0.

and community-based services provided to individuals who would otherwise be placed in a nursing home.[12] Hawaii applied for the waivers in 1983. The waiver programs are funded fifty-fifty by the state and federal governments. The Nursing Home Without Walls program appears to be cost-effective and successful in providing community-based care for a very debilitated clientele. In the federal fiscal year 1984-1985, the program serviced 1,873 skilled nursing clients and 2,191 intermediate care clients.[13] The 1985 Legislature authorized the continuance of the program through June 30, 1987, and provided additional funding for the expansion of the program to the neighbor islands.[14] Further expansion of the program at the federal level, however, is uncertain as the Medicaid waiver programs are experimental and their future is uncertain. In a report to Congress on the evaluation of the Medicaid home and community-based care waivers, the Health Care Financing Administration reported that although home and community-based care is less costly per recipient than institutional care, there is some concern that the waiver program may actually increase federal expenditures if the program provides a new range of services to persons who would not otherwise consider nursing home placement.[15] The Health Care Financing Administration makes it clear that the intent of the waivers was to moderate further cost increases by providing home and community-based services as a substitute for nursing home care to persons who can be more appropriately cared for in a noninstitutional setting at the same or lower cost. Evidently, Congress did not anticipate the uncovering of a whole new segment of the elderly population in need of long-term care services midway between institutional and custodial care and it appears that the Health Care Financing Administration is more concerned about saving aggregate Medicaid dollars rather than providing a more comprehensive range of long-term care services for all those in need.

Other programs under the Department of Social Services and Housing which support community-based care are Project Malama and the Public Health Nurse Case Management programs. These programs work with clients who are limited in their activities of daily living to prevent further deterioration and institutionalization. Case management services are provided, at no cost to the client, to assess, plan, coordinate, and maximize use of existing long-term care resources in the community.[16]

In the private sector, Day Health Centers or Day Hospitals and Adult Day Care Centers provide care to clients who require some level of institutional care but choose to remain at home. Care is provided while the client's family members are at work or at school. Cost of the Day Health Centers or Day Hospitals range from $36 to $45 a day for part-time care while the cost for the Adult Day Care Centers range from $24 to $25 a day or $310 to $475 a month for full-time care.[17] Medicaid will provide assistance to eligible clients under these programs.

The Projected Need

One of the difficulties in planning for long-term care is determining the extent of the need for institutional as well as noninstitutional care. While there is unanimous agreement as to the graying of America, there is considerable disagreement as to how this will impact on long-term care. Some researchers believe that improvements in lifestyle will reduce the prevalence

of chronic disease while others believe that chronic disease and disability will increase as life expectancy is increased.[18] One gerontologist contends that the population is moving toward a more "rectangular" life span where there is a prolonged healthy life followed by a relatively short, sharp drop-off into illness and death.[19]

The institutionally biased nature of the current financing system through Medicare and Medicaid further complicates long-term care planning. Present long-term care services reflect the limits of available financing mechanisms rather than deliberate planning as to the types of services to be provided and which groups are to be served. This bias has resulted in the bulk of public funds being absorbed by institutional costs serving less clients and in the lack of funds for the development of noninstitutional alternatives. The absence of a wide range of viable, cost-effective noninstitutional alternatives thwarts any projections for long-term care needs.

Finally, the factor which hinders predictions most is the absence of longitudinal demographic data on the long-term care population in Hawaii from which assumptions can be made as to the types of care that might be needed and by how many persons. There is a need to know what types of persons are presently receiving home care, what kinds of assistance they and their caregivers are receiving, and the nature and extent of their financial resources; how many of the current nursing home patients would have remained at home if there were financial assistance programs for home care, how many became impoverished after their placement in a nursing home, and how many were living alone or only with their spouses at the time they entered the nursing home. There is a need to establish data on the Medicaid clientele to obtain a profile of the elderly who are applying for public assistance to identify which groups are being served and which groups are not covered, to ascertain whether the Medicaid applicants would still apply for public medical assistance if other financial options were available to them, and to ascertain whether Medicaid clients in nursing homes ever return home or if they remain institutionalized until their death. Only after such data are developed can the State accurately determine the types of long-term care services that will be required for the future and begin planning and budgeting accordingly.

Despite these barriers to accurate projections, most policymakers at both the federal and state levels are assuming that the need for long-term care services will increase just because of the sheer numbers of elderly projected for the year 2000 and are planning accordingly.

The Elderly Population

The Executive Office on Aging has estimated that in 1985 the age 65 and over group consisted of about 99,650 persons and projected that it would increase to 123,206 persons in 1990.[20] The Department of Planning and Economic Development reported that there were 76,300 elderly, 65 years of age and over, which comprised 7.9 per cent of the total state population (968,000) in 1980 and that number is projected to increase to 159,500 or 12.6 per cent of the total population (1,267,800) in the year 2000.[21] If the military which is predominantly a young group is excluded from the count the

proportion of the elderly increases from 7.9 per cent to 9 per cent in 1980 and from 12.6 per cent to 14 per cent in the year 2000.[22] Life expectancy in Hawaii is among the highest in the world at 75 years for men and 81.5 years for women. The average life expectancy for the United States is 70 years for men and 77.5 years for women. Although income levels of the elderly are low and the cost of living in Hawaii is high, a high percentage of them allay financial stress by residing with relatives.[23]

Retirement usually means lower income and limits the financial options for the elderly to finance their health needs which increase with age. In 1980, out of 76,150 persons over age 65, 10.5 per cent or 7,654 were below the U.S. poverty level.[24] Over 59 per cent of the elderly over 65 received federal and state supplemental income in 1980.[25] On the other hand, Hawaii's elderly with taxable income appear to have a higher proportion of income-generating assets when compared to the average taxpayer. The Department of Taxation reported that "...the elderly's average income from sources such as interest, dividends and capital assets/other property gains were $4,964, $4,973, and $4,256, respectively. In contrast, the averages for the same income sources reported by all other resident taxpayers were much lower, or $1,417, $1,663, and $2,637, respectively."[26] It must be remembered that this observation is based on those elderly taxpayers who file tax returns. There are many elderly who have no tax liability since pension and social security income are not subject to state tax in Hawaii.

These population statistics indicate that there will be a greater number of elderly in Hawaii who will probably require some kind of long-term care and that a good portion of that population may be able to privately finance such care if appropriate alternatives were available.

Chapter 3

SHORTCOMINGS OF THE CURRENT SYSTEM

The cost per day in a nursing home depends on the facility. The rates in Hawaii for skilled nursing care range from $54-$135 a day for a private room, $42-$125 a day for a semi-private room, and $67-$110 a day for a ward. At the intermediate care level the rates are from $59-$105 a day for a private room, $59-$101 a day for a semi-private room, and $54-$81 a day for a ward.[1] The burden on the Medicaid program for nursing home costs in this State is greater than the national burden. Medicaid accounts for about 74 per cent of the cost of nursing home care in Hawaii while payments by the patient and families accounted for 21 per cent, Medicare covered 5 per cent, and other financing or private insurance covered less than 1 per cent.[2] Of the amount covered by other financing or private insurance, no payments were attributable to long-term care insurance. As noted in Chapter 1, Medicaid accounted for only 41.8 per cent of the national nursing home costs in 1985.

Medicare

Medicare is the federally administered health insurance program for the elderly 65 years and older, the disabled entitled to social security, and most persons with end-stage renal disease. The program is composed of two parts. Part A provides coverage for hospital costs and is free for enrollees. Part B, which covers physician and other medical services such as outpatient hospital services, rural health clinic visits, and home health visits, is available to enrollees at a monthly premium payment of $15.50.[3] About 95 per cent of the Nation's elderly are enrolled in the Part A program and most of them voluntarily enroll for Part B. Several health care services such as drugs, dental care, routine eye examinations, preventive services, and intermediate long-term care are not covered.[4]

Both parts require cost-sharing. For inpatient hospital costs, the patient must pay a deductible of $492 for the first 60 days; $123 a day for the 61st to 90th day; and $246 a day for the 91st to 150th day. Copayment on a per diem basis is required for the 61st to 90th day of inpatient hospital care, for the 21st to 100th day of skilled nursing facility care, and for the 60 lifetime reserve days for inpatient hospital care. The patient is also required to pay for the first three pints of blood in a benefit period. Under Part B, in addition to paying the monthly premium, the beneficiary pays a $75 deductible each year. The program reimburses 80 per cent of allowable charges directly to the physician and the patient must pay the balance.[5] (See Exhibit 2 for outline of Medicare coverage.)

Medicare was intended to cover about 80 per cent of the elderly's health care cost but the figure is down to 48 per cent today.[6] There is rampant misunderstanding regarding the coverage under the Medicare program for long-term care. A poll commissioned by the American Association of Retired Persons in 1983 revealed that a shocking 79 per cent of those polled believed that Medicare would be the primary source of financing their nursing home needs. The survey data also suggested that many who had private insurance

EXHIBIT 2

Summary of Medicare Coverage

MEDICARE (PART A): HOSPITAL INSURANCE—COVERED SERVICES PER BENEFIT PERIOD(1)			
Service	**Benefit**	**Medicare Pays****	**You Pay****
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $492	$492
	61st to 90th day	All but $123 a day	$123 a day
	91st to 150th day*	All but $246 a day	$246 a day
	Beyond 150 days	Nothing	All costs
POSTHOSPITAL SKILLED NURSING FACILITY CARE . . . In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge. (2)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but 61.50 a day	$61.50 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE	*Unlimited visits* as medically necessary	Full cost	Nothing
HOSPICE CARE	Two 90-day periods and one 30-day period	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Blood	All but first 3 pints	For first 3 pints

*60 Reserve Days may be used only once; days used are not renewable.
**These figures are for 1986 and are subject to change each year.
(1) A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.
(2) Medicare and private insurance will not pay for most nursing home care. You pay for custodial care and most care in a nursing home.

MEDICARE (PART B): MEDICAL INSURANCE—COVERED SERVICES PER CALENDAR YEAR			
Service	**Benefit**	**Medicare Pays**	**You Pay**
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of the hospital. Some insurance policies pay less (or nothing) for hospital outpatient medical services or services in a doctor's office.	80% approved amount (after $75 deductible)	$75 deductible* plus 20% of balance of approved amount (plus any charge above approved amount)**
HOME HEALTH CARE	Unlimited visits as medically necessary	Full cost	Nothing
OUTPATIENT HOSPITAL TREATMENT	Unlimited as medically necessary	80% of approved amount (after $75 deductible)	Subject to deductible plus 20% of balance of approved amount
BLOOD	Blood	80% of approved amount (after $75 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount (after $75 deductible)

*Once you have had $75 of expense for covered services in 1986, the Part B deductible does not apply to any further covered services you receive the rest of the year.
**YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered. (See page 16.)

Source: U.S. Department of Health and Human Services, Health Care Financing Administration, Guide to Health Insurance for People with Medicare-1986, Pub. No. HCFA 02110, pp. 10-11.

were not aware that the policies they possessed, such as Medicare supplements or limited benefit plans, would not cover extended long-term care.[7]

As will be shown in Chapter 4, local insurance agents also indicated that their primary obstacle in marketing long-term care insurance policies is that many people assume that Medicare and the Medicare supplement policies will cover completely any anticipated long-term care needs. To be sure, Medicare does provide coverage for long-term care...but on a very limited basis. Medicare will pay for up to 100 days of care in a Medicare-approved skilled nursing facility following hospital confinement of at least three days if the patient's doctor prescribes the confinement and the confinement occurs within 30 days after the patient was discharged from a hospital.

What most people do not realize is that Medicare will pay the full cost of confinement in a skilled nursing facility only for the first 20 days. From the 21st through the 100th day, the patient must pay $61.50 a day, or $4,920 for the 80-day period.[8] If the person has a Medicare supplement policy the policy may cover that copayment cost. Medicare supplements, like the Medicare program, are geared to patients in need of care for acute rather than chronic illness. Unfortunately, the growing need in health care for the elderly is in the chronic rather than acute area and statistics bear out the inadequacies of Medicare toward this end. The national average for confinement at the skilled nursing level under Medicare in 1977 was 27.4 days.[9] The number of covered days decreased from 9,296.4 in 1977 to 7,975.8 in 1980,[10] so it is probable that the average period of confinement today is less than 27 days. Most of the time a long-term care patient spends in an institution is at the intermediate care level where there is no Medicare coverage; consequently, less than one per cent of the Medicare expenditures in 1982 were for nursing home care costs.[11] In Hawaii, the average stay at the skilled nursing level, whether or not costs are reimbursed by Medicare, is roughly 10 months while the average stay at the intermediate care level is about three and one-half years. Medicare pays only about 5 per cent of the nursing home costs in Hawaii and the average length of stay for a Medicare patient is about 17 days.[12]

Medicare also provides coverage for home health services, but coverage is conditioned upon the need for skilled nursing care.[13] Medicare does not cover any care provided at the intermediate or custodial levels. Even where Medicare supplement policies provide coverage for extended days of care, there is no coverage for intermediate and custodial care. In 1982, Medicare payments for home health was one per cent of total home health costs.[14]

Medicaid

Medicaid is the federally supported health care program for the poor which is administered at the state level. In the United States, Medicaid covers 21 million persons but only 50 per cent of the poor.[15] Medicaid covers almost all institutional long-term care needs that are not covered by Medicare.[16] As noted in Chapter 2, the program also covers some noninstitutional care through the Nursing Home Without Walls and Queen's Medical Center Community Care programs.

Medicaid payments are made directly to the providers of services rendered. On February 19, 1985, the Medicaid payment system changed from a reasonable cost basis to a prospective payment basis. Under the prospective payment system, each facility is paid a per diem rate based on 1982 costs with adjustments made annually for inflationary purposes. The prospective payment system was selected since it was believed that continual cost increases could be contained by the alteration of past incentives inherent in the cost-based system and the creation of new incentives for facilities to achieve efficiency.[17] Many Hawaii providers, however, have been disgruntled with the new prospective payment system arguing that it does not adequately reimburse actual institutional costs. Nationwide, there is a growing concern that Medicaid patients are receiving less services and care or may be prematurely discharged from an institution because of the prospective payment system's inadequacies. Similar concerns have also been expressed in Hawaii. The Department of Health foresees that the prospective payment system will encourage the development of community-based noninstitutional care as an alternative to more expensive institutional care.[18]

Under the Hawaii Medicaid program there are three categories of persons receiving financial assistance...the categorically needy, the medically needy, and the optionally categorically needy. Applicants in all groups must also meet certain basic requirements such as citizenship and residency.[19]

The categorically needy are those who meet the state's definition of "poor" based on financial eligibility levels for Aid to Families of Dependent Children and Supplemental Security Income.[20] The categorically needy receive assistance through monthly income payments. To qualify as categorically needy, a person may not have a monthly income exceeding $297 a month (amount is higher if applicant has family) and any resources.

The medically needy are those persons who have incomes above the standards established for the categorically needy but whose medical care costs have brought their income to such a low level that they qualify for medical assistance. Currently, to qualify as medically needy, a person may not have more than $1,700 ($2,550 in the case of a couple where both are applying for Medicaid) in resources and the person's monthly income is $300 ($400 in the case of a couple where both are applying for Medicaid) or lower. The income limit, however, is misleading. A person whose monthly income exceeds the income limits can still be eligible for medical assistance if the person's medical costs diminishes the person's monthly income to $300 and the person requires assistance to pay the remaining medical costs.

The optionally categorically needy are those who are eligible for monetary public assistance but who choose only to accept medical assistance.

For the purposes of this study, the group of most importance is the medically needy. Those who are in the categorically needy and optionally categorically needy groups would not be able to afford long-term care insurance and would probably require public medical assistance even if private financing options were available. While it is true that there could be some savings to the Medicaid program if it paid for the premiums of long-term care insurance for all of its categorically needy clients in the same way it pays premiums for health maintenance organizations, this study's scope is

limited to the issue of using a tax credit as an incentive to individuals to purchase long-term care insurance; consequently, this report will not discuss this issue further.

In fiscal year 1986, the medically needy recipients accounted for 9,620, or 12.7 per cent, of the total 75,886 Medicaid recipients. Of the 7,718 aged Medicaid recipients, 2,920 or 37.8 per cent, were in the medically needy category.[21] Of the $172,600,527 in total benefits paid by the Medicaid program, $48,723,977 or 28.2 per cent was attributable to the aged in the medically needy category.[22] In contrast, for the categorically needy and optional groups, only $12,082,976 or 7 per cent and $2,110,699 or 1.2 per cent, respectively, in benefits were attributable to the aged.[23] These figures reveal that while the medically needy aged comprise only 3.9 per cent of the total Medicaid recipients, it accounts for 28.2 per cent of the total amount of Medicaid benefits paid out.[24] Also noteworthy is the fact that most of the Medicaid assistance attributable to nursing home costs is for the aged.

In fiscal year 1986, Medicaid paid $68,992,300, or 40 per cent of its total budget for skilled nursing and intermediate care.[25] Preliminary figures for the 1986 fiscal year from the Health Care Administration Division showed that about 72 per cent of the Medicaid reimbursements to nursing homes was attributable to the medically needy aged group.[26] The preliminary figures also showed that Medicaid reimbursements for the aged medically needy for skilled nursing care totaled $14,178,611 for 1,360 recipients and $26,365,314 for 1,741 intermediate care recipients.[27] The average benefit paid per medically needy aged recipient was $13,074.

In contrast, Medicaid payments for home health services to the medically needy aged totaled $47,037 for only 60 recipients.[28] Under the Medicaid program and Hawaii's laws, custodial care is not recognized as a separate level of care. There is a medical requirement for receiving assistance under Medicaid. Hence, a semi-ambulatory person who requires assistance in daily living tasks but is not designated by a physician to be at the skilled nursing or intermediate care level may either be placed in a care home where only custodial care is provided or remain at home. Medicaid, however, will not pay for that person's care.

Some people believe that since the "welfare stigma" of Medicaid as it relates to long-term care has been essentially removed, more and more people are assuming that they can rely on Medicaid. Still others believe that since they have already paid for Medicaid through taxes, they are entitled to receive Medicaid assistance for long-term care.[29] With such attitudes, many elderly do not feel the need for planning. The problem with this position is that many do not realize that Medicaid is not an entitlement like Medicare and that one must meet income and resource eligibility standards to qualify for benefits. Thus, for those who do not understand how Medicaid works, they must exhaust whatever liquid assets they may have until their resources total $1,700 or less and must pay for their medical costs until their monthly income diminishes to $300. This is most difficult for couples with joint assets since the healthy spouse will not have much in assets for a "rainy-day fund" after the depletion of resources as is required to qualify the institutionalized person for Medicaid assistance.

If a person is institutionalized, all of the person's income, except for a $25 monthly allowance for personal items, must go to the nursing home and Medicaid will pay the balance of the nursing home cost. A spouse's income and assets are considered as resources available to the institutionalized person through the first six months after the couple ceased to live together if both spouses apply and are eligible for assistance but only through the first month if only one spouse applies or is eligible for medical assistance. After the six-month or one-month period, as the case may be, only the income actually contributed by one spouse to the other is considered available to the institutionalized spouse.[30] It is not uncommon for elderly couples to divorce to enable the impaired spouse to qualify for Medicaid without impoverishing the spouse at home.[31] Fortunately for many, the Medicaid applicant's home will not be regarded as a liquid asset if the person and family files a declaration of intent to return to the home upon release from the institution.[32]

Those who understand the Medicaid program often plan ahead and divest their resources by signing over their assets to their children before any illness occurs. This is usually done with an unwritten agreement from the children that while the elderly parents are still healthy, the parents will maintain control over their assets. When long-term care is required, these persons will be eligible for Medicaid without having lost their life savings which could then be enjoyed by their spouses or children. Such divestment surreptitiously violates the spirit of the Medicaid law governing the transfer of assets.[33] It has been argued, however, that this sort of wangling would not occur if the elderly had other options which would assure them of independently handling their long-term care needs.

Financing long-term care through Medicaid has many drawbacks. The divestiture of resources to qualify for aid is demeaning to some and if the patient is rehabilitated to the point of returning home, the standard of living may be too diminished and social structure too disruptive to make such a move possible.[34] Often, patients who pay for themselves pay higher rates than publicly supported patients. This practice of subsidizing care for the poor is common in acute hospital care, but in long-term care, the patients who pay for themselves are almost never insured.[35] Finally, it must be remembered that public revenues are not limitless. During times of fiscal constraints, as efforts to cut costs are intensified, inevitably benefits become more restrictive and less people are covered or less services are provided to those in need.

