

From: jslome@aaltci.org
Sent: Friday, August 9, 2019 6:56 PM
To: LTCITaskForce
Subject: Submission for the LTCI Task Force

In 1997 I co-founded the American Association for Long-Term Care Insurance with the goals of creating heightened awareness among both consumers and insurance professionals and, then, supporting the needs of those professionals. Because I am based in Los Angeles, I rarely have a presence in efforts that require presence in Washington, D.C.

I would share the following suggestions with the Task Force.

1. Don't limit your experts and those participating to the same voices (the ones who have gotten us here). Identify others with different opinions and experience and consider paying for any time/expenses when such is required.
2. Don't simply focus on changes to the existing model upon which the traditional, health-based long-term care insurance policy was created. That 'chassis' is really no longer applicable to what's wanted by consumers and can be reasonably priced by insurers. It was a great idea when conceived in the 1980s. It no longer applies and thus no one wants to offer it. Linked-benefit products make life insurance companies happy, but they are not the answer for what you and this nation really seeks.
3. Don't overlook the value of shorter benefits (one year) and don't let the NAIC force insurers to call it something consumers will never be interested in such as Recovery Care or Limited Long-Term Care. If Washington State sees value in a \$36,000 Long-Term Care benefit for residents, then that should be a viable option offered in the private marketplace.
4. Don't overlook the importance of insurance agents. I run several small trade groups that focus on other insurance products where agents can (and do) play a less important role. After 20+ years, I clearly understand that this is one of those more unique products where expertise benefits the consumer.

I have watched the long-term care insurance industry go from it's heyday when over 750,000 policies were sold in a single year ... when Partnership plans were enthusiastically promoted ... and when we could convene a national conference and have many hundreds of insurance agents pay to attend (agents never pay money). Now as I approach my 67th birthday, I can say that none of that exists.

What does exist, and the reason I am glad to see that you are attempting to address this issue, is the growing need for services and the inability of families and government entities to sufficiently meet needs and expectations.

I wish you well. If asked to be further involved, I would gladly welcome hearing more.

Jesse Slome
Executive Director
American Association for Long-Term Care Insurance
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From: Coronel, Susan <scoronel@ahip.org>
Sent: Friday, August 30, 2019 11:40 AM
To: LTCITaskForce
Cc: Charles Piacentini (chuckpiacentini@acli.com)
Subject: AHIP-ACLI Comments on Potential Federal LTC Reforms to Improve Financial Security of Americans
Attachments: AHIP-ACLI Comment Letter to LTC TF - 8-30-19.pdf

Enclosed is America's Health Insurance Plans (AHIP) and the American Council of Life Insurers' (ACLI) comment letter in response to the Federal Interagency Task Force on Long-Term Care Insurance's (Task Force) invitation for written comments on potential reforms to federal laws, regulations, and policies to complement reforms at the state level relating to the regulation of long-term care insurance.

We appreciate the opportunity to provide comments and look forward to working with the Task Force throughout this process. Please feel free to contact us if we can provide further clarification on any of these comments and to offer additional perspectives on the issues that impact our members.

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August 30, 2019

The Honorable Michael Faulkender
Assistant Secretary for Economic Policy and
Chair of the Federal Interagency Task Force on Long-Term Care Insurance
Department of the Treasury
1500 Pennsylvania Ave. NW, Room 3454 MT
Washington, DC 20220

Submitted electronically via LTCITaskForce@treasury.gov

RE: AHIP-ACLI Comments on Potential Federal LTC Reforms to Improve Financial Security of Americans

Dear Mr. Faulkender:

America's Health Insurance Plans (AHIP) and the American Council of Life Insurers (ACLI), on behalf of their member insurers, appreciate the opportunity to respond to the Federal Interagency Task Force on Long-Term Care Insurance's (Task Force) invitation for comments on potential reforms to federal laws, regulations, and policies that complement reforms at the state level relating to the regulation of long-term care insurance (LTCI). We commend the Task Force for considering the challenges of long-term care (LTC) financing that American consumers face as a matter of national interest, requiring a coordinated response from the federal government.

Millions of Americans' financial and retirement security are at risk from exposure to unfunded LTC events. Access to additional options to meet and finance the need for long term services and supports (LTSS) will enable consumers to address those needs without eroding other assets or imposing on family and friends. We welcome the opportunity to work with the Task Force to develop policies that would improve the private financing of LTSS.

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers. Our members provide a range of products to millions of consumers, including major medical coverage, disability income insurance, dental insurance, LTCI, reinsurance, pharmacy benefits, and administrative services for self-funded health plans.

ACLI advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers' financial and retirement security. Ninety (90) million American families depend on our members for LTCI, life insurance, annuities, retirement plans, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal, and international public policy forums that support the insurance marketplace and the families that rely on life insurers' products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

We understand that the Task Force has been reviewing various proposals to reform federal laws and regulations concerning LTCI, including, among other options, the federal policy options presented by the NAIC to Congress for its consideration in April 2017. Having also reviewed the NAIC options, we offer recommendations that we believe are achievable and would meaningfully improve consumers' access to private LTCI coverage. Further, as the Task Force requested, our recommendations specifically outline potential reforms to federal laws, regulations, and policies that would complement regulatory reforms at the state level related to LTCI. There may be additional and more comprehensive reforms warranted that will require systemic changes to the way we view LTC funding with the ultimate goal of creating a comprehensive LTSS financing system. One such approach that warrants discussion is the government serving as "catastrophic backdrop" and private insurance plans covering initial costs. However, we believe the Task Force's current consideration of the more achievable near-term changes described below would lead to meaningful improvements for American consumers seeking to access LTC coverage.

Below we summarize our recommendations regarding the Task Force's consideration of proposed options to expand consumer access to LTCI coverage:

- Launch a national educational campaign to help consumers understand both the need for and benefits of LTC coverage.
- Provide tax incentives to expand consumer access to LTC coverage through workplace and retirement plan options:
 - Making LTC coverage available through Internal Revenue Code (IRC) Section 125 cafeteria plans and Flexible Spending Arrangements (FSA);
 - Allowing tax-free premium payments for LTCI policies either from or within their 401(k)s, 403(b)s, IRAs, and other retirement plans; and
 - Permitting employees to make additional contributions to their Health Savings Accounts (HSA) to pay for LTCI premiums.
- Support legislation or regulatory guidance that would confirm and allow the payment of LTCI incidental benefits from LTCI policies that enhance care options for policyholders and provide access to benefits, including those intended to support healthy, independent living and aging in place, prior to satisfying the current eligibility requirements of a severe cognitive impairment or substantial assistance with the requisite activities of daily living. This allowance should not cause the policy to forfeit its tax qualified status.

- Revise current federal requirements surrounding inflation protection for LTCI policies to encourage policy design innovations that would meet the needs of consumers more effectively.

Our detailed recommendations are outlined in the enclosed attachment. We believe these recommendations align with our mutual goals to expand consumer choice and access to quality LTCI coverage, reduce LTC costs faced by consumers, manage LTCI premiums, and improve health outcomes for LTCI policyholders in the most cost-efficient manner possible.

We appreciate Treasury's efforts to seek detailed input on how to expand and improve private LTCI coverage to help achieve these mutual goals. We look forward to working with the Task Force throughout this process as a resource to provide further clarification on any of these comments and to offer additional perspectives on the issues that impact our members.

Sincerely,



Susan Coronel
Executive Director for LTC
AHIP



Charles Piacentini
Vice President, Insurance Regulation
& Associate General Counsel
ACLI

Enclosures: AHIP-ACLI Recommendations

AHIP-ACLI RECOMMENDATIONS
TO FEDERAL INTERAGENCY TASK FORCE ON LONG-TERM CARE INSURANCE
IN RESPONSE TO REQUEST FOR PUBLIC COMMENTS ON
PUBLIC POLICY AND REFORM PROPOSALS THAT WOULD HAVE THE MOST IMPACT ON
IMPROVING THE LONG-TERM CARE INSURANCE MARKET

The public and private sectors must partner to improve access to long-term care insurance (LTCI) coverage, enabling individuals to preserve their health and protect their ability to remain financially secure as they age. Initiatives that (1) promote consumer awareness, (2) increase access to coverage, and (3) encourage innovation, both to address the diverse care needs of individuals and families and to respond to changes in the care delivery landscape, will enhance consumer choice and improve access to quality LTCI coverage. In addition, these initiatives will serve to reduce LTC costs, manage premiums, and improve health outcomes for LTCI policyholders. By expanding LTCI coverage among middle class Americans, the social safety net will be preserved for those who need it most.

I. LAUNCH A NATIONAL AWARENESS CAMPAIGN TO HELP CONSUMERS UNDERSTAND THE IMPORTANCE OF PLANNING FOR A LONG-TERM CARE (LTC) EVENT

Recognizing that consumers must appreciate the risks associated with a potential LTC event, implementing a comprehensive awareness campaign is a key component of efforts to expand access to LTCI, especially among the middle class. Educational programs must effectively explain, among other things, (1) the risks of potentially needing long-term supports and services (LTSS) later in life, (2) why planning for LTSS is a necessary part of a comprehensive retirement security strategy, and (3) the meaningful options available to assist consumers in covering their LTC needs, including the purchase of LTCI. A targeted education program will help consumers understand the importance of planning and may encourage the middle class to purchase LTCI.

A well-researched education and awareness effort is critical to encouraging and enabling consumers to take personal responsibility for their future LTC needs. Based on their past effectiveness, the “Own Your Future” Awareness Campaign and the National Clearinghouse for LTC Information website should be re-launched. Notably, consumer interest in purchasing insurance to address potential LTC needs increased as a result of “Own Your Future.”

LTCI carriers are committed to working with federal and state government leaders to support education and awareness efforts to inform consumers about the valuable protection LTCI coverage provides.

II. PROVIDE TAX INCENTIVES TO EXPAND CONSUMER ACCESS TO LTC COVERAGE THROUGH WORKPLACE AND RETIREMENT PLAN OPTIONS

Nearly 180 million Americans obtain health care coverage in the workplace, which suggests that employers are well-positioned to help individuals understand the value of Qualified Long-Term

Care Insurance (QLTCI) and expand investment in this coverage. Workers should be permitted to leverage workplace channels and retirement plan options to save for their LTC needs. Approaches that should be considered include:

- a. ***Cafeteria Plans (IRC 125) and other Flexible Spending Arrangements (FSA):*** Cafeteria plans (often incorporating an FSA) provide employees an opportunity to receive certain qualified benefits on a pre-tax basis. Under current law, qualified benefits include most accident and health benefits, adoption assistance, dependent care assistance, group term life insurance, and health savings accounts.

Permitting LTC coverage to be included in a cafeteria plan would make it more affordable. This solution would have limited impact on the tax dollars received from employees, because most employees would simply shift their cafeteria plan/FSA dollars from other pre-tax benefits to LTCI coverage. Adding QLTCI as a qualified benefit gives employers a new way to add value for their employees—and provides additional opportunities for Americans to become more educated on why QLTCI is important to their financial stability and peace of mind.

- b. ***Distributions from Retirement Plans:*** An uninsured LTC event significantly threatens the financial and retirement security of most Americans. Expanding consumer access to pre-tax funds to purchase LTCI will protect retirement savings from erosion resulting from funding costly LTSS.

Enabling individuals to make LTCI premium payments from their 401(k)s, 403(b)s, IRAs, and other retirement plan options, income tax free (or with a lesser tax burden imposed) and subject to limits, would permit the purchase of meaningful LTCI coverage. Consumers would be able to use these pre-tax assets to fund either a traditional LTCI policy or a “hybrid” (LTC benefits in conjunction with a life insurance policy or an annuity contract), which would reduce the cost of this coverage, making it accessible to more Americans. By utilizing a limited amount of their retirement assets to fund LTCI, consumers can protect themselves against LTC events as these assets accumulate while enhancing overall retirement security.

- c. ***“Within Plan” Investments:*** Individuals currently saving for retirement through 401(k)s, 403(b)s, IRAs, and other retirement plans would be permitted to make premium payments for LTCI coverage that will be considered a retirement plan investment (“Within Plan”).

Individuals would be allowed to leverage their retirement savings through the “Within Plan” approach to invest directly in QLTCI coverage. Premium payments would be treated as a movement of monies from one plan investment to another, so they would not be taxable distributions. Should the policyholder become chronically ill or otherwise entitled to QLTCI policy benefits, the benefits would be paid to the retirement plan which would then pay them to the participant as a plan distribution.

The benefits would be treated in the same manner as income on any other plan investment and, therefore, considered taxable income when distributed under existing tax rules

governing retirement plan distributions. This approach would have only a modest tax revenue loss since pre-existing retirement savings used to pay premiums are already in a tax-favored format.

- d. ***Health Savings Accounts (HSA):*** Under current law, individuals with high deductible health plans can choose to make tax-deductible contributions to an HSA. In addition to helping to pay for out-of-pocket health costs, these tax-deductible dollars can be used to pay premiums for QLTCI.

We support changes to the contribution limits for HSAs that would allow individuals to make additional contributions to their HSAs equal to what they would pay in premiums for qualified LTC plans. In addition, individuals should be allowed to contribute to their spouse's HSA if the spouse is covered by QLTCI.

Under current law, if an individual has an HSA but no longer has high deductible health plan coverage, he or she cannot contribute additional amounts to the HSA. However, under this proposal, if the individual has QLTCI coverage during a taxable year, he or she would be allowed to make additional contributions in that year, pursuant to this special rule, equal to their QLTCI premiums as long as they already have an HSA. This approach provides more flexibility and choice, allowing employees to save more pre-tax dollars to buy LTCI coverage for themselves or their spouse.

III. ALLOW PAYMENT OF LTC INCIDENTAL BENEFITS THAT WOULD ENHANCE CARE OPTIONS FOR LTCI POLICYHOLDERS

Older adults will need assistance as their levels of dependence begin to increase. Waiting until the onset of chronic illness or severe cognitive impairment is too late. LTCI policies can help policyholders and their families delay the need for more substantial levels of facility care and keep them in their homes. Since facilities tend to be more expensive, this would be a benefit to care recipients, their families, and ultimately to private and public payers.

Federal legislation or regulatory guidance should confirm that tax qualified LTCI policies may provide incidental benefits prior to the onset of an insured's chronic illness where such benefits are (a) incidental to a policy's overall benefits (e.g., less than 10% of the policy's lifetime benefit limit), and (b) expected to delay the onset of an insured's chronic illness or the severity of the insured's future chronic illness. Examples would include the provision of home assessments to identify risks which could lead to chronic illness (such as tripping hazards), installation of ramps and railings, caregiver training for family members, and sharing information regarding local LTC providers to those who need (or anticipate needing) assistance.

This allowance should not cause a LTCI policy to forfeit its tax qualified status. Providing these benefits would allow insurers to provide personalized services to their policyholders and permit consumers to stay in their homes and communities, which is what they generally prefer.

IV. AMEND CURRENT FEDERAL INFLATION PROTECTION REQUIREMENTS

Inflation protection is an important LTCI feature. However, existing laws governing this benefit option often discourage consumers from seeking LTC protection altogether. Eliminating or revamping inflation protection requirements could encourage policy design innovations that would meet the diverse needs of consumers. Given that “one-size-fits-all” solutions do not work for everyone, it is important for consumers to have a variety of products and options from which to choose when evaluating their LTC protection needs.

Below are specific recommendations to revise current inflation protection requirements contained in Health Insurance Portability and Accountability Act (HIPAA) and the Deficit Reduction Act of 2005 (DRA):

- a. ***HIPAA - Remove the requirement that 5% inflation coverage be offered to all applicants and replace it with a requirement to offer some form of inflation protection.*** A carrier may offer the applicant inflation coverage (compound, simple, or a guaranteed purchase offer) that best meets their needs without requiring an expensive 5% compound offer that may not even be appropriate. This change would simplify the sales/disclosure process. An LTCI policy should still retain its tax-qualified status with this change so long as some offer of inflation coverage is made that is approved by the applicable state regulatory authority.
- b. ***DRA - Remove the inflation coverage age tier requirements.*** As long as an LTCI policy meets all tax qualification requirements under HIPAA (i.e., the inflation requirement as described above), the DRA Medicaid Partnership requirements should be fulfilled as well. Thus, a tax-qualified policy would satisfy the DRA Partnership requirements.

From: Laura Thornhill <lthornhill@alz-aim.org>
Sent: Monday, August 26, 2019 6:04 PM
To: LTCITaskForce
Subject: Alzheimer's Association Comments to LTCI Task Force
Attachments: Alzheimer's Association Comments to Federal Interagency Task Force on Long-Term Care Insurance.pdf

To Whom It May Concern--

Please find attached the Alzheimer's Association's comments to the Federal Interagency Task Force on Long-Term Care Insurance. We are so pleased to be part of the conversation and look forward to working with the Task Force in the future. Please let us know how we can assist.

Best regards,
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Federal Interagency Task Force on Long-Term Care Insurance
Department of the Treasury
1500 Pennsylvania Avenue NW
Room 3454 MT
Washington, DC 20220

August 26, 2019

To Whom It May Concern:

The Alzheimer's Association appreciates the opportunity to have presented information on persons affected by dementia and their use of long-term care services to the Federal Interagency Task Force on Long-Term Care Insurance at its meeting on July 25, 2019, and we are pleased to provide the following additional data and context.

The Alzheimer's Association is the leading voluntary health organization in Alzheimer's care, support, and research. The Alzheimer's Impact Movement (AIM), the advocacy arm of the Alzheimer's Association, is a nonpartisan, nonprofit organization and works in strategic partnership with the Alzheimer's Association to make Alzheimer's a national priority. On behalf of the more than five million individuals living with Alzheimer's and the more than 16 million unpaid caregivers in the United States, we thank the Task Force, the long-term care insurance industry, and other stakeholders for engaging in this discussion and working to improve the market. We encourage the Task Force, industry, states, and other stakeholders to consider the following as you create new products, markets, and regulatory frameworks. Most of the following information can be found in the [*2019 Alzheimer's Disease Facts and Figures*](#). The entire report provides valuable information about the disease, caregiving, and much more, but we refer the Task Force specifically to the chapter "Use and Costs of Health Care, Long-Term Care and Hospice" beginning on page 42.

Industry Must Be Prepared to Insure Persons Affected by Dementia

As the size and proportion of the United States population age 65 and older continue to increase, the number of Americans with Alzheimer's and other dementias will grow: without a disease-modifying therapy, nearly 14 million people may have the disease by 2050. Every state across the country is expected to experience an increase of at least 12 percent in the number of people with Alzheimer's between 2019 and 2025.¹ Given the growth of this population and their extensive needs across the disease course, the long-term care insurance industry has a tremendous opportunity to develop innovative products and services that can meaningfully improve the quality of life of persons with dementia, caregivers, and families.

People Living with Alzheimer's and Related Dementias Use Long-Term Care Differently

Persons living with Alzheimer's and related dementias and their caregivers have unique needs and, in turn, use long-term care services differently than other individuals. The Task Force and industry should carefully consider these aspects of the disease and care needs.

¹ Alzheimer's Association. (2019). *2019 Alzheimer's Disease Facts and Figures*.

First, people age 65 and older survive an average of four to eight years after a diagnosis of Alzheimer's, and some live as long as 20 years. During that period, individuals will spend an average of 40 percent of this time in dementia's most severe stage and much of it in a nursing home. Stakeholders should anticipate the potential for extended use of services and products by persons living with dementia.

Second, most individuals experience dementia in stages—early, middle, and late. That means that they need different supports and services over the disease course. For example:

- In the early stages, individuals may still function independently. They may still drive, work, and be part of social activities. As some common difficulties develop—like trouble with planning or organizing—individuals (particularly those who live alone) may find it helpful to have access to occasional homemaker services.
- In the middle stage, which can last for many years, people with Alzheimer's will require greater levels of care. They may not be able to work, they may withdraw socially, and they experience increased confusion and behavioral changes, including an increased risk of wandering and becoming lost. These individuals often still need social engagement and assistance with daily activities, and caregivers need increasing support. An adult day program may meet some of these needs.
- In the late stage, individuals lose the ability to respond to their environment, to carry on conversations and, eventually, to control movement. Significant personality changes may take place and they need extensive help with daily activities and personal care. They also become increasingly physically vulnerable, eventually losing the ability to walk, sit, and swallow. These individuals are likely to need intensive nursing care, often provided in a facility.

Additionally, those affected by Alzheimer's are often framed as a dyad: the person living with the diagnosis and the caregiver. Nearly half of all caregivers (48 percent) who provide help to older adults do so for someone with Alzheimer's or another dementia. In 2018, caregivers of people with dementia provided an estimated 18.5 billion hours of unpaid assistance, a contribution to the nation valued at \$233.9 billion. Caring for a person with Alzheimer's or another dementia poses special challenges. For example, family caregivers help individuals with diagnoses manage difficulties communicating, changes in personality and behavior, and the increasing need for supervision and personal care. As symptoms worsen, family caregivers often experience increased emotional stress and depression; new or exacerbated health problems; and depleted income and finances due in part to disruptions in employment and paying for health care or other services.

However, there are evidence-based, effective interventions to support caregivers. The most effective interventions can reduce depression among dementia caregivers, help them cope with their responsibilities, and can help to keep the person living with Alzheimer's in the home longer. Products and services that account for caregiver needs will be desirable to a variety of consumers, including those affected by dementia.

