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Assembly
California Legislature

ASSEMBLY COMMITTEE ON
AGING AND LONG-TERM CARE
CHERYL R. BROWN, CHAIR

Joint Informational Hearing

Assembly Aging and Long-Term Care Committee
Senate Committee on Human Services
and the
Senate Select Committee on Aging and Long Term Care

Assemblymember Cheryl R. Brown, Senator Michael McGuire, and Senator Carol Liu, Chairs

Tuesday, April 7, 2015
2:00 p.m.
State Capitol, Room 444

BACKGROUND PAPER

Demographics Equals Destiny?

We are aging; more specifically, we continue to experience increased life expectancy and overall longevity. According to Fernando Torres-Gil, Director of the Center for Policy Research on Aging at the Luskin School of Public Policy at UCLA; "…this is not new; it has been occurring since the middle of the last century. What is profound is that all groups are enjoying the benefit of added years, but certain groups will be impacted differently than others. The good news in all this: We are all living longer." California is home to the largest number of seniors in the nation and their numbers are expanding at a pace unprecedented in history. The California Department of Finance's Demographic Research Unit estimates that California's 65+ population will have grown 43 percent between 2010 and 2020 (from 4.4 million to 6.35 million). By 2030 the 65+ population will reach nearly 9 million people. The ratio of 65+ people will grow from about one in ten people today, to one in five by 2030, approaching one in four in 2040 and beyond. Though women comprise roughly half of the general population, by age 65 their proportion increases to about 57 percent. By age 85, women outnumber men two-to-one. Diversity, the hallmark of California's population, will increase amongst older age groups as fully 30 percent of the baby-boom generation, those born between 1946 and 1964, who will join the 65+ cohort, are foreign born.

As California's aging population expands at a rate much faster than the general population, the need for long-term services and supports (LTSS) and caregiving, both formal (paid-for) and

informal (un-paid) will increase, with a high risk of outpacing the ability of those in need and their families to pay for such services, leading to depleted resources, financially at-risk surviving spouses, and potential dependency upon scarce public health and social service resources.

Accordingly, projections by the U.S. Department of Health and Human Services indicate a two-fold increase in the need for long-term care over the next four decades. Spending on publicly paid services should be of critical concern to individuals, as well as policymakers within state and federal government. However, efforts to both improve the long-term care system and reduce spending are limited by an historical lack of leadership, information on how much is spent, for what services, and in what settings, and the extent and nature of unpaid help that people arrange and receive.

According to "***A Shattered System: Reforming Long-Term Care in California***," (*A Shattered System*) an exhaustive though rich and informative report, action-plan, and tool-kit for the state of California, authored by the Senate Select Committee on Aging and Long-Term Care, (one of three partners responsible for today's hearing), financing long-term care has emerged as one of the leading critical policy areas requiring on-going legislative and administrative attention and leadership. According to the report:

> *"California and the nation face an unprecedented crisis related to the financing of long-term care. Traditionally, LTC responsibility has fallen on unpaid family caregivers, but when paid services are needed, most Californians are not financially prepared. Individuals and their families initially pay for LTC by utilizing their own resources, even though most people do not have the financial wherewithal to cover these costs on an ongoing basis. Most individuals have not set aside the size and scope of savings necessary for ongoing support to meet functional needs. When LTC needs arise, they often must decrease their standard of living, leave LTC needs unmet, or both.[i] Individuals are often forced to spend down to the poverty level in order to quality for Medi-Cal LTC coverage. LTC expenditures from all sources combined are projected to increase from $211 billion in 2010 to $346 billion in 2040."*[ii]

If "Demographics Equal Destiny," then California decision makers have significant challenges before them. Demographically speaking, and according to data presented to the Assembly Committee on Aging and Long-Term Care, and the Assembly Committee on Human Services during an informational hearing on senior poverty March 17, 2015, fully 1.3 million seniors, and people with disabilities subsist on the SSI/SSP grant on a monthly basis – a grant that lifts individuals only to 90 percent of the Federal Poverty Level (FPL). According to the Elder Economic Security Index, in 2007 nearly 1.8 million (of about 4. 2 million) adults aged 65 or older were unable to make ends meet in the communities where they live in California. Today, with about 1,000 baby-boomers turning 65 each day, the 65+ population exceeds 5.1 million people in California. With an anticipated 9 million seniors over the age of 65 by 2030, two-thirds of whom will likely need long-term care, and roughly 50 percent of whom are barely able to make ends meet, the urgency for a reformed, more efficient system of services along with strategies to help those who can save for - and pay for - their own care, becomes apparent.