Private Financing Alternatives

The increasing cost of medical care and the constraints on public funding for medical care have served as the catalysts for the ardent search for private financing mechanisms for long-term care in recent years. SRI International categorizes private financing instruments either as insurance or cash accumulation instruments. Insurance includes the indemnity type nursing home insurance plans as well as managed-care environment plans such as life care communities and social health maintenance organizations. Cash accumulation instruments include the individual medical account similar to the individual retirement account. Since insurance instruments pool the resources

of a group of persons who share the risk of long-term care, they are regarded as being more appropriate when the long-term care costs are large and the probability of needing coverage is small. Cash accumulation instruments, on the other hand, provide a method of individually setting aside money for oneself. There is no risk sharing involved in cash accumulation instruments so the result is a smaller amount of money available to finance long-term care. Cash accumulation instruments are considered more effective when there is a high probability that a person will need the service at some point in time and when the costs of the service are not beyond the means of a person's lifetime savings capacity.[36]

Aside from long-term care insurance, the two prominent financing instruments most discussed today are the social health maintenance organizations and the individual medical account. The social health maintenance organizations are currently being implemented on a demonstration basis at the Metropolitan Jewish Geriatric Center in Brooklyn, New York; Kaiser Permanente in Portland, Oregon; the Ebenger Society in Minneapolis, Minnesota; and the Senior Care Action Network in Long Beach, California. These social health maintenance organizations provide the standard Medicare inpatient, ambulatory, and diagnostic services as well as long-term care, home health care, homemaker and chore services, and therapeutic services like physical and occupational therapy. Utilization and cost data from these demonstration projects will not be available until 1989.[37]

The individual medical account provides a vehicle for a person to set aside, tax-free, money which can only be withdrawn for medical purposes. Colorado recently enacted such a law which requires the establishment of a trust wherein the trustee must purchase major medical coverage for the account holder to cover all medical, dental, and long-term care expenses in excess of $10,000 annually and limits use of trust assets to medical, dental, and long-term care expenses.[38]

Chapter 4

LONG-TERM CARE INSURANCE

Definition

For the purposes of this report, long-term care insurance means any insurance policy or similar health benefits plan which is designed for or marketed as paying benefits for the care of a policyholder who, due to chronic illness or infirmity, is unable to perform activities of daily living for an extended period of time. Such covered care includes health care services such as nursing home care, personal care, and home health care or related services which may include home and community-based services, or both. Long-term care insurance does not include medicare supplement insurance policies, as defined under section 431-771, Hawaii Revised Statutes,[1] which are designed primarily as supplements to reimbursements under Medicare for hospital, medical, or surgical expenses.

Recent Developments in the Field

Long-term care insurance, which was in its infancy only two years ago, has undergone substantial development. Nevertheless, the long-term insurance field is mercurial and continual changes are expected. Nationwide, there were reportedly only 125,000 long-term care insurance policies in effect in 1985 and most of those policies were underwritten by Firemen's Fund or United Equitable, the two companies which have been marketing nursing home insurance for over a decade. In September, 1986, it was estimated that there are around 200,000 policies in effect and almost 70 companies marketing long-term care insurance.[2] Recognizing that long-term care insurance could be a lucrative business, the insurance industry, while maintaining caution, has been rapidly introducing new products and increasing its promotional efforts. The public sector, on the other hand, has been studying strategies for public policies in long-term care and searching for ways to encourage the development of private financing mechanisms, including long-term care insurance, that will relieve the burden on the Medicaid budget.

With the surge of activity in the long-term care insurance industry within the past two years, the American Health Care Association has warned that as most products are developmental, new products may force the withdrawal of older products from the market and there have been reports of marketing abuses and shallow benefit products.[3] The private and public sectors have recently joined forces to address these long-term care insurance problems. At the federal level, the Wyden amendment to the Consolidated Omnibus Budget Reconciliation Act of 1985 directed the Secretary of Health and Human Services to establish a task force on long-term care insurance. Specifically, the task force has been directed to develop recommendations for long-term care insurance which will include recommendations to limit marketing and agent abuse, provide dissemination of appropriate consumer information to permit informed choices, give assurance that benefits are reasonably related to premiums, and promote the development and availability of insurance

policies meeting these recommendations.[4] The task force is expected to report to the Secretary in the fall of 1987.[5]

At the state government level, the National Association of Insurance Commissioners appointed a task force on Medicare Supplement, Long Term Care and Other Limited Benefit Plans in early 1985. The Task Force, in turn, appointed an Advisory Committee on Long Term Care composed of representatives from the insurance industry to explore various issues related to the development of long-term care insurance plans. In June, 1986, the Advisory Committee submitted a comprehensive draft report of nearly 400 pages to the Task Force. The report contained a series of recommendations, including model legislation, for the development of private insurance as a viable financing mechanism for long-term care.[6] The report emphasized that a fragmented or piecemeal implementation of the recommendations would mitigate the impact of insurance as a financing alternative. (See Appendix B for summary of issues and recommendations as reported by the Advisory Committee.) On December 7, 1986, the National Association of Insurance Commissioners officially received the final report of the Advisory Committee but the Bureau was unable to obtain a copy of the final report before publication of this report. The Bureau believes, however, that little, if any, substantive changes were made since the draft appeared to be very well received.[7]

The message of the advisory committee is clear...long-term care insurance can be the answer to shifting the burden of financing long-term care to private rather than public means. The task is not a simple one. Before long-term care insurance can become a viable financing mechanism, millions of new policies have to be sold. To sell those policies, experience data on current long-term care insurance policies and longitudinal data on the potential long-term care population must be developed and used to improve the marketability of long-term care insurance. Then, there is still the enormous task of educating the public on the limitations of Medicare coverage for long-term care and the consequences of depending on Medicaid.

Basic Elements of a Long-Term Care Insurance Policy

While most long-term care insurance policies generally provide similar coverage, there are subtle differences which can be misleading to the ill-informed consumer who could be paying a high premium for coverage the person may not be getting or might not need. This is not to imply, however, that the insurance industry is trying to mislead the naive elderly population. Indeed, the insurance industry has been trying to carefully design its policies to increasingly meet consumer demands while at the same time limiting its risk. It is the complex nature of the long-term care reimbursement procedure, which has its origins in Medicare and Medicaid guidelines, that defies comprehension by lay individuals.

The American Health Care Association in January, 1986, identified 59 different insurance products that were either reportedly in the market or about to enter the market.[8] The following discussion on policy contents is generally based on various policies reportedly available in the United States.

Definitions - Every insurance policy has definitions for such terms as "nursing home facility", "convalescent home facility", "skilled nursing care", "intermediate care", "custodial care", "pre-existing condition", and "home care". The definitions, however, often differ from policy to policy. It is extremely important to read all the definitions in order to clarify the extent of coverage provided by the policy. When considering the purchase of a policy, a consumer should ascertain which facilities and what types of care in Hawaii would meet the definitions of the policy in order to envision the type of care being purchased.

Insurability - Most companies require a medical clearance although the policies usually do not specify what types of health history might disqualify a person from being insured. The Bureau has been told on numerous occasions, however, that many elderly with histories of ailments such as diabetes, stroke, and cancer are not insurable. At least one policy does not require a health clearance but the coverage is limited to one year. Most companies will not sell a policy to a person over 79 years of age, although some companies will insure a person up to 84 years and others will not insure persons over 75 years old.

Benefits - Most long-term care insurance policies will cover patient stays in a nursing home at the skilled nursing and intermediate care levels that are required by the patient's physician. Some policies, especially the older policies, cover only stays at the skilled nursing level. The newer policies include custodial care coverage by providing that benefits will not be reduced or denied because the care received after admission is reduced to a lower level, such as custodial, as long as the patient remains confined in the same nursing home. More policies are also offering home care at a rate of about 50 per cent of the daily institutional benefit, but, on a limited basis.

The benefits payable in long-term care policies are usually indicated on a per diem, monthly, or annual basis. The policies typically provide only one benefit payment rate regardless of the level of care as long as the care is provided in a qualified institution. The daily benefits range from $20 a day to $120 a day and the duration of the benefit period can range from one year to six years. Most policies provide for a benefit period of three to five years. It should be noted that the average nursing home stay in Hawaii is about three and one-half years and only about five per cent of the nursing home population would require institutionalization for more than five years.[9]

Benefits are payable until either the maximum amount payable or the maximum period of coverage is exhausted. Accordingly, a person who has a policy which will pay four years of benefits can conceivably receive benefits for two or more separate nursing home confinements which total four years of confinement or the maximum amount of benefits payable.

At least one company offers an optional rider which increases daily benefits by five per cent annually for ten years to keep pace with increases in nursing home care costs. This inflationary factor is becoming more important as more people are being encouraged to purchase long-term care insurance at a younger age and it appears certain that nursing home costs will increase each year.

Pre-existing Condition - Most insurance policies will not cover a person with a pre-existing condition at the time the policy goes into effect until a certain period of time elapses, ranging from 60 days to one year.

Elimination Period - Some policies will begin the payment of benefits on the first day a person is placed in a nursing home while other policies will begin on the 21st or the 101st day of the nursing home stay. Usually, a person has the option to select a particular elimination period. The premium cost decreases with a higher elimination period. Those who select the higher elimination period are those who can withstand the cost of the first 100 days and who are more concerned about extended confinement.

Conditions Under Which Benefits are Payable - When evaluating the benefits offered by different policies, the consumer must not only be concerned with the benefit amount and length of time benefits are payable, but also the conditions under which benefits will be paid. For example, most policies require, as a prerequisite for benefits in a skilled nursing facility, a stay in the hospital for acute care for at least three days. While insurance agents often maintain that it is very rare that a person will require placement in a skilled nursing facility without having first undergone extensive tests and treatment at the acute care level in a hospital, some patients, like those afflicted with Alzheimer's Disease, may not require hospitalization and it is probable that some doctors order medically unnecessary hospitalization as preludes to nursing home entry.[10] It is interesting to note that some of the newer insurance products are offering, at a higher premium, an option where prior hospitalization is not required.

Another example of a policy condition is where benefits payable for placement in an intermediate care facility are payable only if the insured has first stayed in a skilled nursing facility for a certain period of time like 14, 20, or even 120 days. The problem with such a condition is that it is highly possible that a person could go from acute care to skilled nursing care then on to intermediate care within a shorter period than 90 days. It is also possible that a person may go directly from acute care to intermediate care and skip skilled nursing care entirely.

Most policies will only pay benefits if the insured is confined to an institution that is Medicare certified or that meets the insurer's definitions of skilled nursing, intermediate, or custodial facilities. Recognizing that home care is preferred by most elderly to institutional care, many companies are now offering such coverage. This coverage, however, is limited to recuperation and rehabilitation following a specified period of covered institutional care and may not include the custodial or personal care services for which most elderly often desire coverage. Insurers deliberately restrict home care benefits since they are aware of the large potential for home care service claims from those who have never been institutionalized.

If confinement is due to a mental or nervous condition that is not "demonstrably organic", most policies will not pay benefits. Usually such policies include coverage for Alzheimer's Disease and senility, but prospective insureds must verify this with the company before signing the contract. This coverage could be very important since there are increasingly more cases of Alzheimer's Disease occurring and often when the disease is diagnosed, the

patient requires more custodial rather than medical and rehabilitative care. Most policies will not pay benefits if confinement results from suicide attempts or self-inflicted injury.

Renewability - An important provision to look for is the terms of renewability. As most insureds will probably be purchasing a policy at age 65 or older, there should be some assurance that the policy will not be canceled when the policyholder is 80 years old and unable to obtain coverage through another insurance company. Many of the newer products are offering a guaranteed renewable feature where the policy is guaranteed to be renewed unless the insured fails to pay the premium. Some policies may be canceled only if all such policies in the same state are canceled. Group policies may be terminated at any time under terms applicable to group insurance. While most insurance agents will maintain that it is unlikely that the insurance company will cancel a policy even though there is no guaranteed renewable provision, the prospective insured would be wise to consider the possibility and examine the company's reputation and stability.

Premium Waiver - Another general provision that must be considered is a premium waiver provision where the payment of premium is waived during the insured's confinement in a nursing home for which benefits under the policy were paid. This ensures that the policy will not be canceled due to failure to pay premium while the insured is confined.

Other Policy Provisions - Insurers are developing new provisions to enhance their policy offerings. The inflation rider mentioned earlier is one example. Other examples include the use of discounts for couples purchasing policies or for particular lifestyles, ambulance benefits, coverage for Christian Science Care, coverage for inhospital private nurse, out-patient prescription benefits, and a 24-hour accidental death benefit.

Premium Cost - The premium cost is dependent on many factors: the insured's age, the range of services covered, the number of conditions limiting payment of benefits, the benefit elimination period, the amount of daily benefit payable, and the duration of benefits. Policies which provide for home health care following institutionalization generally cost more. Many companies offer options on such provisions as the daily benefit amount, the prior hospitalization requirement, and the duration of coverage. Annual premiums run in the range of $50 to $5,000. The average premium for a 65-year old with coverage of about $100 a day for four years is about $900-$1,000 a year. Premiums are higher for older policyholders and those considered high risk. Generally, the more liberal the coverage provided or the more options a policyholder selects, the higher the premium.

Often, policies which contain many restrictive conditions have lower premiums. A person could conceivably purchase a policy and never be eligible for benefits, even though long-term care is required, because of the restrictions. Consumers must, therefore, carefully examine the differences in the levels of long-term care, the availability of services and facilities, and the conditions upon which benefits will be paid, and the premium cost before determining which policy would be most suitable.

Marketing Problems

Insurance is supposed to be an economical way of taking care of a potentially catastrophic financial problem since it involves risk-pooling. The extent of the economy, of course, depends on the size of the pool of insureds. Since long-term care insurance is a relatively new insurance product and there are few policyholders, the premiums tend to be high. The irony is that unless more people can be persuaded to enter the risk pool, the premiums will continue to be high, yet, the high price of long-term care insurance is one reason why many people are discouraged from buying.

Interestingly, ICF Incorporated, a consulting firm specializing in health and environmental issues, examined the affordability issue and concluded that about 50 per cent of the people in the 65 to 69 age group could afford insurance premiums that are less than five per cent of their incomes.[11] Affordability, however, declines rapidly for the older age groups because the premiums increase while the average income decreases with age. ICF Incorporated concluded that although a majority of the elderly can afford long-term care insurance, few policies have been sold primarily because the elderly who can afford the insurance do not believe they need it. The elderly must be convinced of the need for insurance before a significant volume of purchases of insurance will occur.[12]

Insurance companies have argued that the greatest barrier to marketing long-term care insurance is the lack of consumer awareness of the long-term care financing problem. Most elderly believe that Medicare and Medicare Supplement insurance policies will cover any long-term care they may require. Within the past year, however, there has been an increase in activity in both the private and public sectors to overcome this barrier. Throughout the nation, insurance companies and government agencies are offering informational meetings to various community groups and publishing consumer guides to explain the long-term care financing problem and the role of long-term care insurance. Slowly, more people are recognizing the limits of Medicare and the advantages of long-term care insurance.

Another major barrier to the development of long-term care insurance has been the lack of data in the field which makes it difficult to set premium levels, define insurable events, and design policies to meet the needs of potential policyholders. Insurers are seriously concerned about adverse selection where only the high risk types will purchase insurance and moral hazard where there will be a higher use of long-term care services simply because they are covered. Moral hazard has been blamed for much of the rising cost of hospital care and there is a fear that the long-term care costs will similarly rise with more people covered by long-term care insurance policies.[13] Restrictive policy conditions such as the medical requirement for home care are specifically aimed at limiting claims since home care is viewed as highly susceptible to moral hazard.[14]

The Hawaii Market for Long-Term Care Insurance

Although long-term care insurance has been sold in the continental United States for over ten years, in Hawaii, such insurance products have

only been marketed for a few years. In September, 1986, the Insurance Division of the State Department of Commerce and Consumer Affairs surveyed the 700 general agents authorized to transact life and disability insurance business in this State to ascertain the level of activity in the long-term care insurance field. The Division received only 140 responses which is considered unusually low for inquiries made by the Commissioner to general agents. The Division surmised that the poor response was probably due to the low level of interest in long-term care insurance. The survey, however, did reveal some interesting data.

Currently, there are at least eight different long-term care insurance products being marketed in Hawaii by 14 different agents. (See Exhibit 3 for the Bureau's comparison of the eight policies.) One agent noted that the insurance company the agent was affiliated with was test marketing a new insurance product which probably would become available in Hawaii in the future. Of the 126 agents who responded to the survey and reported that they were not currently selling long-term care insurance, 15 said they intended to sell long-term care insurance within the next two years, and 17 said they would if they could find appropriate policies.

Most of the agents have been selling long-term care insurance for only six months and some have not been aggressively selling the new products. Those who have been aggressively selling long-term care insurance have reported that sales over the past few months have been encouraging. To date, more than 400 policies have been sold and agents acknowledge that consumers are becoming better informed about the limits of Medicare coverage and Medicaid eligibility due to increased publicity both locally and nationally. Most will agree, however, that there is still need for more consumer education programs and that incentives to purchase long-term care insurance are necessary to enlarge the pool of policyholders.

Regulating Long-Term Care Insurance

Long-term care insurance in Hawaii, as in most states, is not specifically regulated like Medicare supplement insurance. The primary reason is that up until the past year, there were very few, if any, policies sold. The State's position in 1984 was that the industry should be given flexibility to develop appropriate products and that regulatory action was premature.[15] The National Association of Insurance Commissioners, however, has recently adopted a model law which would maintain flexibility for the industry but ensure some measure of protection for the consumer. The availability of this model law may prompt more states into enacting regulatory laws specifically for long-term care insurance.

EXHIBIT 3

Comparison of Insurance Policies Available in Hawaii

The information presented in this chart was extracted from brochures and sample policies. Readers are advised to exercise caution in the use of this chart since many of the policy terms are subject to further clarification by the insurance companies and companies may be replacing current policies with improved ones in the future.

CARRIER Policy ID	--AETNA LIFE INSURANCE AND ANNUITY CO. --Skilled Nursing Care Facility Indemnity Policy #24236	--AIG LIFE --Care Span #41424
INSURABILITY Health Status Maximum Age	--Short form medical questionnaire. --Minimum age 55 years; Maximum age 84 years.	--Short form medical questionnaire. --79 years
SKILLED NURSING CARE Daily Benefit Restrictions	--$40 - $100 --3-day prior hospitalization required; confinement must begin within 30 days after hospital confinement. Option to drop prior hospitalization requirement available. (See definitions.)	--$20 to $120/day --3-day prior hospitalization required.
INTERMEDIATE CARE Daily Benefit Restrictions	--Same daily benefit for skilled care payable though care reduced to this level as long as care is delivered in skilled nursing facility as defined in policy.	--Same as for skilled nursing.
CUSTODIAL CARE Daily Benefit Restrictions	--Same daily benefit for skilled care payable though care reduced to this level as long as care is delivered in skilled nursing facility as defined in policy.	--Same as for skilled nursing. Confinement to custodial care facility must begin within 30 days after a covered confinement in skilled or intermediate nursing care of at least 14 consecutive days.
HOME HEALTH Daily Benefit Maximum Benefit Restrictions	--50% of daily benefit for skilled care. --2 years. --Must follow 120 days skilled care facility confinement covered under this policy; medical supervision required.	--full skilled care benefit first 30 days; 1/2 for next 60 days. --90 days; option available for $20-$60/day coverage for 2 years. --Must follow approved nursing home stay of 30 or more days; medical supervision required.
ELIMINATION PERIOD	--20 or 100 days.	--0, 20, 100 days
MAXIMUM BENEFIT Amount (lifetime) Duration	--$18,250 for each $10 of daily benefit chosen. --4 years/benefit period; 5 years lifetime maximum.	--5 years lifetime maximum
PRE-EXISTING CONDITION EXCLUSION	--180 days after policy date.	--1 year
OTHER EXCLUSIONS	--War. --Mental disease or disorder without demonstrable organic disease.* --Suicide attempt. --Intentional self-inflicted injury. --Confinement in government institution. --Care outside U.S. or possessions.	--Care outside U.S. or its possessions, Canada, Mexico. --War. --Non-organic mental disease or disorder. --Dental treatment, except due to injury to sound natural teeth. --Suicide attempt. --Intentionally self-inflicted injury. --Air travel. --Treatment or service not medically necessary.
PREMIUM WAIVER	--After 90 consecutive days of benefits paid during continuance of the payment of benefits.	--After 90 days continuous coverage.
RENEWABILITY	--Guaranteed--lifetime.	--Guaranteed--lifetime.
POLICY FEE	--No	--No
OTHER PROVISIONS	--Confinements separated by 90 days require new eligibility period. --Benefits payable in addition to other third-party coverage.	--24-hour accidental death benefit. --Christian Science Care in eligible facility covered. --Confinements separated by 180 days or more subject to new elimination period. --Benefits payable in addition to other third-party coverage.

*Typically, Alzheimer's is considered to be demonstrably organic.