Finally, stakeholders should remember that the needs of persons living with dementia and caregivers extend well beyond health care. Upon diagnosis, affected persons not only need help managing other

chronic conditions, but they often need community-based supports like safety assessments, legal and financial services, and transportation. Eventually, most persons living with a diagnosis will also experience behavioral and psychological symptoms of dementia, such as aggression, hallucinations, or wandering. These behaviors are frequently the impetus to placement in a long-term care facility when the family can no longer manage them in the home. Products that integrate medical, psychological, and social needs and account for these behaviors are likely to appeal to this growing population of consumers.

Persons Affected by Dementia Use a Wide Range of Long-Term Care Supports and Services

Adult day services. Thirty-one percent of individuals using adult day services have Alzheimer's or other dementias. Overall, 69 percent of adult day service programs offer specific programs for individuals with Alzheimer's or other dementias. The median cost of adult day services is \$72 per day, and the cost of adult day services has increased 2.1 percent annually over the past five years.

Residential care facilities. Forty-two percent of residents in residential care facilities, including assisted living facilities, have Alzheimer's or other dementias. Fifty-eight percent of residential care facilities offer programs for residents with dementia. The median cost for care in an assisted living facility is \$4,000 per month, or \$48,000 per year and the cost of assisted living has increased three percent annually over the past five years.

Nursing home care. Fifty percent of nursing home residents in 2014 had Alzheimer's or other dementias. Nursing home admission by age 80 is expected for 75 percent of people with dementia compared with only four percent of the general population. In all, an estimated two-thirds of those who die of dementia do so in nursing homes, compared with 20 percent of people with cancer and 28 percent of people dying from all other conditions. The average cost for a private room in a nursing home is \$275 per day (\$100,375 per year) and the average cost of a semi-private room is \$245 per day (\$89,297 per year). The cost of nursing home care has increased 3.6 percent and 3.4 percent annually over the past five years for a private and semi-private room, respectively.

Total per-person Medicaid payments for Medicare beneficiaries age 65 and older with Alzheimer's or other dementias is 23 times as great as Medicaid payments for other Medicare beneficiaries due to their use of long-term residential care. Total Medicaid spending for people with Alzheimer's or other dementias is projected to be \$49 billion in 2019. Affordable, accessible long-term care insurance could relieve some of this strain on the Medicaid program and consumers' out-of-pocket costs.

Home care. In-home care services, such as personal care services, companion services, or skilled care can allow a person living with dementia to stay in a familiar environment, delay institutionalization, and be of considerable assistance to caregivers. The median cost for a paid non-medical home health aide is \$22 per hour and \$132 per day. Home care costs have increased 2.5 percent annually over the past five years.

Respite. Given the demands on and responsibilities of caregivers, respite is critical to their health and well-being, and may allow individuals with dementia to remain in the home longer. Use of respite care by dementia caregivers has increased substantially, from 13 percent in 1999 to 27 percent in 2015. This is consistent with the growing demand the Alzheimer's Association hears from our constituents. Yet

availability of respite programs in the community is limited. We believe industry has a significant opportunity if it designs products and financing options to meet this need and demand.

Stakeholders Must Account for Those Who Have Been Underserved

Older black/African Americans are about twice as likely to have Alzheimer's or other dementias as older whites and Hispanics are about one and one-half times as likely to be affected. Yet a study of Medicaid beneficiaries with a diagnosis of Alzheimer's indicated that black/African Americans had significantly higher costs of care than whites or Hispanics, primarily due to more inpatient care and more comorbidities. There may be a variety of reasons for this disparity--later-stage diagnosis, delays in timely access to primary care, and a lack of care coordination among them. Industry should account for these disparities as well as cultural considerations in designing products.

Stakeholders Should Provide Basic Education on the Mechanics of Long-Term Care Funding

Finally, we note Policy Option 10 of the Long-Term Care Innovation Subgroup of the National Association of Insurance Commissioners's Retirement Security Initiative:

A federal education campaign around retirement security and the importance of planning for potential LTC needs. The federal government could provide funding and partner with states to provide education to consumers about retirement security. Such a campaign would focus on encouraging people to think about their future retirement and long-term care needs and provide education on the array of private products available to help finance these costs.

The Alzheimer's Association supports the implementation of such a campaign, and it should not assume that the general public understands how long-term care is financed. Results from the 2016 Alzheimer's Association Family Impact of Alzheimer's Survey revealed that 28 percent of adults believed Medicare covered the cost of nursing home care for people with Alzheimer's, and 37 percent did not know whether it covered the cost of nursing home care. Should the government undertake an education campaign, it should include the basics of long-term care, who pays for it, and the options available to the public.

Thank you for the opportunity to comment. The Task Force, states, and industry should encourage the development of products and services that will support persons with dementia, caregivers, and families, and the Alzheimer's Association and AIM would be glad to serve as a resource throughout that process. Please contact Laura Thornhill, Senior Associate Director, Regulatory Affairs, at 202-638-7042 or lthornhill@alz-aim.org if you have questions or if we can be of additional assistance.

Sincerely,

A handwritten signature in black ink, appearing to read 'RE', with a stylized flourish extending from the end.

Robert Egge
Executive Vice President, Government Affairs

From: David Linn <linn@actuary.org>
Sent: Friday, August 30, 2019 10:00 AM
To: LTCITaskForce
Subject: Invitation for Public Comment: American Academy of Actuaries
Attachments: Academy_Comments_Federal_LTCI_Task_Force_083019.pdf

Dear members of the Federal Interagency Task Force on Long-Term Care Insurance:

Members of the American Academy of Actuaries' Long-Term Care Reform Subcommittee appreciate the opportunity to offer comments following our discussion with you earlier this year. In particular, we discussed two of the options (3 and 5) listed in the *Federal Policy Options to Present to Congress* that was published by the Long-Term Care Innovation (B) Subgroup at National Association of Insurance Commissioners (NAIC). This letter reiterates and expands on our original discussion including addressing regulatory hurdles to innovation.

We would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments or on other topics. If you have any questions or would like to discuss further, please don't hesitate to contact me.

David N. Linn
Senior Health Policy Analyst

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AMERICAN ACADEMY *of* ACTUARIES

Objective. Independent. Effective.™

August 30, 2019

Federal Interagency Task Force on Long-Term Care Insurance
Department of the Treasury
1500 Pennsylvania Ave. NW
Room 3454 MT
Washington, DC 20220

Re: Invitation for Public Comment

Dear members of the Federal Interagency Task Force on Long-Term Care Insurance:

As members of the American Academy of Actuaries’¹ Long-Term Care Reform Subcommittee, we appreciate the opportunity to offer comments following our discussion with you earlier this year. In particular, we discussed two of the options (3 and 5) listed in the *Federal Policy Options to Present to Congress*² that was published by the Long-Term Care Innovation (B) Subgroup at National Association of Insurance Commissioners (NAIC). This letter reiterates and expands on our original discussion including addressing regulatory hurdles to innovation.

We would first like to emphasize the importance of actuarial input from the beginning of any process involving the consideration, design, and evaluation of a potential long-term care policy approach. Actuaries are uniquely qualified according to their professional standards and play a crucial role in the financing and design of LTC financing systems—from private long-term care insurance (LTCI) to public programs that provide LTC benefits. Actuaries have specialized expertise in managing the risk of adverse selection in insurance coverages, the ability to recognize and incorporate uncertainty into cost projections and premiums, and experience in evaluating the long-term solvency and sustainability of public and private insurance programs. An actuarial perspective can provide a basis for exploration of new and innovative program designs. We would also refer the task force to two specific publications. One is a recent article in the May/June 2019 issue of *Contingencies* magazine, published by the American Academy of Actuaries, written by four actuaries who have experience with hybrid products.³ The second is a November 2016 Academy issue brief on the criteria that anyone evaluating reforms in the way LTC is covered should consider.⁴

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

² NAIC, [Federal Policy Options to Present to Congress](#).

³ *Contingencies*, “[Unlocking Potential—New combination long-term care insurance solutions show promise](#),” May/June 2019.

⁴ American Academy of Actuaries, [Essential Criteria for Long-Term Care Financing Reform Proposals](#), November 2016.

Option 3: Remove the Health Insurance Portability and Accountability Act (HIPAA) requirement to offer 5% compound inflation with LTCI policies and remove the requirement that Deficit Reduction Act (DRA) Partnership policies include inflation protection and allow the States to determine the percentage of inflation protection.

The NAIC comments that inflation protection substantially increases LTCI premiums, and that removing the protections would increase insurer flexibility when designing products and could lead to lower premium costs.

Although HIPAA requires the 5% compound inflation benefit to be *offered* at the time of sale, it does not require that the product purchased must include inflation protection. In addition, at certain issue ages, a purchased policy must include a stated inflation amount, which may vary by state, in order to qualify for Partnership status enabling asset spenddown protection in the case of Medicaid eligibility.

We agree with the NAIC comments that inflation protection is costly. Premium loads for inflation protection vary by issue age and are not insignificant. We estimate that market premiums for policies sold with a 5% inflation protection benefit can be 4-5 times more expensive than a policy without inflation. Thus, when an applicant declines the offer of inflation protection, their resulting premiums and potential ultimate benefits are significantly lower, which may make a personal purchase of insurance coverage more likely. It is unclear whether the possibility of not being eligible for Partnership is a strong enough influence to encourage the additional required expenditure for the inflation coverage.

We share the following statistics regarding the popularity of these benefit features, based on 2018 sales according to the 2019 Milliman LTCI Survey published by *Broker World*:⁵

What percentage of LTCI sales are tax-qualified under HIPAA?	Very close to 100%. According to the survey, fewer than 0.2% of policies sold in each of the past four years (2015–2018) was not tax-qualified.
What percentage of LTCI sales include inflation protection?	<p>Only 2% of sales included compound inflation of 4.5% or more.</p> <p>Around 37% of sales include an option to purchase additional inflationary coverage often called Guaranteed Purchase Option.</p> <p>Approximately 15.5% of sales did not include any inflation coverage.</p> <p>The remaining sales (45.5%) could have included various other types of inflation coverage, but none would consider the compound level of inflation included in the compound of 4.5% or more category noted above.</p>

⁵ *Broker World*, “[2019 Milliman Long Term Care Insurance Survey](#),” July 1, 2019.

What percentage of LTCI sales are Partnership Policies?	Varies considerably by state. Roughly 1% qualified in original Partnership states. In the DRA states, 52.5% of policies qualified for Partnership status (MN: 82%, WI: 75%, WY: 75%).
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While we do not believe that inflation protection requirements alone would deter carriers from entering or remaining in the LTC market, the requirement to offer inflation protection complicates the sales process. In some cases, an insured may feel more comfortable purchasing a larger base benefit rather than inflation protection. This decision can depend on their ultimate plans for where to retire and other factors related to their individual preferences regarding which risks to cover when making an insurance purchase decision.

Five percent compound inflation protection may not be the appropriate inflation level given current and expected future costs of long-term supports and services (LTSS). We estimate that in the 1990s, LTC inflation rates averaged 4-5%. In more recent years LTC inflation rates appeared to have been closer to 2-3%, which may indicate that the 5% rate is more than is necessary to cover inflationary increases in costs.

Yet, because many policyholders are expected to hold the policies for over 30 years, inflation could increase. Those who project Medicaid budgets need to consider a potential scenario where inflation increases. Medicaid budgets are not harmed, or helped, by an individual being able to choose between spending down their assets or buying Partnership insurance to protect only those assets that are not already exempt. Medicaid budgets are helped when Partnership insurance policyholders receive benefits that exceed the assets they are protecting. If Partnership policyholders are willing to purchase policies with a higher level of inflation protection, it increases the likelihood that they will receive benefits that exceed the assets they are protecting and that the Medicaid program will in turn benefit.

Some policies in the past offered a variable inflation rate design based on Consumer Price Index (CPI). We think this design may be confusing to consumers. In addition, there is a question as to which CPI measure to use, because an LTC CPI does not exist. Unlike medical care, LTC inflation is driven more by wages than cost of medicine, and CPI for nursing home and home care costs for the elderly might be possible indices to use in LTC policies. A CPI peg creates a potentially variable insurance risk. In order for insurance companies to avoid an unknown ceiling on the benefits they promise, a 5% annual or cumulative cap could be included as well.

Finally, inflation protection is just one of many choices that must be made in purchasing LTC coverage. For example, policyholders could purchase higher daily benefit maximums with lower inflation protection. There are also other ways that consumers can select a coverage amount. For example, a spectrum of options are available related to whether a policy covers home health care in addition to skilled nursing facility care. Ultimately, the real question could be whether some coverage is better than no coverage. It is possible that more people would consider covering this risk through insurance if *all* levels of coverage received some sort of beneficial protection (tax or Medicaid spenddown) regardless of whether inflation is part of the benefit calculation.

If the HIPAA and DRA inflation protections were eliminated, replacing them with lower formulas or giving insurance carriers the flexibility to choose the options they want to offer policyholders could be in order. Options and factors to consider include:

- Allow any LTC coverage to qualify for DRA Partnership status if it provides a minimum level of total benefits.
- With respect to Partnership coverage, if issued without inflation protection it may be likely that Medicaid will be needed at an earlier point in time depending on the initial level of insurance purchased.
- Inflation options could add confusion to the sales process without added benefit given the additional cost of the added coverage inflation provides.

Option 5: Allow products that combine LTC coverage with various insurance products (including policies that “morph” into LTCI).

The NAIC recommended the federal government treat products that combine LTC with other coverage in a similar fashion as it treats stand-alone LTCI insurance. The most popular combination product today is a life/LTC hybrid product. The hybrid product could consist of accelerated benefits and an extension of benefits. The accelerated benefits part of the product pays out the death benefit prior to death when the policyholder qualifies for and chooses to access the benefits to cover LTC expenses. The extension of benefits aspect provides LTC coverage after the entire death benefit has been accelerated. The accelerated benefit coverage might be sold as an LTC rider or chronic illness rider. The benefits and benefit triggers can be substantially similar but they are governed under different sections of the Internal Revenue Code and NAIC model regulations. Chronic illness riders typically do not contain some of the features of LTC riders such as the offer of inflation projection; as such they cannot be marketed as LTC insurance. Benefit triggers for acceleration products typically use the LTC benefit qualification standard of being unable to perform at least two activities of daily living or requiring substantial supervision for severe cognitive impairment.

According to a LIMRA study, 2017 sales of policies that included LTC benefits consisted of 21% stand-alone policies, 39% chronic illness riders, and 40% long-term care riders. Clearly the hybrid life products have grown in popularity. Hybrid life policies with an extension of benefits rider make up about 14% of the policies in the hybrid market.

In addition, annuity products might offer an LTC rider where benefits are paid without penalty for early withdrawal and without the interest accumulation being taxed. As in life/LTC hybrid policies, the annuity owner must satisfy the LTC benefit criteria.

Benefits from accelerated benefits are certain, either in the form of living or death benefits, so the cost is higher than for stand-alone LTCI. Presumably, the fixed premium structure of these policies is attractive to those who can afford the hybrid products.

For insurance companies, so far the experience on accelerated benefits has been favorable. The cost of accelerated benefits is offset by the reduction in death benefits, and therefore the risk lies in the time value related to how much sooner the death benefits are accelerated.

The risk for covering extended benefits is much like that for stand-alone LTCI, except generally the premium rates cannot be increased and there might be some value from the policyholder

seeking to preserve the death benefit (an extended benefits rider does not pay benefits until after the acceleration of death benefits is complete).

The complexities associated with hybrid products create questions associated with reserving and reporting, and the NAIC as well as the Interstate Insurance Compact are beginning to address those questions.

Yet another type of combination product provides different coverage at different stages of life. The state of Minnesota prepared a report on “Life Stage” protection,⁶ where a policyholder buys term life insurance coverage for the period until they plan to retire, at which point the coverage amount becomes the lifetime maximum for LTC coverage. In essence, the insurance company’s LTC underwriting is performed at a relatively young age, and the policyholder does not need to be concerned about deterioration in their health prior to being ready to seek LTC coverage. Once again inflation in the cost of LTSS is an important consideration for the policyholder and for those projecting Medicaid budgets should this type of product gain traction in the marketplace. To date, we’re not aware of any insurance company filing such a product.

Regulatory Hurdles to Innovation

Regulatory hurdles remain for innovative products including “Life Stage” protection. Actuarial questions such as proper reserving can be a concern for those considering new types of products, yet regulatory hurdles seem to be a deterrent to the innovation that is required to engender growth. For example, the NAIC model regulation for LTC insurance requires certain levels of benefits. If an innovation does not satisfy the NAIC LTC requirements, the product will be classified as some other health insurance policy. Therefore, some federal requirements or restrictions could be imposed on such health policies that are not imposed on LTC insurance.

We would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments or on other topics. If you have any questions or would like to discuss further, please contact David Linn, the Academy’s senior health policy analyst, at 202-223-8196 or linn@actuary.org.

Sincerely,

Rhonda Ahrens, MAAA, FSA
Member, LTC Reform Subcommittee
American Academy of Actuaries

Al Schmitz, MAAA, FSA
Member, LTC Reform Subcommittee
American Academy of Actuaries

Peggy Hauser, MAAA, FSA
Member, LTC Reform Subcommittee
American Academy of Actuaries

Bruce Stahl, MAAA, ASA
Chairperson, LTC Reform Subcommittee
American Academy of Actuaries

⁶ Minnesota, [LifeStage Protection Product Final Report](#), December 2018.



Federal Interagency Task Force on Long-Term Care Insurance
Comments of California Health Advocates
August 30, 2019

Thank you for the opportunity to contribute to the discussion about the future of financing long-term care and the challenges facing consumers, the private market, regulators, and recommendations the Federal Interagency Task Force will make to the administration.

California Health Advocates (CHA), a non-profit organization founded in 1997, is the leading Medicare Advocacy and educational voice for more than 5.6 million Medicare beneficiaries in California. We support our members, the California SHIPs, known as the Health Insurance and Advocacy Programs (HICAPs) with training, materials, and technical assistance, and we conduct state and national policy advocacy for consumer rights and consumer protections in long-term care insurance.

For forty years, in my capacity as a consultant to CHA and other consumer groups, I have testified about what was then an impending silver tsunami and the lack of preparation for what would be, and is now, a serious demand on public resources for baby boomers needing long-term care. During those 4 decades many proposals for financing long-term care have been discussed, studied, abandoned and then revived multiple times since the 1980's and the Pepper Commission.

During that time, the insurance industry has introduced, modified, and then replaced various insurance products as consumers and regulators rebelled against products that didn't work as advertised. The insurance industry is currently faced with its own unintended consequences that come with the introduction, sale, and use of new products and benefits.

Today the nation is faced with a vastly larger population of aging adults who need care with no system in place to provide or pay for that care. Women in particular face greater obligations as caregivers because they often have less earnings and resources to pay for care, and are in greater danger of institutional care as they age if they are single, divorced, or widowed with no live-in caregiver.

Many proposals for financing care focus on private market strategies such as investment products, retirement funding, tax tradeoffs, and insurance possibilities that higher income people might use.¹ It is unclear how large or how small a role each of these proposals could play on a national scale. What is clear is that these ideas all represent a continuing fragmented approach to financing care. Consumers continue to be left in the dark to find and sort out whatever future approach might work for them, depending on their ability to understand, finance, and retain any option they may find.

¹ See: https://naic-cms.org/sites/default/files/inline_files/cmte_b_senior_issues_related_private_mkt_options_ltc_svc_0.pdf

Regulatory Standards

Insurance regulatory requirements exist for a reason; specific requirements are often the result of something that needed to be changed, required, or prohibited. Marketing standards and disclosures for long term care insurance for instance came to the attention of regulators as a result of consumer complaints, or problems reported by the press.

Premium increases on long-term care insurance products have been an intractable once-a-decade problem for the last 30 years, each one more severe than the last, and each one issuing in enhanced requirements in an attempt to prevent the next increase. Today some people fortunate enough to have afforded and retained coverage are facing astronomical premium increases. These policyholders are being asked to choose between reduced benefits, higher premiums, and in one case, insolvency that comes with state caps on benefits. Many policyholders, and their families, feel betrayed after taking a responsible course of action and providing for the cost of their own care.

We urge the Task Force to recognize the need for strong regulatory standards and requirements for private market options intended to finance long-term care, at both the federal and the state level. The average person buying insurance or a retirement product is not usually knowledgeable about either. When long-term care benefits are added or grafted onto complex financial products confusion is compounded. We believe the following concerns should be included in federal recommendations:

The sales force for insurance and investment products must be trained and regulated to ensure appropriate sales and marketing. Brokers, dealers and agents should operate under strong and enforceable standards of suitability.

Retirement and investment products that provide benefits for long-term care must be understandable in plain language to the average person, and not rife with complex tables or contract language that confuses an individual attempting to protect future income or secure benefits for future care.

State regulators must have the legal authority under state law, and the resources to actively monitor the marketplace, approve and regulate products and sales and marketing materials, and the authority and resources to monitor and regulate sales agents.

Product disclosure requirements should not be allowed to substitute for active and effective regulation and enforcement of standards and requirements.

State regulators will be faced with many innovative insurance products in the future that will be designed to pay for long-term care costs using untested ideas and pricing that will likely take a decade or more to mature. Only years later will state regulators know how well new products have delivered on their promises.

A Changing Population of Elders Needing Care

It is unclear how many younger boomers entering retirement in the near future can afford to pay premiums for insurance, participate in investment products, benefit from tax proposals, or make voluntary contributions for an unpredictable event far in the future. Many middle class families have to make tradeoffs between increases in their basic expenses and their resources. For many elders Medicare premiums, Part D premiums, medical and prescription drug cost-sharing, and Medicare Advantage or Medigap premiums all add up to an increasing amount of post-retirement medical costs leaving little room for additional costs.