Financing Long-Term Care (LTC):

According the *A Shattered System*, LTC is funded through a mix of sources, with individuals and their families relying first on personal resources and then on multiple, uncoordinated, unplanned,

public sources with no central leadership or accountability structure, all with unique requirements, most notably Medicaid (Medi-Cal). Medicaid is the dominant source of payment for long-term care (62 percent of LTC expenditures nationally) borne roughly 50/50 on state and federal tax-supported resources, followed by out-of-pocket payments by individuals and families (22 percent of LTC expenditures nationally). Other private payers, including LTC insurance, play a minor role (12 percent of LTC expenditures nationally). Without viable alternatives for planning for the costs of and financing LTC, individuals and their families will continue to be burdened by the unplanned high cost of LTC, while the state and federal government budgets will face ongoing pressure with increased Medicaid (Medi-Cal) expenditures.

Nationally, over 12 million adults in the U.S. currently need long-term care. According to LeadingAge, a private, non-profit partner in this hearing exercise; "...they are our neighbors, friends and family members." And, that "...despite the temptation to ignore the problem, its consequences are becoming increasingly apparent at the personal, local, state and federal levels and the question for our country is, *What do we need to do NOW?*"[iii] LeadingAge asks the question with no expectation that an answer is immediately available. Wisely, and a chosen approach of this first-of-a-series of annual hearings, engaging stakeholders in a "respectful and spirited" dialogue to consider the range of decisions, the order in which they must be made, and options for achieving the change necessary to avoid costly, crisis-level decisions about the known demands of an aging society is the basis for this "first-step" discussion.

What is Long-Term Care?

Given the Senate Select Committee on Aging's recent publication of *A Shattered System,* maintaining consistency when using terms and definitions is advantageous in order to assure the best group-understanding of the challenges to the state revealed in the report. In that report, "long-term care" is defined as:

> *"...a broad range of services provided by paid or unpaid providers that can support people who have limitations in their ability to care for themselves due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time. These care needs may arise from an underlying health condition as is most common among older adults, an inherited or acquired disabling condition among younger adults, and/or a condition present at birth. LTC services can be provided in a variety of settings including one's home (e.g., home care or personal care services), in the community (e.g., adult day care), in residential settings (e.g., assisted living or board and care homes), or in institutional settings (e.g., intermediate care facilities or nursing homes). The term home-and-community-based services (HCBS) refer collectively to those services that are provided outside of institutional settings. Generally, a person needing LTC is one who requires assistance with activities of daily living (ADLs), including bathing, dressing, eating, transferring, and walking; or instrumental activities of daily living (IADLs), this may include meal preparation, money management, house cleaning, medication management, transportation."*

Paid, or "formal" caregiving includes services provided by professionals and paraprofessionals who are compensated to provide in-home health care and/or personal care services. According to data from the Office of Statewide Health Planning and Development (OSHPD) Annual Utilization Report of Home Health Agencies, home health visits have grown since 2000 by

23.3 percent, from 8.9 million visits to 11.6 million visits in 2010. Over 651,000 Californians received home health care in 2010, with Medicare paying for 64 percent of those visits. Private healthcare providers paid for 14 percent of those visits. Medi-Cal and "other" (out-of-pocket, Long-Term Care Insurance) payment sources split the remaining 22 percent evenly. Because the state only recently began an effort to license and regulate home care agencies (agencies that do not provide a health service), it is difficult to estimate the prevalence of formal home care. According to the California Association of Health Services at Home, (CAHSAH), extrapolations from earning reports suggest that 1,200 home care agencies may have generated up to $1.2 billion in revenue in 2008.

