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STATE OF MAINE
120TH LEGISLATURE
SECOND REGULAR SESSION

Interim Report of the Blue Ribbon Commission to Address the Financing of Long-term Care

November 6, 2002

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ERRATA

On page 2, in the first paragraph the first sentence should read: "State and federal funding for MaineCare long-term care programs in state fiscal year 2001 was $307,005,738."

On page 8, in the fifth paragraph the second sentence should read: "These savings together on a national scale total about $30,000,000,000 per year."

On page 8, in the sixth paragraph the fourth sentence should read: "Over 25 years the benefit to the Medicaid program of a million policyholders who purchase and renew their policies through entry to nursing facilities is between $3,500,000,000 and $6,900,000,000."

For a corrected copy of the report, please visit the Internet website of the Office of Policy and Legal Analysis, http://www.state.me.us/legis/opla/reports2.htm.

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Executive Summary

A. Legislative history and commission process

The Blue Ribbon Commission to Address the Financing of Long-term Care was established by Resolve 1999, chapter 114. The commission is composed of 9 members appointed by the President of the Senate, 10 members appointed by the Speaker of the House of Representatives and the Commissioner of Human Services or the commissioner's designee and the Treasurer of State or the treasurer's designee.

The duties of the commission include analysis of the future costs of providing long-term care and recommendations for an integrated system of financing that preserves and promotes consumer choice. In performing these duties the commission was directed to consider whether the financial risk of long-term care should be shared in a public or private insurance system, whether individual savings for long-term care needs should be encouraged and whether each generation of working adults should pay for the long-term care costs of their parents and grandparents.

The commission met on September 19, October 1, October 15 and October 31, 2002. Four more meetings are authorized during 2003. The resolve contains authorization for one meeting in 2002 and one in 2003 to be public hearings scheduled during nonbusiness hours.

B. Commission recommendation

The commission supports the provisions of LD 2220, the supplemental budget bill that will be considered by the 120th Legislature in a Special Session on November 13, 2002, that impose a licensing fee on nursing facilities and intermediate care facilities and that increase reimbursement for long-term care services, provided the fees and reimbursement increases are tied together. The commission acknowledges that this is a short-term fix for a system that is in crisis due to perennial underfunding. The commission will continue to work through 2003 to identify funding and structural issues in long-term care and to propose new approaches to financing that will ensure a fiscally healthy long-term care system.

C. Continued work

The commission is authorized to meet 4 times during 2003. The commission is forming subcommittees to work on issues during the First Regular Session of the 121st Legislature. When the First Regular Session adjourns the commission will begin its second season of work with reports from the subcommittees. The subcommittees, for which there have been a large number of volunteers, will work on private and public responsibility in the long-term care system. The subcommittees will return to the full commission in 2003 with background information, options and any recommendations on which they are able to agree.

I. INTRODUCTION

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The commission met on September 19, October 1, October 15 and October 31, 2002. Four more meetings are authorized during 2003. The resolve contains authorization for one meeting in 2002 and one in 2003 to be public hearings scheduled during nonbusiness hours.

At the October 31st meeting commission members decided to form 2 subcommittees to continue the work of the commission in preparation for the 2003 meetings. The subcommittees will collect and analyze information on private and public responsibilities in long-term care and will report to the full commission in 2003 after the First Regular Session of the 121st Legislature on options and any recommendations of the subcommittees.

II. BACKGROUND INFORMATION

The commission sought and considered background information on the current long-term care system in Maine, the fiscal health of Maine's long-term care system, long-term care and financing in other jurisdictions within and outside the United States and long-term care insurance. This information provided a solid basis for commission discussion and the interim recommendation.

1. Overview of Maine's long-term care system

The commission has determined to study public responsibility, in which public long-term care programs provide reimbursement for long-term care, during the time period before the 2003 commission meetings and as a topic at those meetings. As documentation of what commission members have learned and to prepare for the 2003 meetings, the following information is noted.

Who pays for long-term care? The federal-state Medicaid program and the Federal Medicare program are the biggest purchasers of long-term care.[1] MaineCare pays for home and community care and nursing facility care for persons with disabling diagnoses who are of low income and

[1] The federal-state Medicaid program is known in Maine as the MaineCare program and will be referred to under that name in this report. Exceptions will be made when the reference is to federal requirements for the program or national statistics.

who have few assets. State and federal funding for MaineCare long-term care programs in state fiscal year 2001 was $307,005,738.[2] Medicare pays for skilled nursing and home health care for a limited period of time. Medicare is entirely federally funded so there are no costs for the state in this category. Medicare funding for long-term care in 2001 totaled $56,708,000. State-funded programs in Maine pay for services not available under the MaineCare program and for individuals whose income exceeds the MaineCare limits. State spending under these programs, the only funding, in state fiscal year 2001 totaled $21,575,926. Individuals and families and any private insurance that they may have pay for long-term care also. In 2001 they paid, through private pay and insurance, $78,778,000 for long-term care.[3]

The Department of Human Services, through Christine Gianopoulos, the Director of the Bureau of Elder and Adult Services, reported that in state fiscal year 00-01 Maine provided reimbursement through joint state-federal programs and through state-only funded programs to over 30,000 persons.[4] Maine served under the MaineCare program 24,130 clients in nursing and residential care facilities, adult day health services, private duty nursing, personal care services, services under waivers for consumer directed care and elders and adults with disabilities and home health care.[5] Ms. Gianopoulos reported that state-only funded programs serve another 6,738 clients in home-based care for elders and adults with disabilities, consumer-directed home-based care, adult day services, congregate housing services and programs, assisted living, Alzheimer's respite care and homemaker services. Additional services were provided in 2000 in Maine under the Medicare home health program for 19,120 persons, through 692,525 total visits, for a total value of $49,907,026.

The Department of Human Services performed assessments of need for long-term care services through a medical eligibility determination process that utilized nurses making home, nursing facility and hospital visits for 16,359 persons between July 1, 2000 and June 30, 2001. Sixty-nine percent of the persons assessed were women and 17% were under 65 years of age. Of the persons assessed 94% needed assistance or were totally dependent on others in the activity of daily living labeled bathing, 86% needed assistance or were totally dependent on others in dressing and 69% needed assistance or were totally dependent on others in toilet use. Of the persons assessed 57% reported receiving assistance from children, 25% from a spouse, 15% from another relative and 21% from a sibling, parent or non-relative.[6]

The medical eligibility determination process results in a calculation of the amount of assistance a person needs with: daily nursing care; therapies; activities of daily living, which include bathing, dressing, toilet use, transferring, moving between locations, moving in bed and eating. The assessment also considers eligibility based on cognitive impairment and behavioral problems and the amount of assistance needed with instrumental activities of daily living, which include

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[2] State of Maine, State and Medicaid Long-term Care Expenditures, Department of Human Services, prepared 2002. Numbers of consumers served is not unduplicated. See Appendix C.
[3] Summary of Historical Nursing Facility Utilization, Maine Health Care Association, Fall 2002. See Appendix D.
[4] Ibid.
[5] Ibid.
[6] MeCare, Maine's Long-term Care Preadmission Screening Program, Summary, July, 2000 to June 2001, Maine Department of Human Services, Bureau of Elder and Adult Services.

preparing meals, shopping, managing money, using the telephone, doing housework and taking medication.