A much larger number of younger boomers, and older millennial's are entering retirement at greater levels of poverty and disability than in past decades. In addition, they are likely to have had fewer children and have higher rates of divorce, resulting in reduced access to family caregivers that might allow them to get their care at home. Without live-in caregivers future elders may need institutional care much sooner, increasing the burden on public resources.

Very soon the numbers of adult millennial's will equal the number of living baby boomers, ensuring that the numbers of aging adults will not be diminished anytime soon.² The middle class continues to be in the most in danger of spending down to Medicaid levels as they age and need care.

Most families in the bottom half of the income distribution have no retirement account savings at all, and a Saver's Credit has proven ineffective in leveling retirement financing disparities between higher and lower income working families.³ This outcome provides little encouragement that tax benefits and savings and investment strategies will be successful models for funding future long-term care expenses for large numbers of Americans.

The Long Term Care Insurance Partnership Program

We were an original participant of the Advisory Group to the California Partnership and the development of the program. It is impossible to discover if the California program or the subsequent participation of other states has resulted in savings to a state Medicaid program or to the federal program. As the GAO noted in its 2005 report, there is no data to make that finding.⁴ It is clear that consumers are able to protect assets equal to the payment of insurance benefits. However, in the absence of insurance those assets would have been spent before qualifying for a state Medicaid program, and it's not known what the cost would have been to the state program in the absence of those insurance benefits and the subsequent required expenditure of any assets.

In California it is clear that purchasers had a policy that met all of the requirements of state law plus additional requirements pertaining to care management and coordination and certain other protections.

² See: <https://www.pewresearch.org/fact-tank/2018/03/01/millennials-overtake-baby-boomers/>

³ See: <https://www.epi.org/publication/retirement-in-america/>

⁴ See: <https://www.gao.gov/new.items/d051021r.pdf>

A recent change in state law was enacted to encourage more participation in the program. Companies can offer a Partnership policy with inflation protection lower than 5%, and a minimum daily benefit of \$100 with a minimum duration of \$73,000.

CHA is a strong believer in building inflation protection into any long-term care insurance benefits to ensure a meaningful benefit when used decades later. While we recognize the cost element at the front end, we are very aware of the pricing cost associated with adding it later at increasingly older ages and the danger of a minimal benefit that has lost purchasing power against inflation.

In Search of a Public Option

Long term care is gaining in public visibility as more families have experience with a need for care by an aging family member. Family caregivers are often plunged into a confusing world of long term care services and providers that vary from one community to another and one payment system to another. Caregivers must develop their own system for care based on the information they are able to get, the services available in their community, and the ability to pay for care that is needed. It comes as a shock to find that Medicare does not cover this kind of care and that the only public option is spending down to Medicaid.

After hearing from their residents states have begun to take action on their own. Minnesota funds a home-care program to enable vulnerable seniors to remain in their home longer. Hawaii subsidizes some caregivers. California is developing a State Master Plan for Aging, and Washington State has taken the first leap with a long-term care public option for their residents.

Medicare has recently begun to experiment with allowing Medicare Advantage plans to provide an array of medical and non-medical services to support chronically ill individuals at home, with a goal of preventing more expensive institutional care. Unfortunately those services will only be available to a very small number of beneficiaries, and only if they are enrolled in a plan in a community where a full range of those benefits are available. The Medicare program could accomplish greater savings by providing supportive services to chronically ill individuals in traditional Medicare, as noted in the Bipartisan Policy Center report *Next Steps in Chronic Care*.⁵

Conclusion

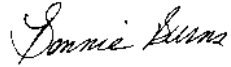
In conclusion, Americans are learning about long-term care by default as more and more families are faced with a family member needing care, or providing that care. Educating the public on an array of issues around the risk of needing care, finding care, and paying for care only to point to an array of complicated insurance or investment products that many people cannot buy because of existing health conditions, or that they cannot afford is not helpful.

We would be happy to participate in any discussion about making benefits for long-term services more affordable to middle income beneficiaries and their families, preventing or delaying spend down, helping to maintain the lives of impaired people in their own homes and communities for

⁵ See: <https://bipartisanpolicy.org/wp-content/uploads/2019/07/Next-Steps-in-Chronic-Care.pdf>

as long as possible, and helping caregiving adult daughters continue their employment and avoid reducing their own ability to pay for their future retirement and care needs

Sincerely,

A handwritten signature in cursive script that reads "Bonnie Burns".

Bonnie Burns, CHA Consultant
NAIC Consumer Representative



Comments for the Center for Economic Justice
To the Federal Interagency Task Force on Long Term Care Insurance
August 30, 2019

The Center for Economic Justice (CEJ) offers the following comments to the Task Force.

We start with the proposition that the goal for the Task Force – and the nation – is to develop institutions and programs to address the absence of long term care services and related financing for the vast majority of Americans and particularly for low- and moderate-income families. CEJ suggests the goal is to identify the most efficient methods of providing and financing long term care services, particularly for low- and moderate-income families

While private long term care insurance (“LTCI”) may be part of a strategy, promoting private LTCI is not and should not be a goal of the Task Force. In fact, LTCI may be an obstacle to more efficient and effective methods of financing LTSS.

Stand-alone LTCI is a failed and defective product. Policymakers and regulators should be leading the transition away from stand-alone LTCI to other methods of financing LTC services.

Stand alone LTCI is a deeply troubled product which should be phased out in favor of other methods of providing and financing LTC services. The problems with stand-alone LTC are significant and include:

- Inefficient delivery of long-term care services;
- Consigned to a niche market, at best, requiring the purchase of a separate insurance policy competing with consumers’ needs for other insurance products and retirement income products in a lengthy period of stagnant incomes for low- and moderate income families;
- Complex product difficult for consumers to understand and coordinate with other related health and retirement income insurance and financing sources;
- Non-viable insurance product requiring public assistance to encourage private insurers to offer the product;
- An increasingly defective product which, due to significant limitations on coverage, no longer provides long term care, but specified care for a period of time limited to periods shorter than many consumers will require; and

- Difficulty in pricing and providing regulatory oversight, including
 - Impossible choices for consumers faced with unaffordable premium increases, reduced benefits and/or giving up decades of investment due to massive and unexpected rate increases;
 - strain on the guaranty fund system due to current and future failures of LTC insurers; and
 - the current regulatory regime which requires LTCI insurers to add a margin (additional premium) to the best estimate of the cost of transfer of risk – despite historically conservative assumptions for investment income, lapse and mortality.

Stand-alone LTCI is a very inefficient method of financing delivery of long-term care services.

Private LTCI is, at best, an inefficient method of financing long-term care services. The NAIC LTCI model regulation,¹ Section 19 of the model provides for a minimum 60% loss ratio, but an earlier provision of the model requires the premiums contain a cushion – “a minimum margin for moderately adverse experience – of at least 10%.

We understand that insurers made errors in initial pricing of LTCI in the 1980s and 1990s. Initial assumptions for lapse rates (the frequency in which a policyholder would surrender the policy and relieve the insurer of further liability) were too high, assumptions for investment income did not contemplate significantly lower interest rates and estimates for claims were too low.

But we are now 30 to 40 years on from those initial assumptions. Insurers have radically changed the policies and benefits – to the point where calling the policy “long-term care insurance” is now misleading. More important, insurers’ key assumptions about lapse and interest rates are very conservative.

While the NAIC model requires the minimum 10% cushion on top of the best estimate actuarial indication, the model also permits an insurer to seek rate increases if experience is worse than expected. The model, however, does not require an insurer to file rate decreases if the experience is better than expected. The result is that current LTCI products are likely to produce a loss ratio around 55% -- at best. Clearly, a method of financing long-term care services that provides 55 cents or less in service benefit for every dollar paid for those services cannot be called an efficient method of financing long term care services.

¹ NAIC Model Law 641 at <https://www.naic.org/store/free/MDL-641.pdf>

Any method of improving the financing of long-term care services must

- reduce the number of products consumer have to purchase;
- simplify the choices consumers have to make;
- utilize mandates as needed to ensure an effective risk pool;
- shift the expenditure of federal funds away from subsidies for the affluent to assistance for those taxpayers who would otherwise not be able to purchase long term care services or insurance; and
- maximize the use of existing social insurance institutions.

The first two points recognize the reality that consumers face a number of demands on their time and resource and that many demands for savings, retirement and insurance require action today before considering long term care needs decades into the future. Consumers in their 20's and 30's must consider the costs of children, housing, student loans, insurance (auto, home/rental, health, life), retirement and more. Older consumers may or may not have student loan debts or minor children, but have all the other demands and more, including care for older parents.

It is unrealistic to expect consumers to go buy another insurance policy limited to long term care services for several reasons in addition to the other demands for their resources. Many consumers don't understand that health insurance does not cover long term care services and explaining the difference between health care and long-term care is complex. Stand alone LTCI products are complex and increasingly so as insurers limit coverage and benefits. Consumer biases against distant future events also prevent purchase of stand-alone LTCI. And, of course, the high cost of private stand-alone LTCI is a major impediment.

Any program designed to improve financing of long term care services must recognize that no amount of "consumer education" can overcome these structural impediments. Consequently, even if private stand-alone LTCI were an efficient method financing long-term care services – and it clearly is not – promoting private stand-alone LTCI as a significant method of financing long-term care services not succeed.

Just as consumers purchase multi-peril residential property (homeowners) insurance and multi-peril auto insurance, so should long-term care coverage be packaged with other types of health or retirement insurance. The growth of private hybrid life-LTC and hybrid annuity-LTC insurance products is a positive change. If there is to be federal expenditure to support private insurance covering long-term care services, such support should be only for those insurance products combining LTC coverage into a more comprehensive retirement or health care package. But, given the limitations of private market solutions, we suggest that federal expenditures to promote the financial of long-term care services should be prioritized to strengthening existing public social insurance programs, as discussed further below.

CEJ asks the task force abandon advocacy of tax incentives for private LTCI and to consider the options for spending tax dollars to facilitate or provide long term care services.

Federal expenditures – whether through tax credits or cash assistance – should be reoriented from current practice. The purpose of tax credits is to encourage a consumer (or business) to engage in an activity that the consumer (or business) would not otherwise do. In the case of LTCI tax credits, the purpose is to encourage consumers who would otherwise not purchase LTCI because, but for the tax credit, the consumer would not be able to afford the LTCI. Current tax credits for purchasing LTCI overwhelmingly benefit the affluent and provide a tax windfall for consumers who would otherwise purchase the LTCI and don't need the tax windfall.

CEJ does not believe it is the role of government to guarantee private market profits nor have taxpayers cover the costs of market failures to allow private interests to operate profitably. We believe the role of government is to create rules of the road to allow competition and to address market failures with regulation or fees to ameliorate those market failures. The problems with stand-alone LTCI are not a result of market failures, but problems with the product and the ability to create a stand-alone insurance product limited to long term care financing.

The premise behind advocacy of LTCI tax credits seems to be that private insurers must be able to sell LTCI and government's role is to facilitate that with taxpayers paying for costs of ensuring that LTC insurers make a profit. We disagree.

We agree that, for some types of product markets, private insurers can be more efficient than public insurers – see our calls for privatization of flood insurance. But in the area of health care delivery, that is not the case. Medicare delivers 95 cents of benefits per dollar of premium. At best, private LTCI will deliver 55 cents on the dollar in benefits, with the remaining 45 cents plus significant investment income going to high sales costs, claims settlement, executive salaries and profit for investors. There is nothing wrong with investors getting a return on investment, but the premise behind such return is that the private enterprise is delivering greater value than the alternatives.

The various proposals to encourage private insurers – shifting catastrophic risks and claims to taxpayers while leaving standard and capped risks to private insurers – will result in at least three negative outcomes for the vast majority of consumers and taxpayers.

First, these proposals would privatize profit while socializing risk. This is unfair. Second, it will result in less efficient delivery of long term care services. Third, it will exacerbate income inequality and impoverish low and moderate income consumers. This last result is clear from a comparison between adding LTC coverage to Medicare versus further subsidizing private LTCI. The former is funded by a progressive tax system with contributions related to ability to pay. The latter redistributes income from low- and moderate-income consumers to more affluent consumers and to management and shareholders of private insurer.

There does not seem to be recognition by proponents of tax credits for LTCI that a tax credit is government expenditure. The task force should compare this type of government expenditures to other types of government expenditures. Proposing continued tax credits, let alone increased tax credits for LTCI, amounts to asking for preferred tax treatment of a defective product that has wreaked havoc on tens of thousands of consumers and now threatens to further punish taxpayers and policyholders through the guaranty fund system. The proposed tax credits represent an upward distribution of income from low- and moderate-income consumers/taxpayers to higher-income consumers/taxpayers to promote inefficient delivery of long term care services.

A tax dollar spent to provide long term care services under Medicare will produce 95 cents of long term care services paid for a progressive tax system. A tax dollar spent to provide a tax credit for stand-alone LTCI will provide subsidies for many consumers who don't need the financial assistance and would purchase stand-alone LTCI or other insurance product in the absence of the tax subsidy. A tax credit approach will predominantly benefit more affluent purchasers at the expense of low-and-moderate income taxpayers who will receive disproportionately fewer benefits, all to promote a far less efficient delivery of LTC services.

Our comparison is rudimentary and clearly a more refined analysis is needed, but that is the point – there has been no analysis of the costs and benefits of proposed tax credits or any comparison to alternative uses of tax dollars.

Consider insurance product development consistent with the “Savings Mentality” goal.

CEJ supports government, including insurance regulators', efforts to help consumers understand lifetime insurance and retirement income needs. But, insurance regulators, in particular, should be promoting insurance product designs which support this education effort and should not be promoting insurance products which thwart the education effort. LTC insurance products designs which combine LTC financing with other common health insurance or retirement income product purchases are consistent with the “Savings Mentality” education theme. Stand-alone LTCI is not.

Consider the experience of long-term care financing in other countries.

In particular, Japan has developed a sophisticated approach to long-term care financing which combines mandates (to address consumer biases), public programs (to facilitate comprehensive federal and local solutions) and private market competition by service providers. Attached is a recent presentation on the Japanese long-term care insurance strategy for your review and consideration.

Long-Term Care Insurance System of Japan

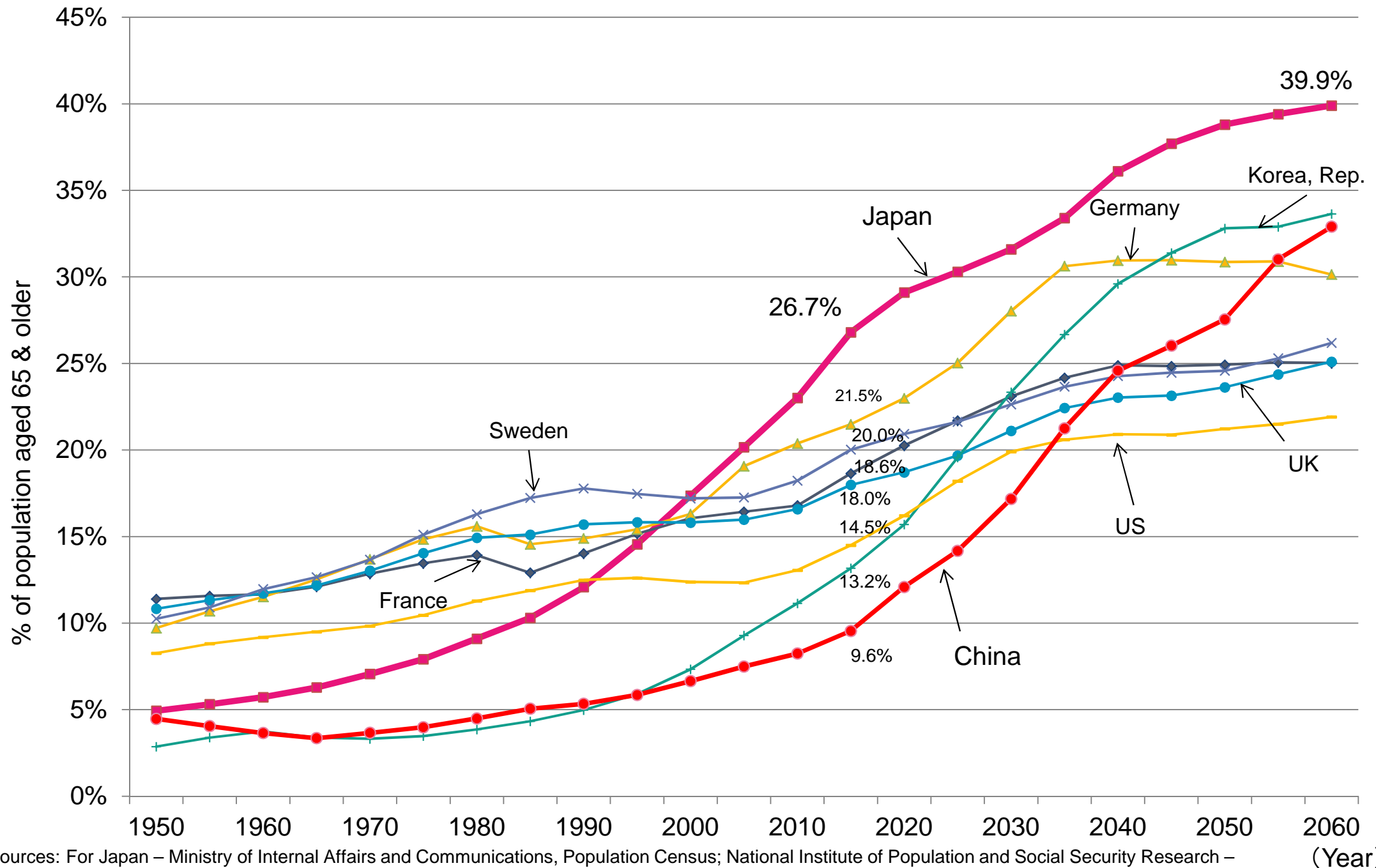
November 2016



Health and Welfare Bureau for the Elderly

Ministry of Health, Labour and Welfare

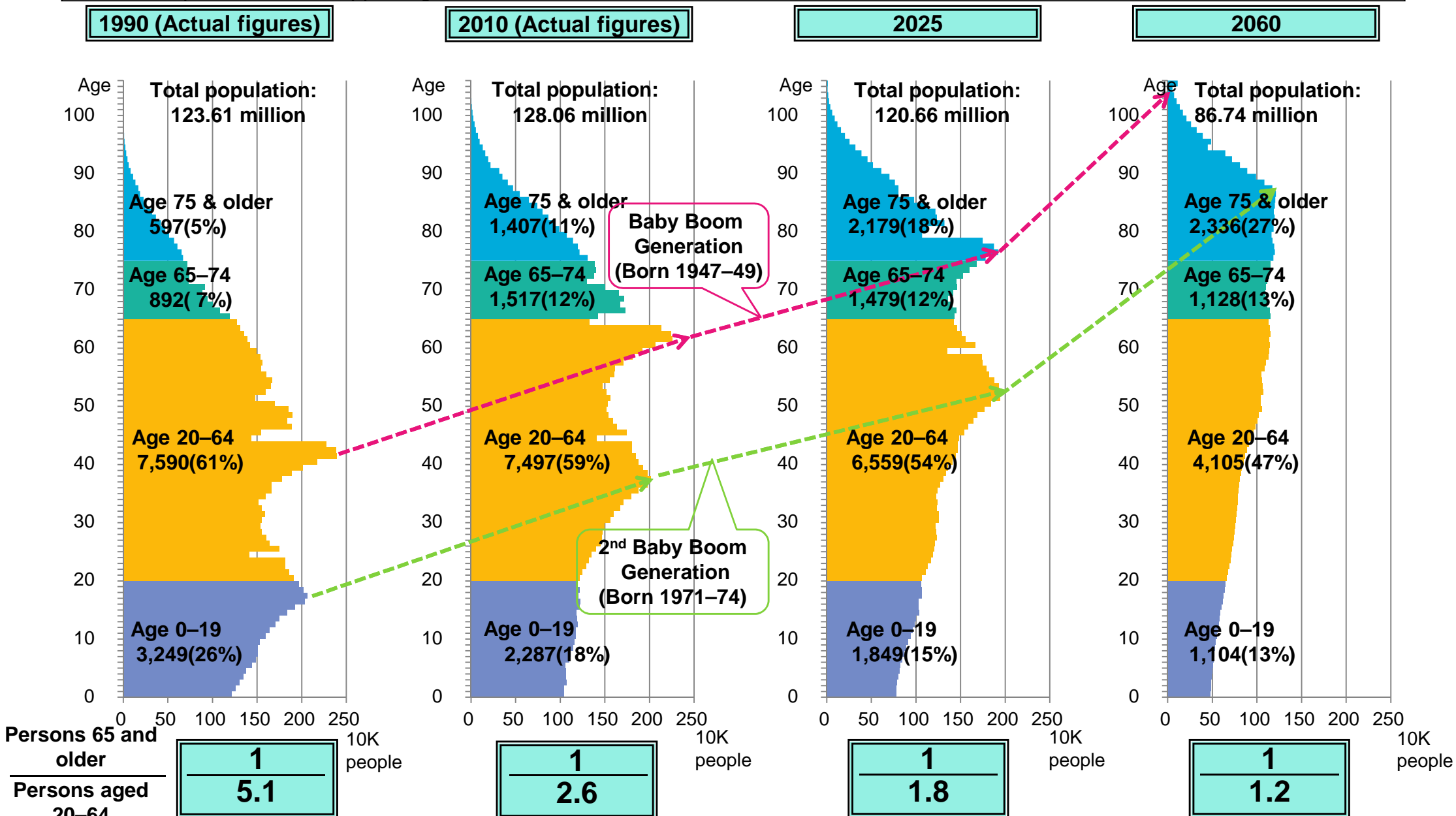
Changes in the Percentage of the Population Over Age 65



Sources: For Japan – Ministry of Internal Affairs and Communications, Population Census; National Institute of Population and Social Security Research – “Population Projections for Japan (January 2012 estimate): Medium-Fertility & Medium-Mortality Assumption” (Figures as of Oct. 1 of each year)
For other countries – United Nations, World Population Prospects 2010

Changes in Japan's Population Pyramid (1990–2060)

○ By examining changes in Japan's demographic makeup, it can be seen that the current social structure consists of 2.6 persons supporting each elderly person. In 2060, with the progression of the aging population and decreasing birthrate, it is estimated that 1.2 person will be supporting one senior citizen.