<table>
<tr><th></th><th>AETNA LIFE INSURANCE AND ANNUITY CO.</th><th>AIG LIFE</th></tr>
<tr><td>ANNUAL PREMIUM RATES</td><td>--for each $10 of daily benefit selected:

<table>
<tr><th></th><th colspan="2">Plan A
Prior Hospitalization</th><th colspan="2">Plan B
No Hospitalization</th></tr>
<tr><th></th><th colspan="2">Elimination Period</th><th colspan="2">Elimination Period</th></tr>
<tr><th>Age</th><th>20 days</th><th>100 days</th><th>20 days</th><th>100 days</th></tr>
<tr><td>55-64</td><td>$ 46</td><td>$ 42</td><td>$ 55</td><td>$ 49</td></tr>
<tr><td>65-69</td><td>86</td><td>77</td><td>124</td><td>110</td></tr>
<tr><td>70-74</td><td>149</td><td>133</td><td>243</td><td>215</td></tr>
<tr><td>75-79</td><td>250</td><td>222</td><td>446</td><td>394</td></tr>
<tr><td>80-84</td><td>368</td><td>325</td><td>703</td><td>617</td></tr>
</table></td><td>--for each $10 of daily benefit selected.

<table>
<tr><th></th><th colspan="3">Elimination Period</th></tr>
<tr><th>Age</th><th>0 days</th><th>20 days</th><th>100 days</th></tr>
<tr><td>-59</td><td>$ 32.65</td><td>$ 31.40</td><td>$ 27.95</td></tr>
<tr><td>60-64</td><td>63.90</td><td>61.45</td><td>54.65</td></tr>
<tr><td>65-69</td><td>120.90</td><td>116.25</td><td>103.45</td></tr>
<tr><td>70-74</td><td>202.80</td><td>195.00</td><td>173.55</td></tr>
<tr><td>75</td><td>270.35</td><td>259.95</td><td>231.35</td></tr>
<tr><td>76</td><td>297.10</td><td>285.70</td><td>254.25</td></tr>
<tr><td>77</td><td>325.70</td><td>313.20</td><td>278.75</td></tr>
<tr><td>78</td><td>356.50</td><td>342.80</td><td>305.10</td></tr>
<tr><td>79</td><td>389.40</td><td>374.40</td><td>333.25</td></tr>
<tr><td>80</td><td>424.45</td><td>408.15</td><td>363.25</td></tr>
<tr><td>81</td><td>461.40</td><td>443.65</td><td>394.85</td></tr>
</table>
Rates available for daily benefits ranging from $20 to $120/day in denominations of ten.
Home Care option available at added cost.</td></tr>
<tr><td>DEFINITIONS</td><td>Skilled Nursing Care Facility--means an institution which is legally operated to provide skilled nursing care for sick and injured persons at their expense. It may be a section of a hospital. It must be supervised by a physician or registered nurse (R.N.) and provide 24-hour licensed nursing care under the direction of a registered nurse (R.N.). It must keep daily medical records for each of its patients and have a utilization review plan for all patients. It is not a hospital, a home for the aged, or a place mainly for rest, retirement care, or for the treatment of alcoholism or drug addiction.</td><td>"Skilled or Intermediate Nursing Care Facility" means a place which meets all of these requirements:
1. is appropriately licensed and legally operated to provide skilled or intermediate nursing care for sick and injured persons for which a charge is made;
2. is certified by or could meet Medicare's standards for certification if so requested;
3. operates under the supervision of a physician;
4. is primarily engaged in providing skilled or intermediate nursing care and room and board for sick and injured persons;
5. has 24-hour nursing service by or under the supervision of a licensed registered nurse; and
6. maintains a daily medical record of each patient.
A skilled or intermediate Nursing Care facility is not a rest home, home for the aged, a place that primarily treats mental illness, alcoholism or drug addiction, or a place that primarily provides Custodial Care.</td></tr>
</table>

CARRIER Policy ID	--AMERICAN INTEGRITY --SNF-100	--AMERICAN INTEGRITY --SNF-86-P
INSURABILITY Health Status Maximum Age	 --No medical clearance required. --Minimum age 45 years; no maximum age.	 --Short form medical questionnaire. --Minimum age 55; no maximum age.
SKILLED NURSING CARE Daily Benefit Restrictions	 --$30 or $40/day --3-day hospitalization required; confinement must begin within 30 days after hospital confinement. Must be medically necessary for continuing care of the sickness or injury. (See definitions.)	 --$20, $30, $40, or $50/day --3-day hospital confinement required; confinement must begin within 30 days after hospital confinement and must be ordered by physician.
INTERMEDIATE CARE Daily Benefit Restrictions	 --Same as for skilled provided insured remains in "skilled nursing facility". (See definitions.)	 --Same as for skilled care. --Care must be rendered in a "skilled care facility".
CUSTODIAL CARE Daily Benefit Restrictions	 --No benefits.	 --Same as for skilled care. --Care must be rendered in a "skilled nursing facility".
HOME HEALTH Daily Benefit Maximum Benefit Restrictions	 --Same as for skilled care; but for private duty nursing only. --Up to 10 days/benefit period. --Within 14 days of discharge from hospital or skilled nursing facility; medical supervision required.	 --None
ELIMINATION PERIOD	--None	--0, 20, or 100 days
MAXIMUM BENEFIT Amount Duration	 --$300 or $400/benefit period --365 days/benefit period	 --Depending on daily benefit and 1 year or 2 year maximum benefit option selected. --1 year or 2 years lifetime maximum (benefit period reduced by elimination period selected).
PRE-EXISTING CONDITION EXCLUSION	--6 months	--6 months
OTHER EXCLUSIONS	--War. --Intentionally self-inflicted injury. --Being intoxicated or under influence of narcotic, unless taken as directed by physician. --Functional mental or nervous disorders. (See definitions.)	--War; participation in insurrection or commission of felony. --Intentionally self-inflicted injury. --Intoxicated or under influence of narcotic. --Drug addiction, alcoholism. --Mental, nervous or emotional disorders without demonstrable organic* cause. --Confinement outside U.S. territorial limits.
PREMIUM WAIVER	--No	--No
RENEWABILITY	--At company's option if it nonrenews all such policies in State and gives 31 days prior written notice of nonrenewal.	--Optionally renewable; may be cancelled if all such policies in State cancelled.
POLICY FEE	--$10	--Yes; amount not known.
OTHER PROVISIONS	--Spouse coverage. --In-hospital private duty nurse benefit for up to 10 days in any benefit period. --Out-patient prescription benefits up to $15/prescription; $75 maximum benefit during a benefit period. --Confinements separated by 60 or more days is new benefit period. --Benefits payable in addition to other third-party coverage.	--Benefits paid in addition to other insurance, including Medicare. --Elimination period must be satisfied only once during lifetime of policy.

*Typically, Alzheimer's disease is considered demonstrably organic.

	AMERICAN INTEGRITY	AMERICAN INTEGRITY
ANNUAL PREMIUM RATES	--Note: These rates could not be interpolated to figures representing $10 of daily benefit. Daily Benefit Age Group | $30 | $40 45 - 54 | $ 86.25 | $110.75 55 - 64 | 150.80 | 196.25 65 - 79 | 235.05 | 308.75 80 & Over | 500.85 | 662.60	--For each $10 of daily benefit selected. Age | 1 year coverage (Elimination Period) 0 day | 20 days | 100 days | 2 years coverage (Elimination Period) 0 day | 20 days | 100 days 55-64 | $ 60 | $ 54 | $ 36 | $ 91 | $ 85 | $ 67 65-69 | 90 | 81 | 54 | 136 | 127 | 100 70-74 | 125 | 112 | 75 | 188 | 175 | 138 75-79 | 171 | 154 | 103 | 279 | 242 | 191 Options of $20, $30, $40, or $50/day benefits.
DEFINITIONS (Level of Care and Facilities)	"Skilled Nursing Facility" means an institution which: (1) is operated pursuant to law; (2) primarily engaged in providing skilled nursing care and/or rehabilitative services under the direction of a physician in addition to room and board accommodations; (3) provides 24-hour-a-day nursing services by or under the supervision of a registernd nurse (R.N.); and (4) maintains a daily medical record on each patient. "Skilled Nursing Facility" will not include: (1) any home, facility or part thereof used primarily for rest; (2) a home or facility for the aged or for the care and treatment of drug or alcohol abuse; or (3) a home or facility primarily used for the care of mental diseases or disorders or custodial or educational care. "Functional Mental or Nervous Disorders" means medically diagnosed neurosis, psychoneurosis, psychopathy, psychosis or any mental, nervous or emotional disorder without demonstrable organic origin.* "Benefit Period" means a period of time beginning with admission to a hospital and ending 60 days after discharge from the hospital or skilled nursing facility or the discontinuance of at-home private duty nursing.	Defintions not available; the Bureau was unable to obtain a sample policy.

*Typically, Alzheimer's disease is considered demonstrably organic.

CARRIER Policy ID	--AMEX LIFE --#E-105914	--BANKERS LIFE --#CR 7211
INSURABILITY Health Status Maximum Age	--Short form medical questionnaire. --80 years; up to 81 years if couple applies and one is under 80.	--Short form medical questionnaire. --Minimum age 60 years; maximum age 79 years.
SKILLED NURSING CARE Daily Benefit Restrictions	--$10 to $100/day. --3-day hospital confinement required (option to drop hospital requirement available); confinement must begin within 90 days after a period of continuous hospital confinement.	--$20 to $100/day --Doctor must certify medical necessity 3-day hospitalization required; confinement must begin within 30 days after hospital discharge.
INTERMEDIATE CARE Daily Benefit Restrictions	--Same benefit as for skilled care even if level of care is reduced as long as patient still confined in a nursing home as defined in policy.	--Same as for skilled care. (See definitions.)
CUSTODIAL CARE Daily Benefit Restrictions	--Same benefit as for skilled care even if level of care is reduced as long as patient still confined in a nursing home as defined in policy.	--Same as for skilled care.
HOME HEALTH Daily Benefit Maximum Benefit Restrictions	--70% for 1st - 30th day; 60% for 31st - 60th day; 50% for 61st day and thereafter. --For each day of covered nursing home confinement. --Must immediately follow period of uninterrupted nursing home confinement for which benefits are payable under policy. No medical supervision requirement.	--50% of daily benefit for skilled care. --180 days/period of confinement --Must immediately follow nursing home stay of at least 90 consecutive days and benefits for those 90 or more days were paid under this policy; must be medically necessary.
ELIMINATION PERIOD	--20 or 100 days	--0, 20, 100 days
MAXIMUM BENEFIT Amount Duration	--$3,000/month (based on $100/day) --2,190 days (6 years) lifetime maximum.	--None --1, 3, 5-year options/benefit period; no lifetime maximum
PRE-EXISTING CONDITION EXCLUSION	--90 days	--6 months after policy date
OTHER EXCLUSIONS	--War. --Confinement in VA or federal government institution unless insured is charged. --Suicide attempt; intentional self-inflicted injury. --Mental disorder or disease not demonstrably organic; Alzheimer's and senility covered.	--War. --Expenses already paid by government. --Suicide attempt; self-inflicted injury. --Mental illness or nervous disorder; "mental illness" means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.
PREMIUM WAIVER	--After 90 days continuous coverage during confinement in nursing home.	--After 90 consecutive days of benefits paid during continuance of benefits under policy.
RENEWABILITY	--Guaranteed--lifetime.	--Company can refuse renewal of all such policies in the State.
POLICY FEE	--$15	--No
OTHER PROVISIONS	--Inflation option available--benefits increase 5% each year for 10 years; provided that daily benefit does not exceed 150% of the initial daily benefit amount. --Confinement separated by 6 months or more subject to new elimination period. --Payment of benefits in addition to other third-party coverage.	--Ambulance benefit of $25/trip to or from nursing home. --Company has right to have physical examination of insured as reasonably necessary while claim is pending. --Confinement separated by 6 months subject to new elimination period. --Benefits payable in addition to other third-party coverage.

ANNUAL PREMIUM RATES

AMEX LIFE

--For each $10 of daily benefit selected.

Issue Age	Prior Hospitalization (Elimination Period) 20 days	Prior Hospitalization (Elimination Period) 100 days	No Hospitalization (Elimination Period) 20 days	No Hospitalization (Elimination Period) 100 days
Under 60	$ 54.00	$ 42.75	$ 87.75	$ 69.75
60	58.50	47.25	95.25	76.50
61	65.25	51.75	104.25	83.25
62	69.75	56.25	113.25	93.00
63	76.50	60.75	125.25	102.00
64	83.25	67.50	136.50	111.00
65	92.25	74.25	150.75	120.75
66	101.25	81.00	166.50	134.25
67	110.25	87.75	183.00	146.25
68	119.25	96.75	199.50	159.75
69	130.50	103.50	220.50	176.25
70	141.75	114.75	240.75	195.00
71	155.25	123.75	266.25	213.00
72	171.00	137.25	294.00	236.25
73	186.75	150.75	327.00	261.75
74	207.00	164.25	363.75	291.75
75	227.25	182.25	401.25	322.50
76	249.75	200.25	442.50	354.75
77	274.50	218.25	486.75	389.25
78	297.00	238.50	531.00	426.75
79	321.75	256.50	576.75	463.50
80	346.50#	276.75#	625.50#	503.25#
81	346.50#	276.75#	625.50#	503.25#

#Available only if spouse is insured for a like or greater amount of indemnity and under age 80.

Options ranging from $10 to $100/day benefits.

Inflation option available at added cost.

BANKERS LIFE

--for each $10 of daily benefit selected.

Benefit Period	Age	Elimination Period 0 day	20 days	100 days
1 year	60-69	$ 84	$ 72	$ 48
	70	120	96	60
	71	144	108	72
	72	156	120	84
	73	168	144	96
	74	192	156	108
	75-79	204	168	120
3 years	60-69	$120	$108	$ 84
	70	168	144	120
	71	192	168	132
	72	228	192	144
	73	252	228	168
	74	288	252	192
	75-79	300	264	204
5 years	60-69	$144	$132	$108
	70	204	192	156
	71	240	216	168
	72	276	240	192
	73	312	276	216
	74	360	312	252
	75-79	372	324	264

Options ranging from $20 to $100/day available.

DEFINITIONS

"Nursing Home" means a facility, other than a Hospital, which is primarily engaged in providing, to inpatients, skilled nursing care and related services under a license issued by the appropriate licensing agency. It can be a freestanding facility (such as a skilled nursing, comprehensive care, intermediate care or convalescent facility); or it can be a distinct part (such as a ward, wing or unit) of a Hospital or other institution.

The skilled care and related services it provides must include 24 hour a day nursing service under a planned program of policies and procedures which was developed with the advice of, and is periodically reviewed and executed by a professional group of at least one Physician and one Nurse. Every patient must be under the care of a Physician; and a Physician must be available to furnish medical care in case of emergency.

It must have at least one Nurse who is employed full time (or at least 24 hours per week if the facility has less than 10 beds); and a Nurse must be on duty or on call at all times. Clinical records must be maintained for all patients; and it must have appropriate methods and procedures for handling and administering drugs and biologicals.

This definition SHALL NOT INCLUDE a facility, or distinctly separate part thereof, which functions as; a rest home; a home for the aged; a sheltered living accommodation; a residence home; or a similar living arrangement.

"Nursing Home" means a place which:

1. is legally operated to provide nursing care (skilled, intermediate, custodial) for sick and injured persons at their expense.
2. has 24 hour nursing service by or under the supervision of a licensed nurse;
3. operates under the supervision of a doctor; and
4. has beds for patients who need nursing care.

"Nursing Home" also means a wing, area or floor of a hospital specifically set aside for nursing care.

It doesn't mean: a hospital, a Home Convalescent Unit, a place that primarily treats the mentally ill, drug addicts or alcoholics or a place owned or operated by a member of your family.

"Home Convalescent Unit" means your home; a private home; a home for the retired or aged; a place providing residential care.

It doesn't mean a hospital, sanatorium or nursing home.

"Custodial Care" means care which is mainly for the purpose of meeting personal needs. It could be provided by persons without professional skills or training. Such examples are: help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

"Skilled and Intermediate Care" means any level of care greater than custodial care.

"Home Convalescent Care" means a program of medically necessary care recommended by a doctor for persons who, for medical reasons, are unable to engage in the normal activities of persons of the same age and sex.

CARRIER Policy ID	--MASSACHUSETTS INDEMNITY --#GP-8200	--RESERVE LIFE --Nursing Home Confinement Indemnity Coverage #PNH86
INSURABILITY Health Status Maximum Age	--Health conditions requiring confinement within past 12 months will be evaluated. --18 years minimum; no maximum age	--Short form medical questionnaire. --Minimum age 50 years; maximum age 84 years.
SKILLED NURSING CARE Daily Benefit Restrictions	--Days 1-60 actual cost to $35/day (under age 65). Day 61 and thereafter to $70/day regardless of age. --3-day hospital stay required; confinement must be within 28 days after hospital stay. Physician must certify medical necessity; recertification required every 30 days. (See definitions.)	--$40, $60, $80, or $100/day --3-day prior hospitalization required; confinement in a convalescent care facility must be within 30 days following a hospital confinement. (See definitions.)
INTERMEDIATE CARE Daily Benefit Restrictions	--Same as for skilled care.	--Same as for skilled care.
CUSTODIAL CARE Daily Benefit Restrictions	--No benefits if patient receiving custodial (residential) care only.	--Same as for skilled care. --Must first be admitted to convalescent care facility for skilled care and remain in same facility.
HOME HEALTH Daily Benefit Maximum Benefit Restrictions	--None	--50% of daily benefit for skilled care. --365 days. --Must follow within 7 days of convalescent care facility confinement for which benefits are payable; requires physician certification.
ELIMINATION PERIOD	--For ages 65 and older, benefits begin from 61st day of confinement.	--20, 100, or 365 days
MAXIMUM BENEFIT Amount Duration	--$105,000 --Approximately 4 years.	--None --3 years/benefit period; 5 years lifetime maximum.
PRE-EXISTING CONDITION EXCLUSION	--12 months	--6 months
OTHER EXCLUSIONS	--War. --Dental treatment not due to accident. --Suicide attempt; self-inflicted injury. --Mental disorder or disease without organic origin.* --Confinement outside U.S., Canada, Mexico. --Intoxication or under influence of narcotic unless taken under doctor's orders. --Illegal occupation.	--War. --Mental or nervous disorder without organic origin.* --Injury or illness covered by Workers' Compensation, Employer's Liability Law, or other similar law. --Alcoholism or drug addiction. --Suicide attempt; intentionally self-inflicted injury. --Confinement outside U.S., Canada. --Confinement to a convalescent facility or home care unit where insured not legally required to pay, except where payment is made by Medicaid.
PREMIUM WAIVER	--No	--After 90 days but not for home care.
RENEWABILITY	--At company's option; providing 30-day notice of intent is given.	--Guaranteed--lifetime.
POLICY FEE	--No	--No
OTHER PROVISIONS	--Company has right to have insured examined as reasonably necessary while claim is pending. --Confinements separated by more than 14 days subject to new elimination period. --Benefits payable in addition to other third-party coverage.	--$36 discount for 2-person coverage. --Discount for nonsmokers. --Benefits payable in addition to nther third-party coverage.

*Typically, Alzheimer's disease is considered organic.