In 2001 25,455 persons who were elderly or disabled adults received financial assistance in obtaining long-term care. Of these persons, 49% received home-based care, 33% received care in a nursing facility and 18% received care in an assisted living facility. By type of expenditure in each setting, 20% of the state's spending for long-term care was spent on home-based care, 61% was spent on nursing facility care and 19% was spent on assisted living care.

Nursing facility care is the most intensive and most costly component of the long-term care system. In 2001 nursing facilities provided care for 1,764,000 patient days under reimbursement through the MaineCare program, while reimbursement through Medicare, private pay and other insurance together totaled 767,000 patient days. MaineCare accounts for 70% of the patient days while paying a total of 64% of the total revenue for nursing facilities. Medicare, private pay and other insurance together account for 30% of the patient days and pay 36% of the total revenue.

2. Fiscal health of Maine's long-term care system

Commission members heard testimony from Christine Gianopoulos, of the Department of Human Services, and from Michael McNeil, of the Maine Health Care Association, both of whom are commission members, establishing that there is estimated to be a gap between allowable costs under the MaineCare program for nursing facility reimbursement and actual reimbursement of $18,000,000 in 2001. Based on 2000 cost report data for non-hospital based nursing facilities, the average actual cost of operations for nursing facilities was $166.81 per day, the average allowable MaineCare cost was $128.80 per day and the average MaineCare reimbursement was $117 per day. Mr. McNeil and Ms. Gianopoulos told the commission that the gap between actual costs and MaineCare reimbursement will continue annually and may grow annually until funding is provided to enable the Department of Human Services to increase reimbursement rates. The commission also heard of a gap in MaineCare reimbursement for residential care facilities of $10,000,000 in 2001, continuing annually in the same manner as the nursing facility funding gap.

Short-term relief for the long-term care system may be in sight. LD 2220 in the 120th Legislature proposes a 6% licensing fee for nursing facilities and intermediate care facilities for mental retardation (ICF-MR'S). These fees are estimated to generate income for the General Fund and funding for the long-term care system. From the nursing facility and ICF-MR licensing fees, the bill proposes to direct $10,400,000 to the General Fund to assist in meeting the budget shortfall, $10,438,777 to increased reimbursement for nursing facilities, $1,614,000 for increased reimbursement for home health agencies and community services and $457,261 for increased reimbursement for intermediate care facilities. Commission members acknowledge that these fee increases are short-term fixes for a system with challenges caused by traditional and continued underfunding in the MaineCare program. The consensus of the commission was to endorse the licensing fees provided the fees are accompanied by a commitment to fund the reimbursement increases. The commission will continue to study long-term care financing and to search for permanent solutions to provide a strong fiscal foundation for the system.

3. Projections of need

Robert Mollica, of the National Academy for State Health Policy and a commission member researched future long-term care needs and presented information to the commission. Based on 2002 figures and using a model developed by the Lewin Group, Mr. Mollica estimated moderate growth in the numbers of persons requiring assistance with activities of daily living in the year 2010: increasing in state and MaineCare funded programs from 14,108 to 15,212 for persons needing assistance with one ADL, from 7,910 to 8,552 for persons requiring assistance with 2 ADL's and from 5,319 to 5,761 for persons requiring assistance with 3 ADL's. Commission members questioned the calculations since the starting total for 2002 amounts to 27,337 while figures from the Department of Human Services show 30,868 persons on state funded and MaineCare programs in 2001. This issue was partly resolved by knowing that the Lewin method was based on 1990 census figures and that the Department of Human Services numbers do include some duplication of consumers. The disparity, which brought into question the accuracy of the Lewin method of estimating growth and thus the projections themselves, was not resolved.

Projections of future need and future costs are intertwined. The Congressional Budget Office estimates that nationally long-term care expenditures will grow by 2.6% annually from 2000 to 2040 while the prevalence of disability will decline by 1.1% annually.[7] National research reported in "A Profile of Older Americans: 2001", from the U.S. Department of Health and Human Services, Administration on Aging, indicates that over the next 30 years, as the "baby boomers" advance to old age, the number of people age 65 and older will increase from 12.4% of the population in 2000 to 20% of the population in 2030. The percentage of Maine's population in 2000 who were age 65 and older was 14.4%. As the population ages concerns grow about the number of persons who need assistance with activities of daily living and instrumental activities of daily living. The percentages of persons with disabilities rise with age. A third of persons age 65 and older report having one severe disability. Of the population age 80 and older, almost three-quarters report at least one disability and 34.9% report needing assistance as a result of a disability. Persons reporting a disability were more likely than others to report poor or fair health. In addition many older persons report chronic conditions and diseases. In addition, as predictions are made for the needs of the elderly, the needs of children and adults with disabilities must be taken into consideration.[8]

Predicting a "perfect storm" of demographic, technological and societal trends, authors Brian Raftery and Carolyn Kates, point out that the "age wave" of "baby boomers" will result in 2050 in 40 Social Security beneficiaries per one taxpayer, as contrasted with one Social Security beneficiary per 40 taxpayers when the program began.[9] They point out that technological advances and healthy lifestyles have led to longer life expectancies and that living longer means collecting benefits for longer. The third factor in the perfect storm is societal changes, the altered American family. They point out the there are more families headed by single adults and adults

[7] "Projections of Expenditures for Long-term Care Services for the Elderly," Congressional Budget Office Memorandum, March 1999.
[8] "A Profile of Older Americans: 2001," U.S. Department of Health and Human Services, Administration on Aging.
[9] "The Perfect Storm," by Brian Raftery and Carolyn Kates, 2001.

working who in previous generations may have been available to provide care for older family members.

"Alzheimer's Disease: The Costs to U.S. Businesses in 2002" reports that 4,000,000 persons in the United States are estimated to suffer from Alzheimer's disease now and that the costs to business totals over $61,000,000,000 per year. The cost is based on estimates that 64% of persons with Alzheimer's disease have a caregiver in the workforce full or part time and that businesses pay direct and indirect health care costs and health care research costs. This report estimates that when the baby boomers age the number of persons suffering from Alzheimer's disease will mushroom to 14,000,000 and the costs to families, business and government will be unsustainable.

4. Long-term care services and financing in other jurisdictions

Commission members studied long-term care systems and financing in other states and countries. They were very interested in the newly enacted Hawaii Long-term Care Financing Act that establishes a long-term care financing program.[10] The program, which will take effect on July 1, 2003, will establish a state long-term care benefits fund overseen by a board of trustees overseen by the Governor. The program will require all Hawaii residents ages 25 and older to pay $10 per month to the fund for a period of at least 10 years in order to receive full benefits. Residents will qualify for benefits from the program through an individual assessment, with a threshold of needing assistance with 2 ADL's or a diagnosis of Alzheimer's disease or dementia. Program materials describe the benefits as partially meeting the cost of long-term care, and as being designed for use in conjunction with private long-term care insurance and other payment sources. Additional information about the Hawaii program will be obtained for consideration during the 2003 commission meetings.