Source: Ministry of Internal Affairs and Communications – Population Census, Population Estimate; National Institute of Population and Social Security Research – “Population Projections for Japan (January 2012): Medium-Fertility & Medium-Mortality Assumption” (Figures as of Oct. 1 of each year)

(1) Outline of Long-Term Care Insurance System

Development of welfare policies for the elderly

	Aging rate (year)	Major policies
1960s <u>Beginning of welfare policies for the elderly</u>	5.7% (1960)	1963 Enactment of the Act on Social Welfare Services for the Elderly ◇ Intensive care homes for the elderly created ◇ Legislation on home helpers for the elderly
1970s <u>Expansion of healthcare expenditures for the elderly</u>	7.1% (1970)	1973 Free healthcare for the elderly
1980s <u>“Social hospitalization” and “bedridden elderly people” as social problems</u>	9.1% (1980)	1982 Enactment of the Health and Medical Services Act for the Aged ◇ Adoption of the payment of co-payments for elderly healthcare, etc. 1989 Establishment of the Gold Plan (10-year strategy for the promotion of health and welfare for the elderly) ◇ Promotion of the urgent preparation of facilities and in-home welfare services
1990s <u>Promotion of the Gold Plan</u>	12.0% (1990)	1994 Establishment of the New Gold Plan (new 10-year strategy for the promotion of health and welfare for the elderly) ◇ Improvement of in-home long-term care
<u>Preparation for adoption of the Long-Term Care Insurance System</u>	14.5% (1995)	1997 Enactment of the Long-Term Care Insurance Act
2000s <u>Introduction of the Long-Term Care Insurance System</u>	17.3% (2000)	2000 Enforcement of the Long-Term Care Insurance System

Problems before introducing the Long-Term Care Insurance System

Welfare system for the elderly

Services provided:

- Intensive Care Home for the Elderly, etc.
- Home-help service, Day service, etc.

(Problems)

- **Users could not choose services :**
Municipal governments decided services and service providers.
- **Psychological resistance :**
Means test was required when applying services.
- **Services tended to be unvarying without competition:**
Services were basically provided by municipalities or organizations entrusted.
- **Service fee could be heavy burden for the middle/upper income group:**
The principle of ability to pay according to income of the person/Supporter under Duty.

Medical system for the elderly

Services provided:

- Health center for the elderly,
Sanatorium medical facility, general hospital, etc.
- Home-visit nursing, day care, etc.

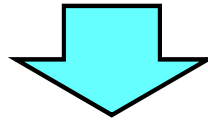
(Problems)

- Long-term hospitalization to be cared in hospitals (“social hospitalization”) increased:
hospitalization fee is less expensive than welfare services for middle/upper income group, as well as basic maintenance of the welfare service was insufficient.
- **Medical cost increased:**
Hospitalization fee was more expensive comparing with Intensive Care Home for the Elderly and Health center for the elderly.
- **Facilitation of hospital was not sufficient enough for long-term care with staff and living environment:**
Hospitals are expected to provide “cure” (e.g. Limited room area for care, dining hall or bathrooms)

These systems had limitations for solving problems.

Background of the introduction of the Long-Term Care Insurance System

- As society ages, needs for long-term care have been increasing because of more elderly persons requiring long-term care and lengthening of care period, etc.
- Meanwhile, due to factors such as the trend towards nuclear families and the aging of caregivers in families, environment surrounding families has been changed.

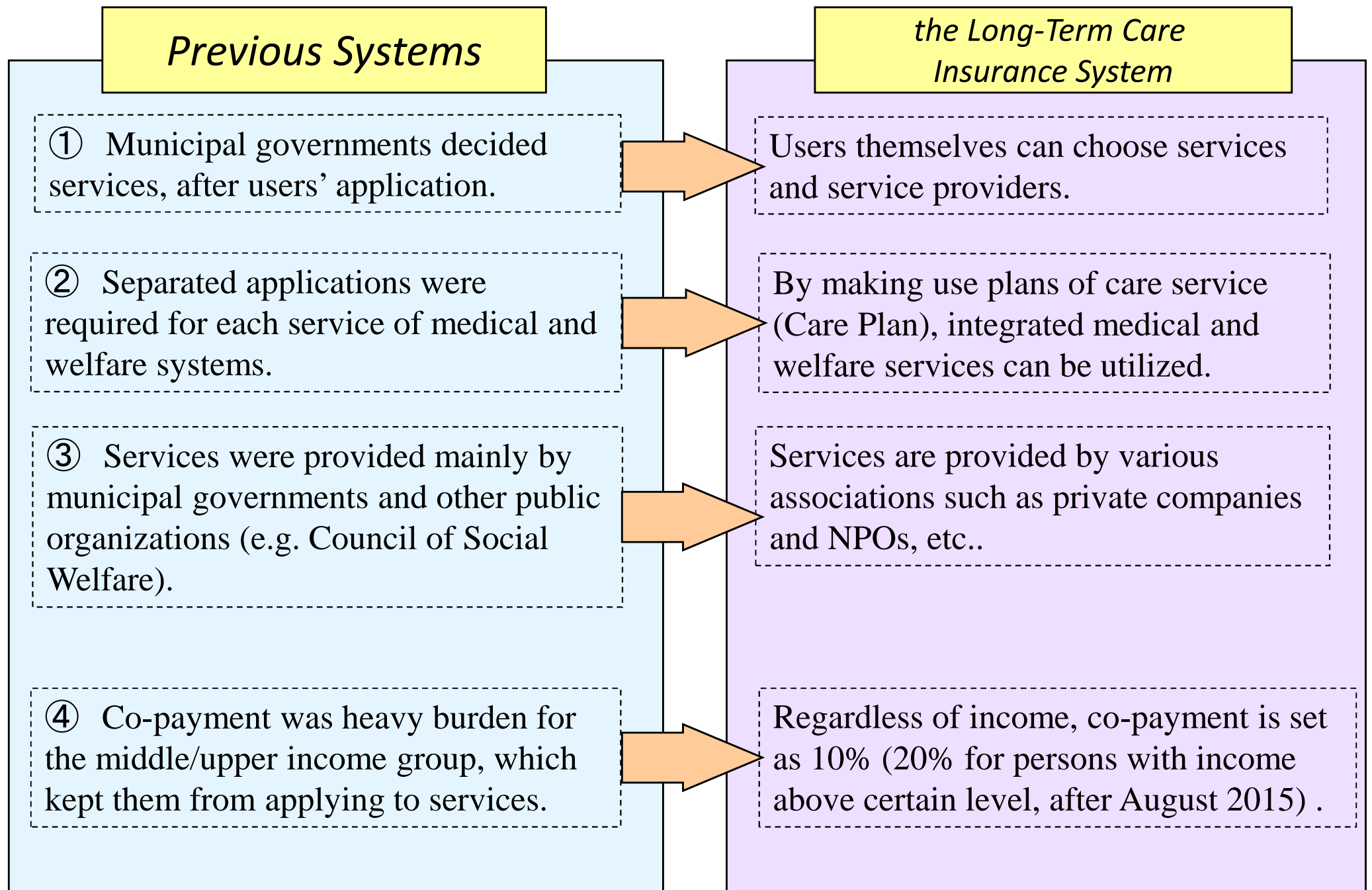


Introduction of the Long-Term Care Insurance System (a mechanism to enable society to provide long-term care to the elderly)

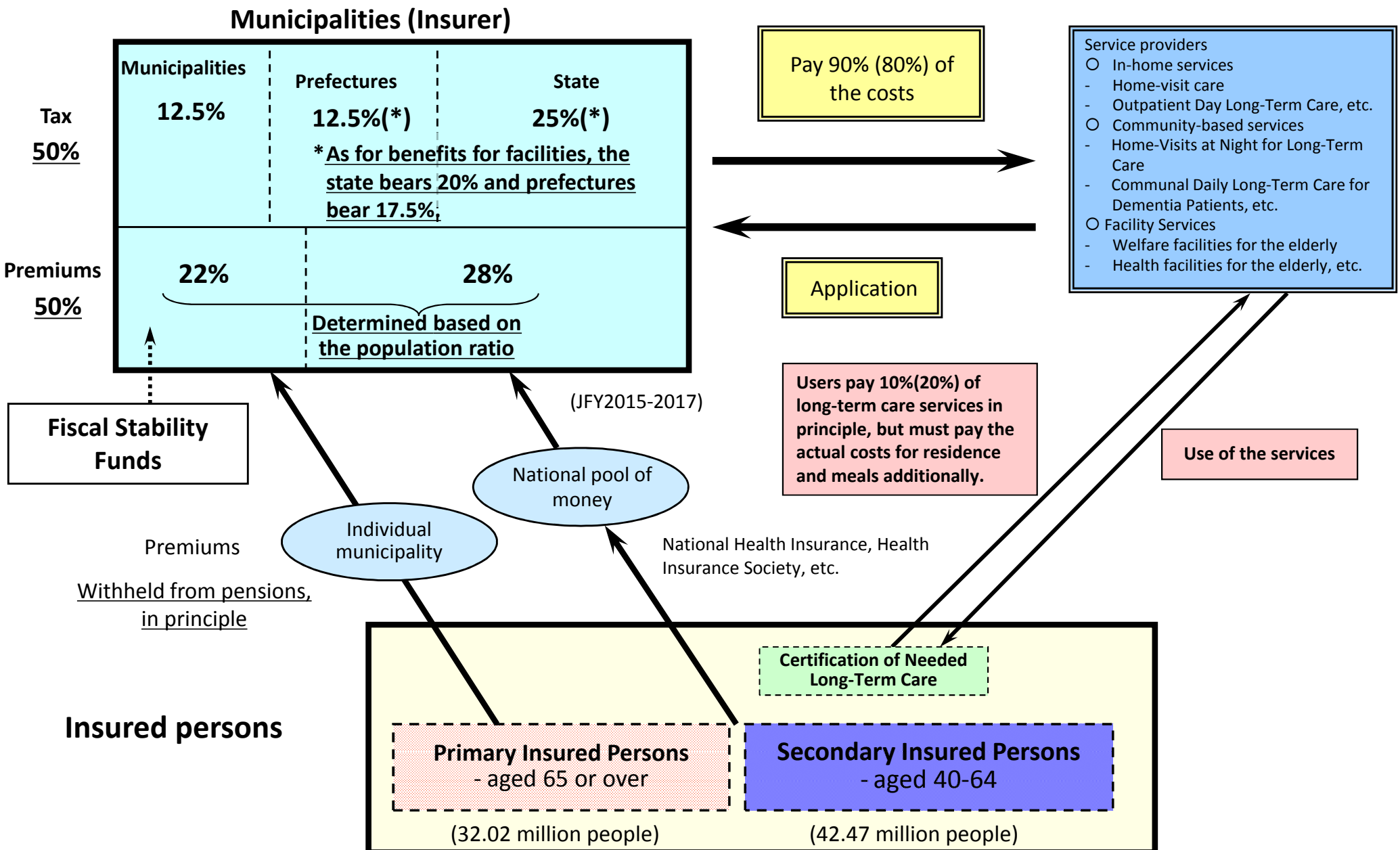
【Basic Concepts】

- Support for independence: The idea of Long-Term Care Insurance System is to support the independence of elderly people, rather than simply providing personal care.
- User oriented: A system in which users can receive integrated services of health, medicine, and welfare from diverse agents based on their own choice.
- Social insurance system: Adoption of a social insurance system where the relation between benefits and burdens is clear.

Outline of difference between previous systems and present



Structure of the Long-Term Care Insurance System



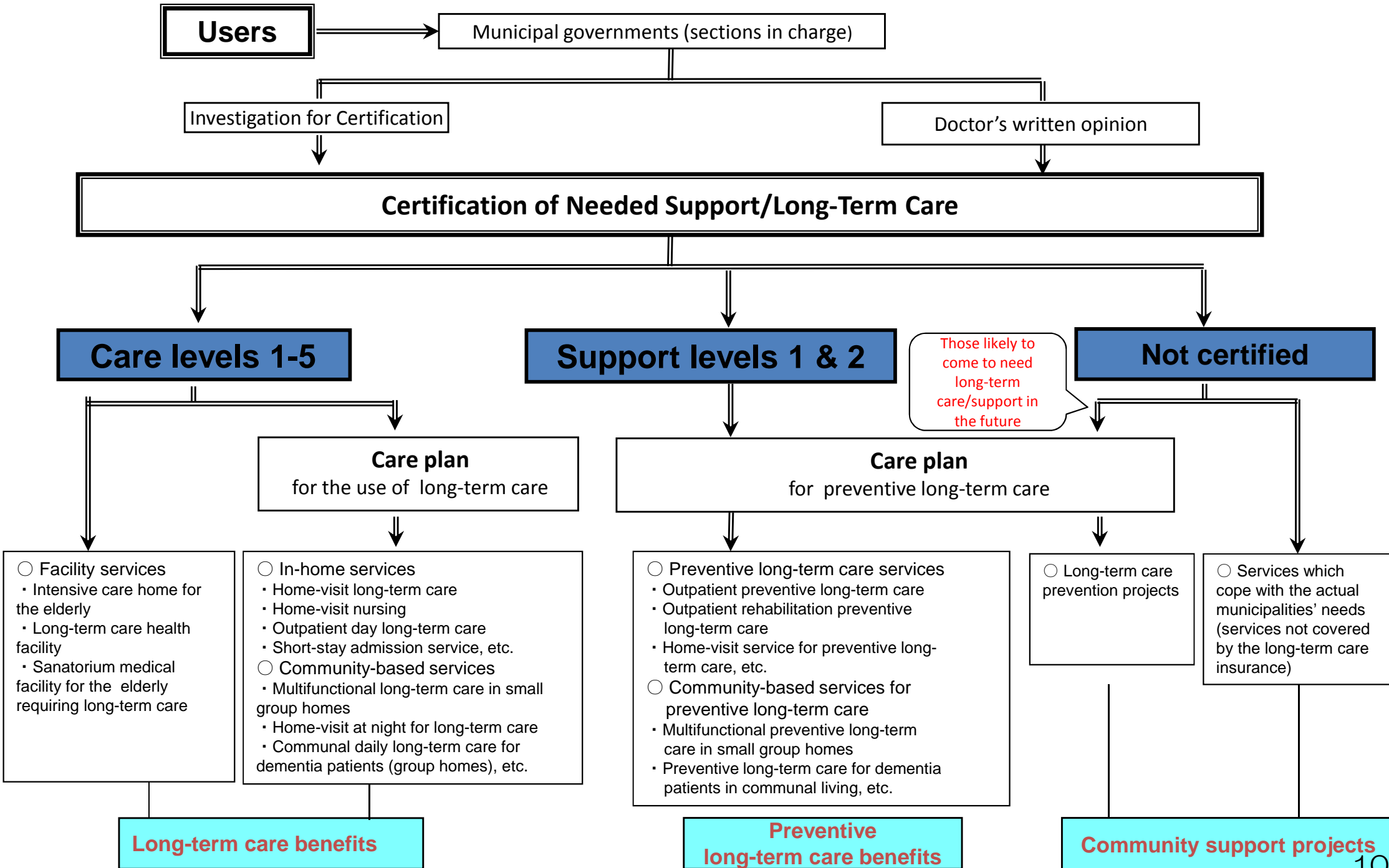
Note: The figure for Primary Insured Persons is from the Report on Long-Term Care Insurance Operation (provisional) (April, 2009), Ministry of Health, Labour and Welfare and that for Secondary Insured Person is the monthly average for JFY2008, calculated from medical insurers' reports used by the Social Insurance Medical Fee Payment Fund in order to determine the amount of long-term care expenses. Burden ratio for persons with income above certain level is 20:80, after Aug 2015.

The insured

- The insured under the Long-Term Care Insurance System are (1) people aged 65 or over (Category 1 insured persons) and (2) people aged 40-64 covered by a health insurance program (Category 2 insured persons).
- Long-term care insurance services are provided when people aged 65 or over come to require care or support for whatever reason, and when people aged 40-64 develop aging-related diseases, such as terminal cancer or rheumatoid arthritis, and thereby come to require care or support.

	Primary insured persons	Secondary insured persons
Eligible persons	Persons aged 65 or over	Persons aged 40-64 covered by a health insurance program
Number	32.02 million aged 65-74:15.74 million	42.47 million
Requirement for service provision	<ul style="list-style-type: none"> - Persons requiring long-term care (bedridden, dementia, etc.) - Persons requiring support (daily activities requires support) 	Limited to cases where a condition requiring care or support results from age-related diseases (specified diseases), such as terminal cancer and rheumatoid arthritis
Percentage and number of persons who are eligible for services	5.69million (17.8%) aged 65~74: 0.72million (4.4%) aged 75~: 4.97million (32.1%)	0.15million (0.4%)
Premiums collection	Collected by municipalities (in principle withheld from pension benefits)	Collected together with medical care premiums by medical care insurers

Procedure for Use of Long-term Care Services



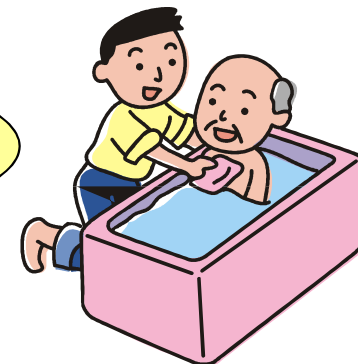
Varieties of Long-term Care Insurance Services

Private Home



Home-visit Services

Home-visit Care, Home-visit Nursing, Home-Visit Bathing Long-Term Care, In-Home Long-Term Care Support, etc.



Day Services

Outpatient Day Long-Term Care, Outpatient Rehabilitation, etc.

Short-stay Services

Short-Term Admission for Daily Life Long-Term Care, etc.

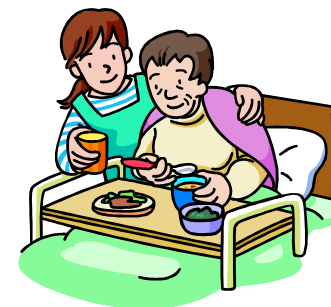


Residential Services

Daily Life Long-Term Care Admitted to a Specified Facility and People with Dementia etc.

In-facility Services

Facility Covered by Public Aid Providing Long-Term Care to the Elderly, Long-Term Care Health Facility, etc.



Long-term
Care Facility



(2) Present condition and future prediction of Long-Term Care Insurance System

Increase in number of persons who are eligible for LTC insurance and users

○While the number of insured persons aged 65 or older has increased by approximately 1.5 times over 15 years since 2000, when the Long-term Care Insurance System was established, that of care service users has increased by approximately 3 times over the same period. The surge in the number of in-home care users accounts for the threefold increase of the care service users.

①Increase in number of insured persons aged 65 and older

	End of April,2000		End of April,2015	
Number of first insured persons	21.65 million	⇒	33.08 million	1.53 times

②Increase in number of persons with care needs & support needs certification

	End of April,2000		End of April,2015	
Number of persons with care needs & support needs certification	2.18 million	⇒	6.08 million	2.79 times

③Increase in number of service users

	End of April,2000		End of April,2015	
Number of users of in-home care	0.97 million	⇒	3.82 million	3.94 times
Number of users of facility care	0.52 million	⇒	0.90 million	1.73 times
Number of users of community-based care	—		39 million	
Total	1.49 million	⇒	5.11 million	3.43 times

(Source: Report on Long –Term Care Insurance Service)

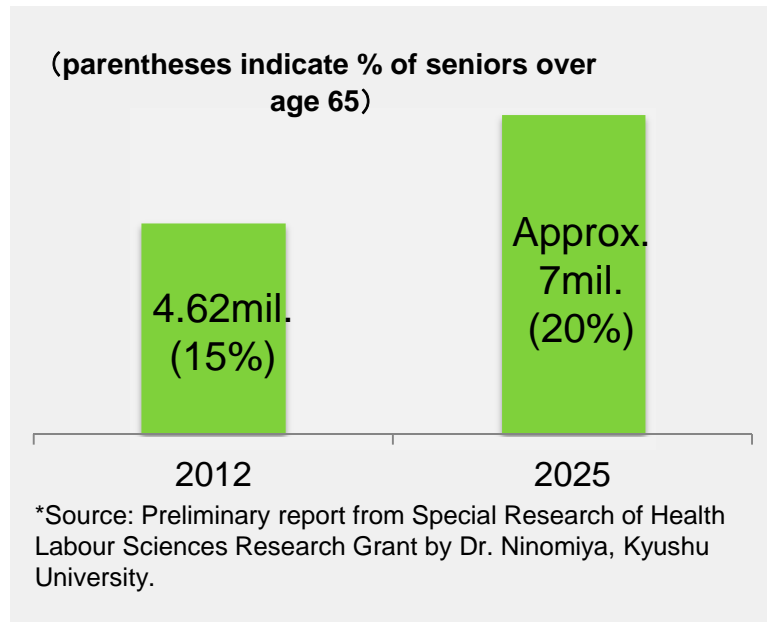
State of Affairs Regarding Long-Term Care Insurance in the Future

1. The no. of seniors over age 65 is predicted to reach 36.57 million by 2025 and reach a peak of 38.78 million in 2042. Additionally, the percentage of seniors over age 75 is expected to grow, surpassing 25% by 2055.