	MASSACHUSETTS INDEMNITY	RESERVE LIFE
ANNUAL PREMIUM RATES	--For each $10 of daily benefit selected. Age / $ 15 18-39 / 21 40-54 / 37 55-64 / 62 65-69 / 110 70-74 / 143 75-79 / 188 80-84 / 249 85+ Rates increase as age increases.	--For each $10 of daily benefit selected. Elimination Period Age / 20 days / 100 days / 365 days 50-59 / $ 51 / $ 45 / $ 33 60-64 / 72 / 63 / 48 65-69 / 102 / 87 / 66 70-74 / 162 / 138 / 105 75-79 / 261 / 225 / 171 80-84 / 381 / 327 / 249 Options of $40, $60, $80, or $100/day benefits.
DEFINITIONS	Skilled Nursing Home Facility means a place which meets all of these requirements: (1) operates lawfully; (2) provides room and board; (3) provides to in-patients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for rehabilitation of injured, disabled, or sick persons; (4) has policies (developed with the advice of and perindically reviewed by a professional group which includes one or more physicians and one or more professional nurses (RN) to govern the skilled nursing care and related medical or other services it provides; (5) has a physician, registered professional nurse or a medical staff experienced in such policies; (6) provides for a continuous 16 hour a day nursing service by or under the supervision of a registered graduate professional nurse (RN); (7) maintains a daily medical recurd of each patient; (8) provides for having all physicians on call to furnish necessary medical care in case of emergency; (9) has in effect a utilization review board; and (10) will grant us reasonable access to the patient and the patient's records during pendency of a claim. It must not be one of these: (a) a rest home for the aged; (b) a place set up mainly to treat alcnholics or drug addicts; or (c) a place set up mainly for the care and treatment of mental diseases or disorders. Custodial (Residential) Care means board and personal assistance for people unable to care for themselves (due to age; illness; physical or mental infirmity). Daily nursing care is not required.	Convalescent Care Facility--A facility or part thereof which is recognized by the state in which it is located as a Skilled Nursing facility and is primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Care under the supervision of a licensed physician; and provides continuous 24 hour a day nursing service by or under the supervision of a graduate professional nurse (R.N.); and maintains a daily record of each patient. Or a Convalescent Care Facility is recognized as an Intermediate Care facility by the state in which it is located. Custodial Nursing Care--Care which is primarily for the purpose of meeting personal needs; can be provided without professinnal skills or training; must be performed under the orders of a physician; and must be performed at the direction and under the supervision of a licensed registerod nurse (R.N.), Hicensed practical nurso (L.P.N.) or licensed vocational nurse (L.V.N.). Home Care--A program of medically necessary care recommended by a physician for an insured person who for medical reasons is unable to engage in the normal activities of persons of the same age and sex. A Home Care Unit is: an insured person's home; a private home; a home for the retired or aged; an institution which provides residential care; or an institution which provides Custodial Nursing Care. It does not include a hospital or sanatorium or a Convalescent Care facility. Skilled Nursing Care--Nursing Care which recognizes and utilizes professional nursing methods and ineludes post-hospital care, administering medications, injections, catheterization and similar nursing procedures; is performed under the orders of a physician; is performed at the direction and supervision of a licensed registered nurse with care by licensed registered nurses or lieensed practical nurses being provided on a 24 hour basis; follows one or more professional nursing method(s) and procedure(s) for the benefit of an insured person.

Chapter 5

THE ROLE OF TAX INCENTIVES

Tax incentives are often used to achieve social goals because tax credits and deductions are politically more acceptable than direct general revenue outlays.[1] In recent years, numerous studies on long-term care financing have suggested that both the federal and state governments should look at tax incentives to stimulate the interest in long-term care insurance. Beyond this general recommendation, there has been very little, if any, detailed discussion on specific types of tax incentives or as to their comparative worth to other government actions to encourage the purchase of long-term care insurance.

Essentially, there are two types of tax incentives that could be readily applied to the purchase of long-term care insurance...a tax credit or a tax deduction. Tax credits are subtracted from the total tax due while tax deductions are usually subtracted from the adjusted gross income which is the base upon which the tax due is calculated. Tax deductions only reduce the tax liability to the extent of the applicable tax rate. Under Hawaii's tax laws, a reduction in tax liability through a tax deduction would mean, at most, benefits of 11 per cent of the total deduction since Hawaii's top tax rate is 11 per cent. Tax credits are a more direct and effective means of reducing tax liability since they provide a dollar-for-dollar reduction of the tax liability. At the risk of being overly simplistic, the difference between a credit and a deduction is that a person claiming a credit receives 100 per cent of the benefit (assuming that 100 per cent of the premium paid is allowed as a credit) while a person claiming a deduction receives only up to 11 per cent.

At the time of this writing, Colorado was the only state that had enacted a law providing for a tax incentive for long-term care insurance. The Colorado law provides for a tax deduction for any taxpayer paying premiums for long-term care insurance policies in an amount equal to the total premiums spent for policies certified by the insurance commissioner. The law also provides incentives for companies offering the policies by reducing the premium tax rate by one per cent on such policies. The law was approved on April 14, 1986, and became effective on July 1, 1986.[2] (See Appendix C for text of bill.)

In 1985, a Colorado Legislative Council Committee on Medical Cost Containment studied the long-term care problem and concluded that legislation in 1986 would not be necessary except for legislation to establish individual medical accounts (similar to individual retirement accounts).[3] A bill allowing tax deductions for individual medical accounts[4] was enacted, but interestingly, the tax deduction measure for long-term care insurance premiums was also enacted.

In California, a measure which passed the Assembly but died in the Senate during the 1986 session provided for a tax deduction ranging from five to fifty per cent of the total premiums paid on a long-term care insurance policy.[5] (See Appendix D for text of bill.) The percentage of the deduction

decreased with income and was only permitted for those with adjusted gross incomes under $55,000 for single taxpayers or married taxpayers filing separate returns, or under $82,500 for married taxpayers filing joint returns. The language in California's proposed legislation appears to restrict tax deduction claims to one policy whereas Colorado appears to allow deductions from premiums paid on more than one policy.

Tax Credits in Hawaii

Tax credits were first introduced in Hawaii in 1965 as a means to offset the increased tax burden on the low-income taxpayer resulting from the income tax rate increase that same year. Gradually, the Legislature began using tax credits as incentives to promote elderly, energy conservation, and public safety issues.[6] For the 1984 tax year, there were a total of eight different state tax credits available to individual Hawaii residents: (1) Excise Tax Credit; (2) Renter's Tax Credit; (3) General Tax Credit; (4) Household and Dependent Care; (5) Solar Energy Device; (6) Heat Pump; (7) Heater Insulation Tax Credit; and (8) Child Passenger Restraint System.

The excise tax credit provides a means to offset the excise tax on food and consumer goods purchased by the lower-income families. The elderly, because of their fixed incomes are entitled to claim double the excise credit as long as their adjusted gross income is under $20,000. The credit ranges from $8 to $48 and any excess credit over the amount of taxes due is refundable to the taxpayer.[7]

The renter's tax credit also limits the eligibility for the credit to those with adjusted gross incomes under $20,000. Each qualified exemption is allowed a credit of $50 but elderly taxpayers may claim double the credit.[8]

A general tax credit is offered whenever the state general fund closing balance after two successive fiscal years exceeds five per cent of general fund revenues. The legislature determines the amount of credit which may be claimed by all resident taxpayers, regardless of income bracket and any credit in excess of a taxpayer's tax liability is refundable. In 1981, the first year this credit was applied, the credit was $100; in 1984 it was $1.[9]

The household and dependent care expense tax credit allows a claim for expenses of up to $2,400 for one qualifying individual and $4,800 for two or more, for resident taxpayers. There is no income limitation to qualify for this credit but the amount of credit ranges from 15 per cent for the up to $10,000 income bracket to 10 per cent for the $18,001 and over income bracket.[10] Although most of the claims under this credit are for child care expenses, it is possible for a taxpayer to claim for expenses incurred for caring for an impaired elderly person who is qualified as a dependent of that taxpayer under the tax laws.[11] The Tax Department could not provide us with information as to the number of claims made under this credit attributable to elderly dependent care.

The solar or wind energy device and heat pump tax credits were provided by the legislature as incentives to individuals to promote energy conservation devices. The credit allowed, until 1986,[12] is not more than 10

per cent of the total cost of the device, accessories, and installation. Credit in excess of a taxpayer's tax liability is not refundable, but may be used as credit against income liability in subsequent tax years until exhausted. Although the average cost for a solar energy device in 1984 was $3,579 as opposed to $532 for the heat pump, the solar credit was claimed by more taxpayers. The Tax Department surmised that taxpayers were more inclined to purchase solar devices since the federal government also offered a tax credit.[13] The heater insulation credit is up to $30 for cost of insulation.[14]

The child passenger restraint system credit was enacted to promote the use of proper child passenger restraint systems. A blanket credit of $25 is allowed for the purchase of a new child passenger restraint system which meets the requirements of law. Any credit in excess of a taxpayer's tax liability is refundable to the taxpayer.[15]

Of the above credits, only those for energy efficient devices and child passenger restraint systems were intended primarily as incentives to promote certain desired consumer behavior. The Tax Department's study of tax credits shows that in the first year a tax credit is introduced, the number of claims is relatively small and in subsequent years the claims dramatically increase in number, peaking after about three or four years.[16] It cannot be denied that the public today has become more conscious of energy efficient devices and child rider safety. Whether or not the success in achieving those goals can be primarily attributed to the tax credits is debatable. The Tax Review Commission maintains that energy conservation devices are economically justifiable without the tax credits and that the child passenger restraint systems are now required by law so the credit has no impact on the use of car seats.[17]

Pros and Cons of a Tax Credit for Long-Term Care Insurance

Tax provisions targeting the elderly are likely to result in only modest reductions because the number of people in the group is small and those with income tax liability are even smaller. Current federal tax policies providing tax breaks on the basis of age do not ordinarily provide for a payment to the taxpayer of any excess of the taxes due. They only reduce the amount of taxes due to the government. Therefore, tax policies ordinarily have little effect on gross income received; they do not furnish extra income for those who have no tax liability.[18] Any tax modifications which would provide "negative income", i.e., a payment to individuals from whom no tax is due, would substantially increase the number of elderly required to file returns, substantially increasing the administrative complexity and costs of the tax collection system.[19]

Tax credits that are not limited to the elderly, on the other hand, would provide a substantial incentive since they reduce tax liability directly. A tax credit which can be claimed by any taxpayer to encourage the purchase of long-term care insurance policies for a related dependent would probably result in the purchase of more policies by other individuals, such as children, for those elderly who could not afford to purchase a policy for themselves and by the pre-retirement age groups. A tax credit would probably stimulate the interest of consumers in long-term care insurance since

monetary incentives, rather than information dissemination strategies, are often more effective in convincing the consumer to try something new. This is apparent when one examines the promotional efforts on new consumer products entering the market replete with rebate and coupon offers.

Tax incentives only at the state level may not significantly reduce costs of coverage since state tax rates are relatively low compared to the federal tax rates. Moreover, any reduction in state taxes will be offset by an increase in federal taxes, as state taxes paid are deductible on federal tax returns. The impact of this offset, however, will be lessened under the federal Tax Reform Act of 1986 due to lower federal tax rates. For example, a taxpayer in the top federal tax bracket today may pay 50 cents in federal taxes on every dollar of income. In 1988, when the top tax rate will be 28 per cent, that same taxpayer will be paying only 28 cents. Because of such federal tax offsets, it was pointed out in California that direct grants rather than tax benefits might be a better way of encouraging the purchase of long-term care insurance not only because program administrators would have more control over eligibility but because some of the resources would not be diverted to the federal government in taxes.[20]

Some who oppose tax incentives for long-term care insurance premiums believe that such government support is inappropriate since long-term care insurance is institutionally biased and the use of state revenues in this manner would inhibit further progress in noninstitutional program development. Another drawback with the implementation of tax incentives is that there must be minimum standards established to ensure that the policies purchased provide for long-term care. At a time when the field of long-term care insurance is still evolving, minimum standards are difficult to establish. Rigid standards could shut down the market as occurred in Wisconsin[21] or lenient standards could result in consumers purchasing ineffective policies.

The State Department of Taxation and the Tax Foundation of Hawaii oppose the implementation of a tax credit to encourage the purchase of long-term care insurance on the basis that tax preferences should not be used to implement social policy.[22] This position is supported by the report of the Tax Review Commission. The Commission which conducted the first comprehensive review of Hawaii's tax system since the mid-1950's recommended in its 1984 report that the narrow tax preferences in the existing state tax code be eliminated in order to broaden the tax bases and keep tax rates low. The Commission noted that:

> ...There is growing evidence that narrow tax preferences for specific industries or individuals have very little impact on economic behavior. Thus, whatever positive goals may be intended by these preferences the effect is to reduce revenues while doing little to achieve these goals....The Legislature should evaluate these preferences taking into consideration that the primary purpose of a tax system is to equitably collect revenues to run the State. Attempting to promote economic and social goals may be better achieved through direct expenditure programs rather than tax preferences.[23]

The Tax Foundation of Hawaii also noted that a tax credit would amount to a subsidy of the insurance carriers who handle long-term care insurance at the expense of those who do not.[24]

Determining Impact on State Revenues

Although the Bureau provides a revenue impact estimate in the last chapter of this report, the Bureau emphasizes that any revenue impact estimate is, at best, a "guesstimate". It is impossible to assess the impact a tax credit will have on state revenues since there are too many unknown factors. There is no way of predicting how many persons will purchase long-term care insurance policies, how much the premiums will cost, and how much tax liability will be offset by the credit. The experiences of Colorado and California in assessing the fiscal impact of their proposed tax incentive measures were no different.

The Colorado Office of State Planning and Budget, an agency under the Governor's Office which issues fiscal impact notes on proposed legislation, found no fiscal impact on the proposed tax deduction legislation. In arriving at that conclusion, it was noted that there was no measure of the potential number of policies to be sold so the impact on expenditures and revenues was indeterminate.[25] Loss of revenue was not a significant concern with the Colorado Department of Revenue. The Department explained that it did not wish to make a revenue estimate until the Colorado Department of Health had completed its survey on the use of long-term care insurance. The survey results were not available at the time the revenue estimates were made; however, there was a general feeling that the tax deductions authorized under the new law would probably not exceed $200,000 and would not seriously affect revenue collections.[26] As of this writing, Colorado could not furnish any data as to any changes in activity in long-term care insurance sales resulting from the new law.

California, on the other hand, appeared to be concerned about the potential revenue loss. The original version of the proposed tax deduction measure, A.B. No. 4231 called for a deduction ranging from zero to 100 per cent depending on the income brackets. The version which passed the Assembly reduced the percentages to zero to 50 per cent.[27] To obtain a rough estimate of the potential revenue loss, California used a median figure of $1,400 as the annual premium cost and assumed that the major purchasers would be those between the ages of 50 and 65 (3.6 million in California) with an average joint income of $30,000. The result was that the potential loss could be as low as $5 million or as high as $80 million.[28]

Despite the difficulty and uncertainty in estimating revenue losses as a result of a tax credit in Hawaii, most people generally agree that if more people had long-term care insurance, it is more likely than not that the Medicaid program would not have to shoulder such a large financial burden. The investment the state government makes in the form of tax credits today could translate into less sums spent on long-term care in the future. The problem with this kind of savings is that it is not immediate, so on today's ledgers this can only be entered as a loss. If fear of a large revenue loss is of more concern than the objective of getting more people to purchase

insurance, tax credits are flexible in that restrictions can be imposed such as an income qualification or limit on the credit amount allowable.

The Proposed Tax Credit for Long-Term Care Insurance

The tax credit proposal considered during the 1986 legislative session provided for a credit not to exceed two times the amount of the annual premium paid for long-term care insurance. The credit would be claimed against an individual's net income tax liability and any excess credit could be carried over in subsequent years until exhausted. The bill also directed the insurance commissioner to issue rules to establish minimum standards for benefits for policies that would qualify for the tax credit.

The Hospital Association of Hawaii submitted testimony on the proposed bill containing an estimate that the revenue loss would be $1,400,000 based on the purchase of 1,000 policies at an average premium of $700.[29] This loss of revenue would be offset by an increase in premium tax revenue[30] of $28,000 and in savings to the Medicaid program. Using the most conservative estimate of savings to the Medicaid program of $560,000 where only two per cent of the policyholders become claimants, the Association estimated a net revenue loss of only $812,000.

The problem with the Association's estimate is that there is no accurate way of predicting how many policies actually will be sold or how many policyholders who become claimants could or would have sought Medicaid assistance. The use of 1,000 policies sold appears extremely conservative when it is understood that the tax credit will not apply only to the elderly but may also be claimed by children of the elderly who purchase long-term care insurance for their parents or by people in the pre-retirement group. Indeed, it was the intent of the bill's proponents to encourage the children of the elderly to purchase insurance for their parents.[31] Under the proposed bill, a person who pays a $700 premium, could receive a credit of $1,400, in effect earning $700 by purchasing a policy. It is certainly possible that such a generous credit might be claimed by more than 1,000 taxpayers since a person would be getting free insurance and would be paid for it, too. Moreover, it is at least arguable that if many of those who might buy insurance have substantial assets to protect, they may not be potential Medicaid clients even after paying their own bills during a three and one-half-year period which is the average nursing home stay.

A positive feature of the proposed bill was the provision to carry over any credit in excess of the taxpayer's tax liability. This precludes a refund to a person who has no tax liability. If, however, the tax credit is limited only to persons aged 65 and over, this provision might not be appropriate since many retirees have little or no taxable income. The proposal further provided increased incentive to the children of retired persons to purchase long-term care insurance on their parents' behalf.

The Executive Office on Aging testified in favor of the proposed bill, but noted that long-term care insurance should also cover community-based long-term care services since the national trend is to develop more community-based, in-home services.

Chapter 6

CONCLUSIONS AND RECOMMENDATIONS

The importance, from a humane perspective, of developing alternatives to Medicaid to finance long-term care is aptly expressed by William D. Fullerton:

> Older people like all of us, need to feel independent and self-sufficient to maintain happiness. The very need for long-term care services tends to erode those feelings, since the individual, to one extent or another, must depend on others--family, friends, or professionals--to assist him or her with some of the most personal activities--eating, bathing, and toileting, for example. This erosion of spirit can lead to severe depression if people perceive not only that they are now more limited in performing daily tasks, but that they are also losing control over who will make those decisions. I contend that the ability to pay for needed services retains, in the eyes of the individual, the capacity to make one's own decisions (with advice of others, perhaps) about how those needs are to be met. Keeping the individual in control of his or her life should be a paramount goal in all discussions of long-term care issues. (Emphasis in original)[1]

Reliance on the Medicaid program runs contrary to this goal.

The main obstacle to resolving the long-term care financing dilemma is the public attitude that it is a problem with which only the sickly and frail elderly need be concerned. It is this attitude that forestalls meaningful planning for long-term care and compels policymakers to give higher funding priority to other areas which are believed to affect a greater portion of the population. Long-term care is indeed a problem which touches all segments of the population, especially when it is recognized that the children of today will become the elderly of tomorrow and that a large portion of formal long-term care is paid by public funds. With a steadily growing elderly population and increasing competition over limited government resources there is reason for concern by all segments of the population as to how long-term care will be financed in the future. This study examined the concept of using a tax credit for long-term care insurance as one type of incentive to encourage people to provide for themselves rather than relying on government assistance. The Bureau's findings and recommendations are reported below.

Findings

1. Impact and Benefits of Long-Term Care Insurance

As the debate continues inconclusively over whether the elderly of the future will require more institutional or community-based care, it is apparent that a multifaceted approach to planning long-term care services is in order. Long-term care services today are more reflective of available financing mechanisms rather than deliberate planning to provide the best care possible in a cost-efficient manner. There is a basic conflict between the goal of

long-term care which is the achievement of maximum functional independence and the financing of long-term care through Medicaid which fosters dependency. Critics of the current Medicaid system argue that the medically needy coverage further disintegrates familial responsibility by making it easy to obtain financial assistance for institutional care but difficult to obtain assistance for home care. Once a person is institutionalized, there is no incentive for the patient's return to the family home when only custodial care is required because there is no financial relief in this area. It is far easier and less costly to the family to keep the patient institutionalized.

It is estimated that about 80 per cent of the care of frail elderly is being provided at home by families and friends. Government should encourage and enhance, rather than supplant, this tendency. While there is a growing belief among long-term care professionals and the public-at-large that segregated institutional placement is undesirable and that home care is far more effective, noninstitutional care is more difficult to monitor and there is a fear that increased public funding or incentives directed toward home care may result more in broadening the net of coverage rather than diverting persons from institutionalization.

With the high and continually rising cost of institutional care, it is evident that more government attention must be directed toward the development of cost-efficient community-based care and incentives to use such community-based care. Government commitment to community-based care, thus far, has been tentative with funding primarily for a few demonstration projects. The development of viable, cost-effective community-based services remains an objective yet to be fully achieved. As demonstration projects become successful in diverting clients from institutional care, the approaches to developing financing mechanisms will no doubt change.

Until substantial progress is made in establishing noninstitutional community-based long-term care programs which will successfully divert large numbers of elderly from long-term care institutions at less cost, we must still wrestle with the problems of financing institutional care. Long-term care insurance, while not a panacea, offers a viable and immediate alternative to dependency on Medicaid for institutional coverage. It provides an opportunity for people to control their destinies by planning for their fragile retirement years and to prevent the unecessary depletion of personal and family resources. In its present state, long-term care insurance is institutionally biased, however, and is viewed by some as a hinderance to the development of community-based care programs. Nevertheless, there will continue to be a portion of the elderly population requiring institutional care and something must be done to alleviate the burden of this State in financing a large portion of institutional long-term care.

Although the long-term care insurance field is still evolving, it is more established than other alternative mechanisms being seriously considered. The social health maintenance organization concept, a mechanism for which many professionals in the field have great expectations, is still experimental and its wide applicability is still in question. The individual medical account concept which is an offshoot of the individual retirement account has not been adopted by many states and is not as immediately beneficial to the elderly since it takes a number of years to build up an account substantial enough to

cover long-term care costs whether community-based or institutional. Moreover, without comparable federal legislation, savings deposited in an individual medical account and interest earned on such savings are taxable at the federal level. In view of the new federal tax reform law, it is unlikely that legislation to provide tax incentives for individual medical accounts will be enacted in the near future.