The Canadian long-term care system varies by province. It is financed through a mixture of federal grants and provincial taxes. Administration is done on a provincial level but may be contracted out to regional or district agencies. Financial eligibility varies from province to province. Benefits for facility-based care require payment of room and board costs.[11]

Commission members looked at long-term care in Germany, Japan, New Zealand, Sweden and England.[12] All countries provided long-term care in the full range of settings, from home care to nursing facility care. The German system includes mandatory contributions from employer and employee, or retiree and pension fund, and includes benefit payment through vouchers or cash. Out-of-pocket contributions are required in addition to payments for room and board. Japan has a newly enacted system funded half through general taxes and half through employer/employee or retiree/pension fund. Co-payments of 10% are required and benefits are capped depending on the service setting. The New Zealand program is integrated with the national health program and relies on general tax financing at the national level. Maximum benefit levels and co-payments

[10] The Hawaii Long-term Care Financing Act, HB 2638, Act 245, 2002.
[11] "Long-term Care: Other Countries Tighten Budgets While Seeking Better Access," Government Accounting Office, 1994.
[12] Preliminary Comparison of Long-term Care System Financing. See Appendix E.

depend on the level and location of service. In Sweden the long-term care program is locally run and 90% locally financed, 10% nationally financed. Facility-based care does not include the cost of room and board. The last country studied, England, incorporates local administration and national funding. Facility-based care requires room and board payments while other services require income-based co-payments.

5. Long-term care insurance

The commission has determined to study private responsibility, in which private long-term care insurance plays a large role, during the time period before the 2003 commission meetings and as a topic at those meetings. As documentation of what commission members have learned and to prepare for the 2003 meetings, the following information is noted.

Long-term care insurance provides payment for long-term care in a variety of settings and under the terms and conditions specified when the purchaser and the insurance company execute a contract for benefits. Purchasing long-term care insurance can be confusing as there are a whole set of terms to learn and factors to weigh. The Bureau of Insurance, within the Department of Professional and Financial Regulation, puts out a consumer guide to long-term care, nursing home care and home health care insurance. The publication is also available on line, as are guides to tax qualified policies.

What are all the variables? Long-term care insurance in Maine offers coverage for skilled, intermediate and custodial care in a skilled nursing or intermediate care facility, custodial care benefits and home health coverage. Benefits for the covered person begin through a diagnosis of a clinical deficiency in activities of daily living or cognitive impairment and upon the expiration of any contractually agreed upon elimination period. Coverage continues as long as the beneficiary continues to qualify, for a maximum of the contractually agreed upon benefit period. Policies are purchased annually, with renewal guaranteed upon payment of the next year's premium. Inflation protection, which may be purchased as part of the contract, protects against premium increases in excess of a stated amount each year.

The choices to be made in purchasing a long-term care insurance policy include the elimination period after which benefits are payable, benefit level, duration of benefits, the types of benefits desired and inflation protection. This is best illustrated by example: 3 years of benefits, paying $125 per day for nursing facility or home care, with a 90 day elimination period, for a person 30 years old could cost $604 per year. Five years of benefits, under the same terms could cost $767 per year and unlimited lifetime benefits could cost $1,184 per year. Raising the purchaser's age to 70 increases premiums for the same policies to $2,401, $2,997 and $4,117 per year. It is a balance of anticipated needs, preferences and personal resources and assets. Purchasing more coverage and purchasing later in life costs more. Purchasing less coverage and purchasing earlier in life costs less.

Are there tax consequences from purchasing long-term care insurance? Yes. Premiums paid for tax qualified long-term care insurance are deductible up to a certain amount from federal income

tax provided the taxpayer itemizes deductions on Schedule A.[13] In Maine, under Title 36, Maine Revised Statutes Annotated, sections 2525-A, subsection 2, paragraph C, employers are allowed tax credits for premiums paid on behalf of their employees. Under section 5122, subsection 2, paragraph P, individual resident taxpayers are entitled to a tax deduction for long-term care insurance premiums for policies certified by the Maine Superintendent of Insurance. Benefits for federally tax qualified long-term care insurance are, with a few exceptions, not taxable as income. For non-tax qualified policies, the Internal Revenue Service has not provided guidance. Prior to the enactment of the Kennedy-Kassenbaum bill in 1996, setting up the tax qualified category and affording it specific tax treatment, long-term care insurance benefits had for 30 years not been taxable to the individual beneficiary.

Studies have been done on consumers who purchase long-term care insurance and the potential benefit to the beneficiary and to the public treasury from the purchase of long-term care insurance. Following are the reported results from a number of those studies.

- ✓ Purchasers of long-term care insurance who live in the community are more likely than non-purchasers to have cognitive impairment and less likely to need help with ADL's. Purchasers are more likely to live alone, at some distance from family members and to rely on formal services. Middle and upper income Americans may benefit from long-term care insurance. Further efforts are needed in educating the public about the use of long-term care insurance and the potential need for long-term care.[14]

- ✓ Assisted living residents who have private long-term care insurance, as compared to residents without private insurance, are more likely to be younger, male and married, and to have higher income, have functional impairments and have cognitive impairments. Twenty-eight percent of the insured living in assisted living are likely to report that their needs are not being met. Nursing facility residents who have private long-term care insurance, as compared to residents without private insurance, are more likely to be younger, male and married, and to have higher income and a college education. Forty-six percent of the insured living in a nursing facility are likely to report that their needs are not being met.[15]

- ✓ Nationally long-term care insurance paid less than $5,000,000 for facility-based and home-based long-term care in 2000. Expenditures by long-term care insurers for facility-based care are anticipated to rise to $5,500,000 in 2010 and $10,200,000 in 2020. Similarly their expenditures for home-based care are anticipated to rise to $16,700,000 in 2010 and $36,200,000 in 2020.[16]

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[13] "Tax Qualified Long-term Care Insurance: 2 Years Later," Clifford P. Ryan, CLU, ChFC, CFP, RHU, 2002. See Appendix F.
[14] "The Impact of Private Long-term Care Insurance on Claimants: Formal and Informal Care in the Community," The Center for Home Care Policy and Research, Visiting Nurse Service of New York, Spring 2002.
[15] "The Use of Nursing Home and Assisted Living Facilities Among Private Long-term Care Insurance Claimants: The Experience of Disabled Adults," The Center for Home Care Policy and Research, Visiting Nurse Service of New York, Spring 2002.
[16] See footnote 7 above.