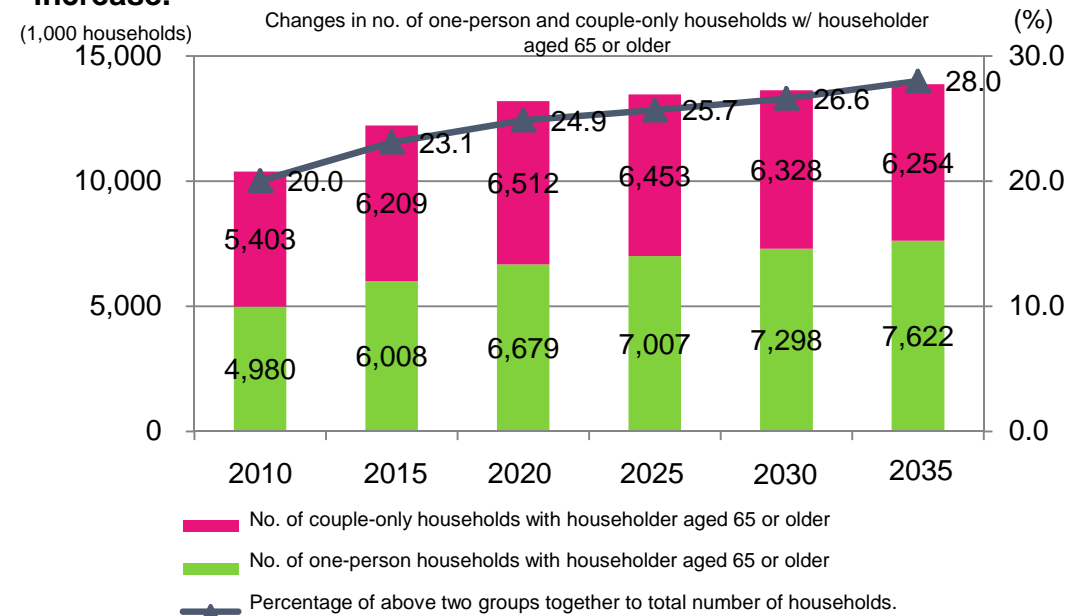
	2010	2015	2025	2055
No. of seniors 65 & older (ratio)	29.48million (23.0%)	33.95million (26.8%)	36.57million (30.3%)	36.26million (39.4%)
No. of seniors 75 & older (ratio)	14.19million (11.1%)	16.46million (13.0%)	21.79million (18.1%)	24.01million (26.1%)

*Source: "Projection of the number of households for Japan (nationwide projection) "compiled in Jan. 2013, National Institute of Population and Social Security Research (1&3)

2. Among seniors over age 65, seniors with dementia will increase.



3. Individual/ couple-only households with householders over age 65 will increase.



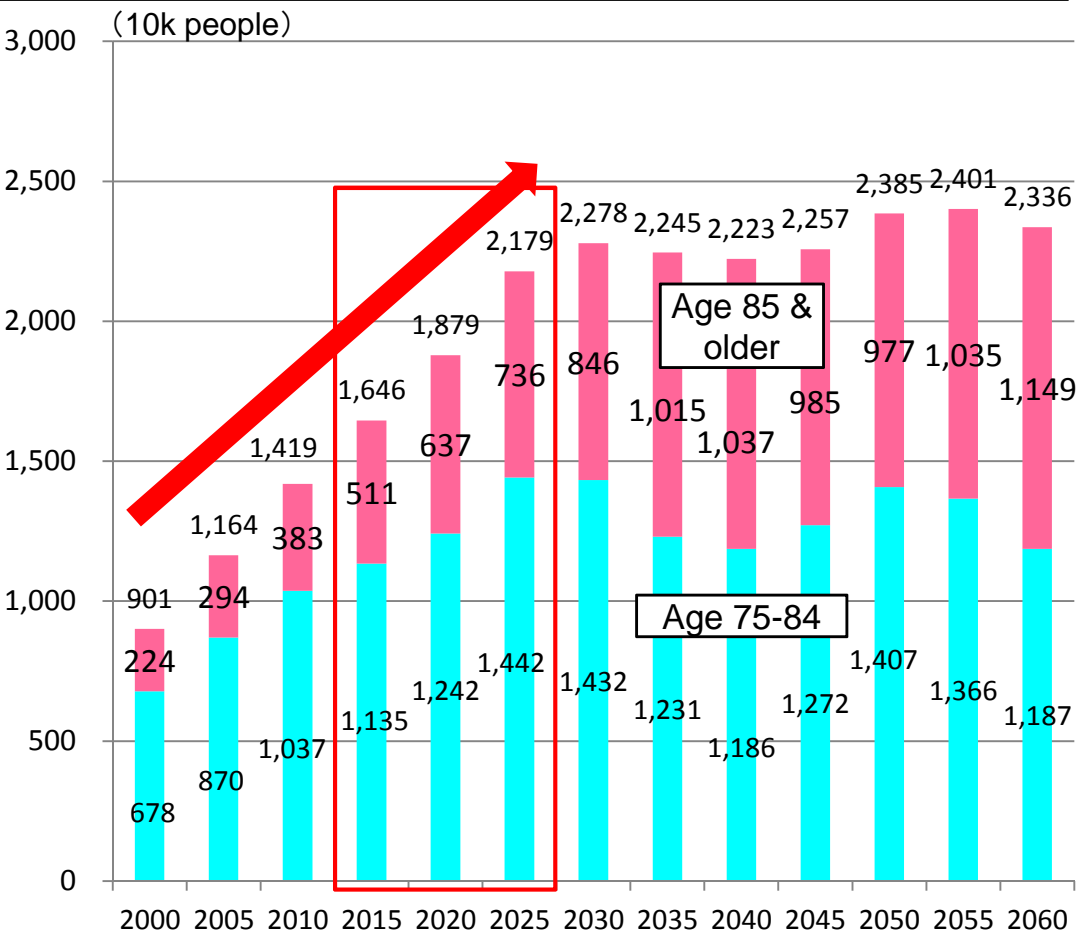
4. The no. of seniors over age 75 will rapidly grow in cities and gradually grow in rural areas with originally high senior population. Tailored response according to regions is necessary as aging circumstances differ according to region.

	Saitama Pref.	Chiba Pref.	Kanagawa Pref.	Aichi Pref.	Osaka Pref.	--	Tokyo	--	Kagoshima Pref.	Akita Pref.	Yamagata Pref.	Nationwide
2015 < > = Ratio	0.765 mil. people <10.6%>	0.717 mil. people <11.6%>	1.016 mil. people <11.1%>	0.817 mil. people <10.9%>	1.070 mil. people <12.1%>		1.473 mil. people <11.0%>		0.267mil. people <16.2%>	0.188mil. people <18.4%>	0.190mil. people <17.0%>	16.458 mil. people <13.0%>
2025 < > = Ratio () = Factor of Increase	1.177 mil. people <16.8%> (1.58x)	1.082 mil. people <18.1%> (1.51x)	1.485 mil. people <16.5%> (1.46x)	1.166 mil. people <15.9%> (1.43x)	1.528 mil. people <18.2%> (1.43x)		1.977 mil. people <15.0%> (1.34x)		0.295mil. people <19.4%> (1.10x)	0.205mil. people <23.0%> (1.09x)	0.207mil. people <20.6%> (1.09x)	21.786 mil. people <18.1%> (1.32x)

*Source: "Regional Population Projection for Japan" compiled in Mar. 2013, National Institute of Population and Social Security Research

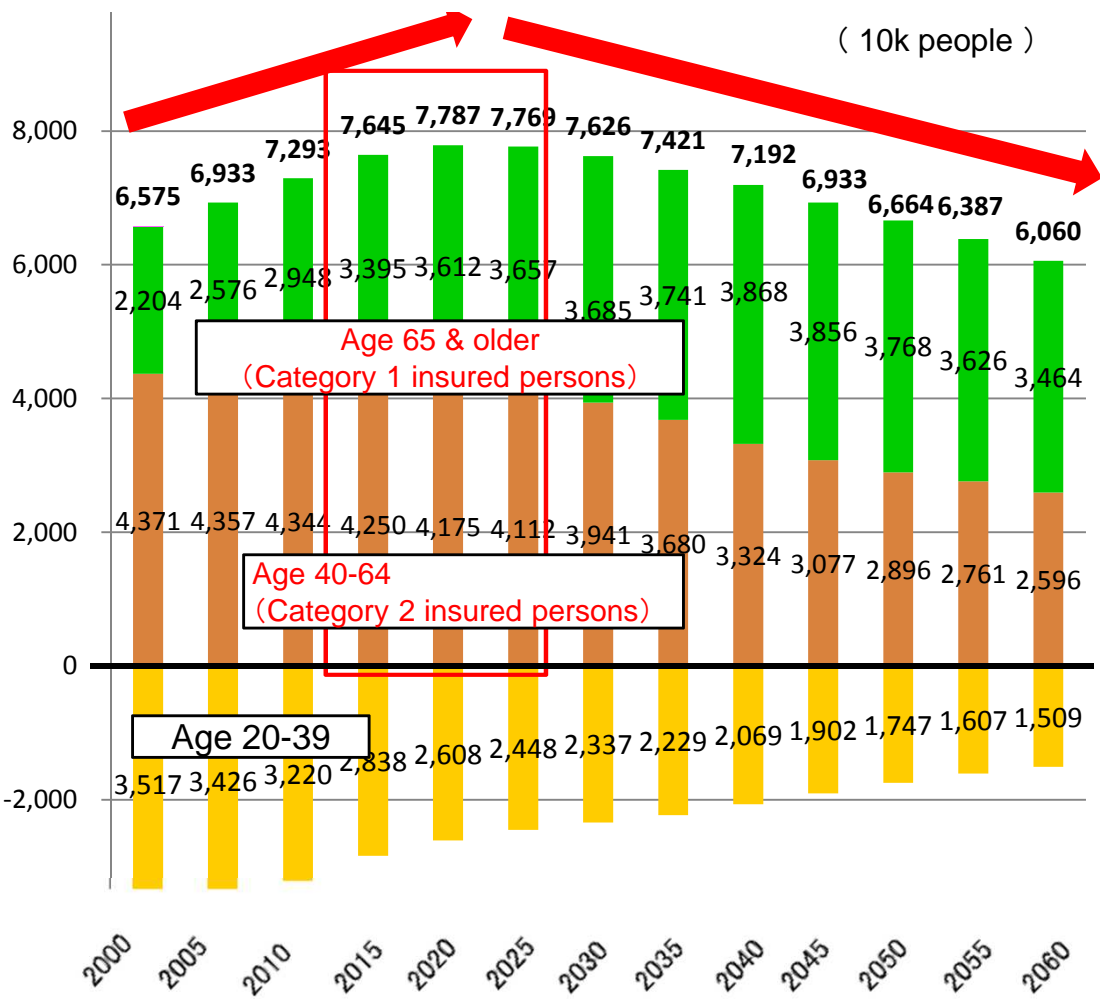
5. Changes in the Population Over Age 75 (Age group with high percentage of persons requiring care)

- Since the establishment of the long-term care insurance system in 2000, the population over age 75 has increased rapidly and such increase will continue for 2025.
- From around 2030, the rapid growth of the population over age 75 will level off but the population over age 85 will continue to increase for another 10 years.



6. Changes in the Population Over Age 40 (Age group paying for long-term care insurance system)

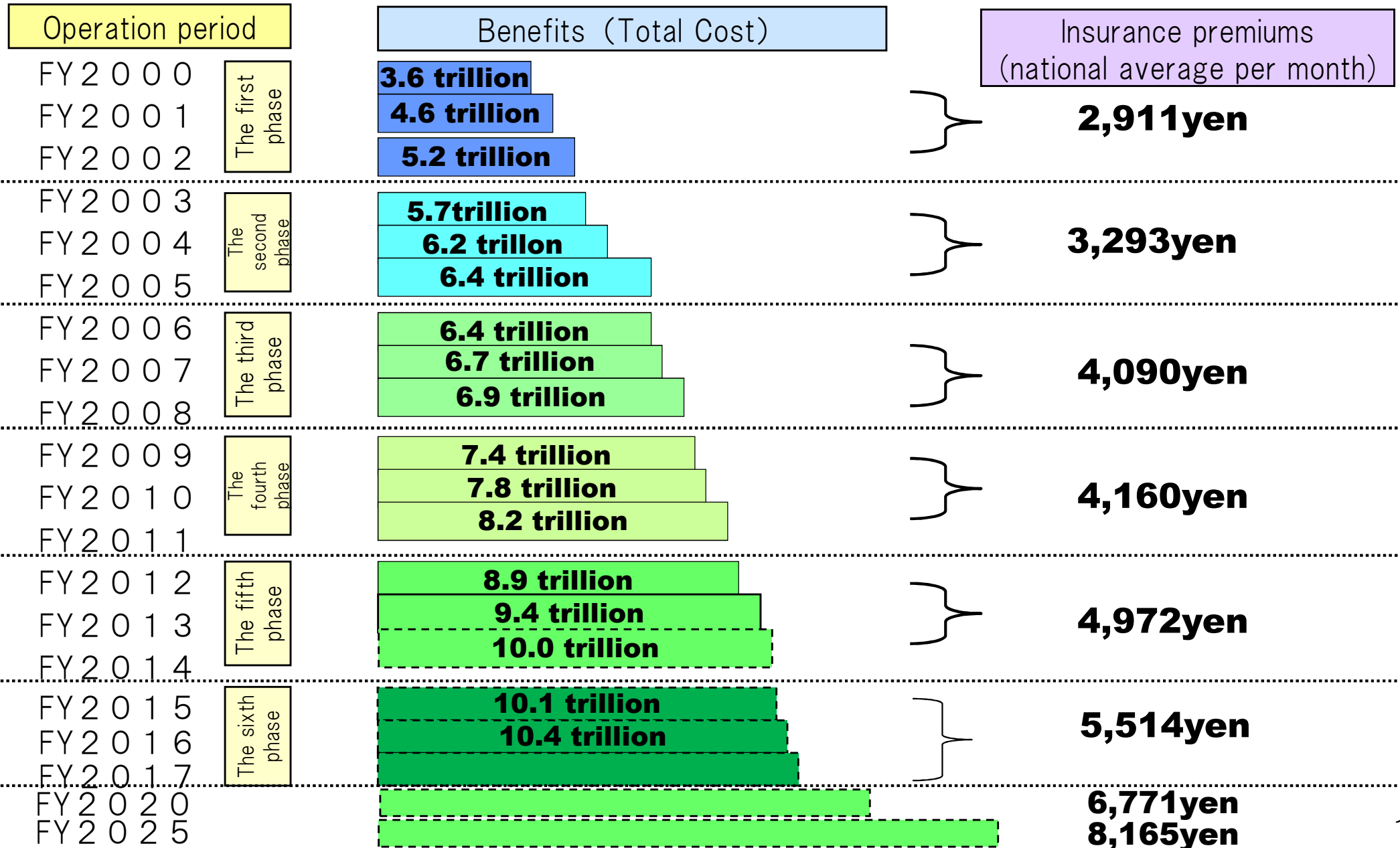
- The population over age 40, who pay for the long-term care insurance, has increased since the establishment of the long-term insurance system in 2000 but will start to decrease after 2021.



Sources: Future population estimates were taken from the National Institute of Population and Social Security Research's "Population Projections for Japan (January 2012): Medium-Fertility (Medium-Mortality) Assumption"
Actual past figures were taken from the Population Census by the Statistics Bureau of the Ministry of Internal Affairs and Communications (population with proportional corrections for those of unknown nationality/age)

Trends and the Future Prospects of Long-Term Care Benefits and Premiums

- The municipal governments formulate Long-term Care Insurance Service Plan which designates 3 years as one term and is reviewed in every 3 years.
- As ageing proceeds, premiums estimated to rise to 6,771 yen in 2020 and 8,165 yen in 2025. In order to maintain sustainability of the Long-Term Care Insurance System, it would be necessary to establish the Community-based Integrated Care System, and to make services more focused and efficient.



(3) Revision of Long-term Care Insurance System

Major Contents of Revision of Long-term Care Insurance (2014 revision)

(1) Establishing the Community-based Integrated Care System

Enriching long-term care, healthcare, support and preventive services in order for elderly people to continue their lives in their accustomed areas.

Enriching Services

Enriching Community Support Projects towards establishing the Community-based Integrated Care System:

- ① Enhancing coordination between In-home Medical Care and In-home Long-term Care
- ② promoting measures against dementia
- ③ Enhancing Community Care Meetings
- ④ Improving the Livelihood Support Services

Making Services More Focused and Efficient

- ① Transferring nationally-unified Preventive benefits (Home-visit Care and Out-patient Long-term Care) to Community Support Projects of municipalities, and diversifying them.
- ② Restricting users of in-facility services of Special Long-term Care Health Facilities to people whose care level is 3 or higher in principle.

(2) Making Contribution Equitable

Expanding reduction of premiums of people with low-income, and reviewing co-payments of those who have certain income or assets in order to suppress increase of premiums.

Expanding Reduction of Premiums of People with Low-income

Expanding the reduction rate of premiums of people with low-income:

(An example of reduction of premiums)

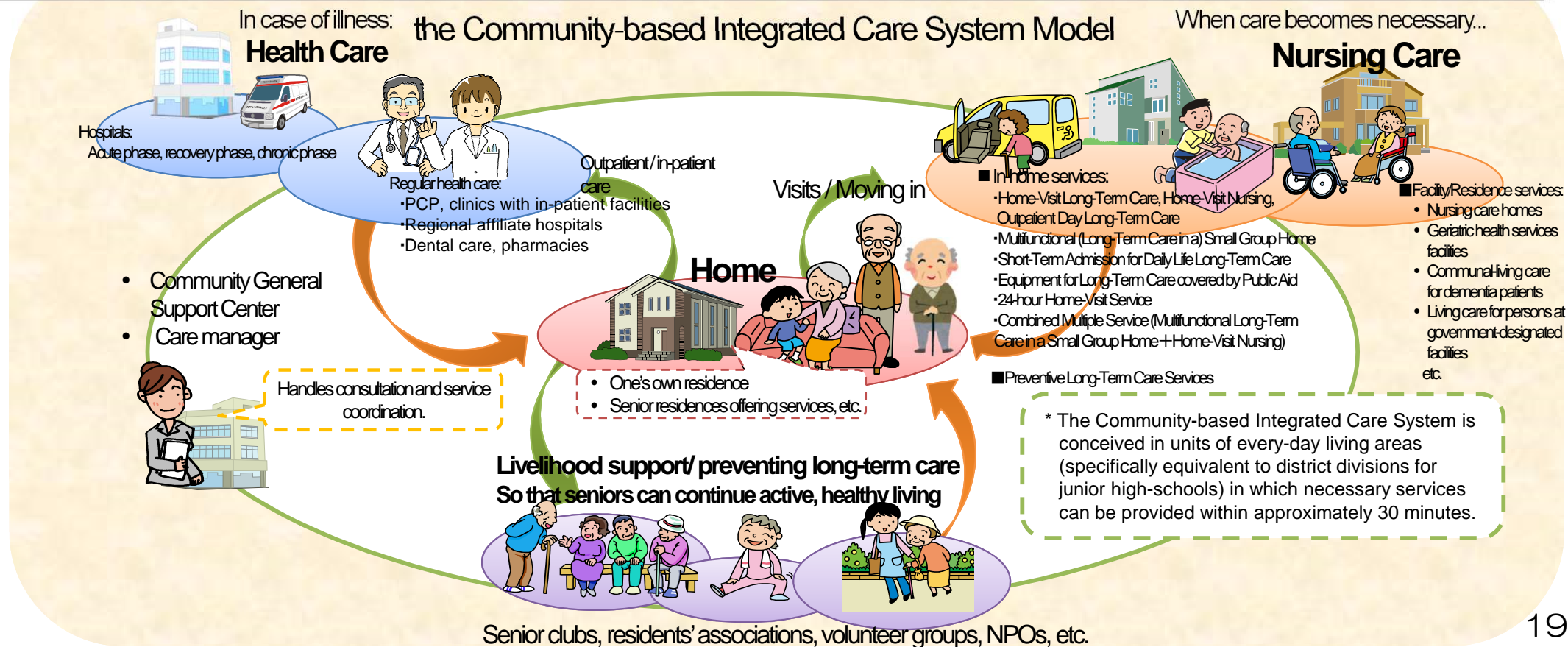
For people with pension income lower than 800,000 yen per year, the reduction rate will be expanded from 50% to 70%.