According to the Family Caregiver Alliance and the AARP, The value of the services family caregivers provide for "free," when caring, was estimated to be $450 billion in 2009. The estimated value of unpaid care in California in 2010 was about $47 billion, accounting for over 3.8 billion hours of care at $12.17, the average caregiver wage in 2009. On the personal side, long term caregiving has significant financial consequences for caregivers, particularly for women. Informal caregivers personally lose about $659,139 over a lifetime: $25,494 in Social Security benefits; $67,202 in pension benefits; and $566,443 in forgone wages. Caregivers face the loss of income of the care recipient, loss of their own income if they reduce their work hours or leave their jobs, loss of employer-based medical benefits, shrinking of savings to pay caregiving costs, and a threat to their retirement income due to fewer contributions to pensions and other retirement vehicles.[iv] Employers, too suffer as trained technicians flee the workplace to tend to loved ones, often with little notice and no opportunity to plan for the absences.

A Shattered System goes on to state that "(T)he aging population, increasing longevity, and a corresponding increase in disability prevalence will amplify the need for LTC services. Given that public dollars fund a substantial amount of paid LTC services, it is likely that this projected increase in demand will place significant fiscal pressure on federal, state, and local governments." Although today's hearing is not intended to focus upon the needs of those with no resources to pay for their long-term care, the system that supports them becomes the default provider of their care when those who can and do pay for their own care exhaust their personal savings, and exhaust themselves and personal relationships that provide informal care.

Who Will Likely Require Long-Term Care?

Seventy percent of the U.S. population is predicted to need some form of long-term care services during their lifetimes, and this kind of care is expensive. According to Health and Human Services figures, individuals can expect to pay:

- About $84,000-92,000 per year for a private room in a nursing home.
- About $40,000 per year for care in an assisted living (non-health) facility.
- $19-21 per hour for home care, or home health care (recent labor rulings have impacted the hourly costs of home care, and home-health care causing volatility in the industry and potentially significantly increasing the typical hourly costs.)

How Do Individuals Protect Themselves From the Risk of Long-Term Care Costs?

Long-term care insurance may be purchased from companies through insurance agents, or a variety of groups or employers. Some private employers sponsor LTC insurance and public employers such as the California Public Employees' Retirement System (CALPERS) and the Federal Employees Long Term Care Program (FLTCP) sponsor their own LTC programs.

California state employees, and others covered in the CalPERS system, may purchase coverage through the CalPERS Long-Term Care Insurance Program during periods of open enrollment. Long-term care insurance primarily pays for supervision or assistance with ADLs (eating, bathing, dressing, toileting, continence, and moving about inside one's home). When one acquires a physical impairment (usually brought on by age), and needs supervision of these activities, or when one has a cognitive impairment such as Alzheimer's disease, or complex but stable medical conditions, benefits are triggered after a deductible period, typically 90 days. Benefits are generally meant as reimbursement for LTC services which can be in the home, in a community program, in an assisted living facility, or in a nursing home. Since long-term care services can be triggered over a long period of time, benefits are usually intended to help support a beneficiary in the least restrictive environment. However, LTC services are often provided by family members and typically do not require the skilled care that nurses and doctors are licensed to provide, and are therefore often difficult to recognize for reimbursement of benefit purposes. Policies offer daily benefit amounts to pay for home care, and other needs. LTC insurance benefits may be part of a life insurance or annuity policy, or contained in a freestanding LTC policy. As a courtesy to this hearing and informational effort, the Senate Committee on Insurance and the Assembly Committee on Insurance offers the following contribution to help advance the understanding of long term care insurance (LTCI):

Long-term care insurance (LTCI) covers the costs of some or all long-term care services when insureds are unable to take care of themselves. Coverage is triggered when an insured develops a "chronic illness" typically defined as an inability to perform a set number of "activities of daily living" such as feeding, dressing, and bathing themselves, or as specified cognitive impairments. A policy may cover facility care or home care or both. Approximately 599,000 policies are currently in force in California, up from about 497,000 five years ago.