- ✓ Long-term care insurance provides benefits to policyholders, family caregivers and the Medicaid and Medicare programs.[17]
  - o Long-term care beneficiaries report that their insurance allows them to stay at home and out of an institution and makes them feel more secure about the future. They spend less out of pocket and are less likely to have to spend down to Medicaid eligibility.
  - o Family caregivers of beneficiaries of long-term care insurance suffer less stress and are more likely to be able to remain employed.
  - o Medicare savings are estimated at $1609 per beneficiary per year. Medicaid savings are estimated at about $5000 per beneficiary per year. These savings together on a national scale total about $30,000,000,000 per year.
- ✓ Savings accrue to the Medicaid program, in 1990 real dollars, at the rate of $3500 to $6854 per long-term care policyholder. Current expenditures are not greatly affected by current purchases, particularly when younger persons are buying policyholders. The benefits accrue over time. Over 25 years the benefit to the Medicaid program of a million policyholders who purchase and renew their policies through entry to nursing facilities is between $3,500,000,000 and $6,900,000,000.[18]

6. The ostrich effect

Given that we are living longer and the long-term care is extraordinarily expensive, one might think that Americans would be learning about their long-term care options and preparing for the future. Maybe. But that's not what Americans are doing. Even if the news is bad and we could do something about it, we would prefer not to know. It's the ostrich effect.

"The Costs of Long-Term Care: Public Perceptions Versus Reality," a study undertaken by the American Association of Retired Persons in 2001 revealed that Americans are imitating the ostrich on the subject of long-term care.[19] Based on a survey of 1,800 adults ages 45 and older, the study found that only 60% of respondents said that they were somewhat familiar with their long-term care options, and only 15% could estimate the costs within 20%. Fifty-one percent underestimated nursing facility costs and nearly twenty-five percent had no idea of cost. Forty-six percent reported that they were not very prepared or not at all prepared to pay for long-term care. Although Medicare's long-term care coverage is very limited, a quarter of respondents who

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[17] "Benefits of Long-term Care Insurance: Enhanced Care for Disabled Elders, Improved Quality of Life for Caregivers and Savings to Medicare and Medicaid," by Marc A. Cohen, Health Insurance Association of America, September 2002, Fall 1994.
[18] "Long-term Care Insurance and Medicaid," by Marc Cohen, Nanda Kumar and Stanley Wallach, *Health Affairs*, Fall 1994.
[19] "Most Americans Unprepared for Long-term Care Costs," American Association of Retired Persons, news release, December 20, 2001. See Appendix G.

classified themselves as very familiar with their options intended to rely on Medicare. AARP concludes that Americans have a false sense of financial preparedness regarding long-term care.

In "Can Medicaid Long-term Care Expenditures for the Elderly Be Reduced?" author Joshua Weiner, PhD, analyzes ways to save on Medicaid long-term care expenditures and explores encouraging the purchase of private long-term care insurance. The author observes that younger people do not purchase long-term care insurance because the risk of needing care is too distant and they have more immediate needs for their resources: child care, mortgage payments and college education. Dr. Weiner concludes that there are 3 reasons why so few older people purchase private long-term care insurance:[20]

- ✓ First and most importantly, long-term care insurance is too expensive for most of the elderly, with a high-quality policy unaffordable for all but 10% to 20% of the elderly.
- ✓ Second, many older people believe that Medicare will take care of their long-term care needs. They think they already have coverage.
- ✓ Third, although older people may admit that they may eventually need hospital and physician care (which they get from the Medicare program), they are unwilling to admit that they face a significant lifetime risk of becoming disabled and thus needing extensive care at home or in a nursing facility.

Like the ostrich, we prefer not knowing.

III. RECOMMENDATION

The commission supports the provisions of LD 2220, the supplemental budget bill that will be considered by the 120th Legislature in a Special Session on November 13, 2002, that impose a licensing fee on nursing facilities and intermediate care facilities and that increase reimbursement for long-term care services, provided the fees and reimbursement increases are tied together. The commission acknowledges that this is a short-term fix for a system that is in crisis due to perennial underfunding. The commission will continue to work through 2003 to identify funding and structural issues in long-term care and to propose new approaches to financing that will ensure a fiscally healthy long-term care system.

[20] "Can Medicaid Long-term Care Expenditures for the Elderly Be Reduced?" by Joshua Weiner, PhD, *The Gerontologist*, volume 36, number 6, 1996.

APPENDIX A

Authorizing Joint Order

APPROVED

APR 11 '02

BY GOVERNOR

CHAPTER

114

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
TWO THOUSAND AND TWO

H.P. 1436 - L.D. 1933

Resolve, Establishing the Blue Ribbon Commission to Address the Financing of Long-term Care

Emergency preamble. Whereas, Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the cost of long-term care in the State is among the highest in the nation; and

Whereas, the demographic profile of the State indicates a population that is rapidly aging and quickly approaching the need for long-term health services; and

Whereas, elderly and disabled individuals are without sufficient resources to finance the cost of their long-term care and depend upon the State to assist them in gaining access to these services; and

Whereas, the increased rate of growth in the state contribution for these services requires a comprehensive plan that will anticipate future need and creatively design a solution for financing this need while maintaining high quality in the system and ensuring choice and independence for the consumer of these services; and

Whereas, the commission established in this resolve must begin its work as soon as possible to address the escalating costs in the delivery and financing of long-term care services for the people of the State; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Commission established. Resolved: That the Blue Ribbon Commission to Address the Financing of Long-term Care, referred to in this resolve as the "commission," is established; and be it further

Sec. 2. Commission membership. Resolved: That the commission consists of the following members:

1. Nine members appointed by the President of the Senate as follows:

A. Two members of the Senate. When making these appointments, the President of the Senate shall give preference to a member serving on the Joint Standing Committee on Appropriations and Financial Affairs and to a member serving on the Joint Standing Committee on Health and Human Services;

B. A representative of a provider of long-term care insurance;

C. A member of a statewide organization representing business entities;

D. A member of a statewide organization representing labor;

E. A member of a statewide organization representing providers of long-term care;

F. A member of a statewide organization representing hospitals;

G. A member of a statewide organization representing physicians; and

H. A member of a statewide organization representing financial institutions;

2. Ten members appointed by the Speaker of the House as follows:

A. Two members of the House of Representatives. When making these appointments, the Speaker of the House shall give preference to a member serving on the Joint Standing

Committee on Health and Human Services and to a member serving on the Joint Standing Committee on Banking and Insurance;

B. A member of a statewide organization representing elderly persons;

C. A member of a statewide organization representing people with disabilities;

D. A representative of the long-term care ombudsman program;

E. A member of a statewide not-for-profit organization providing legal services to elderly persons;

F. A member of a statewide organization representing homecare providers;

G. A member of a statewide organization representing individuals with Alzheimer's disease or other dementias;

H. A representative of an academic or public policy institute with expertise in health care economics or finance; and

I. A representative of an accounting firm with expertise in health care financing; and

3. The following 2 members:

A. The Commissioner of Human Services or the commissioner's designee; and

B. The Treasurer of State or the treasurer's designee; and be it further

Sec. 3. Appointments. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The first named Senate member and the first named House of Representatives member serve as cochairs of the commission. The appointing authorities shall notify the Executive Director of the Legislative Council upon making their appointments. The cochairs shall convene the first meeting of the commission no later than 15 days after the appointment of all members is complete; and be it further

Sec. 4. Duties. Resolved: That the commission shall analyze the future costs cf providing long-term health care to elderly and disabled adults and recommend an integrated system of

financing the projected costs of these services that preserves and promotes consumer choice. The commission shall investigate all relevant questions on this issue, including but not limited to the following:

1. Whether the financial risk associated with uncertain long-term health care costs should be shared through some type of public or private insurance system;

2. Whether individuals should be encouraged or required to begin saving for predictable long-term health care needs at earlier ages; and

3. Whether each generation of working adults should pay for the long-term care costs of their parents' and grandparents' generations.