Review of Co-payments etc.

- ① Increasing co-payments of users with income more than a certain level.
- ② Adding assets to the check list of requirement for "Supplementary Benefits," which provides money for food and residence to in-facility users with low income.

Establishing 'the Community-based Integrated Care System'

- By 2025 when the baby boomers will become age 75 and above, a structure called 'the Community-based Integrated Care System' will be established that comprehensively ensures the provision of health care, nursing care, prevention, housing, and livelihood support. By this, the elderly could live the rest of their lives in their own ways in environments familiar to them, even if they become heavily in need for long-term care.
- As the number of elderly people with dementia is estimated to increase, establishment of the Community-based Integrated Care System is important to support community life of the elderly with dementia.
- The progression status varies place to place; large cities with stable total population and rapidly growing population of over 75, and towns and villages with decrease of total population but gradual increase of population over 75.
- It is necessary for municipalities as insurers of the Long-term Care Insurance System as well as prefectures to establish the Community-based Integrated Care System based on regional autonomy and independence.



Comprehensive Strategy to Accelerate Dementia Measures (New Orange Plan) ~To Realize Age and Dementia-Friendly Community~

Basic Concept

Realization of a society where persons with dementia can live with dignity in a pleasant and familiar environment as how they hope to be as long as possible.

- Formulated by MHLW in collaboration with Cabinet Secretariat, Cabinet Office, NPA, FSA, CAA, MIC, MOJ, MEXT, MAFF, METI, and MLIT
- Targets at 2025 when the baby boomers turn 75 years and older
- Prioritizing the standpoint of persons with dementia and their families

Seven Pillars of New Orange Plan

1 RAISING AWARENESS

Raising awareness and promoting understanding of dementia

2 INTEGRATED SERVICES

Providing health care and long-term care services in a timely and appropriate manner as the stages of dementia progress

3 EARLY ONSET DEMENTIA

Strengthening the measures for early onset dementia

4 CARER SUPPORT

Supporting those looking after people with dementia

5 COMMUNITY

Creating age and dementia-friendly community

6 RESEARCH & DEVELOPMENT

Promoting research and development and disseminating the results of prevention, diagnosis, cure, rehabilitation model, and care model for dementia

7 VIEWPOINT OF PERSONS WITH DEMENTIA

Prioritizing the standpoint of persons with dementia and their families

New Orange Plan

Coordination of
Medical Care and
Long-term Care

Research for
Prevention and
Cure

Age and Dementia-
Friendly
Community

“Comprehensive Strategy to Accelerate Dementia Measures”

① Early Support

(Initial Phase Intensive Support Team, etc.)

② Improving Ability of Care Providers

(Training Programs)

③ Coordination of Medical Care and Long-term Care

(Dementia Coordinator)

④ Risk Reduction

(Nationwide Prospective Dementia Cohort)

⑤ Cure

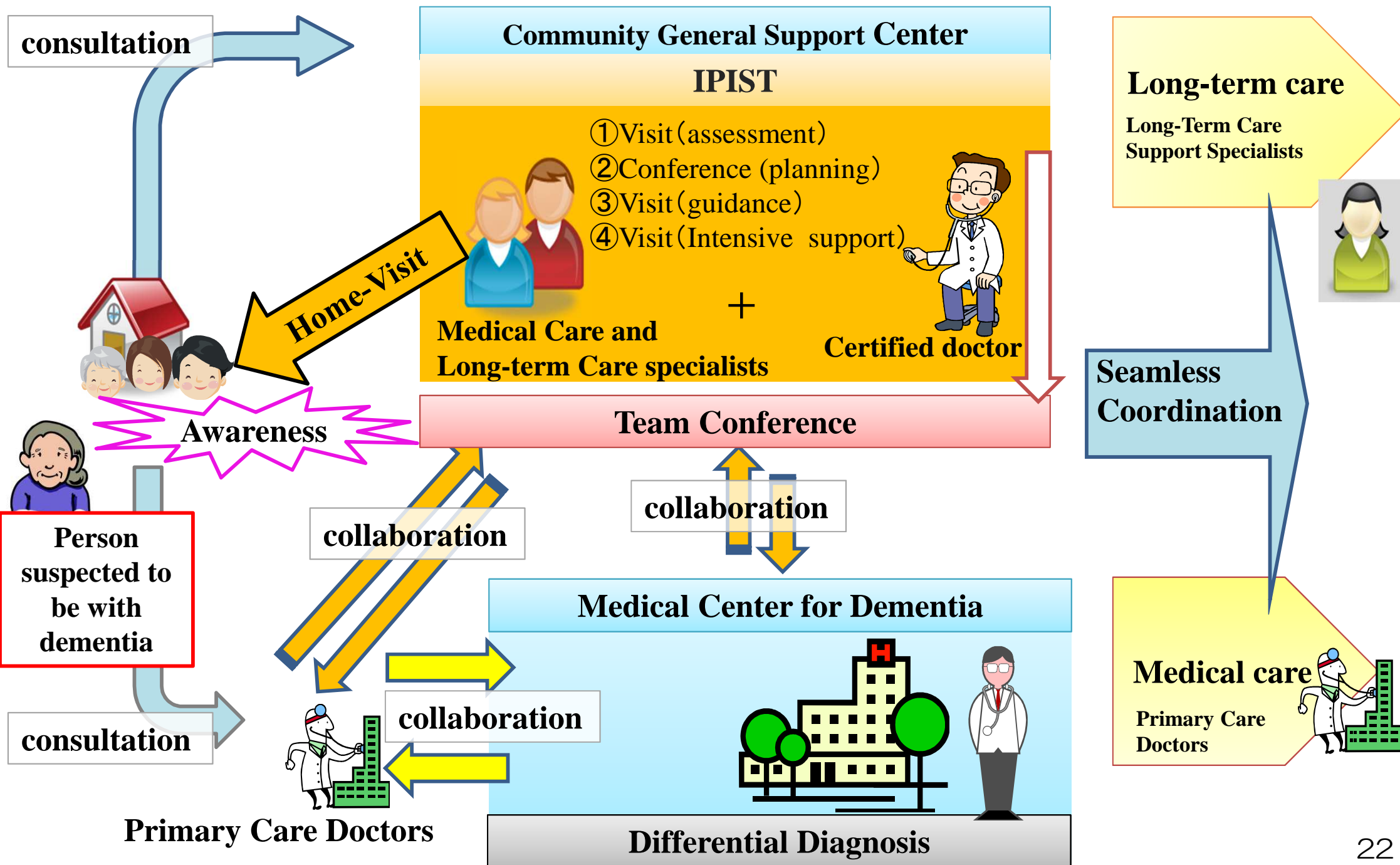
(Project for Psychiatric and Neurological Disorders)

⑥ “Dementia Supporters”

already 6.34 million ⇒ 8 million

⑦ Safety (Cross-ministerial support: watching system in the community, etc.)

Initial-Phase Intensive Support Team (IPIST)



“Dementia Supporters” Training Program

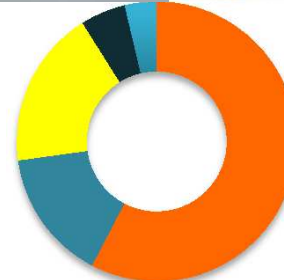
people of every generation, every occupation are becoming “Dementia Supporters”

Over 8 million

supporters have been trained as of September 2016.

Dementia Supporters Program

- ✓ **Voluntarily**
- ✓ **with proper knowledge and understanding**
- ✓ **in communities and work places**



- Community
- Office
- School
- Public office
- LTC Service Providers



August 30, 2019

Mr. Michael Faulkender
Chair, Federal Interagency Task Force on Long-Term Care Insurance
Assistant Secretary for Economic Policy
Department of the Treasury
1500 Pennsylvania Avenue, NW
Room 3454 MT
Washington, DC 20220

Re: Public comments on the business of the Federal Interagency Task Force on Long-Term Care Insurance

Dear Assistant Secretary Faulkender:

Healthsperien appreciates the opportunity to submit comments to the ongoing work of the Federal Interagency Task Force on Long-Term Care Insurance in developing laws, regulations and policies at the federal level to complement reforms at the state level relating to the regulation of long-term care insurance. Additionally, we are happy to offer additional perspectives to the committee's consideration of topics related to the social need for long-term services and supports and the future of the individual private long-term care insurance market.

Healthsperien, LLC is a Washington, D.C.-based policy and health care consulting firm focused on strategic, regulatory, legislative and implementation issues with a specific focus on solutions for aging, frail and complex populations. We bring a "system" perspective to our work and specialize in payment and delivery models, regulatory issues facing Medicare, Medicaid and commercial payers, and emerging trends in value-based payment. We help hospices, palliative care organizations, health systems, non-profits, foundations, patient groups and other stakeholders interested in understanding and improving care for people with advanced and serious illness. We support the National Partnership for Hospice Innovation, a partnership of non-profit, hospice, palliative care and advanced illness providers with advocacy and strategy and work with the Coalition to Transform Advanced Care - C-TAC. We also help clients interested in developing and advancing initiatives that help individuals enrolled in Medicaid, people who require long-term services and supports, and others with complex health conditions. Our work supports organizations that provide managed long-term services and support services (MLTSS) and developing care models that address social determinants of health.

Our experience working with private sector clients who address the needs of the senior population underscores for us the need for important alternative to the unstable and declining, traditional long-term care market. A government-financed safety net for a subset of low-income institutionalized and

community-based individuals will continue to be a foundational aspect of the long-term care system of the future. That fact makes it important to find ways to limit government spending by coupling any solution with private sector innovation to enhance people's ability to "age in place" and address periods of health decline with access to important home care and community services – before they need more intensive institutional care.

Perspectives on gaps in current system

Individuals trying to plan, organize and pay for their health care in retirement face a service environment characterized by fragmentation in benefits and services, confusion about treatment options and costs, and substantial gaps in programs to serve their growing needs. Many people face fears about how they and their family will manage when their health declines and they need long-term care. The Medicare program only covers a limited home health benefit (not needed long-term care services), has significant out-of-pocket costs and leaves beneficiaries to navigate a range of complex decisions alone. Long-term care insurance (LTCI) policies are sold to a minority of the retired population (high-income individuals), but offer no planning/management opportunities and only activate when people have high care needs – often institutional.

Importantly, a great need exists for services to help people understand their options before their health declines, make decisions at critical touch points in their lives, and guide them to high-quality home care providers and community resources that can delay or prevent need for costly long-term care. However, home health, home care, and related support services for individuals are managed by inefficient agency models relying on low-quality providers and often pursuing egregious billing practices. Alternative services today needed for care in the home are haphazard, non-scalable or non-existent. Benefit advocacy and clinical navigation services are offered through employers or on a direct-to-consumer basis – underused with no overarching organizational model for the consumer. Current business start-ups are generally limited to technology-based approaches to organize the home care workforce.

Advance long-term care policies in a way that engages seniors in advance of health and function decline

Healthsperien believes that federal solutions in the long-term care insurance arena will require programs and support for seniors before their health and function decline. We view the following approaches can help to achieve those goals:

Develop new home care insurance options. New approaches to insurance that focus on care in the home with meaningful financial support and access to credentialed caregivers could help to change the delivery of long-term services and supports in a way that might help to delay or eliminate the need for traditional care options. Those options could offer more limited, but still meaningful, benefits to consumers at reasonable price points and incentivize prepayment of long-term care. Designing products in this area that are simple (e.g., without overly complex approach to underwriting) and accessible through trusted distribution partners will support their success.

Embed managed care solutions in approach. Managed care models, when combined with insurance for long-term care, could help to delay the need for expensive and isolating institutional care. Those models have long been deployed in the managed Medicaid sector and enhance long-term services and supports (LTSS) for poor, high-need individuals in the Medicaid program. The use of high-touch community support bolsters those models and helps to keep seniors at home.

Lead with active benefit and clinical guidance. No long-term care solution ultimately will be effective without guidance and navigation along the path from retirement to advanced illness at the end of life. We see opportunities for benefit counseling, planning and advice for managing costs and access to quality providers, and guidance on navigating the care delivery system at critical points in people's lives. Federal policies in this area should encourage the development of services that address health care needs and let individuals stay in their homes longer, address fears associated with health decline and its burden on loved ones, and make better use of costly health care services, such as with transparency tools. Consideration should be given in finding ways to allow programs to enter peoples' lives just before or after retirement and helps them get organized for their health care future and aging in place well before long-term care needs emerge. Regulatory approaches should encourage a personalized approach that will create trust and lead to improved financial and health outcomes and better advanced illness decisions.

Conclusion

In closing, we appreciate the work of the Task Force in advancing long-term care solutions and product innovation.

Sincerely,

Jeanne De Sa, Principal
Healthsperien

From: LINDA A TIMURA <ltimura@sbcglobal.net>
Sent: Friday, August 30, 2019 10:37 AM
To: LTCITaskForce; LINDA A TIMURA
Subject: LTCI 1.0

The Legacy Long Term Care Insurance 1.0 that has not been sold in years is in deep trouble. There are many articles on this topic on the internet and on the NAIC website. The NAIC has been studying this problem for years.

The industry is underfunded! The insurance companies do not have enough reserve money to pay claims. The insurance companies stopped selling these policies when they had an indication that they were in trouble and could not make money on this product.

Thus instead of the insurance company bearing the risk they shifted the risk (paying the claims) to the remaining policyholders. Thus, policyholders have been hit with outrageous premium rate hikes! This trend cannot sustain itself.

The finite policy count (created by the insurers) is going down while the claims costs are skyrocketing. In my case in the last 8.25 years the policy count has gone down 21% while the claims costs have gone up over 400%.

The solution that the insurance companies and many state Department of Insurance have is to raise rates on the remaining policyholders. There are not enough remaining policyholders to pay for the raising claims. When I asked the CT Department of Insurance if they would approve a rate increase that would bring an annual premium to \$10,000 or \$25,000 or \$50,000 or \$100,000 the reply I received was "All approved rate increases must be actuarially justified and in compliance with Connecticut's statutory minimum loss ratio". So there is no limit as to how high our premiums can go!

The Federal Government must investigate this! Re insurers of these Long Term Care Insurance obligations such as GE have been recently found to not have enough reserve money to pay these claims.

I am asking the Federal Government to investigate this situation. The situation described here impacts senior citizens all of whom are on a fixed income. This troubled industry needs to be investigated! Senior citizens are being discriminated against and we cannot afford another rate increase! We did not create this situation, the insurance companies did, yet we are being held accountable!

I have much more information on this topic and would welcome the opportunity to talk to the task force and Federal legislators.

Thank you, Linda Timura
9 Wells Rd
Ellington, CT 06029
860-871-1672 (h)
860-402-6673 (c)

From: LINDA A TIMURA <ltimura@sbcglobal.net>
Sent: Tuesday, August 27, 2019 4:00 PM
To: LTCITaskForce; LINDA A TIMURA
Subject: Long Term Care Insurance

To: LTCI Long Term Care Insurance Task Force

I would like to see LTCI part of Medicare. Just like Medicare recipients have the choice to buy a medicare supplement, senior should have the choice to purchase Long Term Care Insurance via Medicare perhaps Part E.

LTCI offered 15-20 years ago by private companies in separate states has failed. Policyholders such as myself have been hit with outrageous premium increases that are unsustainable for Senior Citizens.

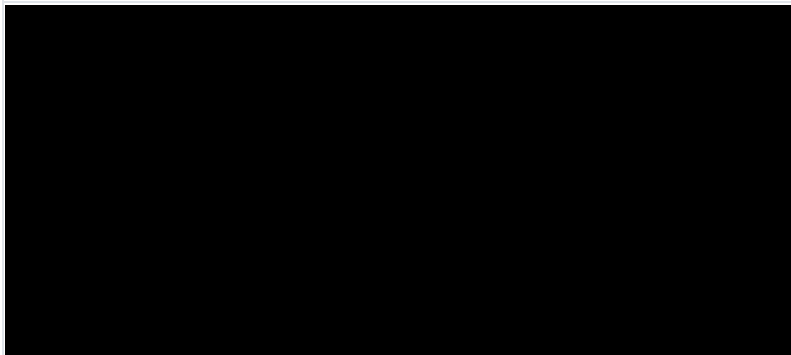
Having a Federal program attached to Medicare would widen the pool of people and help keep the premiums under control.

If you would like to discuss further, don't hesitate to contact me.

Linda Timura
860-871-1672

P.S. Here is my story

[Long-term care insurance](#)



Long-term care insurance

Jim Michaud / Journal Inquirer

Linda Timura goes through the hundreds of pages of documents related to her long-term care insurance plan on Sat...

https://www.journalinquirer.com/politics_and_government/insurance-squeeze/article_24b40f5c-8163-11e9-bae3-c336685fd271.html

EXCLUSIVE

TOP STORY

Insurance squeeze

JI Exclusive: Long-term care premiums on the rise

By Will Healey

whealey@journalinquirer.com May 28, 2019



Linda Timura goes through the hundreds of pages of documents related to her long-term care insurance plan on Saturday, May 24, 2019, at her Ellington home.

Jim Michaud / Journal Inquirer

Linda Timura is a planner.

In 1999, when the Ellington resident was 47, she and her husband Kenneth purchased a long-term care insurance policy to cover any assisted living or nursing home care they might need when they became elderly.

“We thought we were being responsible, thinking ahead,” she said.

The Timuras have lately been penalized for their forward thinking, however, as have many others nationwide, because of flaws in the forward thinking of insurance industry experts who crafted the policies, resulting in ever-increasing premium rate increases.

For more than a decade, Timura's monthly premium held level at \$45.68. In 2010, the premium increased for the first time, bumping up to \$51.47, a nearly 13 percent increase. The following year, it increased again, to \$59.51, a more than 15 percent increase, and again in 2012, to \$68.27, a nearly 15 percent increase.

Timura said that at the time, those increases weren't very noticeable, particularly because there hadn't been any for so long. After 2012, Timura's premium held level for four years.

In 2016, Timura received a letter from her provider, Transamerica Life Insurance Co., informing her that the company would be increasing premium rates for its policies statewide, due to the company's "claims experience with all long term care insurance policies like the one you hold."

The company told Timura her increase would be phased in over the next three years, due to a law passed in 2014 requiring rate increases of 20 percent or more to be spread out over a minimum of three years. Based on the schedule Transamerica provided, Timura's premium would increase by about 10.3 percent in each of the next three years, to \$75.30 in 2017, \$83.08 in 2018, and \$91.68 in 2019.

The company noted, however, that it had filed for a larger increase than the state Insurance Department approved, and that it anticipated filing for "additional similar premium increases in each of the next two years."

"We want you to understand it is very likely that your premiums will increase again in similar fashion," the company wrote.

Increase they did.

In February 2018, Timura received a letter from Transamerica informing her that the state had approved another rate increase, effective that April, that also would be phased in over the next three years. The new increase would cause her premium to rise to \$91.68, the rate she'd earlier been told would be her rate in 2019, and a 21.8 percent increase over what she paid in 2017. Her premium also would increase to \$111.68 in 2019, and \$123.28 in 2020.

“The prior rate increase, combined with this rate increase, results in overlapping rate increase approvals,” the company wrote.

In March of this year, Timura received another letter from Transamerica. The state again had approved a rate increase request, effective May 20, to also be phased in over three years.

The latest increase, added to the previous two increases, raised Timura’s 2019 premium to \$123.28, an increase of 34.5 percent over what she paid last year. According to the letter, her premium would be \$150.27 in 2020, a nearly 22 percent increase, and \$165.91 in 2021, a nearly 10.4 percent increase. Based on those projections, Timura’s premium will have increased 263 percent from what it was when she purchased the plan.

Timura, who is retired and on a fixed income, said the communications from Transamerica have been confusing, misleading even. Now almost 68, Timura, who is in good health, said the prospect of facing potentially 20 more years of paying increasing premiums isn’t sustainable for her and her husband.



“They’re pricing me out,” she said.

State Insurance Department officials said they shared Timura’s concerns about the overlapping rate increases, noting they’re the result of an industry-wide problem.

The officials said that decades ago, hundreds of insurance companies offered long-term care insurance, however today, just a handful remain. Officials said that incorrect assumptions were made by the companies and a number of factors, including not setting high-enough premiums at the

outset, too few policyholders dropping out of plans, and low returns on investments, in addition to higher-than anticipated claims costs, have necessitated rate increases to keep the plans solvent.

Reps. Michael Winkler, D-Vernon, and Thomas Delnicki, R-South Windsor, co-sponsored a bill this legislative session that sought to increase from three to five years the minimum number of years over which a long-term care insurance premium rate increase of 20 percent or more has to be spread. Winkler acknowledged recently that the bill doesn't address the issue of overlapping, and said he intends to put a bill addressing overlapping forward in the next session.

The problem is so pervasive that the National Association of Insurance Commissioners announced in April that it was creating a task force solely focused on stabilizing the long-term care insurance market. A release announcing the creation of the task force said it would be tasked with "developing a consistent national approach for reviewing long-term care insurance rates that result in actuarially appropriate increases being granted by the states in a timely manner, and eliminates cross-state rate subsidization."

The announcement said the task force also would work to identify options to provide consumers with choices regarding modifications to their policy's benefits, something Timura and her husband already have done with their plan.

In the letter Transamerica sent Timura in March, it said Timura could keep her premium from going up by reducing her plan's benefits in a variety of ways. Timura and her husband recently decided to reduce their annual benefit increase option rate from 5 percent to 2.75 percent, in order to keep their premium at their 2018 rate, \$91.68.