Once a consumer purchases a policy, the insurer may not raise the premium on an individual policy due to a change in the individual's circumstances, such as the development of a health condition. Subject to the approval of the Insurance Commissioner, the insurer may raise the rate on a "block of business" (a group of policies sold by the same insurer using the same forms and rates) if the insurer demonstrates that an increase is warranted. All policyholders in that group will receive the same increase.

LTCI is relatively new form of insurance, but has a volatile history. Insurers first sold LTC covering nursing homes in the 1970s and expanded coverage in the 1980s to cover a wider variety of settings. Unfortunately, those insurers failed to accurately estimate future costs and losses. (Some consumer advocates also argue that some insurers underpriced the product as a "teaser rate" to induce consumers into purchasing the policy.) Increasing life expectancies, faulty assumptions on lapse ratios and the cost of care, as well as the poor performance of insurer investments, have all worked to drive dramatic increases in LTCI premiums.

Attempts in the 1990s and early 2000s to stabilize rates have had some impact, but some carriers are still requesting and waiting on approval for additional rate hikes as they are informed by more recent loss data.

Usually, consumers purchase LTCI policies as life-long estate management tools. Policyholders tend to keep their policies, despite rate hikes; lapse rates for LTCI policies fall between one half to one-and-one-half percent. A policy lapse places the consumer in an extremely disadvantageous position since the insured will likely lose all benefits under the policy unless the consumer purchased an optional "nonforfeiture benefit" that provides a very limited vested benefit once the insured meets eligibility criteria (such as making a specified number of premium payments). When consumers lose their original coverage, they also lose most of their bargaining position. Obtaining a new or replacement policy may require additional underwriting and the potential for much higher premium since a new policy will be priced at the consumer's attained age. Consumers with poor health may not be able to purchase a policy at all.

Market Conditions. *Many LTCI carriers, such as Prudential and MetLife, have already stopped offering new LTCI policies in California. Presently, only 12 insurers are writing new business in California, a drop from the 16 insurers that were active five years ago. Genworth Financial, with 32 percent of California's individual LTCI market, warns that its ability to continue to offer LTCI nationally depends on its ability to obtain approval on pending rate increases.*

Further adjustments in LTCI carrier operations may be necessary as data from losses accrues and actuarial analyses are updated. Genworth discovered last year that it failed to set aside the necessary assets to pay future claims on policies that were already drawing benefits. Fortunately, it had the assets to correct its reserves, but it still must complete its analysis on policies that have yet to involve a claim.

LTCI Alternatives*. Insurance as a tool has many uses and LTCI products are not the only insurance-based approach to addressing the needs of the chronically ill. Some life and disability insurer offers products timed to be helpful during a chronic illness, but are not specifically designed to pay for long-term care services. For example, some life insurance policies offer accelerated benefits triggered by a chronic illness that pay insureds all or a portion of the death benefit of a life insurance policy when they develop a chronic illness.*

In the face of continuing rate adjustments, whether LTCI will retain its appeal as a long-term estate planning tool, remains to be seen. It is well accepted that the average American worker has inadequate retirement savings. A worker is considered to be at risk for serious economic hardship in old age if his or her retirement income falls under 200 percent of the poverty threshold for individuals. A study of retirement readiness published in 2011 by the UC Berkeley Center for Labor Research and Education found that 47 percent of Californians are projected to have retirement incomes below 300 percent of the poverty level ($34,470 in 2013). Individuals who have not been able to save enough to provide adequate retirement income are unlikely to be able to support the added cost of LTC insurance premiums either before or, especially, during retirement. Individuals with low retirement incomes who need LTC services are most likely going spend down their assets and rely on Medi-Cal to pay for those services.

Finding a way to pay for long-term care will remain a growing concern for consumers and policy makers alike. Though it is ideal when one needs long-term care to have a long-term care insurance policy, most people rely on their own incomes and assets to pay for care when they need it, and often end up on Medicaid and other public and community social services when those funds are depleted. The high cost of long-term care insurance combined with screening out those likely to need care, and the future risk of higher premiums, or prospects for gender-based pricing, may be limiting the number of people likely to have these benefits when they need care. Although long-term care insurance can be a valuable resource for those who can qualify for coverage and who have the means to pay for it over their lifetime, experts are beginning to suggest that it will not provide enough people with benefits to have a meaningful impact on a reduction in the reliance of public benefits. Since there are correlations between long-term care insurance and a reduced reliance upon public social services, the question of a public solution has been raised.