The commission shall examine programs and techniques that are employed in other states or other countries; explore opportunities for expanded federal assistance or demonstrations, waivers or pilot projects; and solicit suggestions from groups and individuals with expertise in long-term care finance and delivery; and be it further

Sec. 5. Meetings and hearings. Resolved: That the commission may hold up to 4 meetings per year. One of the meetings of the commission held each year may be a public hearing scheduled during nonbusiness hours in the State. The commission may not meet during the legislative session; and be it further

Sec. 6. Staff assistance. Resolved: That, upon approval of the Legislative Council, the Office of Policy and Legal Analysis shall provide necessary staffing services to the commission; and be it further

Sec. 7. Funding. Resolved: That the commission may seek and accept other sources of funds to advance its work. Prompt notice of solicitation and acceptance of funds must be sent to the Legislative Council. All funds accepted must be forwarded to the Executive Director of the Legislative Council along with an accounting record that includes the amount of funds, date the funds were received, from whom the funds were received and the purpose and any limitation on the use of the funds. The Executive Director of the Legislative Council administers any funds received; and be it further

Sec. 8. Compensation. Resolved: That those members of the commission who are Legislators are entitled to receive the legislative per diem as defined in the Maine Revised Statutes, Title 3, section 2 and reimbursement for travel and other

necessary expenses related to their attendance at authorized meetings of the commission. Other members of the commission who are not otherwise compensated by their employers or other entities that they represent are entitled to receive reimbursement of necessary expenses incurred for their attendance at authorized meetings. If other sources of funds become available, these funds may be used to compensate members of the commission; and be it further

Sec. 9. Report. Resolved: That the commission shall submit its report, together with any recommended implementing legislation, to the Legislature no later than November 6, 2003. The commission may also submit an interim report as it determines necessary. The commission shall also make an interim report to the Legislature and the Long-term Care Implementation Committee, established pursuant to Public Law 1999, chapter 731, Part BBBB, section 15, by November 6, 2002. If the commission requires an extension of time to make its reports, it may apply to the Legislative Council, which may grant the extension; and be it further

Sec. 10. Budget. Resolved: That the cochairs of the commission, with assistance from the commission's staff, shall administer the commission's budget. Within 10 days after its first meeting, the commission shall present a work plan and proposed budget to the Legislative Council for approval. The commission may not incur expenses that would result in the commission's exceeding its approved budget. Upon request from the commission, the Executive Director of the Legislative Council shall promptly provide the commission chairs and staff with a status report on the commission's budget, expenditures incurred and paid and available funds; and be it further

Sec. 11. Appropriations and allocations. Resolved: That the following appropriations and allocations are made.

LEGISLATURE

Study Commissions - Funding

Initiative: Provides a base allocation from Other Special Revenue funds in the amount of $500 in the event grants are awarded and outside funds are received.

Other Special Revenue Funds	2001-02	2002-03
All Other	$0	$500

Emergency clause. In view of the emergency cited in the preamble, this resolve takes effect when approved.

APPENDIX B

Membership list, Name of Study Commission

BLUE RIBBON COMMISSION TO ADDRESS THE FINANCING OF LONG-TERM CARE

Resolves 2001, Ch 114

Appointment(s) by the President

Sen. Betty Lou Mitchell, **Chair** P.O. Box 6 Etna, ME 04434	Senate Member
Sen. Michael F. Brennan 49 Wellington Road Portland, ME 04103	Senate Member
Dr. Laurel Coleman 40 Glenridge Drive Augusta, ME 04330	Representing a Statewide Organization Representing Physicians
Mr. Rick Erb Maine Healthcare Association 317 State Street Augusta, ME 04330	Representing a Statewide Organization Representing Long-term Care Providers
Mrs. Elaine Harriman 4 Maura Court Waterville, ME 04901	Representing a Statewide Organization Representing Business Entities
Mr. Ned McCann AFL-CIO PO Box 1072 Augusta, ME 04332	Representing a Statewide Organization Representing Labor
Mr. Clifford Ryan Elder Planning Advisors 1006 Broadway South Portland, ME 04106	Representing Providers of Long-term Care Insurance
Mr. Dale Shaw Goodall Hospital 25 June Street Sanford, ME 04073	Representing a Statewide Organization Representing Hospitals
Mr. Mark Walker Maine Bankers' Association PO Box 735 Augusta, ME 04330	Representing a Statewide Organization Representing Financial Institutions

Appointment(s) by the Speaker

Rep. Thomas J. Kane, **Chair** 39 Oceanside Drive Saco, ME 04072	House Member
Leo Delicata Legal Services for the Elderly P.O. Box 10480 Portland, ME 04101	Representing a Not-for-Profit Organization Providing Legal Services to the Elderly
Brenda Gallant Long-term Care Ombudsman Program P.O. Box 128 Augusta, ME 04332	Representing Maine's Long-term Care Ombudsman's Office
Rep. Arthur F. Mayo 83 Green Street Bath, ME 04530	House Member

Member	Representation
Michael T. McNeil Berry, Dunn, McNeil & Parker 100 Middle Street Portland, ME 04112	Representing a Health Care Financing Accounting Firm
Mr. Robert Mollica, Senior Program Dir. National Academy for State Health Policy 50 Monument Square, Suite 502 Portland, ME 04101	Representing a Public Policy Institute
John Moran Maine Council of Senior Citizens P.O. Box 1072 Augusta, Maine 04332	Representing a Statewide Organization Representing Elderly Persons
Ms. Kathy Pears, Dir, Public Policy Maine Alzheimer's Association 163 Lancaster Street, Suite 160B Portland, ME 04101	Representing Individuals with Alzheimer's Disease
Ms. Vicki Purgavie, Executive Director Home Care Alliance of Maine 20 Middle Street Augusta, ME 04330	Representing Homecare Providers
Mr. Steve Tremblay, President Alpha One 127 Main Street South Portland, ME 04106	Representing a Statewide Organization Representing Persons with Disabilities
Ex Officio	
Dale McCormick, State Treasurer Department of the Treasury 39 State House Station Augusta, ME 04333	State Treasurer
Christine Gianopoulos, Director Bureau of Elder & Adult Services #11 SHS Augusta, Maine 04333-0011	Commissioner's Designee

APPENDIX C

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
BUREAU OF ELDER AND ADULT SERVICES
442 CIVIC CENTER DRIVE
11 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0011

ANGUS S. KING, JR.
GOVERNOR

KEVIN W. CONCANNON
COMMISSIONER

Memo

To: Members, Blue Ribbon Commission to Address Financing of Long-term Care
From: Christine Gianopoulos, Director
Date: September 30, 2002
Subject: State and Medicaid Long-term Care Spending

The attached chart shows State and Medicaid spending for the years 1997-2001. The data is for programs that serve elders and adults with primarily physical disabilities. It does not include spending on programs that serve children, or for persons with mental health or developmental disabilities.