Timura said she believes it's unfair that that her policy's quality should have to diminish to cover mistakes someone else made.

"I feel like I bought a Cadillac, and I've been paying faithfully, but then years later they say 'We didn't charge you enough, so now you're going to have a Chevy, but still pay the same premium,'" she said.

From: Romeo Raabe <rraabe@thelongtermcareguy.com>
Sent: Monday, August 12, 2019 2:40 PM
To: LTCITaskForce
Subject: regulation of long-term care insurance COMMENTS

Federal rules currently allow states to choose to ignore the at-home spouse's IRA and 401k (qualified accounts) completely in determining Medicaid eligibility for LTC.

I understand approximately 19 states currently choose to ignore such assets when determining Medicaid eligibility for LTC.

Why ignore qualified savings of unlimited amounts when giving out Medicaid dollars intended for the impoverished? Many lower or middle class families will be paying taxes to provide Medicaid LTC benefits to wealthy people who are allowed to keep their money and get Medicaid.

If this loophole were closed as most states have done (federal rules give them that choice) and wealthy families qualified accounts were considered when giving out Medicaid:

1. More Medicaid dollars would be available for the poor who need it.
2. Some of those wealthy might choose LTC insurance if they realized they can't get Medicaid and keep their wealth
3. The entire business of paying for LTC would be more fair.

Why give Medicaid to wealthy people?

Romeo Raabe LUTCF, LTCP

Kathy Lichter MS

(920) 884-3030 (800) 219-9203

<https://hyperlink.services.treasury.gov/agency.do?origin=www.TheLongTermCareGuy.com>

Finding ways to help people pay for their LTC OR

protecting assets from the Medicaid spend-down

<https://hyperlink.services.treasury.gov/agency.do?origin=HTTP://TheLongTermCareGuyBlog.com>

From: Lori Suzik <lorisuzik@yahoo.com>
Sent: Monday, August 26, 2019 3:20 PM
To: LTCITaskForce
Subject: Recent substantial rate increases in long term care premiums

In Connecticut, since approximately 2016, many seniors have been hit with huge premium increases on closed long term care policies. Many seniors have had these policies for 16-20 plus years. Overlapping increases have also occurred. These increases are not sustainable to seniors on a fixed income. The result is forcing seniors to reduce or drop their coverage at a time when they need to use these policies. These policies were sold by financial advisers who said the premiums would remain flat. Whether this was deliberate deception or lack of understanding of the product by the advisors is unknown. Seniors bought these policies taking into account their fixed incomes. It appears insurance companies are deliberately forcing seniors to reduce coverage or relinquish policies to avoid their prior obligations to customers. MetLife made a separate division called Bright House to separate out long term care policies. As an advocate for my 86 year old parents, I think insurance companies should be made to reduce seniors long term care premiums to prior levels. My parents policies have increased from \$5,000 to over\$8,000 a year in four years. This is calculated and unfair of insurance companies to prey on the vulnerable elderly. Shame on them! Insurance companies are not going out of business. If long term care is a losing product, insurance companies can stop selling new products. Big insurance companies should be forced to uphold their prior obligations, especially on closed policies. Overlapping increases should not be allowed and should be stopped. Premiums on closed policies should be restored to levels that were promised upon initial purchase. Loopholes in the fine print have unfairly allowed these skyrocketing, calculated increases. Thank you for considering this matter on behalf of Connecticut seniors.

Sincerely,
LORI Suzik
15 Morris road BroadBrook CT.
06016
860-922-9989

Sent from my iPad

From: Diane R. Boyle <Dboyle@naifa.org>
Sent: Tuesday, August 27, 2019 10:59 AM
To: LTCITaskForce
Subject: Comments to the Interagency LTC Task Force
Attachments: 190827NAIFA comments Interagency LTC Task Force.pdf

Attached please find the National Association of Insurance and Financial Advisors' written statement on potential reforms relating to the regulation of LTC insurance.

Diane R. Boyle
Senior Vice President - Government Relations



National Association of Insurance and Financial Advisors
2901 Telestar Court | Falls Church, VA 22042
Email: Dboyle@naifa.org | Office: 703-770-8252
<https://hyperlink.services.treasury.gov/agency.do?origin=www.NAIFA.org>





National Association of Insurance
and Financial Advisors

August 27, 2019

Via Electronic Filing –LTCITaskForce@treasury.gov

Federal Interagency Task Force on Long-Term Care Insurance
Department of the Treasury
1500 Pennsylvania Ave. NW, Room 3454 MT
Washington, DC 20220

RE: Federal reforms to complement state level long-term care insurance reforms

Dear Chairman Faulkender and Task Force members:

The National Association of Insurance and Financial Advisors (“NAIFA”) appreciates this opportunity to comment on potential reforms to federal laws, regulations, and policies to complement reforms at the state level relating to the regulation of long-term care insurance (LTCI).

Founded in 1890 as The National Association of Life Underwriters (NALU), NAIFA is the oldest, largest and most prestigious association representing the interests of insurance professionals from every Congressional district in the United States. NAIFA members assist consumers by focusing their practices on one or more of the following: life insurance and annuities, health insurance and employee benefits, retirement planning, multiline, and financial advising and investments. NAIFA’s mission is to advocate for a positive legislative and regulatory environment, enhance business and professional skills, and promote the ethical conduct of its members.

NAIFA supports proposals at the federal and state level to increase consumer conversations and awareness of the social need for long-term care supports and services. The NAIFA Limited & Extended Care Planning Center is a community with a common purpose to maximize professional and consumer awareness and the distribution of limited and extended care solutions.

LTCI can be vital in addressing our nation’s long-term care needs, particularly with an aging “boomer” generation that could eventually overwhelm our nation’s already financially strained government programs. LTCI is sold to individuals or through a group plan offered by an employer. It is imperative that LTCI play a significant role in the financing of long-term care services. LTCI can ensure that significant personal care expenses are met without burdening one’s family or depleting other financial assets, while lowering Medicaid and Medicare costs for taxpayers.

NAIFA supports a broad array of solutions to increase coverage opportunities that fit individual and family needs as well as provide affordable meaningful benefits to a wider consumer market including the following:

Establish a Federal Retirement and LTC Education Campaign

While Americans recognize the need to save for retirement, few are aware of the need to protect their savings against the steadily growing costs of long-term care services. Unfortunately, far too many individuals mistakenly believe health insurance, Medicare or Medicaid will cover their long-term care services. Others believe they can self-finance only to learn that their assets will not pay for care unless they are sold. These misconceptions stop or delay planning for long-term care expenses. A robust education campaign to increase the public's knowledge of LTCI, promote the need for LTCI planning, and educate consumers on the options for LTCI coverage – both private and public plans - and the benefits and limitations of those options.

NAIFA was a strong supporter of the previous Own Your Future Awareness Campaign and the National Clearinghouse for LTC Information Website. A relaunch of these initiatives, especially with the vast array of social media opportunities now available, can increase awareness and planning to meet care needs.

Permit LTCI Purchase Through Sec. 125 Cafeteria Plans and Flexible Spending Arrangements

Helping people plan for their long-term care needs by allowing them to purchase LTCI coverage at their place of employment should be part of our nation's answer to the long-term care financing challenge. Nearly 180 million Americans get health care coverage through their place of employment. Federal legislation could facilitate access to LTCI coverage, such as amending federal law to permit workers to buy LTCI with contributions to their employer-sponsored cafeteria plans or flexible spending arrangements (FSAs). We believe workplace offerings will raise workers' awareness of the risk, increase their understanding of coverage options, and enable them to plan for long-term care expenses in an affordable manner.

Permit Penalty-free Distribution from Retirement Plans to Purchase LTCI

For well over a century, NAIFA members have helped individuals, families and businesses reduce risks and protect assets, fund major expenses like college, long-term care and retirement, plan their estates, provide employee benefits and group insurance, and reach their financial goals. Public policy should support initiatives to encourage comprehensive planning and flexibility to address evolving financial needs. Allowing retirement plan participants to make tax-free distributions from 401(k), 403(b) or an Individual Retirement Account (IRA) to purchase LTCI - both traditional and hybrid policies – will allow workers to customize and comprehensively address their financial protection needs to include long-term care.

Enhance Use of HSAs for LTC Expenses and Premiums

Permitting workers to make additional contributions to their Health Savings Accounts (HSA) to pay for LTC plans. Under current law, individuals who have a high deductible health plan can choose to make tax deductible contributions to an HSA. In addition to helping to pay for their out-of-pocket costs immediately, these tax-deductible dollars can be used to pay premiums for Qualified Long-Term Care Insurance (QLTCI). The tax-preferred treatment of HSAs, combined with higher deductibles, offer an incentive for people to make informed health care choices often leading to the greatest cost value. The same benefit can be recognized in QLTCI by adding flexibility for consumers. NAIFA supports changes to HSA contribution limits allowing individuals to make additional contributions to their HSAs equal to what they would pay in QLTCI premiums. Account holders should also be allowed to contribute to their spouse's HSA if the spouse is covered by QLTCI.

Revamp Inflation Protection Requirements

Current inflation protection requirements substantially increase LTCI premiums and often discourage consumers from seeking LTC protection. Inflation protection is an important LTCI insurance feature. However, flexibility in feature design, including inflation protection, would encourage policy design that would better meet the needs of consumers and broaden protection coverage. Recommended revisions follow:

- **Health Insurance Portability and Accountability Act (HIPAA)** - Remove the requirement that 5% inflation coverage be offered to all applicants; and replace it with a requirement to offer some form of inflation protection. The carrier may offer the applicant inflation coverage (compound, simple or a guaranteed purchase offer) that best meets their needs without requiring an expensive 5% compound offer that may not even be appropriate for the applicant and his or her needs. This would simplify the sales/disclosure process. A LTCI policy should still retain its tax-qualified status with this change so long as some offer of inflation coverage is made that is approved by the applicable state regulatory authority.
- **Deficit Reduction Act (DRA)** - Remove the DRA inflation coverage age tier requirements. If an LTCI policy meets all tax qualification requirements under HIPAA (i.e., the inflation requirement as described above), the DRA Medicaid Partnership requirements should be treated as met, too. Essentially, this simplifies DRA Partnership requirements so that if it is a tax-qualified policy, DRA requirements are satisfied.

We appreciate this opportunity to provide comments and your consideration of our views. Should you have any questions, please contact NAIFA staff Diane Boyle dboyle@naifa.org or Steve Kline skline@naifa.org.

Sincerely,



Jill M. Judd, LUTCF, FSS
NAIFA President

From: john@olearymarketingassociates.com
Sent: Friday, August 30, 2019 4:57 PM
To: LTCITaskForce
Subject: Public Comments
Attachments: Suggested Initiatives to help reform Long.docx; ATT00001.htm

Attached please find my comments and suggested initiatives to the Task Force. Please feel free to contact me at via email or phone as below with any questions.

John

SUGGESTED INITIATIVES TO HELP REFORM LONG-TERM CARE FINANCING IN THE UNITED STATES

Presented to:

THE FEDERAL INTERAGENCY TASK FORCE ON LONG-TERM
CARE INSURANCE
AUGUST 30, 2019

Presented by:

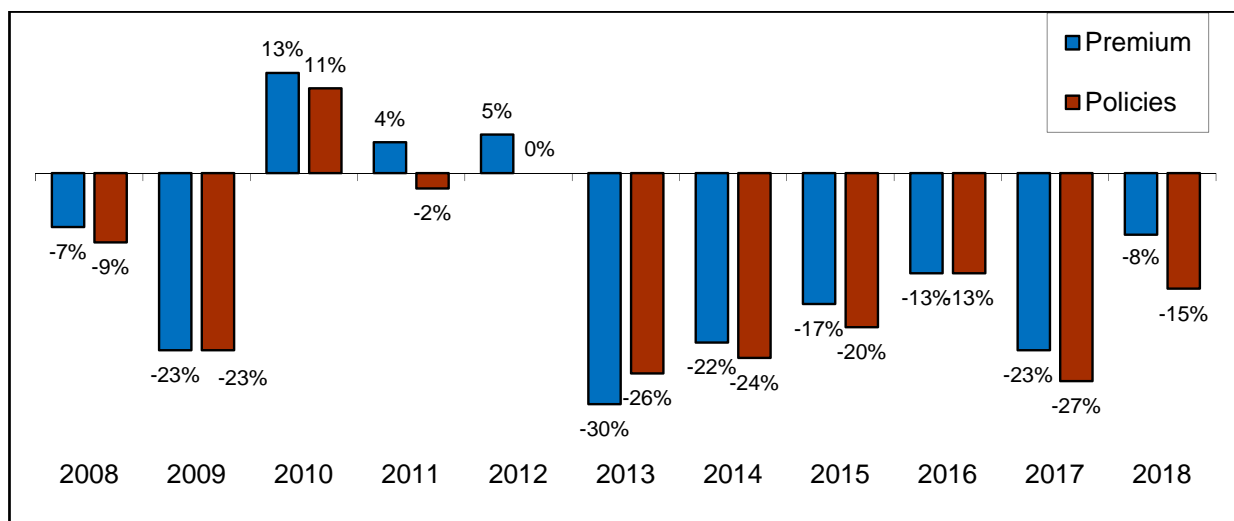
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Background: The State of Long-term care industry today- An overview

In order to inform recommendations for initiatives that the Federal Interagency Task Force on Long-Term Care Insurance might consider it is important to provide some grounding in terms of key factors occurring in the long-term care insurance market landscape today. At the risk of highly oversimplifying a complex issue, this section outlines some recent data that can provide insight for the suggested initiatives that follow to help reform Long-term Care financing in America.

Recently the Life Insurance and Market Research Association (LIMRA) released 2018 sales information on the long-term care industry for both standalone long-term care insurance sales and what is called hybrid or combination long-term care insurance sales. The data tell two very different stories and help explain some of the dynamics facing the long-term care insurance industry today. Figure 1 below shows the percentage changes in annual Long-term care standalone sales for the past 10 years.

Figure 1. LIMRA Standalone LTC product Sales Trends 2008-2018



Since 2013, year to year sales for both number of standalone policies and premium dollars have declined, often by double digit percentages.

Figure 2 below compares LIMRA policy and premium sales for standalone sales for the years 2010 and 2018 and shows the dramatic decline in the levels of both sales (76%) and premiums (67%) over that time period. Meanwhile the average premium increased by about 1/3. Clearly the standalone long-term care insurance business is in a precipitous decline.

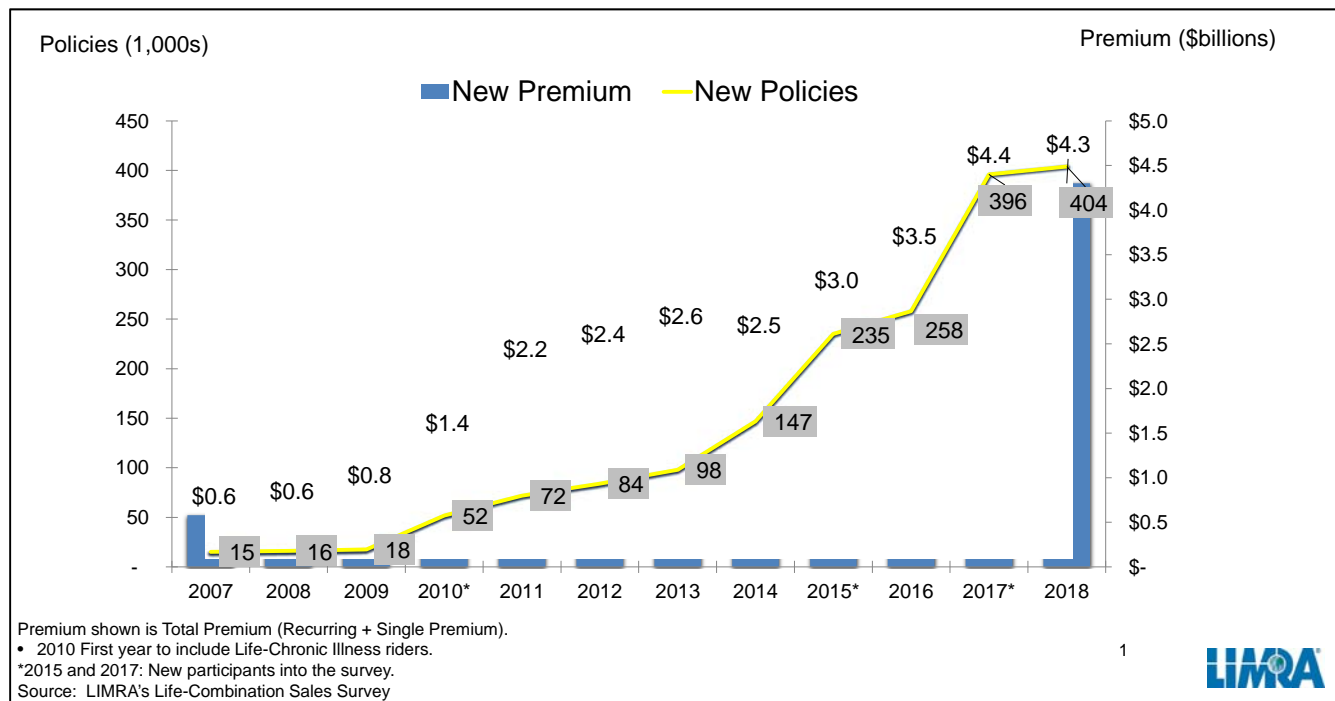
Figure 2. LIMRA Standalone Policies and Premium for the years 2010 and 2018

Year	Policies Sold (#s)	Premium (\$s)	Avg. Premium (\$s)
2010	234,800	\$525 MM	\$2,233
2018	57,000	\$169MM	\$2,965
% CHG.	-76%	-67%	33%

(LIMRA data for 2010 and 2018 aggregated by O'Leary Marketing Associates LLC)

On the other hand, as Figure 3 shows, the picture for combination or hybrid products (products that combine life insurance or annuities with a long-term care benefit) is much more optimistic.

Figure 3. LIMRA US Life Combination Product Sales 2007-2018



Sales have shown consistent year to year growth reaching over 400,000 policies sold in 2018 and over \$4 billion in premiums. Of note, that premium includes single premium policies which while they only represent a

small portion of policies sold (approximately 7%) are very expensive. When including single premium policies, the average premium from figure 3 is approximately \$10,600. The average annual premium for policies with annually recurring premiums (93% of policies) is much lower at \$4,600, but still nearly \$400 per month.

Key takeaways from the current market situation:

- The decline in traditional standalone long-term care policies is due to several factors, but one of the more important ones, that is often overlooked, is that the current standalone product doesn't deliver a **viable value proposition for most consumers**. Said another way, the benefits consumers perceive they will receive from standalone long-term care are not worth the price they are being asked to pay. Having a viable consumer value proposition is a key success element for any product or business and without that, the future viability of the standalone long-term care business is highly questionable.
- The uncertainty of what that price will actually be, due to the very significant across the board rate increases, adds to consumer's negative perception of the value of standalone long-term care. Importantly, that perception extends well beyond consumers to all the potential stakeholders that make up the long-term care landscape. That includes carriers, (who have exited the market in large numbers because of the risk to their future earnings, distribution, regulators, employers, and the investment community.
- The positive growth seen in the combination products are a reflection of a number of factors, including a more positive value proposition for that product, (which provides a consumer benefit whether or not you encounter a long-term care situation), and a market demand for product approaches that provide at least some protection against possible long-term care expenses.
- While combination product growth has been very positive, the average premium, even of policies with annually recurring premiums, (\$4,600 annually) is out of reach of many middle-income households with more compelling, competing demands on their pocketbooks. And the total annual sale of approximately 400,000 policies is still low, relative to the potential societal need.

Assumptions for Future Actions

As the Task force considers initiatives to help reform long term care financing the following assumptions might be useful to keep in mind:

- The product design of traditional long-term care standalone products isn't a viable one without major innovations to provide a better value for consumers. Combination products represent one example of

a product design that does add consumer value, but it is by no means the only or perhaps even the optimal approach. Incorporating wellness and prevention approaches into consumer's lifestyle is another direction that holds significant promise and increasingly is being linked to more positive outcomes even for serious diseases like Alzheimer's. (the number one reason for long-term insurance claims.) Encouraging multiple potential solutions should be a guiding principle going forward.

- The current regulatory landscape, while developed with the best of intentions, is extremely difficult to negotiate and limits what carriers can do to incorporate innovations that would be more valuable to consumers and yet entail less risk, or perhaps even mitigate risk for carriers.
- While consumers and carriers are key to the success of any future product and business initiatives, such initiatives must work for other stakeholders including distribution, regulators, employers, and the investment community.
- Most leaders in the private insurance market would agree that a private solution alone will not by itself head off the emerging long-term care crisis. Rather a set of combined public/private solutions will be required, particularly to address long-duration catastrophic claims like Alzheimer's and Parkinson's.

Minnesota- A potential Model for state action

Minnesota is seen as one of the nation's leading states in recognizing and putting in place an action plan to address the care their aging population will need in the future. Given that a major part of this Task Forces mission is to help support regulatory reform to support state initiatives, Minnesota's experience is relevant in understanding the kinds of activities a state can undertake to innovate in the area long-term care financing.

Under their Own your Future program, Minnesota's began with an educational mailing from the Governor to all its citizens, encouraging them to plan for the possibility of their needing care in their later years. However, several years ago they made a decision to broaden their work to investigating, analyzing and developing product options that would offer Minnesotan's viable solutions to help them finance their long- term care needs.