Federal Strategies:

The "Cat-Act:" In 1986, President Reagan unveiled "The Medicare Catastrophic Coverage Act" during his State of the Union Speech. His proposal altered benefits and financing of Medicare, phasing in changes over several-years, starting in 1989. According to *Health Affairs*[v], the three most important new benefits involved hospital care (Medicare Part A), physician care (Part B), and prescription drugs. Beginning in January 1989 (and continuing until repeal in November of that year), beneficiaries were no longer responsible for substantial daily copayments for hospital stays in excess of sixty days, and they had to pay the $560 initial deductible only once in a calendar year. Starting in 1990, a $1,370 annual cap was to be placed on Part B copayments. Although there were some modest changes in the Medicare nursing home benefit, one of the primary complaints about the legislation was that it did not extend Medicare coverage to long-term nursing home care. This is the type of care that is most likely to impoverish the elderly. One benefit enhancement was not repealed by Congress was the liberalization of Medicaid regulations to allow the spouse of a nursing home resident to retain enough income to avoid impoverishment. A strategy that continues to prevents spousal impoverishment to this day.

In a new precedent, Medicare beneficiaries would have financed the new benefits in their entirety. The controversial "supplemental premium," an additional amount of income tax to be paid by an estimated 40 percent of the elderly, would have been the primary source of additional revenue needed. The legislation established a maximum tax liability, which would have been paid by less than 10 percent of the elderly, at $800 per person ($1,600 for a couple). In addition to the supplemental premium, the Part B monthly premium, charged to all program beneficiaries whose incomes were above the poverty level, would have risen by $4. The problem at the time was that most Medicare beneficiaries received most of the additional Cat-Act benefits through employer retirement packages, yet they were being asked to finance the needs of lower-income seniors who did not.

The "CLASS-Act:" The Community Living Assistance Services and Supports Act (or CLASS Act) was a U.S. federal law, enacted as part of the Patient Protection and Affordable Care Act. Few private mechanisms are available to help people plan ahead to pay for their future care. Long-term care insurance, by far the most popular private option available, can be costly and difficult to purchase, particularly for those with pre-existing health conditions or disabilities. Only about 2.8 percent of Americans currently have a policy. For workers who already

experience a disability, the options are even more limited. The CLASS Act would have created a voluntary and public long-term care insurance option for employees, but in October 2011 the Obama administration announced it was unsustainable and would be dropped. The CLASS Act was repealed January 1, 2013. Key provisions included monthly premium through payroll deduction, guaranteed-issue, and eligibility within five years. Enrollees would have received a lifetime cash benefit after meeting eligibility criteria.

State Level Innovation in California:

Partnership for Long-Term Care: According to The California Partnership for Long-Term Care (Partnership) website, the Partnership program is dedicated to educating Californians on the need to plan ahead for their future long-term care and to consider private insurance as a vehicle to fund that care. The California Partnership for Long-Term Care is an innovation of the Department of Health Care Services in cooperation with a select number of private insurance companies. These companies have agreed to offer high quality policies that must meet stringent requirements set by the Partnership and the State of California. These special policies are commonly called "Partnership policies."

Partnership approved policies are intended to take the guesswork out of ensuring that a consumer purchased a quality policy. In addition to many other consumer protection features, Partnership policies offer the special benefit of Medi-Cal "Asset Protection." Asset Protection helps consumers avoid liquidating assets to pay for long-term care, and grants Medi-Cal eligibility when consumers would otherwise need to first impoverish themselves in order to qualify for benefits under the Medi-Cal program.

Bonnie Burns, one of the architects of the Partnership program, and long-time consumer advocate, along with a representative from the Department of Health Care Services, will be available as witnesses during today's hearing.