It is undisputed that long-term care insurance can play an important role in the financing of long-term care in Hawaii. What has been in dispute is what role, if any, should government take in promoting long-term care insurance. As early as 1984, the State recognized that long-term care insurance would have a positive impact on the State's Medicaid budget and should, therefore, be encouraged.[2] Yet, since the report in 1984, beyond the lectures to elderly groups funded under the auspices of the Executive Office on Aging, the State has done very little toward such encouragement. There is an abundance of rhetoric about Medicaid's disproportionate share of long-term care costs, but little has been done to remedy the problem. State government agencies involved in long-term care for the elderly have been so immersed in the daily operational problems of their respective service delivery programs that they have not had the time, nor acquired the capability, of addressing the more systemic problems causing Medicaid's disproportionate share of nursing home costs. Until this is done, the State will not be in any position to effectively resolve the long-term care financing problem. Hopefully, the long-term care plan for the elderly being developed by the Executive Office on Aging through its Policy Advisory Board for Elderly Affairs Long-term Care Task Force will lay the necessary foundation for an appropriate and coordinated course of action by state government.[3]

While it is true that private industry has the responsibility for the actual marketing of policies, the State is duty-bound to establish policy regarding the State's role in the financing of long-term care for the elderly and to provide direction for both the public and private sectors in developing programs in accord with its policy. The State will be faced with a larger financial burden in the Medicaid program with increased dependency on Medicaid as long as no viable alternative exists. It cannot stand by idly until the private sector resolves the problem. The State can and must take positive action in communicating to the public the need for individuals to assume responsibility for their destinies by early planning for future long-term care needs to prevent unnecessary self-impoverishment and demeaning reliance on Medicaid. The State also has a duty to monitor the insurance industry to protect consumers from purchasing unnecessary and ineffective policies in the same way government intervened in the sale of Medicare supplement insurance.

2. Impact and Benefits of a Tax Credit

Judging from the history of tax credits implemented in Hawaii, it is probable that any revenue loss from a tax credit in the first year of its availability may be negligible since it may take a while before the general public is aware of the credit. Revenue losses in ensuing years are more difficult to estimate because there is no way of predicting how many persons will purchase long-term insurance policies, but the loss should be expected to increase with each successive year since the number of tax credit claims will

be cumulative each year. Although the impact of a tax credit on the Medicaid budget cannot be accurately estimated, it can be assumed that future savings in the Medicaid program will be realized if more people are encouraged to purchase long-term care insurance. ICF Incorporated estimated that if 20 per cent of the 65 to 69 age group purchased long-term care insurance, total cumulative Medicaid expenditures would decline about eight per cent. This estimate was based on a policy which paid up to $40 a day for four years of nursing home care with a premium cost of $480. ICF Incorporated noted that greater savings would result as more elderly purchased insurance.[4] Some proponents of long-term care insurance believe that disincentives must be created to preclude the middle class from using Medicaid. Should the Medicaid eligibility standards and asset transfer provisions become more stringent, there would probably be an increase in the demand for long-term care insurance.

The Bureau could not determine the impact of a tax credit on the County/State Hospitals Division of the Department of Health. The Division is experiencing problems under the prospective payment system since Medicaid reimbursement does not cover the costs of the Division and over 90 per cent of its patients are Medicaid assisted. The Division's budget is funded primarily through fees collected with only 15 per cent of its revenues from state general fund appropriations. The Bureau is of the opinion that long-term care insurance could affect the Division's problems at a later date if there is a substantial decrease in Medicaid patients or if savings from the Medicaid program is translated into increased general fund appropriations to the Division.

A tax credit could benefit the elderly in all income levels. For those elderly who have tax liability, a tax credit would directly offset some of that liability. For those elderly who do not have tax liability and who might find long-term care insurance too expensive, a tax credit which is not limited to insureds could serve as an incentive to their children to purchase insurance policies for them. Although a tax credit would mean revenue loss, some of the revenue loss to some extent may be offset by the additional collections in premium taxes on long-term care policies sold.

A tax credit for the purchase of long-term care insurance may be a desirable way of raising the consciousness of the public to the long-term care issue in the same manner the environmental consciousness was raised by the tax credits for energy efficient devices; however, it is not by any means the only way for the State to encourage the purchase of long-term care insurance. The Bureau believes that a well-developed informational program on long-term care financing options directed to the general public can be equally effective. Irrespective of what method is used to increase consumer awareness, state moneys must be involved. It is for the Legislature to decide whether such involvement should be through a reduction of tax collections by the offering of tax incentives, through increased direct program appropriations, or both.

Recommendations

1. Whether or not a tax credit is enacted, the State must assume a more active role in consumer education. People will not buy long-term care insurance unless they understand that planning for long-term care needs is no different from planning for a happy and healthy retirement. It must begin at an early age, deliberately planned, and timed so that the appropriate amount of money is available when the need arises. Individuals must be informed of all possible private financing options in order to decide which financing mechanism is appropriate for their personal concerns and what they perceive their needs to be. If insurance is the mechanism chosen, an individual must understand what long-term care is and what the different insurance policies offer before that individual will know which policy is most suitable.

The Legislature should appropriate funds and designate the Executive Office on Aging as the lead and coordinating agency to develop a plan for a comprehensive public educational program on long-term care for the elderly. The program should include such activities as the publication and dissemination of informational materials on long-term care and the conduct of a series of group lectures or even public television programs. Information should include cautions about the limitations of the Medicare and Medicaid programs and Medicare supplement insurance policies in providing for long-term care; the importance of early planning; and the financing options that are currently available in Hawaii, not only long-term care insurance. A separate consumer guide on long-term care insurance, similar to the one proposed by the National Association of Insurance Commissioners, should be published in conjunction with the Insurance Division and distributed to the general public in the same manner brochures are disseminated on no-fault insurance. (See Appendix E for the proposed guide.)

All public information efforts should be directed not only to the 65 years of age and over group but should include the general public. The current lecture series sponsored by the Executive Office on Aging has been targeting organized elderly groups such as the senior citizen centers; however, the senior centers represent only a small segment of the elderly population. If early planning is to be emphasized all elderly persons must be reached. Other appropriate audiences are the pre-retirement groups where the people might already be concerned about the health of their parents and are ready to start thinking about their own future needs.

2. If the Legislature decides to implement a tax credit, it should be done in conjunction with the enactment of a law, like the model law of the National Association of Insurance Commissioners (see Appendix F), which establishes guidelines for the sale of long-term care policies. Without appropriate guidelines, consumers could be misled into purchasing ineffective and unnecessary policies in the same way consumers were in purchasing Medicare supplement policies before they were regulated. There is a paucity of data from which individual states can make informed decisions as to the appropriate regulatory limits. The National Association of Insurance Commissioners reported that numerous studies were underway but most data sets would not be available until the end of this year or during 1987. There

is a danger that too restrictive minimum guidelines could inhibit market growth and too liberal guidelines will work against the consumer's interest.

The Bureau believes that if a tax credit is implemented, it should not exceed 50 per cent of the amount of premium paid. A taxpayer should be allowed to claim the tax credit for more than one policy to allow for the purchase of policies by adult children for their elderly parents. There should be a dollar ceiling for the credit claimed for each qualifying policy which represents, perhaps, 50 per cent of the average premium for a policy that meets the minimum guidelines established by the insurance commissioner. There should also be a dollar ceiling on the total amount of credit a taxpayer can claim, e.g., $1,000. In this way, those who can afford the more expensive policies will not be unduly enriched by the credit. Finally, excess credit should be allowed to carry over into the next tax year. The tax credit statute should be enacted only for a short term, such as five years. The Bureau further recommends an income limitation with a declining percentage of credit if the tax credit is 50 per cent in order to provide greater incentive to those who can least afford the insurance. In this way, the loss of revenue would be coordinated with tax benefits to a larger number of taxpayers. The Bureau's revenue impact estimates based on 10 per cent, 25 per cent, and 50 per cent can be found in Exhibit 4. The Department of Taxation believed that the Bureau's estimates of the impact on revenues were too low and the Department's estimates can be found in Exhibit 5.

The determination of eligible policies should rest with the Insurance Commissioner. Certain basic minimum requirements are necessary, however, to provide guidance to the Commissioner. The model legislation of the National Association of Insurance Commissioners provides for the adoption of rules by the Insurance Commissioner to establish disclosure and performance standards for long-term care insurance policies. It also imposes certain restrictions on the policy contents and requirements for disclosure. The enactment of this model law should provide the Insurance Commissioner with sufficient guidance and support to review insurance policies and ascertain whether or not a policy qualifies as a long-term care insurance policy.

At this time, the Bureau does not recommend that policies be required to cover community-based services that are not medically necessary, such as personal care, in order to qualify for a tax credit. Existing long-term care insurance policies do not provide such coverage. Such a requirement would eliminate most of the current policies available thereby defeating the purpose of the credit. If and when insurers can offer coverage for community-based care at reasonable premium rates, then it would be appropriate to require long-term insurance to provide such coverage.

3. The Bureau reiterates that long-term care insurance, in its present form, is a financing mechanism primarily aimed at relieving the cost burden of institutional care. Accordingly, a tax incentive for premiums paid for such insurance is just one method of possibly alleviating the Medicaid burden. Increased community-based care is another way of lowering the cost to Medicaid if it diverts people from institutional care and provides comparable care at less cost. Rather than requiring insurers to provide coverage for community-based long-term care, attention should be directed to the consideration of tax incentives to families who care for their frail elderly at

home. The Bureau did not examine this concept since it was beyond the scope of this study; however, it is recommended that a study be conducted, perhaps by the Executive Office on Aging, on this and other incentives if the encouragement of increased use of community-based care is a priority to the Legislature.

EXHIBIT 4

Estimates of Revenue Impact

The Bureau made revenue impact estimates using three different tax credit amounts of the total premiums paid: 10 per cent, 25 per cent, and 50 per cent. These estimates were based on the assumptions that the average premium would be $1,000 and that there would be about 2,000 policies eligible for the tax credit (in 1986 there were over 400 policies in effect and it is projected that sales will double over the next year). The amount collected from premium taxes is subtracted from the revenue loss from tax credits claimed for the net revenue loss. The tax rate of .043 for foreign and alien insurers is applied here since there are no domestic insurers presently offering long-term care insurance.

The Bureau is wary about any estimate of the impact on the Medicaid budget because there is no way to predict how many of those purchasing long-term care insurance would require long-term care and, of those, how many would have turned to Medicaid in the absence of such insurance coverage. Moreover, any savings would probably not occur in the same year that a tax credit is implemented since it may be some time before new policyholders become frail and debilitated. The Bureau, however, has ventured a guess based on an analysis made by ICF Incorporated. ICF Incorporated calculated that if 20 per cent of the 65 to 69 age group purchased long-term care insurance, total cumulative Medicaid expenditures would decline about eight per cent. The Bureau speculates that there could be a savings of about $3,243,514 to the Medicaid budget in future years if 7,200 policies for the 65 to 69 age group are in effect. This figure is based on the Department of Planning and Economic Development's 1985 population estimate of 36,000 persons in the 65 to 69 age group and the $40,543,925 of the Medicaid budget spent on nursing home care in 1986. As more policies are purchased there could be increased savings each year. ICF Incorporated's estimate was based on an insurance policy that paid up to $40 a day for four years of nursing home care. Although the Bureau has been using, in its calculations, a policy which pays $100 a day, the eight per cent used by ICF Incorporated provides a reasonable estimate since the Health Care Administration Division informed the Bureau that Hawaii's nursing home rates are twice the national average.

Caution is advised in using these estimates. The Bureau reiterates that revenue impact projections are not solid since the number of policies, the premium rates, and the savings to the Medicaid program are indeterminate.

Revenue Loss From Tax Credits

1. $1,000 X .10 = $100 (tax credit); 2,000 X $100 = $200,000 (revenue loss)

2. $1,000 X .25 = $250 (tax credit); 2,000 x $250 = $500,000 (revenue loss)

3. $1,000 X .50 = $500 (tax credit); 2,000 X $500 = $1,000,000 (revenue loss)

Revenues Gained From Insurance Tax Collections

$1,000 X 2,000 = $2,000,000 (total premiums)

$2,000,000 X .043 (tax) = $86,000

Net Revenue Loss

1. 10 per cent credit: $200,000 - $86,000 = $114,000
2. 25 per cent credit: $500,000 - $86,000 = $414,000
3. 50 per cent credit: $1,000,000 - $86,000 = $914,000

Medicaid Budget Savings:

Medicaid expenditures in fiscal year 1986 for nursing home reimbursements = $40,543,925 X .08 = $3,243,514 - estimated future savings if 7,200 policies are in effect. Being that the State/Federal share on Medicaid funding in Hawaii has been about 60/40, the savings to be realized in general funds would be about $1,946,108.

Exhibit 5

December 19, 1986

TO: Lawrence Nakano
Income Technical Officer

FROM: Robert Koike
Tax Research & Planning Officer

SUBJECT: Revenue Impact of Tax Credit for Long-Term Care Insurance

In its confidential draft report "Assuring Dignity in Long-Term Care for the Elderly," the Legislative Reference Bureau (LRB) has made estimates of the net tax revenue impact of a tax credit for premiums paid for long-term care insurance. Based on assumptions that 1) the average annual premium would be $1,000, 2) tax revenue on the premiums would be 4.3% of the premium amounts, and 3) 2,000 taxpayers would take advantage of the credit, LRB projects a net revenue loss of $114,000 for a 10% credit, $414,000 for a 25% credit, and $914,000 for a 50% credit.

We agree with all of LRB's assumptions except the one which projects only 2,000 claimants for the credit. Once the public becomes fully aware of the possible disastrous consequences of not having long-term care insurance, many would purchase it on its insurance merit alone. Only those with very little income would not need to purchase it since they would be covered by Medicaid. As a conservative estimate of those who would need long-term care insurance, we are taking those taxpayers who claim an age exemption and whose AGI is $5,000 and above. For the tax year 1984, 31,152 returns fell in this category. Of course, this total does not include older persons under 65 who would have need for the long-term care insurance. Using the LRB's assumptions, we project revenue impact as follows:

$1,000 per premium x 31,152 = $31,152,000 total premiums

10% credit = $ 3,115,200
25% credit = $ 7,788,000
50% credit = $15,576,000

Revenue gain from insurance premium tax at 4.3%

$31,152,000 x .043 = $1,339,536

Net revenue loss

10% credit: $ 3,115,200 - $1,339,536 = $ 1,775,664
25% credit: $ 7,788,000 - $1,339,536 = $ 6,448,464
50% credit: $15,576,000 - $1,339,536 = $14,236,464

It can be argued that not everyone who needs insurance to prevent economic disaster would purchase it. To obtain an even more conservative estimate of revenue impact, we attempted to estimate the number of taxpayers who would purchase long-term care insurance for its tax credit benefit. We applied the percentage of taxpayers who invested in IRAs in 1984 to the number of 1984 returns with age exemptions (see Table 1).

Table 1: 1984 Resident Returns

		Number of Returns	Returns With IRA	% With IRA	Returns With Age Exemption	Returns With Ins. Credit
	Under $ 1	30,406	329	1.1	8,654	95
$ 1	" 5,000	95,188	1,118	1.2	21,614	259
5,000	" 10,000	63,129	3,428	5.4	11,540	623
10,000	" 20,000	93,433	14,160	15.2	11,517	1,751
20,000	" 30,000	53,823	13,860	25.7	3,915	1,006
30,000	" 40,000	36,886	13,295	36.0	1,397	503
40,000	" 50,000	24,098	10,712	44.4	1,080	480
50,000	" 75,000	19,757	10,688	54.1	871	471
75,000	" 100,000	3,190	2,227	69.8	227	158
100,000	and over	2,335	1,578	67.6	605	409
					TOTAL	5,755

This procedure, which assumes that taxpayers 65 or over would "invest" in long-term care insurance at the same rate that they invested in IRAs yielded 5,755 projected claimants for the insurance credit.

Using this total and LRB's other assumptions, we project a conservative revenue impact as follows:

$1,000 per premium x 5,755 = $5,755,000 total premiums

10% credit = $ 575,500
25% credit = $1,438,750
50% credit = $2,877,500

Revenue gain from insurance premium tax at 4.3%

$5,755,000 x .043 = $247,465

Net revenue loss

10% credit: $ 575,500 - $247,465 = $ 328,035
25% credit: $1,438,750 - $247,465 = $1,191,285
50% credit: $2,877,500 - $247,465 = $2,630,035

In any case, we believe that the LRB estimate of 2,000 policies is too low. With our estimate of anywhere from 5,755 to over 31,000 policies, revenue loss would be as much as 15 times the LRB estimate.

RK:ltv

FOOTNOTES

Chapter 1

1. "Modern Horror Story", Honolulu Star-Bulletin, June 27, 1986, p. A-14.

2. Cyril F. Brickfield, "Long Term Care Financing Solutions Are Needed Now", American Health Care Association Journal, October 1985, p. 14.

3. Anne Somers, "Long-term Care for the Elderly and Disabled: An Urgent Challenge to New Federalism", New Federalism and Long-term Health Care of the Elderly, ed. Burton D. Dunlop, Center for Health Affairs, Project HOPE (Milwood: 1984), p. 50.

4. Louis H. Butler and Paul W. Newacheck, "Health and Social Factors Relevant to Long-term Care Policy", Policy Options in Long-term Care, ed. Judith Meltzer, Frank Farrow, & Harold Richman (Chicago: University of Chicago Press, 1981), p. 38.

5. Ibid., p. 40.

6. Rosalie A. Kane and Robert L. Kane, "Long-term Care: A Field in Search of Values", Values and Long-term Care, edited by Rosalie A. Kane and Robert L. Kane (Lexington: Lexington Books, 1982), p. 7.

7. "Spending for Health Care in 1985 Rose at Lowest Rate in 2 Decades", The New York Times, July 30, 1986, p. B9.

8. In the last several years the Reagan Administration has proposed capping the Medicaid budget at the 1984 spending level with increases or decreases tied to fluctuations in the consumer price index. "Long-term Health Care Financing", CSG Backgrounder, May 1986, p. 4.

9. The House of Representatives also adopted House Resolution No. 74 during the 1986 Regular Session which called for a joint study of Hawaii's long-term care system by the Department of Health, the Department of Social Services and Housing, and the Executive Office on Aging. The study is to encompass (1) a statewide definition and philosophy toward long-term care; (2) the organization and delivery of institutional and community-based services in long-term care; (3) resources allocation mechanisms that affect the long-term care system; and (4) a framework and planning process for a comprehensive plan in long-term care. A report is to be submitted to the Legislature prior to the convening of the 1987 Regular Session.

10. Telephone conversation with Representative Reynaldo Graulty, June 6, 1986.

Chapter 2

1. Charlene Harrington and James H. Swan, "Institutional Long-term Care Services, Long Term Care of the Elderly: Public Policy Issues, ed. Charlene Harrington, Robert J. Newcomer, Carroll L. Estes and Associates (Beverly Hills: Sage Publications, 1985), p. 153.

2. Hawaii Rev. Stat., sec. 321-11(10).

3. Hawaii Rev. Stat., ch. 457B.

4. Hawaii Rev. Stat., secs. 323D-12, 323D-42 to 323D-55.

5. Hawaii, State Health Planning and Development Agency, Health Services and Facilities Plan for the State of Hawaii, 1986 (Honolulu: 1986), p. 8.32, (hereinafter Health Services and Facilities Plan).

6. Health Services and Facilities Plan, pp. 8.19-8.20.

7. Ibid.

8. Results of telephone surveys by the Hawaii Long Term Care Association and the Hospital Association of Hawaii taken during October and November, 1986. The Hawaii Long Term Care Association polled its 17 members and received responses from 16. The Hospital Association of Hawaii polled its four largest and long-standing facilities. The polls were informal and were intended to obtain a general pictnre of the breakdown of payment sources for institutional long-term care in Hawaii. Although the results may not be very accurate, they confirm claims that the percentage of Medicaid's share for nursing home costs in Hawaii is a lot higher than the national percentage of 41.8 per cent as was reported in Chapter 1 of this report.

9. Hawaii Rev. Stat., sec. 321-11(10).

10. Hawaii, Executive Office on Aging, Ola Na Iwi, Aging With Care: A Long-term Care Report (Honolnlu: 1983), pp. 14-15.

11. The Nursing Home Without Walls Program accepts individuals at the skilled nursing and intermediate care levels. Many recipients live with family and other caregivers who participate in the planning and provision of care (15 per cent live alone). Care management services are provided by a nurse and social worker who work closely with the recipient, family, caregivers, personal physician, and other interested parties. Services provided include: day health, emergency alarm response systems, environmental modifications, respiratory services, training for the visually impaired, home maintenance, homemaker services, home-delivered meals, moving assistance, nutritional counseling, personal care, respite care, skilled nursing, and transportation assistance. The program provides care at costs 50 per cent to 60 per cent of that of institutional care. The law prohibits costs exceeding 75 per cent of instititional care.