The chart reflects only the cost of services. Other costs associated with administering the publicly funded long-term care system would include:

- Eligibility determination, both financial and medical
- Licensing and Quality Assurance
- Payment Systems (Claims Processing, Audit)
- Ombudsman/Legal Services
- Administrative Hearings Unit

PHONE: (207) 287-9200 1-800-262-2232 FAX: (207) 287-9229 TTY: (207) 287-9234 Deaf - Hard of Hearing TTY: 1-888-720-1925 Deaf - Hard of Hearing

State of Maine
State and Medicaid Long-term Care Expenditures

	SFY 97		SFY 98		SFY 99		SFY 00		SFY 01	
	Total Expenditure	Clients	Total Expenditure	Clients	Total Expenditure	Clients	Total Expenditure	Clients	Total Expenditure	Clients
Medicaid										
Nursing Facilities	$202,292,500	8,963	$185,581,203	8,649	$184,099,858	8,624	$200,535,349	8,504	$202,697,747	8,275
Res.Care: Medical & Remedial PNMI	$24,555,594	3,017	$29,924,699	3,248	$33,115,280	3,672	$41,089,054	4,063	$45,084,992	4,325
Res.Care: Med. & Rem. Room & Board			$10,799,194	3,367	$12,554,016	3,690	$16,519,630	4,103	$16,698,724	4,403
Adult Day Health Services	$424,492	122	$577,618	147	$592,650	135	$711,217	156	$787,015	173
Private Duty Nursing (adults only)	$1,036,028	49	$575,833	82	$892,712	355	$1,149,190	869	$1,297,346	1,088
Personal Care Services (adults only)	$529,518	158	$1,206,232	391	$2,844,222	901	$3,703,145	1,152	$4,986,955	1,388
Waiver: Consumer Directed	$5,062,143	269	$5,552,487	283	$6,185,082	305	$7,246,772	336	$7,261,920	303
Waiver: Elder & Adults	$10,272,214	1,343	$14,604,975	1,618	$21,521,767	1,904	$21,190,181	1,776	$19,096,433	1,589
Consumer-directed Personal Care	$2,123,423	216	$3,068,619	288	$3,495,101	297	$3,314,388	303	$3,765,039	348
Home Health (adults only)	$10,084,810	4,665	$11,072,562	4,826	$11,458,290	4,967	$9,367,904	3,851	$5,329,567	2,238
Subtotal - Medicaid	$256,380,722	18,802	$262,963,422	22,899	$276,758,978	24,850	$304,826,830	25,113	$307,005,738	24,130
General Fund										
Home Based Care: Elder & Adults	$6,747,308	2,899	$7,083,230	1,772	$8,266,300	2,547	$12,004,121	3,056	$12,441,142	3,863
Home Based Care: Consumer Directed	$2,484,207	173	$2,921,945	145	$3,018,374	220	$3,118,228	219	$3,118,374	203
Adult Day Services	$121,909	120	$200,000	112	$200,000	129	$280,000	82	$304,240	119
Congregate Housing Program	$560,105	150	$311,890	199	$535,582	272	$492,122	272	$592,156	260
Assisted Living CHSP	n/a	n/a	$713,977	104	$605,917	111	$1,266,360	145	$1,812,206	199
Alzheimer's Respite	$400,000	332	$400,000	550	$400,000	743	$484,000	437	$754,609	430
Homemaker	$1,000,000	1,121	$1,087,891	1,077	$1,505,267	1,500	$1,594,321	1,301	$2,553,199	1,664
Subtotal - General Fund	$11,313,529	4,795	$12,718,933	3,959	$14,531,440	5,522	$19,239,152	5,512	$21,575,926	6,738
Total Expenditure	**$267,694,251**		**$275,682,355**		**$291,290,418**		**$324,065,982**		**$328,581,664**	

total 1/3 state 2/3 federal

all state $

Note: Subtotal client numbers are not unduplicated across programs.

Note: FY 01 Private Duty Nursing figures revised on 2/7/02.

Print Date: 09/30/02

APPENDIX D

Summary of Historical Nursing Facility Utilization

Payer	2001 (1) Days of Care	2001 (1) Net Revenue	Days of Care Provided (2) 2000	1999	1998	1997
Medicaid	1,764,000 (70%)	$236,758,000(64%)	1,847,949 (71%)	1,927,608 (73%)	2,016,803 (72%)	2,123,214 (73%)
Medicare	767,000 (30%)	56,708,000 (15%)	265,915 (10%)	256,143 (10%)	287,239 (10%)	279,807 (10%)
SelfPay /Pvt Ins		78,778,000 (21%)	472,061 (19%)	472,703 (17%)	497,838 (18%)	491,191 (17%)
	2,531,000	$372,244,000	2,585,925	2,656,454	2,801,880	2,894,212

(1) From DHS summary of 2001 Medicaid NF cost report and revenue information.

(2) From BDMP Medicaid NF cost report data base information which does not include utilization for non nine"hospital affiliated" NF units.