The Partnership prioritizes public awareness to encourage sales, and thus discourage future dependency upon public social services. However, the program remains relatively unknown, and there is no data that shows how the Partnership has made in-roads into markets that wouldn't otherwise be accessing mainstream LTCI policies. As a small program within a very large agency, the Partnership relies on dedicated staff to maintain a presence in an often chaotic healthcare policy environment, where leaders are heavily invested in health care expansion, the Coordinated Care Initiative, or other priorities.

HICAP: Besides providing personalized counseling, community education, and outreach events for Medicare beneficiaries, the California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP) is the primary local source for accurate and objective information and assistance with long-term care insurance policies under consideration by California consumers. HICAP is part of a national network of State Health Insurance Assistance Programs (SHIP). SHIP is a Federal grant program that helps states enhance and support a network of local programs, staff, and volunteers. Local programs are charged with directly helping beneficiaries to understand how to use their Medicare benefits as well as long term care insurance. The Centers for Medicare and Medicaid (CMS) administers the SHIP grant programs nationally.

HICAP provides free community education and unbiased confidential individual counseling statewide. HICAP Counselors are trained to assist consumers with choosing and/or enrolling in Prescription Drug Plans and Medicare Health Plans, filing original Medicare and private insurance claims and/or preparing Medicare appeals. If citizens are considering purchasing long-term care insurance or Medicare supplement insurance, HICAP counselors can help them compare policies and explain what services each policy provides.

Administered by the California Department of Aging, in 2012-13, HICAP counselors provided guidance over 420,000 times to consumers in California. There are 26 local HICAP offices in California. Counseling is for individuals age 65 or older on Medicare, individuals younger than age 65 with a disability and on Medicare, individuals close to eligibility for Medicare and at least age 60. Individuals of any age may attend HICAP community education events. Other individuals needing assistance with long-term care insurance policy comparisons, of any age, are also eligible.

Related, Pending Legislation:
AB 332 (Calderon) -- This bill would require the Insurance Commissioner to convene a task force composed of specified stakeholders and representatives of government agencies to examine the components necessary to design a statewide long-term care insurance program, as specified. The bill would require the task force to recommend options for establishing this program and to comment on their respective degrees of feasibility in a report submitted to the commissioner, the Governor, and the Legislature by January 1, 2017.

SB 575 (Liu) -- Provides for surrogate notification in the event a LTCI policy is lapsed, and the policy holder elects to maintain a contingent benefit. The bill would require the insurer, within 90 days of receipt of notice that a policyholder elected the contingent benefit upon lapse, to mail and receive from each policyholder a form that allows the policyholder or certificate holder to submit one of the following: (1) a written designation of the name, address, and telephone number of at least one person, in addition to the policyholder or certificate holder who is to receive the annual notice described above, or (2) a waiver signed and dated by the policyholder or certificate holder electing not to designate additional persons to receive notice.

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[i] The Commission on Long-Term Care. "Report to the Congress." September 2013. Accessed at: http://ltccommission.lmp01.lucidus.net/wp-content/uploads/2013/12/Commission-on-Long-Term-Care-Final-Report-9-26-13.pdf., and, The SCAN Foundation. "Shaping Affordable Pathways for Aging with Dignity." March 2013. Accessed at:http://thescanfoundation.org/shaping-affordable-pathways-aging-dignity-current-issues-and-potential-solutionsaddressing-america.

[ii] The SCAN Foundation. "Who Pays for LTC in the U.S.?" January 2013. Accessed at: http://www.thescanfoundation.org/sites/thescanfoundation.org/files/who_pays_for_ltc_us_jan_2013_fs.pdf.

[iii] LeadingAge PATHWAYS: A Framework for Addressing Americans' Financial Risk for Long-Term Services and Supports

[iv] Valuing the Invaluable: 2011 Update: The Growing Contributions and Costs of Family Caregiving, Lynn Feinberg, Susan C. Reinhard, Ari Houser, and Rita Choula, AARP Public Policy Institute

[v] T Rice, K Desmond and J Gabel, " The Medicare Catastrophic Coverage Act: a Post Mortem" Health Affairs, 9, no.3 (1990):75-87