    The Queen's Community Care Program provides foster care to frail elderly at the intermediate care level as an alternative to nursing home care. Elderly residents and their foster

families receive case management services by nurses and social workers. Foster families provide the personal care and homemaker services to recipients and respite for each other. Care provided by this program is less than one-third of comparable institutional care. Foregoing information from brochure entitled "Community Long Term Care" published by the Community Long Term Care Services Office, Hawaii, Department of Social Services and Housing, undated.

12. Omnibus Budget Reconciliation Act of 1981, Section 2176, 95 Stat. 812 (1981).

13. Hawaii, Department of Social Services and Housing, Third Annual Report of the Nursing Home Without Walls Demonstration Project (Honolulu: 1986), p. 42.

14. 1985 Haw. Sess. Laws, Act 207.

15. U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations, Report to Congress: Studies Evaluating Medicaid Home and Community-based Care Waivers (Washington, D.C.: 1984), pp. 1-2.

16. Health Services and Facilities Plan, pp. 8.14-8.17.

17. Ibid.

18. Dorothy P. Price, "Health Care Needs of the Elderly", Long Term Care of the Elderly: Public Policy Issues, ed. Charlene Harrington, Robert J. Newcomer, Carroll L. Estes and Associates (Beverly Hills: Sage Publications, 1985), p. 50.

19. "Why We Are Aging Differently", Newsweek, October 20, 1986, p. 61.

20. Health Services and Facilities Plan, pp. 8-10.

21. Hawaii, Department of Planning and Economic Development, The State of Hawaii Data Book, 1985: A Statistical Abstract, Table 19, p. 39; and The State of Hawaii Data Book, 1984, Table 22, p. 44.

22. Eleanor C. Nordyke, Richard K. C. Lee, and Robert W. Gardner, A Profile of Hawaii's Elderly Population, Papers of the East-West Population Institute, No. 91 (Honolulu: 1984), p. 8 note.

23. Ibid., pp. 12, 33-34.

24. Hawaii, Executive Office on Aging, Characteristics of the Elderly Population: A Resource Document for State and Area Agencies on Aging, Vol. III, p. 1.

25. Hawaii, Executive Office on Aging, The Elderly in Hawaii, A Data Digest, Table 98, p. 134.

26. Hawaii, Department of Taxation, Hawaii Income Patterns, 1984, p. 25.

Chapter 3

1. Hawaii, Statewide Health Planning and Development Agency, Health Services and Facilities Plan for the State of Hawaii, 1986 (Honolulu: 1986) p. 8.31.

2. Results of telephone surveys taken by the Hawaii Long Term Care Association and the Hospital Association of Hawaii. See footnote 8 in Chapter 2.

3. U.S. Department of Health and Human Services, Health Care Financing Administration, Guide to Health Insurance for People with Medicare-1986, Pub. No. HCFA 02110, P. 15. (hereinafter Guide to Health Insurance). The amount will be increased to $17.90 in 1987.

4. U.S. Health Care Financing Administration, Office of Research and Demonstrations, The Medicare and Medicaid Data Book, 1983 HCFA Pub. No. 03156 (Baltimore: 1983), pp. 1-2, (hereinafter The Medicare and Medicaid Data Book).

5. Ibid., and Guide to Health Insurance, p. 15.

6. A. Fleming, "Reflections on the Distribution of Federal and State Responsibility", New Federalism and Long-term Health Care of the Elderly, ed. Burton D. Dunlop, Center for Health Affairs, Project HOPE (Milwood: 1984), p. 111.

7. Cyril F. Brickfield, "Long Term Care Financing Solutions are Needed Now", American Health Care Association Journal, October 1985, p. 14.

8. Guide to Health Insurance, pp. 10-11.

9. U.S., Health Care Financing Administration, "Medicare: Use of Skilled Nursing Facilities, 1976-1977", Health Care Financing Notes, p. 1.

10. The Medicare and Medicaid Data Book, Table 2.12, p. 38.

11. Carroll L. Estes and Philip R. Lee, "Social, Political, and Economic Background of Long Term Care Policy", Long Term Care of the Elderly: Public Policy Issues, ed. Charlene Harrington, Robert J. Newcomer, Carroll L. Estes and Associates (Beverly Hills: Sage Publications, 1985), p. 27.

12. Results of telephone surveys taken by the Hawaii Long Term Care Association and the Hospital Association of Hawaii during October and November, 1986. See footnote 8 of Chapter 2. As there is no clear definition of "average length of stay" the data collected from these surveys should be considered "soft".

13. Covered home health services include skilled nursing care; physical, occupational, or speech therapy; part-time or intermittent services of a home health aide; medical supplies; medical appliances; and certain intern or resident services. Services must be furnished by an

approved home health agency. The Medicare and Medicaid Data Book, p. 59.

14. Estes and Lee, p. 27.

15. Lucien Wilson, "Adopting a Medically Needy Program", Clearinghouse Review, Vol. 18, No. 8, December 1984, p. 844.

16. Medicaid covers the following services for the medically needy: inpatient hospital services other than those provided in institutions for mental disease; outpatient hospital services with certain limits on psychiatric services; rural health clinic services and other ambulatory services furnished by a rural health clinic; other laboratory and x-ray services; skilled nursing facility services (other than services in an institution for mental diseases) for persons 21 years or older (authorization by department's medical consultant required for level of care and admission to a skilled nursing facility); early and periodic screening and diagnosis of individuals under 21 years, and treatment; family planning services and supplies for individuals of child-bearing age; physician's services whether furnished in office, patient's home, hospital, skilled nursing facility, or elsewhere (limited to two visits a month for patients in skilled nursing/intermediate care for acute episodes); medical care and any other type of medical care recognized by state law furnished by licensed practitioners within the scope of practice under state law, including, services by podiatrists, optometrists, psychologists; home health services, such as, (1) intermittent or part-time nursing service provided by a home health agency or a registered nurse when no agency in area, (2) home health aide services provided by a home health agency, (3) medical supplies, equipment and applicances suitable for home use, (4) physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility; clinic services with some limitations for outpatient hospital services; dental services with limits; physical therapy and related services (occupational therapy, speech, hearing, and language disorders) with limitations; prescribed drugs and prosthetic devices and eyeglasses with limitations; other diagnostic, screening, preventive, and rehabilitative services; intermediate care facility services (other than for institutions for tuberculosis or mental diseases) for persons in need of care in accord with section 1902(a)(31)(A) of Act (authorization by department's medical consultant for recommended level of care required); other medical care and remedial care recognized under state law, specified by the Secretary, i.e., transportation, skilled nursing facility for 21 years and under patients, emergency hospital services, personal care in patient's home, prescribed in accord with plan of treatment and furnished by a qualified person under supervision of a registered nurse (recipient requires intermediate care and must live in own home). Hawaii, Department of Social Services and Housing, State Plan for Medical Assistance Programs, Title XIX, Social Security Act, Attachment 3.1-B and Supplement to Attachment 3.1A and 3.1B.

17. Hawaii, Department of Social Services and Housing, Long-Term Care Prospective Payment System Policy Documents, prepared by Compass Consulting Group, Inc., January 1985, Chapter V, p. 4.

18. Hawaii, Department of Health, County/State Hospitals Division, unpublished and undated report describing System, p. 1.

19. Interview with Earl Motooka, Assistant Administrator, Health Care Administration Division, Department of Social Services and Housing, August 19, 1986.

20. The Medicare and Medicaid Data Book, pp. 2, 75.

21. Information obtained from the Hawaii Medical Service Association with permission from the Health Care Administration Division of the Department of Social Services and Housing, preliminary draft of the Medicaid Report for the State of Hawaii, July 1, 1985 to June 30, 1986, Exhibit IV-2.

22. Ibid., Exhibit V-1.

23. Ibid.

24. Ibid.

25. Ibid., Exhibit V-2. It must be noted that in addition to the $172,600,527 in expenditures reported by the Hawaii Medical Services Association in the Medicaid Report, there is an additional $7 million in Medicaid dollars which is processed by the Department of Social Services and Housing. Thus, the actual total Medicaid budget is about $180 million. The $7 million in expenditures are for payments which cover payments for Medicare Part B insurance; for institution utilization reviews; medical transportation such as handivans; waiver programs such as the Nursing Home Without Walls; biodyne center (federally funded project offering psychological intervention to preclude dependency and necessary medical treatment); indigent burial; Kaiser Health Maintenance Organization for the categorically needy and home health. If the $180 million is used to calculate the percentage, it would be about 38 per cent.

26. Information on the finer details of the expenditure for nursing homes reported in the Medicaid Report was furnished to the Bureau by the Health Care Administration Division on October 7, 1986. The information however, was preliminary so the total expenditures are not the same. In view of the difficulty the Bureau encountered in obtaining the finer details and the toal expenditures at the same time, the figures reported herein must suffice to provide a general picture of expenditures attributable to the medically needy aged. Since the total

nursing home expenditure amount in the Medicaid Report was $68,992,300 and the total amount in the finer detail report was $56,423,597, the Bureau has assumed that the amount in the finer detail report was incomplete and that the percentage of the medically needy for nursing home expenditures should be in the same ballpark.

27. Ibid.

28. Ibid.

29. Penny Bjornstad, "Tax Benefits for Long-term Care of the Elderly: The Idaho Experience", Long-Term Care Fiuancing and Delivery Systems: Exploring Some Alternatives (Washington, D.C.: 1984), p. 103.

30. Interview with Earl Motooka, Assistant Administrator, Health Care Administration Division, Department of Social Services and Housing, August 19, 1986; and Public Welfare Rules Manual §17-744-29.

31. B. C. Vladeck, Unloving Care: The Nursing Home Tragedy (New York: Basic Books, 1980), p. 24, cited in Anne Somers, "Long-term Care for the Elderly and Disabled: An Urgent Challenge to New Federalism", New Federalism and Long-Term Health Care of the Elderly, ed. Burton D. Dunlop, Center for Health Affairs, Project HOPE (Millwood: 1984), p. 51.

32. Interview with Earl Motooka, Assistant Administrator, Health Care Administration Division, Department of Social Services and Housing, August 19, 1986.

33. The law concerning the transfer of assets provides that resources owned by an individual or eligible spouse within the preceding 24 months shall be included in determining the resources of the individual if the resource or interest was given away or sold at less than fair market value for the purpose of establishing eligibility. Any transaction so described shall be presumed to have been for the purpose of establishing eligibility unless the individual or eligible spouse furnishes convincing evidence ro establish that the transaction was exclusively for some other purpose. 42 U.S.C.A., sec. 1382b(c) and sec. 1396p.

Hawaii's Medicaid rules hold a person ineligible for benefits if the person possesses resources exceeding the maximum allowed for a period of 24 months from the point of transfer or disposal of assets for less than fair market value. Hawaii, Department of Social Services and Housing, State Plan for Medical Assistance Programs, Title XIX, Social Security Act, Supplement 9 to Attachment 2.6-A, p. 7.

34. Rosalie A. Kane and Robert L. Kane, "Long-Term Care: A Field in Search of Values", Values and Long-Term Care, ed. Robert L. Kane and Rosalie A. Kane (Lexington: Lexington Books, 1982), p. 15.

35. Ibid., p. 18.

36. SRI International, Increasing Private Financing of Long-Term Care: Opportunities for Collaborative Action, Conference Report (Menlo Park: 1986), pp. 11-12.

37. Ibid., pp. 15-16.

38. HB 1102, Colorado General Assembly, Approved May 23, 1986.

Chapter 4

1. Hawaii Rev. Stat., sec. 431-772(3) reads as follows:

> (3) "Medicare supplement policy" means a group or individual policy of disability insurance or a group contract or individual subscriber contract of a nonprofit medical indemnity or hospital service association which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare by reason of age. The term does not include:
>
> (A) A policy or conrract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organization; or
>
> (B) A policy or contract of any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such association:
>
> (i) Is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation;
>
> (ii) Has been maintained in good faith for purposes other than obtaining insurance; and
>
> (iii) Has been in existence for at least two years prior to the date of its initial offering of such policy or plan to its members;
>
> (C) An individual policy or contract issued either pursuant to a conversion privilege under a policy or

contract of a group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of sections 431-772 to 431-779 or rule adopted thereunder, or issued to employees or members as additions to franchise plans in existence on the effective date of the applicable rule;

2. "Health Insurance for Elderly: A New Option", The New York Times, September 27, 1986, p. 56.

3. Memorandum from the American Health Care Association to State Executives, dated April 25, 1986.

4. P.L. 99-272. Section 9601, of the Consolidated Omnibus Budget Reconciliation Act of 1985 reads as follows:

Subtitle C--Task Force on Long-Term Health Care Policies

Sec. 9601. RECOMMENDATIONS FOR LONG-TERM HEALTH CARE POLICIES.

(a) Establishment of Task Force. (1) The Secretary of Health and Human Services (hereinafter in this section referred to as the "Secretary") shall establish a Task Force on Long-Term Health Care Policies (hereinafter in this section referred to as the "Task Force"). The Task Force shall be established not later than 60 days after the date of the enactment of this Act and in consultation with the National Association of Insurance Commissioners.

(b) Composition of Task Force.--The Task Force shall be composed of 18 members, which shall include--

(1) two members representing the National Association of Insurance Commissioners,

(2) three members representing Federal and State agencies with responsibilities relating to health or the elderly,

(3) three members representing private insurers,

(4) three members from organizations representing consumers or the elderly,

(5) three members from organizations representing providers of long-term health care services.

The Secretary shall designate a member of the Task Force as chair.

(c) Development of Recommendations.--The Task Force shall develop recommendation for long-term health care policies, including recommendations designed--

(1) to limit marketing and agent abuse for those poilcies,

(2) to assure the dissemination of such information to consumers as is necessary to permit informed choice in purchasing the policies and to reduce the purchase of unnecessary or duplicative coverage,

(3) to assure that benefits provided under the policies are reasonable in relationship to premiums charged, and

(4) to promote the development and availability of long-term health care policies which meet these recommendations.

(d) Report.--Not later than 18 months after the date of the enactment of this Act, the Task Force shall report to the Secretary, to the Committee on Energy and Commerce of the House of Representatives and to the Committee on Labor and Human Resources of the Senate respecting--

(1) the recommendations developed under subsection (c), including an explanation of the reasons for their selection, and

(2) such recommendations for additional activities respecting long-term health care policies as the Task Force finds appropriate.

The Secretary, in cooperation with the National Association of Insurance Commissioners, shall provide for the dissemination of the report to each of the States.

(e) Termination of Task Force.--The Task Force shall terminate 90 days after the date of submission of the report required under subsection (d).

(f) Reports of Secretary.--The Secretary shall transmit to the Committee on Energy and Commerce of the House of Representatives and to the Committee on Labor and Human Resources of the Senate two reports on--

(1) actions taken by the States to implement the recommendations developed under this section and to recommend additional action; and

(2) recommendations for legislative and administrative action, if any, needed to respond to issues raised by the Task Force or to improve consumer protection with respect to long-term health care policies.

The first report shall be transmitted 18 months after the date the report is made under subsection (d), and the second report shall be transmitted 18 months later.

(g) Long-Term Health Care Policy Defined.--In this section, the term "long-term health care policy" means an insurance policy, or similar health benefits plan, which is designed for or marketed as providing (or making payments for) health care services (such as nursing home care and home health care) or related services (which way include home and community-based services), or both, over an extended period of time.

(h) Assurance of States' Jurisdiction.--Nothing in this section shall be construed as recommending Federal preemption of the States in overseeing the

operation and regulation of insurance carriers in their respective jurisdiction.

5. "Washington Watch", The NAIC News, Vol. III, No. 11, p. 7.

6. National Association of Insurance Commissioners, Report Submitted to NAIC Medicare Supplement, Long Term Care and Other Limited Benefits Task Force by the Industry Advisory Committee, Exposure Draft dated July 9, 1986.

7. Telephone call from the NAIC office on September 26, 1986 to Samuel B. K. Chang, Director, Legislative Reference Bureau in response to letter to S. David Childers, Chair of the NAIC Medicare Supplement, Long Term Care and Other Limited Benefit Plans Task Force, dated September 8, 1986, inquiring into the status of the Exposure Draft.

8. Memorandum from the American Health Care Association to State Executives, dated April 25, 1986.

9. Interview with Richard McCord, Vice President, HAVI Insurance Agency, Inc., July 30, 1986; and with Don P. Desonier, CLU, ChFC, July 15, 1986.

10. Karen Slater, "Insurance for Nursing Bills Can Be Costly, Leave Holes", The Wall Street Journal, October 13, 1986, p. 17.

11. David L. Kennell, "Can Elderly Afford Long-term Care Insurance", American Health Care Association Journal, October 1985, p. 6.

12. Ibid., p. 8.

13. "Financing Long-term Care", Topics in Health Care Financing, Vol. 10, No. 3, Spring 1984, p. 16.

14. SRI International, Increasing Private Financing of Long-term Care: Opportunities for Collaborative Action, Conference Report, March 1986 (Menlo Park: 1986), p. 28.

15. Hawaii, Insurance Division, Department of Commerce and Consumer Affairs, Department of Health, and Department of Social Services and Housing, Report in Response to S.R. No. 76 - 1983 SLH, October 1984.

Chapter 5

1. William D. Fullerton, "Finding the Money and Paying for Long-Term-Care Services: The Devil's Briarpatch", Policy Options in Long-Term Care, Meltzer, et al. editors, p. 193).

2. House Bill No. 1158, Colorado General Assembly, approved April 14, 1986.

   The Colorado Insurance Division informed the Bureau that the proposed regulations for the implementation of the tax deduction law had been completed and the public hearing on the regulations was scheduled for November 6, 1986. According to the Division, the proposed regulations would provide flexible guidelines for the determination of which policies will qualify for the tax deductions. Telephone call to Lee Stolberg, Supervisor in Life, Accident, and Health Insurance, Insurance Division, Colorado Department of Regulatory Agencies, October 23, 1986.

3. Colorado Legislative Council, Report to the Colorado General Assembly: Recommendations for 1986 Committees on: Medical Care Cost Containment, Sentencing and Criminal Justice, Research Publication No. 296, December, 1985, p. 38.

4. House Bill No. 1102, Colorado General Assembly.

5. Assembly Bill No. 4231, California Legislature, as amended in Assembly June 16, 1986.

6. Hawaii, State Department of Taxation, Tax Credits Claimed by Hawaii Residents - 1984 (Honolulu: 1984), pp. 3, 4-8 (hereinafter referred to as Tax Credits).

7. Hawaii Rev. Stat., sec. 235-55.5; Tax Credits, p. 14.

8. Hawaii Rev. Stat., sec. 235-55.7

9. Section 6, Article VII, of the Constitution of the State of Hawaii provides that "Whenever the state general fund balance at the close of each of two successive fiscal years exceeds five percent of general fund revenues for each of the two fiscal years, the legislature in the next regular session shall provide for a tax refund of tax credit to the taxpayers of the State, as provided by law."

10. Hawaii Rev. Stat., sec. 235-55.6.

11. Interview, Herbert Dias, Director of Taxation, August 27, 1986.

12. This credit increases to 15 per cent for individuals in 1987. 1986 Haw. Sess. Laws, Act 66.

13. Hawaii Rev. Stat., sec. 235-12.

14. Hawaii Rev. Stat., sec. 235-12.2.

15. Hawaii Rev. Stat., sec. 235-15.

16. Tax Credits, pp. 24-28.

17. Hawaii, Tax Review Commission, Report of the First Tax Review Commission to the Thirteenth Legislature State of Hawaii, December 17, 1984, p. 15.

18. Fullerton, "Favorable Tax Treatment for the Elderly", Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives, p. 99.

19. Ibid., p. 101.

20. California, Third reading analysis sheet of A.B. 4231, as amended June 16, 1986, p. 2, California Legislature 1985-1986 Regular Session.

21. The Wisconsin Office of the Commissioner of Insurance adopted rules on November 1, 1981, which strictly defined the type of nursing home insurance allowed to be sold to individuals in the State in order to reduce the abuses and confusion the Office had found associated with long-term care insurance. As a result of the rules, all but one insurer ceased to offer long-term care insurance in the State and the one remaining company raised its rates and stopped advertising. The rules required that a policy provide: (1) coverage of care received in any licensed Wisconsin nursing home; (2) minimum benefits of $10 a day; (3) if there is a deductible, it cannot exceed 60 days; (4) lifetime maximum of 365 days; and (5) coverage of care certified by a physician as necessary. The rules also prohibited a policy from containing: (1) coverage limited to only certain levels of care, such as skilled care; (2) coverage limited to care received as a result of sickness or injury; and (3) coverage limited to care received after hospital confinement. Wisconsin, Department of Health and Social Services, Long-Term Care Financing: The Role of Private Insurance, December 28, 1984, pp. 9-10

22. Interview, Herbert Dias, Director of Taxation, August 27, 1986.

23. Tax Review Commission, p. 5.

24. Tax Foundation of Hawaii, Legislative Tax Bill Service, S.B. No. 2479-86, S.D. 1, and H.B. No. 1925-86, February 25, 1986.