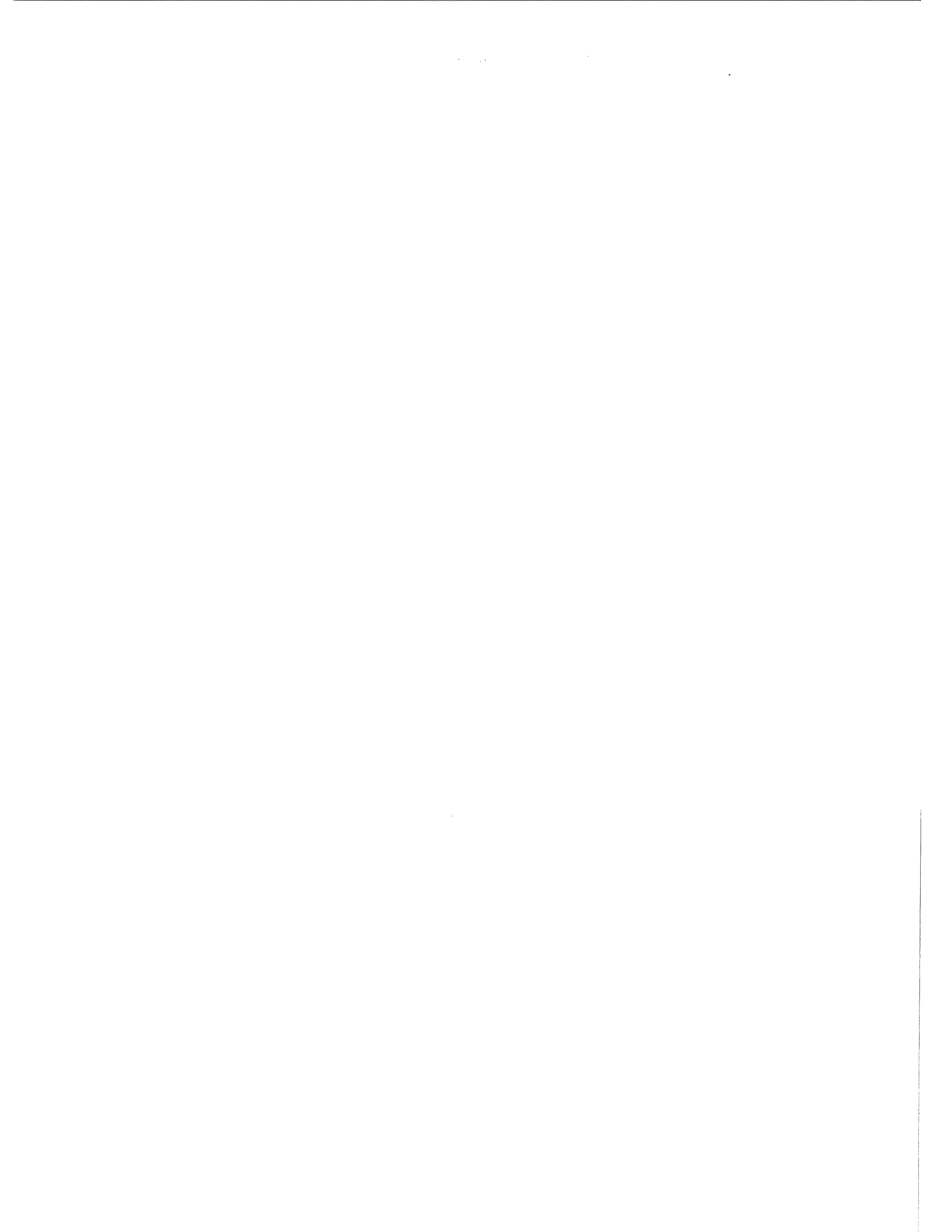
APPENDIX E

Preliminary Comparison of Long-term Care System Financing
Blue Ribbon Commission to Address the Financing of Long-term Care, October 2002

Topic	Germany	Japan	New Zealand	Sweden	England
Administrative structure	Financed separately from acute care. Shared administration with acute care.	Administered through municipalities, financed nationally and locally	Health, long-term and residential care and disability support services administered together through regional health agencies.	Local administration (reorganized from 1980's when administration was local and county)	Local administration. (reorganized from 1980's when administration was fragmented)
Funding	Mandatory contributions of 1.7% of salary (1/2 from employer and ½ from employee) or for retirees 1/2 from pension fund and ½ from retiree's pension. Can opt out if purchase LTC insurance.	Half paid by general taxes. Half paid by: a. If 40 to 64 employer and employee equally. b. If 65 by deduction from pension benefit.	General tax financing, on national level.	Funding is 90% local, 10% national	General tax financing, on national level.
Service location	Home care, community services, residential care or nursing home.	Six levels of care provided, from home assistance to skilled nursing care.	Home care, community services, residential care, nursing care, long-term care hospitals.	Home care, community services, residential care, nursing facility care.	Home care, community services, residential care, nursing facility care.
Benefit structure	Home care may be paid in cash ($200-650/mo) or services ($375-$1875/mo). Facility care ($1000-1650/mo). Facility care does not include room and board. Out-of-pocket payments required.	10% co-pay. Care manager writes care plan. Consumer choice of provider. Maximum benefits depend on services and settings, $560-3260/mo.	Maximum depends on need level and service location. Co-pays higher in facilities.	Facility-based care does not include room and board.	Co-payments required to cover room and board in facility-based care, often based on income Income-related co-pays for home care services.

Topic	Germany	Japan	New Zealand	Sweden	England
Financial eligibility	No requirements.	No requirements.	Income and asset tests, above which consumer pays a deductible each month for residential care. Some community support services provided free by non-profits with lottery proceeds.	No requirements.	Income standards for eligibility.
Physical, cognitive eligibility	Require 2 ADL's of 6-month duration and 1 IADL. Assessment of cognitive abilities has been a problem area.	On-site assessment of physical and mental condition.	Assessment required for public assistance for home and facility care.	Assessment of functional need.	Assessment of functional need.
Comments	Benefits fall substantially short of need. Consumers have favored home care and cash benefits. Shortage of home care workers. Quality assuarance a recent issue.	Provider fees limited by national government. Providers may be non-profit and proprietary.	National quality of care standards. Coordination and integration of system pose challenges. Staffing shortages exist in some areas.	Municipalities pay family members to provide care.	
Sources	Article by Alison Evans Cuellar, Health Affairs, 2000, vol 19, no.3	Article by John Creighton Campbell and Naoki Ikegani, Health Affairs, 2000, vol 19, no3	Article by Toni Ashton, Health Affairs, 2000, vol 19, no3. Article by Paul Saucier, Promoting a National Vision for People with Disabilities, August 2002	Long-term Care: Other Countries Tighten Budgets While Seeking Better Access, GAO, 1994	Long-term Care: Other Countries Tighten Budgets While Seeking Better Access, GAO, 1994

APPENDIX F



Tax Qualified Long-Term Care Insurance: 2 Years Later

Clifford P. Ryan, CLU, ChFC, CFP, RHU

Back in the fall of 1996, Congress enacted legislation known as "Kennedy-Kassenbaum" bill. Amongst other things, this legislation created a second class of long-term care insurance (LTCI) which is now known as "tax-qualified" LTCI (TQLTCI). The legislation was praised for it's efforts to encourage people to purchase LTCI by offering "tax advantages". Although the public loves a "tax break", we feel that access to quality LTCI and focus on real benefits is the key issue when choosing a policy. Here are some of the key issues to consider:

1) **Tax Deductible Premiums**: Premiums for TQLTCI are deductible if a) you file a "Schedule A" (itemized deductions) and b) your premiums (along with other medical deductions) exceed 7.5% of your adjusted gross income. According to the IRS, less than 4% of people over 65 itemize deductions. There is also a table which limits deductible premiums from $220 (age 40) to $2,750 (age 70) which could further limit your ability to deduct. Most individuals will not benefit from this "tax benefit".

2) **Non-Taxable Benefits**: This part of the new law states that benefits (for nursing care) will not be taxable when you receive them (with a few limitations for per-diem plans) from TQLTCI plans. Congress did this by "defining" TQLTCI as "health insurance" under the IRS code. As many are aware, health insurance benefits such as those from dental and major medical and Medicare Supplements, are not included in taxable income.

What about benefits from Non Tax-Qualified (NTQ) LTCI? It has been *implied,* by agents and carriers, that benefits from NTQ policies "MAY" be taxable. This type of insurance has been around for over 30 years and people have not paid taxes on benefits. The section of the tax code that deals with what is and is not included in taxable income is Title 26, Section 104(a)(3). This section states that "amounts received through accident or health insurance <u>or through an arrangement having the effect of accident or health insurance for personal injuries or sickness</u>..." are excluded from taxable income. I would suggest that benefits from NTQLTCI constitutes a "similar" arrangement and are not taxable.

It should be noted that the IRS has not issued any position on taxation of NTQ policy benefits. The IRS has been asked several times, about this issue. Nothing yet! There is, however, no evidence that NTQLTCI benefits are taxable.