25. Colorado General Assembly, "Statement of No Fiscal Impact" accompanying H.B. No. 1158.

26. Telephone calls to Stan Schwartz, Office of Research and Statistics, Department of Revenue, October 23, 1986, and to Lee Stolberg, Superviser in Life, Accident, and Health Insurance, Insurance Division, Colorado Department of Regulatory Agencies. Mr. Stolberg noted that the Insurance Division was not really certain as to the level of activity in long-term care insurance so could not provide estimates on anticipated sales. Nevertheless, the Division does not anticipate a huge volume of sales for 1987. The Division was generally in favor of the measure and was hopeful that with the new law they will have a better idea as to the number of agents and sales involved in long-term care transactions.

27. A.B. No. 4231 as introduced on February 21, 1986 and as amended June 16, 1986.

28. California, Third Reading analysis sheet of A.B. No. 4231, as amended June 16, 1986, p. 2, California Legislature, 1985-1986 Regular Session.

29. Testimony presented to the Committee on Human Services of the House of Representatives on H.B. No. 1925, February 14, 1986.

30. In Hawaii, the premium tax rates are as follows: (1) For insurers other than life and ocean marine insurers, 2.9647 per cent for domestic insurers and 4.2824 per cent for other insurers on the gross premiums received; (2) For life insurers, 1.918 per cent for domestic insurers and 3.197 per cent for others on the gross premiums received less return premiums, dividends paid, and reinsurance accepted; and (3) For ocean marine insurers, .8775 per cent of gross underwriting profit. Hawaii Rev. Stat., sec. 431 318.

31. Stanley Snodgrass, President, Hospital Association of Hawaii, Interview, July 14, 1986.

Chapter 6

1. William D. Fullerton, "Favorable Tax Treatment for the Elderly, Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives, Conference Proceedings, ed. Patrice Hirsch Feinstein, Marian Gornick, and Jay N. Greenberg (Washington, D.C.: 1984), p. 99.

2. Hawaii, Insurance Division, Department of Commerce and Consumer Affairs, Department of Health; and Department of Social Services and Housing, Report in Response to S.R. 76 - 1983 SLH, pp. 13-14.

3. The Long-term Care Task Force was created as a subcommittee of the Policy Advisory Board as a result of the Governor's Executive Office on Aging designation by the as the lead agency in planning for long-term care of the elderly. This designation was recommended by the Long-term Care Planning Group which was appointed by the Governor in 1981 and which submitted to the Legislature a series of reports on long-term care. Following the Planning Group's recommendations, Senate Resolution No. 12o, Regular Session of 1984, set forth policy guidelines for long-term care of the elderly and House Resolution No. 31, Regular Session of 1985, requested the Governor to designate the Executive Office on Aging as the lead agency.

4. David L. Kennell, "Can Elderly Afford Long-term Care Insurance", American Health Care Association Journal, October 1985, pp. 6-7.

HOUSE OF REPRESENTATIVES
THIRTEENTH LEGISLATURE, 1986
STATE OF HAWAII

H.R. NO. 177 H.D. 1

HOUSE RESOLUTION

REQUESTING A STUDY OF LONG TERM CARE INSURANCE AND THE FEASIBILITY OF ALLOWING A TAX CREDIT FOR LONG TERM CARE INSURANCE PREMIUMS.

WHEREAS, 9.6% of Hawaii's population is now over the age of 65 and Hawaii's rate of growth in the 65+ population is higher than the national; and

WHEREAS, of those over 65, one in four will need long term care and of those over 85, the fastest growing population group, three out of five will need long term care; and

WHEREAS, the average stay in long term care facilities is 1.6 years at a cost of about $50,000 and this cost can have a catastrophic impact by depleting all of patient's assets and causing dependency on Medicaid; and

WHEREAS, most people are not aware that their insurance does not cover the cost of long term care: in an American Association of Retired Persons survey, 79% believed Medicare would pay for long term care when in fact Medicare coverage is very limited and subject to conditions; and

WHEREAS, Medicaid, which pays for about 90% of our long term care patients, is only available to persons who fall below certain income and asset levels; and

WHEREAS, long term care insurance holds promise to permanently cut the cost of long term care services to the Medicaid program, the County/State Hospitals system and to private citizens; and

WHEREAS, long term care insurance offers a new private source of revenue for both public and private long term care institutions and would have a major impact on both access and quality of care because Medicare and Medicaid reductions under Gramm-Rudman and the administration budget proposal will reduce the resources available to deliver quality care; and

WHEREAS, a credit against state income tax liability for long term care insurance premiums will foster the growth and expansion of long term care coverage in the State, thereby protecting the financial independence and assets of our elderly, reducing financial burden and catastrophic impact on spouses, children and families, offsetting the impact of reduction in their responsibility to safeguard themselves and their families against catastrophic long term care costs; now, therefore,

BE IT RESOLVED by the House of Representatives of the Thirteenth Legislature of the State of Hawaii, Regular Session of 1986, that the Legislative Reference Bureau study the benefits and impact of both long term care insurance and a tax credit for long term care insurance premiums, including an assessment of the desirable elements to be included in long term care policies to qualify for the credit, impact on the State budget due to spending for the Medicaid program and the County/State Hospitals system, and the feasibility of implementing such a tax credit; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau submit its findings and recommendations, along with recommended legislation, to the Legislature not less than twenty days prior to the convening of the Regular Session of 1987; and

BE IT FURTHER RESOLVED that certified copies of this Resolution be transmitted to the Legislative Reference Bureau, the Director of Social Services and Housing, the Director of Health, the Director of the Executive Office on Aging, the Director of Taxation, the State Insurance Commissioner, and the Hospital Association of Hawaii.

Appendix B

Summary of NAIC Issues & Recommendations

ISSUE 1
CONSUMER AWARENESS

The lack of consumer demand is a primary reason why insurers have not developed long term care insurance products. Many people remain unaware of the financial risks associated with nursing home care and erroneously believe that Medicare and medicare supplement insurance policies will address their long term care needs.

RECOMMENDATIONS

. States, Foundations and Senior Citizen Groups and Associations should develop every available avenue for providing consumer education on long term care issues informing consumers that Medicare does not cover all long term care needs, that Medicare supplement policies are not designed to cover long term care expenses, and that Medicaid has very restrictive financial eligibility requirements.

- Public service announcements and advertisements should be prepared and used to educate the public regarding long term care.

- Seminars and programs on long term care issues should be developed and promoted.

The National Association of Insurance Commissioners (NAIC) should publish and State Insurance Departments should distribute a Consumers Guide to Long Term Care in a form substantially similar to the Consumer Guide developed by the Long Term Care Advisory Committee (Appendix C)

ISSUE 2
DATA NEEDS & SERVICES

Insufficient data exists for an actuarially sound basis for the pricing and underwriting of long term care insurance benefits. Existing data describes utilization of services in an uninsured environment and therefore underestimates insured experience. If able to more accurately forecast liabilities associated with providing long term care benefits, insurers

RECOMMENDATIONS

. The National Association of Insurance Commissioners (NAIC) and the health insurance industry in a joint effort should under the auspices of the Society of Actuaries, sponsor a symposium on actuarial issues related to long term care. To encourage the sharing of actuarial experience, the Society could gather, compile

will be more willing and better equipped to develop products.

and make available technical data while protecting the proprietary interests of the contributing firms.

- The health insurance industry should more fully use existing data sets.

- The health insurance industry should work together with researchers in designing surveys that include questions relevant to long term care cohort analysis and other data essential to the industry's capacity to underwrite and price long term care policies.

- Insurance regulators must consider the lack of data related to experience in an insured environment when reviewing and approving long term care filings.

ISSUE 3
UNDERWRITING & POLICY DESIGN

In addition to the need for data, there are additional concerns related to the overall issue of policy design such a the insurability of custodial type long term care services and the possible effects of insurance induced demand.

RECOMMENDATIONS

- Renewability. Health insurers should design their renewability provisions in long term care policies according to the following:

  - Optionally Renewable long term care policies are not appropriate.

  - Conditionally Renewable are appropriate. Long term care policies should not allow for cancellation based on age or health.

  - Guaranteed Renewable and Noncancellable long term care policies are appropriate.

- Non Forfeiture Values

  Long term care insurance premiums that are designed to prefund for the long term care

benefit should allow for withdrawal of benefits consistent with the NAIC Nonforfeiture Value Benefits Guidelines.

. Three Day Hospital Stay.

Insurers should have the option to require a 3 day stay of hospitalization in order to qualify for benefits under a long term care policy.

. Loss Ratios

- Since sufficient experience under long term care insurance does not yet exist, minimum loss ratios, if determined necessary by regulators, should take into account the particular nature of the product.

- State insurance regulators must evaluate loss ratios over the entire period for which rates are calculated, as set forth in the NAIC Model Guidelines for Filing of Rates for Individual Health Insurance Forms.

ISSUE 4
REGULATORY ENVIRONMENT

In order that the development of long term care insurance realize its fullest potential, the regulatory climate, both at the state and federal levels, must be positive. Existing barriers to the growth and diversification of the marketplace must be addressed.

RECOMMENDATIONS

State Government Activity

. States, in concert with Federal Government, should introduce Medicaid reforms to encourage the purchase of private long term care insurance.

  - Tighten Medicaid eligibility requirements

  - Enforce Medicaid asset transfer restrictions

- States should consider the benefits of undertaking a demonstration project waiving Medicaid spend down provisions for those persons who have purchased long term care policies containing certain minimum benefits and who have exhausted the policy benefits.

State Insurance Department Activity

. State insurance regulators should support product development, experimentation and market entry by regulators.

. State insurance regulators should not judge long term care insurance products by the standards set forth by State Medicare supplement laws and regulations.

Federal Government Activity

. Federal tax policy should promote, and not discourage, planning for future financial needs to purchase long term care services, and especially focus on long term care insurance.

. The Department of Health and Human Services should develop legislative proposals aimed at reducing access to the Medicaid program by the middle-income elderly who divest themselves of resources to obtain program eligibility.

. State Legislators should consider using state tax policy to encourage financial planning for retirement and long term care expenses.

- Allow consumers a tax deduction or credit for premiums paid on qualifying long term care insurance policies.

- Reduce the premium tax rate paid by insurers on qualifying long term care insurance policies.

. State Legislators should enact appropriate laws regulating Life Care Communities and place regulatory jurisdiction for the communities within the Insurance Department to ensure solvency and consumer protection.

. To allow the broadest base of product suppliers, legislators should remove any existing statutory barriers to market entry by Health Maintenance Operations and Blue Cross and Blue Shield plans.

. State Legislators should adopt the Long Term Care Insurance Model Act.

. The Department of Health and Human services, in working on the Consolidated Omnibus Budget Reconciliation Act (COBRA) task force activity and the catastrophic health care expense report, should seek to encourage the provision of private long term care insurance and not discourage the policies developing in the marketplace.

. The Department of Health and Human Services should help to provide data and research assistance to those seeking to design and market long term

	care insurance when possible. It should also encourage experimentation in the provision of long term care insurance.
ISSUE 5 MARKETING CONCERNS	RECOMMENDATIONS
In addition to the previously mentioned issues that have a material impact on marketing efforts, distribution systems of major insurance companies are not ready to market long term products; employers are not ready to support employee benefit program changes that would include long term care insurance.	. Insurance companies should develop riders to existing policies in order to employ existing distribution systems. . New companies capable of offering unique products and services should be encouraged to enter market . Consideration should be given to designing a federal/state private industry program that would provide minimum-type benefits and promote the need for additional coverage via purchase of insurance products.

SOURCE: National Association of Insurance Commissioners, Report Submitted to NAIC Medicare Supplement, Long Term Care and Other Limited Benefits Task Force, by the Industry Advisory Committee, Exposure Draft dated July 9, 1986.

An Act

HOUSE BILL NO. 1158.

BY REPRESENTATIVES Markert, M.L. Bird, Bond, Bowen, Fish, Groff, P. Hernandez, T. Hernandez, Herzog, Knox, Kopel, Pankey, Philips, Reeser, Romero, Tanner, Taylor-Little, Tebedo, Trujillo, Webb, and K. Williams;
also SENATORS Lee and Baca.

CONCERNING INCENTIVES FOR INSURANCE POLICIES FOR LONG-TERM CARE.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 10-1-108, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-1-108. Duties of commissioner - reports - publications - disposition of funds. (14) It is the duty of the commissioner to evaluate insurance policies for long-term care to determine their compliance with the provisions of article 19 of this title and to provide insurance companies with a written statement indicating the results of such determination.

SECTION 2. 10-3-209 (1) (d), Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SUBPARAGRAPH to read:

10-3-209. Tax on premiums collected - exemptions - penalties. (1) *(d) (V) (A) On and after January 1, 1987, the* rate imposed by this section on the gross amount of all premiums collected or contracted for on insurance policies for long-term care, which policies are certified by the commissioner as complying with article 19 of this title, shall be reduced by one percent from the rate that otherwise would have been imposed.

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

(B) This subparagraph (V) is repealed, effective July 1, 1989.

SECTION 3. Title 10, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 19
Insurance Policies for Long-term Care

10-19-101. Definitions. As used in this article, unless the context otherwise requires:

(1) "Home health agency" has the same meaning as that ascribed to it in section 26-4.5-103 (6), C.R.S.

(2) "Insurance policy for long-term care" means a group or individual insurance policy, or portion thereof, which provides benefits for a period of not less than twelve months for each person covered under the policy, on an expense incurred, indemnity, or annuity basis, or combination thereof, for necessary diagnostic, preventive, therapeutic, rehabilitative, or custodial services, as defined by regulations adopted by the commissioner pursuant to this article, in or by a duly licensed home health agency, intermediate nursing facility, or nursing care facility.

(3) "Intermediate nursing facility" has the same meaning as that ascribed to it in section 26-4-103 (3.4), C.R.S.

(4) "Nursing care facility" has the same meaning as that ascribed to it in section 26-4-103 (6.5), C.R.S.

10-19-102. Incentives for insurance companies and consumers. (1) (a) Any insurance company choosing to offer an insurance policy for long-term care, which policy is certified by the commissioner as complying with the provisions of this article, shall qualify for the reduced premiums tax on premiums collected or contracted for pursuant to section 10-3-209 (1) (d) (V).

(b) This subsection (1) is repealed, effective July 1, 1989.

(2) Any person paying premiums for an insurance policy for long-term care, which policy is certified by the commissioner as complying with the provisions of this article, shall qualify for the income tax deduction provided for in section 39-22-113 (4) (f), C.R.S.

10-19-103. Form and content of policy. (1) (a) Within a reasonable time of being asked by an insurance company offering a policy for long-term care, the commissioner shall

examine each such policy to determine compliance with the provisions of this article and issue a written opinion stating the results of such examination.

(b) In addition to examining for any other requirements for certification pursuant to this article, the commissioner shall examine each insurance policy which the commissioner is asked to certify as complying with the provisions of this article to determine whether or not such policy is a group or individual insurance policy, or portion thereof, which provides benefits for a period of not less than twelve months for each person covered under the policy, on an expense incurred, indemnity, or annuity basis, or combination thereof, for necessary diagnostic, preventive, therapeutic, rehabilitative, or custodial services, as defined by regulations adopted by the commissioner pursuant to this article, in or by a duly licensed home health agency, intermediate nursing facility, or nursing care facility.

(c) The commissioner shall report the results of the examination as required by paragraph (b) of this subsection (1) to the general assembly on or before January 1, 1988.

(2) The general assembly intends that policies of insurance for long-term care shall not exclude coverage for chronic conditions closely correlated with the normal aging process.

10-19-104. Rule-making authority. The commissioner of insurance shall promulgate such rules and regulations as are necessary to provide for the implementation of this article.

SECTION 4. 39-22-113 (4), Colorado Revised Statutes, 1982 Repl. Vol., is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

39-22-113. Colorado itemized deduction of a resident individual. (4) (f) For income tax years commencing on or after January 1, 1987, an amount equal to the total premiums spent for insurance policies for long-term care, which policies are certified by the commissioner of insurance as complying with article 19 of title 10, C.R.S.

SECTION 5. Effective date. This act shall take effect July 1, 1986. This act shall only apply to policies which are approved by the commissioner of insurance after the effective date of this act.

SECTION 6. Safety clause. The general assembly hereby

finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Carl B. Bledsoe
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Ted L. Strickland
PRESIDENT OF
THE SENATE

Lee C. Bahrych
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Marjorie L. Nielson
SECRETARY OF
THE SENATE

APPROVED April 14, 1986 9:15 A.M.

Richard D. Lamm
GOVERNOR OF THE STATE OF COLORADO

AMENDED IN ASSEMBLY JUNE 16, 1986

AMENDED IN ASSEMBLY APRIL 22, 1986

AMENDED IN ASSEMBLY APRIL 9, 1986

CALIFORNIA LEGISLATURE—1985–86 REGULAR SESSION

ASSEMBLY BILL No. 4231

Introduced by Assembly Member Calderon

February 21, 1986

An act to amend Section 17072 of, and to add Section 17232 to, the Revenue and Taxation Code, relating to taxation, to take effect immediately, tax levy.

LEGISLATIVE COUNSEL'S DIGEST

AB 4231, as amended, Calderon. Personal income taxation: deductions: long-term care insurance policies.

Existing Personal Income Tax Law allows various deductions in computing income subject to the tax imposed by that law.

This bill would allow a deduction for a percentage of the total premium expenses paid or incurred by a taxpayer for the purchase of a long-term care insurance policy, as defined. The applicable percentage of those premium expenses allowable as a deduction would vary in accordance with the taxpayer's adjusted gross income.

Existing Personal Income Tax Law permits various deductions as adjustments to gross income.

This bill would permit the above deduction as an adjustment to gross income.

This bill would take effect immediately as a tax levy *and would apply to taxable years beginning on or after January 1, 1987.*

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 17072 of the Revenue and Taxation Code is amended to read:

17072. Adjusted gross income shall be defined by Section 62 of the Internal Revenue Code, except as follows:

(a) No deduction shall be allowed for any of the following:

(1) The deduction allowed by Section 62(3) of the Internal Revenue Code (relating to long-term capital gains).

(2) The deduction allowed by Section 62(9) of the Internal Revenue Code (relating to pension plans of electing small business corporations).

(3) The deduction allowed by Section 62(11) of the Internal Revenue Code (relating to lump sum distributions from pension plans).

(4) The deduction allowed by Section 62(15) of the Internal Revenue Code (relating to repayments of supplemental unemployment compensation benefits).

(b) In the case of a life tenant of property, or an income beneficiary of property held in trust, or an heir, legatee, or devisee of an estate, the deduction for depreciation allowed by Section 167 of the Internal Revenue Code and the deduction allowed by Section 17681 shall be allowed.

(c) The deduction allowed by Section 17232 shall be allowed.

SEC. 2. Section 17232 is added to the Revenue and Taxation Code, to read:

17232. (a) There shall be allowed as a deduction, the applicable percentage (determined under subdivision (b)) of the total premium expenses paid or incurred by the taxpayer in the taxable year for the purchase of a long-term care insurance policy (as defined in subdivision (c)).