The Real Issue: As we are all aware, the feds don't usually give us something without strings. In this case the "tax benefits" come at the price of potentially decreased access to benefits. It is generally recognized that TQLTCI policies contain less favorable definitions of when an insured can receive benefits (benefit triggers) than NTQLTCI. TQLTCI policies also limit the types of services that are available to the policyholder (qualified services). This adds up to less claims for the insurance company and less benefits for the insured. There are also provisions within TQLTCI that tie eligibility for benefits to definitions created by the IRS and Healthcare Finance Administration (this is med-classification for you Elder Law Attorneys). I don't see this as a good trend.

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The purpose of purchasing LTCI is to provide access to care and services. I suggest that policies that are more likely to pay benefits and will pay for a wider range of care are better (NTQLTCI).

Limiting Access to NTQ LTCI: Because of the popularity of "tax benefits" and the probability of lower claims, carriers have made a big effort to promote these (TQ) policies. Many of the major LTCI carriers within Maine and throughout New England have discontinued selling NTQ policies. This has limited access to NTQ policies for many people who would like to protect their estates and provide benefits if they need nursing care. Last year a bill was sponsored (Maine) that would require carriers to offer a NTQ version if they wish to offer TQ LTCI. The idea was to maintain consumer choice in the matter. The insurance industry representatives came to speak against the bill. It was not enacted. There was, however, a bill introduced that limits the Maine LTCI tax deduction to TQ policies. This bill was enacted. These are not good trends for the consumer. The other place that this trend will show up is in the state Medicaid budgets. As people find it more difficult to qualify for TQ policy benefits, they will shift this burden back onto the public programs.

Market Conduct Issues: I see two disturbing trends: 1) Agents representing that TQ policies are better because they are "new" and "federally qualified" (implying approval). Agents can now imply that even the State of Maine thinks that these are better because they only approve the tax deduction for TQ policies and 2) Agents are not even discussing the difference between TQ and NTQ contracts. A majority of carriers no longer offer NTQ policies, so why confuse the client with the choice? If an agent sells only TQ policies, why discuss the issue? Sales managers (because they are being instructed by the home office) are instructing their agents to just sell TQ policies "in case" the benefits are taxable. I am very concerned that consumers are mostly unaware of the issue and are not being given information or options.

It is important that consumers understand the differences between TQ and NTQ LTCI so that they can make a fully informed decision based on their own circumstances. If you are considering the purchase of LTCI, you should ask the agent to discuss his/her understanding of the TQ vs. NTQ issue. You should also ask whether this agent (and their company) offer both TQ and NTQ LTCI.

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December 20, 2001
Washington, DC

- News Release Index
- Press Center
- Long-Term Care Executive Summary
- Long-Term Care Report

news release

Most Americans Unprepared for Long-Term Care Costs

AARP Survey Finds Misperception and Confusion About Options for Paying

Over half (60 percent) of Americans age 45 plus say they are at least "somewhat familiar" with long-term care services currently available. But most Americans are uninformed about the costs of, and funding sources for, long-term care services. Yet the need for these services is expected to increase in the future.

According to the latest U.S. Census Bureau projections, today's 65 or older population numbers are expected to double to about 70 million in 2030 and the 85 and older population will also nearly double to about 8.5 million.

"With the onset of the aging demographic revolution, it is essential that the general public not only learn about the long-term care options but understand their costs, and begin planning for their future care requirements," said AARP CEO Bill Novelli. "Unfortunately most of us pay little attention to the cost of such care until we or our loved ones need it. AARP sees our role as informing and assisting people to make good choices."

The AARP survey asked Americans age 45 and older a range of questions designed to measure their level of understanding of the costs and funding sources associated with three types of long-term care: nursing homes, assisted living facilities, and in-home care.

The results show that Americans age 45 plus generally do not know how much long-term care services cost. Only 15 percent could identify the cost of nursing home care within ± 20 percent of the national average cost. Another quarter (24 percent) said they did not know the cost. And more than half (51 percent) estimated the cost too low. [The national average monthly cost of nursing home care is $4,654.]

Only one in four (27 percent) could come within ± 20 percent of the estimated median cost of care in an

assisted living facility and 38 percent said they did not know. [The national estimated median cost for assisted living per month is between $2,000 and $2,500.]

Americans age 45 and older also are generally unaware of how much an in-home visit from a skilled nurse or aide costs. Americans age 45 plus gave a wide range of answers, with no real consensus. One in three (33 percent) "didn't know" the cost. [The average Medicare reimbursement is $109 for a skilled nurse visit and $64 for a home visit by an aide.]

About three in ten (31 percent) Americans age 45 and older say they have insurance that covers the costs of long-term care, when they probably do not. Although it is difficult to know exactly how many Americans currently have long-term care insurance policies, the Health Insurance Association of America estimates that only about 6 percent of Americans purchased such insurance.

People who say they have insurance that covers the cost of long-term care are more likely to say they feel prepared to meet the financial challenges of long-term care than those who say they do not have such coverage (70 percent versus 39 percent). This suggests that people who say they have long-term care coverage when they do not may have a false sense of financial preparedness. Overall, Americans age 45 and older are split as to whether they feel prepared to meet the financial challenges associated with long-term care. About half (49 percent) feel "very" or "fairly" prepared; 46 percent said they are "not very" or "not at all" prepared.

According to the new study, there is also a discrepancy between what people think Medicare and Medigap cover and what they actually cover. More than half (55 percent), including those who say they are "very familiar" with long-term care (58 percent), believe Medicare covers long-term nursing home stays. And nearly a quarter says they would rely on Medicare to pay for such stays. The reality is that Medicare does not cover long-term nursing home stays.

Four in ten (41 percent) thought Medicare covers assisted living care and more than one in three (34 percent) didn't know whether it does or does not. Medicare does not pay for assisted living.

Over half (57 percent) correctly said that Medicare covers the cost of in-home visits from a skilled nurse. However, many Americans do not understand the difference

between a home visit from a skilled nurse and a home visit by a home health aide. More than half (52 percent) thought Medicare covers aide visits. In fact, Medicare covers only home health aide services for care that is medically necessary. It does not cover costs of custodial care.

Novelli said that, "AARP will use the findings from this survey to educate our members, the public, and policy-makers about long-term care and its costs for individuals and their families. Equally important, we will continue to advocate for the support for long-term care that people want and need in their homes and communities."

The survey, entitled "The Costs of Long-Term Care: Public Perceptions Versus Reality", was conducted by RoperASW on behalf of AARP. The results are based on telephone interviews with a random sample of 1,800 Americans age 45 and older. With a sample this size, the maximum margin of error at a 95 percent confidence level is within ± 3 percentage points. In addition to the national survey, five state-specific surveys were conducted with a random sample of 400 people age 45 and over in California, Florida, New Mexico, Washington, and Wisconsin.

AARP is a nonprofit, nonpartisan membership organization for people age 50 and over. It provides information and resources; advocates on legislative, consumer, and legal issues; assists members to serve their communities; and offers a wide range of unique benefits, special products, and services for its members. These benefits include AARP Webplace at www.aarp.org, Modern Maturity and My Generation magazines, and the monthly AARP Bulletin. Active in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP celebrates the attitude that age is just a number and life is what you make it.

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