(b) The applicable percentage of total premium

expenses allowable as a deduction pursuant to subdivision (a) shall be determined in accordance with the amount of the taxpayer's adjusted gross income for the taxable year as follows:

(1) For single taxpayers or married taxpayers filing a separate return:

~~Adjusted Gross income~~	~~Percentage of Premium Expenses~~
~~$ 9,999 or less~~	~~100%~~
~~$10,000/14,999~~	~~90%~~
~~$15,000/19,999~~	~~80%~~
~~$20,000/24,999~~	~~70%~~
~~$25,000/29,999~~	~~60%~~
~~$30,000/34,999~~	~~50%~~
~~$35,000/39,999~~	~~40%~~
~~$40,000/44,999~~	~~30%~~
~~$45,000/49,999~~	~~20%~~
~~$50,000/54,999~~	~~10%~~
~~$55,000 or more~~	~~0%~~

Adjusted Gross income	*Percentage of Premium Expenses*
$ 9,999 or less	*50%*
$10,000-14,999	*45%*
$15,000-19,999	*40%*
$20,000-24,999	*35%*
$25,000-29,999	*30%*
$30,000-34,999	*25%*
$35,000-39,999	*20%*
$40,000-44,999	*15%*
$45,000-49,999	*10%*
$50,000-54,999	*5%*
$55,000 or more	*0%*

(2) For married taxpayers filing a joint return:

~~Adjusted Gross income~~	~~Percentage of Premium Expenses~~
~~$14,999 or less~~	~~100%~~
~~$15,000/22,499~~	~~90%~~
~~$22,500/29,999~~	~~80%~~
~~$30,000/37,499~~	~~70%~~
~~$37,500/44,999~~	~~60%~~
~~$45,000/52,499~~	~~50%~~
~~$52,500/59,999~~	~~40%~~
~~$60,000/67,499~~	~~30%~~
~~$67,500/74,999~~	~~20%~~
~~$75,000/82,499~~	~~10%~~
~~$82,500 or more~~	~~0%~~

Adjusted Gross income	*Percentage of Premium Expenses*
$14,999 or less	*50%*
$15,000-22,499	*45%*
$22,500-29,999	*40%*
$30,000-37,499	*35%*
$37,500-44,999	*30%*
$45,000-52,499	*25%*
$52,500-59,999	*20%*
$60,000-67,499	*15%*
$67,500-74,999	*10%*
$75,000-82,499	*5%*
$82,500 or more	*0%*

(c) For purposes of this section:

(1) "Total premium expenses" means the amount of premium charges made by an insurer for the taxable year for a long-term care insurance policy.

(2) "Long-term care insurance policy" means any policy of insurance issued by an admitted insurer which provides any of the following benefits:

(A) Care in a licensed long-term health care facility, as defined in Section 1418 of the Health and Safety Code, following certification by the beneficiary's attending physician that his or her institutionalization is necessary.

(B) Reimbursement for care received in a licensed long-term health care facility *following certification by* the beneficiary's attending physician that his or her institutionalization is necessary.

(C) Reimbursement for services provided by a home health agency regardless of prior confinement in an acute care hospital or skilled nursing facility.

(D) Reimbursement for in-home supportive services, as defined in Section 12300 of the Welfare and Institutions Code, regardless of *prior confinement in* an acute care hospital or skilled nursing facility.

SEC. 3. This act provides for a tax levy within the meaning of Article IV of the Constitution and shall go into immediate effect. *However, this act shall apply to taxable years beginning on or after January 1, 1987.*

72

O

Appendix E

Consumer Guide

EXPOSURE DRAFT

Many people are expressing increased interest in obtaining insurance coverage to protect against the expense of long term care services. However, what most people do not realize is how costly long-term care can be, or what their chances are of requiring such care or whether their other health insurance plans cover long term care.

Most people believe that Medicare combined with their private Medicare Supplement insurance will meet this need if it should develop. This however, is NOT TRUE! Medicare and Medicare Supplement insurance cover a very limited amount of skilled care, but custodial care, which is the type of care many people often require, is not covered. (see the Glossary at the end of the Guide for definitions of skilled and custodial care.)

This "Guide to Long Term Care Insurance" is intended to help you recognize whether your existing health insurance coverage is adequate to cover long term care expenses. More importantly, the guide will help you determine whether the insurance policies currently available would help meet the expenses associated with long term care.

What is Long Term Care?

"Long term care" refers to a wide range of services for people who, due to chronic illness or infirmity, need assistance with the activities of daily living for a long period of time. Although "long term care" has traditionally meant nursing home care, the full spectrum of long term care services may include home health care, adult day care, respite care, care and services

provided in senior centers or congregate housing, aides/chore services, and friendly visiting services.

Long term care insurance may or may not cover all of the above services.

Who Needs Long Term Care?

Individual risk of needing long term care varies according to health and other factors, such as age.

- It is estimated that today about 1 in 4 people will spend some time in a nursing home, with about 1/3 of those spending over 3 months in a nursing home.

- If you are 75 or older, you are 7 times more likely to be in a nursing home than if you are 65 to 74 years old.

- If you are 85 or older, you are 14 times more likely to be in a nursing home than if you are 65 to 74 years old.

Even if you never spend time in a nursing home there is a strong possibility that you will someday need assistance with the activities of daily living, such as eating, dressing, bathing, etc. It is very important for you to realize and plan for the possibility that at some point in your life you may require some form of long term care services.

How Much Can Long Term Care Cost?

Long term care can be very expensive. On average, one year in a nursing home costs $20-30,000. Home health care can also be costly if services are provided frequently for a long period of time. Three home health aid visits (unskilled care) per week, for one year, can easily cost $5,300. Three skilled care visits per week, can run as much as $8,200 per year.

Who Pays for Long Term Care?

Responsibility for the payment of most these bills lives with you! The Medicare program was not designed to pay for long term care and its benefits for nursing home and home health care are limited. Similarly, existing Medicare Supplement policies are not intended to pay for long term care. Combined they cover only about 3% of the nation's $32 billion annual nursing home expenses.

A large share of long term care expenses are paid for out of pocket by individuals. Because long term care can be so expensive, many nursing home residents run out of money and must seek assistance from Medicaid, the government program that provides health care assistance for the poor. About half of the nursing home residents receiving Medicaid assistance were not poor enough to qualify for Medicaid when they entered the nursing home, but after exhausting their own resources paying their nursing bills they became eligible for Medicare.

What is the Role of Insurance in Long Term Care?

One way people can meet the cost of long term care is to buy insurance. There are many policies available which pay benefits for certain long term care services. Each policy is different. Before you buy any policy you must know what resources you have to take care of your long term care needs. Then you must consider what kind of coverage you need to buy. It is essential that you examine and carefully compare policies. Some of the major factors that you should review in a long term care policy are listed below.

I. Types of Care and Facilities

Long term care policies may pay for Skilled, Intermediate, or Custodial/Personal Care. Some policies also provide Home Care benefits. Each policy may define these terms differently. It is important that you understand what the definitions mean, because you will only receive benefits if the care that you receive matches the definitions in the policy.

Some policies may pay benefits only if you are confined in a Medicare approved nursing home. Others will pay only if you are in a nursing home that meets the policy's definition of a Skilled, Intermediate or Custodial Care facility. Still others will pay if you are confined in any facility licensed by the state. Therefore it is extremely important to know what

kind of nursing home and other long term care services and facilities are available in your area. Before buying a policy be certain that you understand which nursing homes and services in your area qualify for benefits under the policy. For more information contact _____.

II. Coverage Limitations

Health Status: When you apply for long term care insurance, you may be asked questions relating to your health status, prior hospitalizations, and nursing home confinements. Each insurance company has its own standards for evaluating answers to these questions and determining your eligibility for coverage based on your answers. Be sure you answer all of these questions truthfully and accurately, or you may later be denied coverage.

Pre-existing conditions: You may be sick or being treated by a doctor when a policy is sold to you. You may not be eligible for benefits for that condition until a certain period of time passes. This is called a pre-existing condition limitation. Be sure to check and see if this restriction applies to you.

Qualifying for Benefits: Policies have different requirements that you may have to satisfy before benefits are payable. Some require a hospital

stay or a doctor's approval before you can qualify for benefits. In order to qualify for home care benefits under some policies, you must first be in a nursing home. Be sure to check and see if this restriction applies to you.

Policy Exclusions: Long Term Care policies might not pay benefits for mental or nervous conditions. It is important to know if a policy excludes coverage for Alzheimer's disease and senility. Policies may also exclude coverage for other conditions or situations. Find out if any of these exclusions apply to you.

Renewability: The Renewal provision of a policy is usually found on the first page of the policy. This tells you whether the policy can be cancelled and if rates can be raised on your policy by the insurance company.

Eligibility: Be aware that after a certain age you may not be eligible for coverage. Each company sets its own age limit, which is usually 75 or 80. Another factor which may make you ineligible for coverage is your health status. Based on your answers to the health questions on your application, the company may deny you coverage if your health status does not meet the company's standards for eligibility.

III. SOME FACTORS OF POLICY COST WHICH DETERMINE HOW MUCH YOU WILL PAY FOR A POLICY

The premium charged for a long term care insurance policy may vary according to many factors including policy benefits and your age.

Age: Your premium may be determined in part by your age when you buy the policy. In general, the younger you are, the lower the premiums will be.

Elimination or Waiting Periods: Policies frequently have waiting periods before benefits are available. Sometimes they are called deductible periods. This is the number of days you must be confined in a facility or the number of home care visits you must receive before benefits are paid. Usually, the longer the deductible period, the lower the premium.

Amount and Duration of Benefits: The amount and duration benefits that you may receive will vary from policy to policy. Usually the larger the benefit, the more you will pay for the policy. It is important to know the average cost for nursing home and home care in your area before you buy a policy. Keep in mind that inflation will cause these costs to rise over time. This will help you decide the amount of coverage that is right for you.

IV. Questions to ask

Following is a list of questions you should consider in comparing long term care insurance policies.

1. Does this policy provide benefits for:

   Skilled Care

   Intermediate Care

   Personal/Custodial Care

   Home Care

   Other

2. According to the policy, what is:

   Skilled Care

   Intermediate Care

   Personal/Custodial Care

   Home Care

3. How long may I receive benefits for:

   Skilled Care

   Intermediate Care

   Personal/Custodial Care

   Home Care

4. How much are my daily benefits for:

   Skilled Care

   Intermediate Care

   Personal/Custodial Care

   Home Care

5. What is the pre-existing condition limitation of this policy?

   Does it apply to me?

6. Must I meet any special requirements before I go into the nursing home in order to receive benefits? If so, what are they?

7. Are there any special levels of care that I must receive in a nursing home to be eligible for benefits?

8. Must I be in a certain type of nursing home in order to receive skilled, intermediate or custodial benefits? If so, what type? Does this type of nursing home exist in my area?

9. Is there any waiting or elimination period before I can receive benefits after I am in a nursing home? If so, how long must I wait?

10. Must I meet any special requirements before I can receive home care benefits? Are such home care services available in my area?

11. Can the company cancel or refuse to renew my policy? If so, under what circumstances?

12. What happens if I fail to pay my premiums?

13. Can the company raise rates on my policy? If so, under what circumstances?

14. What is not covered under this policy?

15. Does this policy cover Alzheimers Disease?

16. How much does this policy cost?

    What will the total cost be over a 10 year period? (note: some plans may be inexpensive at first but premiums may increase dramatically over time.)

17. Will I receive benefits if I have duplicate or other coverage?

LONG TERM CARE TERMS

Skilled Nursing Care -- nursing and rehabilitative services given by skilled medical personnel, on a daily basis, under orders of a physician.

Intermediate Care -- same as above except procedures may be performed on an occasional basis.

Custodial/Personal Care -- assistance in daily living requirements which can be provided by persons without medical skills.

Home Care -- may include skilled nursing care, speech therapy, physical therapy, social work, lab services and personal care, homemakers and choreworkers.

Skilled Nursing Facility -- A facility licensed by the state and legally qualified to provide intermediate or custodial care but not skilled care.

Intermediate Care Facility -- A facility licensed by the state and legally qualified to provide intermediate or custodial care but not skilled care.

Medicare -- acute care hospital and physician cost benefit program established by the Federal Government for those over 65 and certain disabled individuals.

Medigap or Medicare Supplement -- a group or individual accident and sickness insurance policy or a subscriber contract underwritten by a hospital and medical service association which is advertised, marketed or designed primarily as a supplement to reimbursement under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

Custodial/Personal Care Facility - provides a level or care below intermediate care, primarily for the purpose of meeting personal needs.

*Please note that these definitions may not be the same as those in a long term care policy, but are included to help you understand what these terms generally mean.

SOURCE: National Association of Insurance Commissioners, Report Submitted to NAIC Medicare Supplement, Long Term Care and Other Limited Task Force, by the Industry Advisory Committee, Exposure Draft dated July 9, 1986, Appendix C.

Appendix F

Long-Term Care Insurance Model Act

Table of Contents

Section 1. Purpose

Section 2. Scope

Section 3. Short Title

Section 4. Definitions

Section 5. Disclosure and Performance Standards for Long-Term Care Insurance

Section 6. Administrative Procedures

Section 7. Severability

Section 8. Effective Date

Section 1. Purpose

The purpose of this Act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance as defined from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Comments: The purpose clause evidences legislative intent to protect the public while recognizing the need to permit flexibility and innovation with respect to long-term care insurance coverage. It makes clear that entities subject to the Act must continue to comply with other applicable insurance legislation not in conflict with this Act.

Section 2. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance. A policy which is not advertised,

marketed or offered as long-term care insurance or nursing home insurance need not meet the requirements of this Act.

Section 3. Short Title

This Act may be known and cited as the "Long-Term Care Insurance Act."

Comments: This section is self-explanatory.

Section 4. Definitions

Unless the context requires otherwise, the definitions in this section apply throughout this Act.

A. "Long-Term Care Insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

B. "Applicant" means:

(1) in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits, and

(2) in the case of a group long-term care insurance policy, the proposed certificate holder.

C. "Certificate" means, for the purposes of this Act, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

D. "Commissioner" means the Insurance Commissioner of this state.

Drafting Note: Where the word "Commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. "Group long-term care insurance" means a long-term care insurance policy:

(1) Delivered or issued for delivery in this state and issued to:

(a) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(b) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

(i) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(ii) Has been maintained in good faith for purposes other than obtaining insurance; or

(c) A group other than as described in subsections E(1)(a) and E(1)(b), subject to a finding by the Commissioner that:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged.

(2) Affording coverage to a resident of this state under a group policy issued in another state to a group described in E(1)(c), if this state or another state having statutory and regulatory requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

F. "Policy" means, for the purposes of this Act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization or any similar organization.

Drafting Note: This Act is intended to apply to the specified group and individual policies, contracts, and certificates whether issued by insurers, fraternal benefit societies, non-profit health, hospital, and medical service

corporations, prepaid health plans, health maintenance organizations, or any similar organization. In order to include such organizations and arrangements, each state should identify them in accordance with its statutory terminology or by specific statutory citation. Depending upon state law, insurance department jurisdiction, and other factors, separate legislation may be required. In any event, the legislation should provide that the particular terminology used by these plans, organizations and arrangements may be substituted for, or added to, the corresponding terms used in this Act. The term "regulations" should be replaced by the term "rules and regulations" or "rules" as may be appropriate under state law.

Comments: A minimum time limit for existence of an association was not included since there is no such requirement in the current NAIC Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act.

The definition of "long-term care insurance" under this Act is designed to allow maximum flexibility in benefit scope, intensity and level, while assuring that the purchaser's reasonable expectations for a long-term care insurance policy are met. The Act is intended to permit long-term care insurance policies to cover either diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, or any combination thereof, and not to mandate coverage for each of these types of services. Pursuant to the definition, long-term care insurance may be either a group or individual insurance policy or a rider to such a policy, e.g., life, or accident and sickness. The language in the definition concerning "other than an acute care unit of a hospital" is intended to allow payment of benefits when a portion of a hospital has been designated for, and duly licensed or certified as a long-term care insurance long-term care provider or swing bed.

Section 5. Disclosure and Performance Standards for Long-Term Care Insurance

A. The Commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, pre-existing conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

Comments: This subsection permits the adoption of regulations establishing disclosure standards, renewability and eligibility terms and conditions, and other performance requirements for long-term care insurance.

Regulations under this subsection should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual long-term care insurance policies.

B. No long-term care insurance policy may:

(1) Be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or,

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

C. Pre-existing Condition:

(1) No long-term care insurance policy or certificate shall use a definition of "pre-existing condition" which is more restrictive than the following: Pre-existing condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within the limitation periods specified in (a) and (b) below:

(a) 6 months preceding the effective date of coverage of an insured person who is 65 years of age or older on the effective date of coverage; or

(b) 24 months preceding the effective date of coverage of an insured person who is under age 65 on the effective date of coverage.

(2) No long-term care insurance policy may exclude coverage for a loss of confinement which is the result of a pre-existing condition unless such loss or confinement begins with the periods specified in (a) or (b) below:

(a) 6 months following the effective date of coverage of an insured person who is 65 years of age or older on the effective date of coverage; or

(b) 24 months following the effective date of coverage of an insured person who is under 65 years of age or older on the effective date of coverage.

(3) The commissioner may extend the limitation periods set forth in subsections 5(C)(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "pre-existing condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the

answers on that application, from underwriting in accordance with that insurer's established underwriting standards.

Comments: The definition of pre-existing condition is consistent with the requirement of Section 5 of the NAIC Model Regulation to implement the Individual Accident and Sickness Insurance Minimum Standards Act. Companies now selling long-term care insurance generally use much shorter pre-existing condition periods than those authorized, in part for business and competitive reasons. It is not anticipated that competitive forces would permit significant lengthening of such periods. However, by authorizing a company to base claim exclusions on information obtained from a longer period preceding the effective date of coverage, some persons now refused coverage could qualify for a period of limited coverage leading to full coverage. Longer pre-existing condition periods could also be used in developing products for younger and as yet untapped markets.

D. Prior Institutionalization:

No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

E. The Commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

F. An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions and limitations contained in the policy;

(3) A statement of the renewal provisions, including any reservation in the policy of a right to change premiums; and

(4) A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

G. Right to Return - Free Look Provision:

(1) Individual long-term care insurance policies shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the

policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(2) A person insured under a long-term care insurance policy issued pursuant to a direct response within thirty (30) days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

H. No policy may be advertised, marketed or offered as long-term care or nursing home insurance unless it complies with the provisions of this Act.

I. A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(3) A statement that the group master policy determines governing contractual provisions.

Comments: The above provisions are deemed appropriate due to the particular nature of long-term care insurance, and are consistent with group insurance laws. Specific standards would be contained in regulations implementing this Act.

Section 6. Administrative Procedures

Regulations adopted pursuant to this Act shall be in accordance with the provisions of (cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable).

Comments: This section is self-explanatory.

Section 7. Severability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Comments: This section is self-explanatory.

Section 8. Effective Date

This Act shall be effective (insert date).

Drafting Note: The effective date of the Act should be that date customarily used by the state. Requirements of the Act should be made applicable to policies and certificates delivered or issued for delivery on and after the first day of the year following the adoption of the regulations in order to allow ample time to develop policy forms.

12/7/86

PUBLISHED REPORTS OF THE LEGISLATIVE REFERENCE BUREAU

1972
1. New Car Warranties. 71 p.
2. The Implications of Year-Round Education for Hawaii's Public Schools. 88 p.

1973
1. Elderly Affairs. 273 p.
2. In-Migration as a Component of Hawaii Population Growth: Its Legal Implications. 90 p.
3. Child Care in Hawaii: An Overview. 284 p.

1974
1. Window to the Sea: A Study of the Waikiki Aquarium. 239 p.

1975
1. Sanctify the Scales—A Study of Consumer Protection. 196 p.
2. Vocational Education in Hawaii—An Examination of Its Administration. 130 p.
3. Feed for Hawaii's Livestock Industry—Some Problems and Prospects. 124 p.
4. Prepaid Legal Services and Hawaii. 87 p.

1976
1. Privileged Communication and Counseling in Hawaii. 143 p. (out of print)

1977
1. Towards a Definition of Death. 181 p. (out of print)
2. Iolani Palace Complex: Some Directions for the Future. 186 p.

1978
1. The Feasibility of Integrating Human Services in Hawaii: Some Issues, Problems, and Opportunities. 262 p.

1979
1. Generic Drug Substitution: Feasibility for Hawaii. 204 p.
2. Preserving the Quality of Life in Hawaii: A Strategy for Population Growth Control. 220 p.
3. Equality of Rights—Statutory Compliance. 73 p. (out of print)

1980
1. Economic Security for Older Persons in Hawaii: Some Issues, Problems, and Opportunities. 192 p.

1982
1. Review of the Implementation of the Hawaii Correctional Master Plan. 76 p.
2. Condominium Conversions in Hawaii. 95 p.
3. Marine Resources and Aquaculture Programs in the State of Hawaii. 43 p.

1983
1. A Department of Corrections for Hawaii: A Feasibility Study. 87 p.

Hawaii Legislators' Handbook. Eighth Edition. 120 p. $1.00

1984
1. A Home Equity Conversion Program for Hawaii's Elderly Homeowners. 90 p.

Guide to Government in Hawaii. Eighth Edition. 186 p. $3.00

Hawaii Legislative Drafting Manual. Seventh Edition. 112 p.

1985
1. The Feasibility of Environmental Reorganization for Hawaii. 145 p.
2. Third-Party Reimbursement of Clinical Social Workers. 61 p.
3. Statewide Standardized Testing Program of the Department of Education. 71 p.
4. The Flexible Working Hours Program for State Employees. 92 p.

1986

How to Research Constitutional, Legislative, and Statutory History in Hawaii. 91 p.

1. The Residential Landlord-Tenant Code. 113 p.

1987
1. Definition of "Independent Contractor" Under Hawaii's Labor Laws. 181 p.