Minnesota began that effort with five simple principles. Products should be:

- Simplified and streamlined so easily understood by Minnesotans
- Limited in duration but robust in benefit levels- some coverage is better than none
- Affordable premiums for their middle-class target of Households with incomes of \$50-\$125K
- Strong and understandable consumer protections
- Multiple solutions for different target ages

Beginning with a list of 15 different ideas they honed that down to two:

- “LifeStage Protection” that provides term life insurance protection against untimely death during working years and then converts to LTC insurance in later years, when those care needs become more relevant and important to consumers.
- “Medicare Enhanced Home Care Benefit” that would add an affordable package of nonmedical services and supports to Minnesota’s Medicare supplement plans to help seniors remain in their own homes as long and as safely as possible.

Minnesota then undertook a rigorous process for evaluating both ideas that included actuarial studies to determine pricing and feasibility; consumer research to determine consumer interest and appeal; economic studies to determine potential savings to the state Medicaid program; and regulatory assessment with the state commerce department. The results of those evaluations have been very positive with the studies resulting in affordable pricing, strong consumer appeal and positive potential for Medicaid savings for both products. The state is currently working through remaining state regulatory and operational issues for both products and is optimistic that there is a pathway to implementation for both.

Coordinating with state efforts like those of Minnesota to provide whatever regulatory assistance is possible to help facilitate their efforts would be extremely valuable.

Suggested Initiatives to help reform Long-term Care Financing

Following are five suggested initiatives that the Task Force should consider as they move forward with recommendations to help states in their efforts to develop a more viable long-term care marketplace.

1. Encourage additional long-term care product ideas that combine multiple benefits for added consumer value and are affordable for middle-income individuals

The growth seen in the combination product market reflects a trend that consumers are interested in products that incorporate long-term protection but also provide additional benefits. (i.e. the Lifestage product discussed above.) Middle income consumers are also interested in affordable prices. Interestingly, some states have regulations that prohibit combining such products with the thinking that they may cause consumer confusion. While that’s a realistic concern, I believe it is possible to provide such a product that is both affordable and potentially easier to understand than some traditional long-term care product offerings. Exploration of a wider range of LifeStage like approaches should be encouraged as potential long-term care financing solutions for middle-income Americans.

2. Modify LTC definitions to enable pre-claim interventions

The current regulatory environment for long-term care was designed with the best of intentions, however in linking the NAIC Model Act with the federal tax code and HIPPA it makes for a confusing, difficult to navigate regulatory environment. Attempting to determine whether and how an innovative new product, such as the LifeStage, fits with the regulations, is time consuming and expensive. And because of the prescriptive nature of regulations, many states take the position that if a product benefit is not specifically defined in one or another of those places, it is not allowed. Unfortunately, that discourages the very kind of innovation that long-term care insurance needs most.

As an example, according to current definitions of what constitutes a long-term care product, benefits don't begin until an insured meets the qualifying trigger, that is requires assistance for 2 or more activities of daily living or has severe cognitive impairment. (i.e. Is a chronically ill individual) Unfortunately, by the time that a person becomes chronically ill, especially for cognitive impairment situations, it is too late for interventions that might prevent or at least mitigate the condition to have any effect. I believe that consumers would place a higher value on a product where the benefit could be access before the claim, and the product helped them stay healthier longer, compared to a product that pays for the expenses of their condition once it occurs.

This is particularly true of cognitive claims, where evidence is mounting that lifestyle interventions such as exercise, nutrition, stress management and sleep programs are having a positive impact delaying or mitigating the effects of dementia and Alzheimer's.

Similarly, technology advances are enabling more consumer friendly and effective capabilities in fall detection, which is one of the major drivers for hospitalizing and subsequent institutionalization of seniors. And the use of predictive analytics to diagnose conditions leading up to falls and potentially preventing them in the first place is now emerging as not only possible but available today. Improving how we address falls, ideally before they happen, will significantly improve the mobility and health of many seniors and save significant medical and long-term care claim dollars.

3. Encourage the NAIC to modify the Model Act to explicitly allow for and encourage wellness programs and new technologies as qualified long-term care services

In conjunction with number 2, make changes to federal long-term care regulations and encourage the NAIC to modify the LTC Model Act to specifically enable and encourage the incorporation of prevention oriented wellness programs and new technologies into long-term care product offerings. Doing so would be a major

step forward towards helping carriers re-think their long-term care product offerings to go beyond financial reimbursement. It would also encourage the development of proactive programs with the potential to minimize long-term claims on existing in-force business and help carriers better manage the morbidity risks many are projecting

4. Resurrecting the Group market for long-term care will require safe harbors for employers

The group market early in the decade of 2000 was a vital and growing segment of the long-term care market. Major insurance carriers including Met Life, Prudential, John Hancock, CNA, Genworth and UNUM competed for employer groups of all sizes and types. The nation's largest benefit brokers and consulting houses were key elements of broad distribution system, and carriers implemented long term care benefit using classic worksite methodologies that included educational on site meetings, interactive websites and sophisticated direct mail campaigns bolstered by strong employer support to encourage enrollments.

Strong employer support turned out to be the most important factor in whether or not an enrollment was successful. Employee enrollments averaged approximately 5% of eligible employees but went as high as 20% or more when strong employer support was present.

Today, there is only one remaining true group carrier in the market, and a handful of carriers who market what is known as multi-life individual long-term care product at the worksite. What happened to dissolve the group business is very closely related to the decline seen in the individual market, with the key differences of the presence of employers and the large broker community.

Toward the later part of the decade, rumblings about the adequacy of long-term care pricing began to be more widespread and employers began questioning whether their support of the benefit would leave them open to liabilities based on their proactive supporting of the benefit. As a result, that support was largely withdrawn, and a downward spiral of increasingly low participation ensued. Losing the role of large employer support effectively made the "true group" model long-term care marketing a thing of the past.

Attempts to resurrect the group market to viability will, I believe, require "safe harbor" supports which would hold employers and brokers harmless in the events of financial issues like price increases over which they have limited control. Additionally, however products marketed to groups need to be designed for that channel. They need to be affordable for the bulk of employees, consistent in pricing with other employee benefits, and simple enough to be marketed on-line along with other employee benefit offerings.

5. Modify federal tax regulations to make it easier to use retirement accounts to fund long-term care protection products

Currently, it is difficult and costly for employees to access funds from their 401K type accounts to pay for long-term care protection products. Any withdrawals prior to age 59 are subject to a penalty, and after that withdrawals are counted and taxed as ordinary income. A recent Society of Actuaries (SOA) project developed and tested a product concept called Retirement Plus that incorporated a long-term care benefit into the plan design. The idea was consumer tested and very well received. This recommended modification of tax regulations would enable that products like Retirement Plus to use funds in their retirement account to pay for long-term care insurance on a simplified tax favorable basis.

From: Bodnar, Vince <vince.bodnar@oliverwyman.com>
Sent: Friday, August 30, 2019 2:06 PM
To: LTCITaskForce
Cc: Saul, Bruce
Subject: Electronic comments
Attachments: Oliver Wyman-FITFLTCI .pdf

Please see the attached document, which is provided in response to the invitation for public comment emailed to me on August 5th.

Due to the limited time provided for a response and limits on my availability in the past few weeks, the document is a summary as opposed to a more in-depth report. I am happy to further discuss its contents or provide a walk-through at your convenience.

Kind regards,
Vincent L. Bodnar

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COMMENTS ON POTENTIAL REFORMS FOR THE FEDERAL INTERAGENCY TASK FORCE ON LONG-TERM CARE INSURANCE

AUGUST 30, 2019

Executive Summary

Introduction

The purpose of this paper is to respond to an invitation from the Federal Interagency Task Force on Long-Term Care Insurance to the public to provide comments on potential reforms to federal laws, regulations, and policies to complement reforms at the state level relating to the regulation of long-term care insurance. It is primarily authored by Vincent L. Bodnar, ASA, MAAA, Partner and Long-Term Care Practice Leader of Oliver Wyman, with the support of several colleagues at Oliver Wyman.

Summary of comments

Several viable proposals have been developed in the past few years that, by themselves, would address portions of the long-term care (“LTC”) financing crisis. Rather than select one proposal, we believe that an overall framework should be constructed in which several of the proposals would fit, and that the federal government is in the best position to facilitate this.

The proposed framework consists of four pillars of an integrated approach to effectively address the LTC financing crisis in a holistic manner. These pillars are as follows:

1. Universal access to **affordable basic benefits** that cover the initial costs of LTC services.
2. A vibrant market of **private funding plans** comprised of LTC insurance and other financing vehicles that fund services beyond the initial stages of receiving LTC.
3. A **catastrophic social insurance** program that provides benefits for the most costly LTC events.
4. Universal access to **non-medical aging in place services**.

We believe that the existing proposals listed in this paper could be implemented as designed or with minor modifications through reforms to federal laws, regulations and policies in order to create these four pillars. This paper provides a more in-depth description of the four pillars, their importance in an integrated approach and how they could be created from existing proposals.

The four pillars of an integrated LTC financing structure

Lifetime LTC costs:

\$0 to \$50,000

\$50,000 to \$250,000

Over \$250,000

Covered by...

1

Affordable basic benefits

- **68% of people** never exceed \$50k, including 50% that never receive formal care
- Provided by Medicare Advantage, Medicare supplement or stand-alone short-term care plans
- **Offered at initial Medicare enrollment** on a guaranteed issue basis, underwritten if elected afterwards

2

Private funding plans

- **32% of people** have costs that exceed \$50k, including 12% where costs exceed \$250k
- **Tax incentives** for private insurance and self-funding to cover all or part of this cost corridor
- Plans include **stand-alone LTC and hybrid LTC insurance, savings-based LTC insurance and LTC savings accounts**

3

Catastrophic social insurance

- **12% of people** have costs that exceed \$250k
- **Compulsory program** funded by a small increase in payroll tax
- **Means tested** attachment points, down to \$50k, essentially replacing Medicaid funding of LTC services

...with the entire care continuum supported by:

4

Non-medical aging in place services

- Provided by **Medicare Advantage** and **Medicare supplement** plans
- Services **enable and prolong healthy aging in place**
- Examples include: Periodic in-person assessments, care coordination, medication management, home monitoring systems, meal delivery services, transportation and service referrals
- **Data sharing** with insurance plans in the three coverage pillars maximizes care delivery efficiency

Each pillar is addressed by the best suited sector, reinforced by a coordinated framework

Source of LTC costs: *Formal Costs of Long-Term Care Services*, PwC, 2017, after applying the estimate cited in the study that at least 50% of persons reaching age 65 will receive formal care



Affordable basic benefits

Universal access to benefits that fund initial LTC costs

Problems with the current landscape

- Although Medicare provides limited coverage for skilled nursing home care and rehabilitative home health care, the initial portion of LTC costs are generally not covered by insurance plans
- This coverage gap catches many people by surprise and creates tremendous stress on family and informal caregivers
- Since medical plans do not cover LTC costs, they lack incentives to implement programs that prevent or delay the need for LTC as they successfully do with some chronic diseases

Objectives of this pillar

- Provide universal access to affordable basic coverage of LTC services, which will be sufficient for 68% of all persons
- Extend LTC benefits beyond what is covered by Medicare to fund the initial stages of LTC services
- Integrate with Medicare Advantage or Medicare supplement plans to create incentives for a more holistic approach to managing care, including early detection and interventions based on utilization of basic health coverage
- Increase awareness of the need to plan for the potential of incurring LTC services

Coverage structure

- Optional benefit of Medicare Advantage plans and Medicare supplement policies
- Potentially offered as a stand-alone short-term care insurance policy

Benefits

- Qualified LTC services, up to \$50,000 lifetime
- Lifetime maximum benefit increases annually according to a published index
- Reimbursement at Medicare or Medicare Advantage plan negotiated rates

Eligibility

- Guaranteed issue to new Medicare enrollees
- Subject to underwriting if elected for the first time in future enrollments or after a break in coverage
- Once enrolled, election must continue in future enrollments or face underwriting

Funding

- Premium payments from enrollees

Existing proposals that include core concepts

- *Financing Long-Term Services and Supports: Seeking Bipartisan Solutions in Politically Challenging Times*, Bipartisan Policy Center, July 2017 (New Recommendation #3)
- *Federal Policy Options to Present to Congress, NAIC Long-Term Care Innovation (B) Subgroup*, April 2017 (Options 8, 9 and 10)

Private funding plans

A diverse market of products to fund costs beyond basic benefits

Problems with the current landscape	<ul style="list-style-type: none"> Traditional stand-alone LTC products are less appealing to today's consumers than in previous years Features required by or prohibited by archaic regulations stifle product innovation General lack of consumer awareness of financing plans besides stand-alone LTC Financial planning for LTC is as important as retirement planning, yet solutions are not tax advantaged
Objectives of this pillar	<ul style="list-style-type: none"> Provide options and incentives for people to privately fund LTC costs beyond basic coverage of \$50,000, which will occur for 32% of all persons Enable and encourage new product innovation with modifications to existing state and federal laws regulations that affect LTC insurance policies (e.g., removal of the requirement to offer 5% compound inflation benefits and allowance of cash values)
Coverage structures available	<ul style="list-style-type: none"> Traditional stand-alone LTC insurance policies Hybrid life / LTC and annuity / LTC insurance policies Insurance policies that transition into LTC, such as LifeStage (see Society of Actuaries report cited below) Savings-based LTC insurance plans, such as Retirement Plus (see Society of Actuaries report cited below) Self-funded accounts, including HSAs
Benefits	<ul style="list-style-type: none"> Qualified LTC services, up to \$250,000 lifetime Lifetime maximum benefit increases annually according to a published index
Eligibility	<ul style="list-style-type: none"> Most insurance coverages are subject to underwriting Self-funded accounts are not subject to underwriting
Funding	<ul style="list-style-type: none"> Premium payments and contributions from enrollees, which are excluded from taxable income
Existing proposals that include core concepts	<ul style="list-style-type: none"> <i>Federal Policy Options to Present to Congress</i>, NAIC Long-Term Care Innovation (B) Subgroup, April 2017 (Options 2, 3, 4, 6, and 7) <i>Long-Term Care and the Middle Market: Sizing the Opportunity for New Ways to Finance Long-Term Care</i>, Society of Actuaries, July 2018 (LifeStage and Retirement Plus)



Catastrophic social insurance

A social safety net for catastrophic LTC episodes

Problems with the current landscape

- With very few exceptions, insurance companies no longer offer unlimited LTC insurance benefits due to the nature of the risk of large LTC claims
- Catastrophic LTC events will occur for 12% of the population
- Many persons with catastrophic LTC events will exhaust their assets and cause them to become eligible by Medicaid

Objectives

- Provide coverage where a key gap currently exists
- Reduce Medicaid spend for persons that experience a catastrophic LTC event

Coverage structure

- Social insurance program
- Potentially added as a new benefit to Medicare

Benefits

- Qualified long-term care services in excess of \$250,000 in a person's lifetime
- Attachment point increases annually according to a published index
- Attachment point is means tested, and is as low as \$50,000, effectively ending Medicaid funding of LTC services

Eligibility

- Mandatory program

Funding

- Increase in payroll tax of about 1%, according to the first proposal listed below

Existing proposals that include core concepts

- *A New Public-Private Partnership: Catastrophic Public and Front-End Private LTC Insurance*, Developed for the Bipartisan Policy Center by Marc Cohen and Judy Feder, March 2018
- *Medicare Long-Term Care Services and Supports Act of 2018, Draft*, Representative Frank Pallone, May 2018



Non-medical aging in place services

Universal access to services that enable aging in place

Problems with the current landscape

- LTC recipients and their families are often confused by and unaware of care options when they first need care
- Many people transition to care facilities from their homes due to a breakdown in community services
- LTC insurance policies generally lack provisions that allow LTC carriers to provide preventive, interventive and care coordination services

Objectives

- Provide universal access to services that enable and prolong healthy aging in place
- Prevent or delay the need for LTC in a healthy population
- Prevent or delay a transition to a care facility for persons receiving LTC at home
- Implement emerging, innovative services and technology that enables people to safely age in place

Coverage structure

- Optional benefit of Medicare Advantage plans and Medicare supplement policies

Benefits

- Early detection and preventative services: Periodic in-person assessments, tracking of changes in key health metrics, home safety checks, medication management, allowance for home monitoring systems, information on community resources
- For persons receiving LTC at home: Personalized care coordination services, informal care provider training, service provider curation and referrals, minor home modifications (e.g., grab bars), meal delivery services, non-emergency medical transportation

Eligibility

- Available to all Medicare enrollees

Funding

- Premium payments from enrollees

Existing proposals that include core concepts

- CMS allowed the provision of some of these services in Medicare Advantage plans starting in 2019, which could be expanded to include the additional aging in place support services shown above

QUALIFICATIONS, ASSUMPTIONS AND LIMITING CONDITIONS

Oliver Wyman prepared this report in response to an invitation from the Federal Interagency Task Force on Long-Term Care Insurance to the public to provide comments on potential reforms to federal laws, regulations, and policies to complement reforms at the state level relating to the regulation of long-term care insurance.

Oliver Wyman shall not have any liability to any party in respect of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein.

The opinions expressed herein are valid only for the purpose stated herein and as of the date hereof. Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified. No warranty is given as to the accuracy of such information. Public information and industry and statistical data are from sources Oliver Wyman deems to be reliable; however, Oliver Wyman makes no representation as to the accuracy or completeness of such information and has accepted the information without further verification. No responsibility is taken for changes in market conditions or laws or regulations and no obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date hereof.

From: Ann Weber <aweber@soa.org>
Sent: Friday, August 30, 2019 12:39 PM
To: LTCITaskForce
Cc: Dale Hall; Joe Wurzburger
Subject: SOA Comments for Federal Interagency Task Force on LTC
Attachments: SOATreasuryLTCComments8-30-19.pdf

Follow Up Flag: Follow up
Flag Status: Completed

TO: Federal Interagency Task Force on Long-Term Care Insurance
Department of the Treasury

Attached please find the Society of Actuaries' comments regarding long-term care. Please let us know if we can assist in the future with objective research that would aid in analyzing potential policy decisions.

Thank you, Ann Weber

Ann Weber
Director, Government Affairs

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August 30, 2019

Federal Interagency Task Force on Long-Term Care Insurance
Department of the Treasury
1500 Pennsylvania Ave. NW
Room 3454 MT
Washington, DC 20220

Sent electronically to: LTCITaskForce@treasury.gov

RE: Comments for Federal Interagency Task Force on Long-Term Care Insurance

Dear Federal Interagency Task Force on Long-Term Care Insurance:

The Society of Actuaries (SOA) appreciates the opportunity to provide comments to the Federal Interagency Task Force on Long-Term Care Insurance. The SOA's mission statement includes measuring and managing risk to improve financial outcomes for individuals, organizations, and the public. The SOA considers policymakers, regulators and the public as our stakeholders, in addition to our candidates and members.

The SOA serves its stakeholders by delivering high-quality education, and relevant objective research, insight and analysis. Long term care (LTC) risk is significant to the full US population and the SOA has committed resources to review potential solutions and to test new concepts with consumers.

LTC Think Tank & Resulting Research

Several years ago, the SOA worked to organize and sponsor a group called the LTC Think Tank. Members included not only actuaries, but experts from the fields of mortality, neurology, caregiving, economics, aging, geriatrics, biodemography and genetics.

The [results](#) include many highlights, and while not definitive conclusions, they should be useful for expanding thinking regarding LTC and making future projections:

- How insured population experience relates to general population data
- Impact of lifestyle difference with respect to the timing of Alzheimer's onset
- How claim experience may change over time
- Likelihood of a cure for Alzheimer's
- Potential drugs that may impact the against process

In addition, the product innovations work of the LTC Think Tank resulted in two main product concepts coming to light: LifeStage Protection and Retirement Plus. SOA consumer tested both concepts and

the [findings](#) provide that both products have the potential appeal of centering in on providing LTC solutions to a middle market:

LifeStage Protection

The LifeStage Protection concept focuses on the benefit of providing life stage insurance during a consumer's working years, but then flexes and converts to provide LTC benefits at more senior ages. The LTC benefit levels in the concept ranges from \$100,000 to \$300,000 with monthly premiums from \$63 to \$186.

Consumer research findings included:

- Top Consumer-Rated Feature: The ability to lock in LTC insurance early and at lower premium levels - allowing consumers to afford larger benefit levels was the most desirable feature among 74% of consumers.
- 57% of consumers consider this product concept a good fit for their future long-term care needs.
- 49% of surveyed consumers are extremely likely to investigate the product further.
- Life-Stage Protection scored well on clarity and uniqueness – 67% and 59%, respectively.

The research showed a potential reduction in Medicaid spending of 42%.

Retirement Plus

The Retirement Plan is like a 401(K)/IRA, but with LTC insurance directly built into the product. The product concept offers LTC benefit levels ranging from \$100,000 to \$200,000 with minimum monthly contributions ranging from \$119 to \$225 (these minimums contribution levels are for male ages 43-47, with other levels varying based on age and gender).

The product concept would require federal legislation to be permissible.

Consumer research findings included:

- Top Consumer-Rated Feature: Access to additional funds to pay for LTC needs in case of exhausting savings and investment accounts was a desirable feature for 75% of consumers. The ability to transfer retirement funds to beneficiaries upon death was also attractive for 75% of consumers.
- 61% of consumers consider this product concept to be a good fit for their future LTC needs.
- 48% of surveyed consumers are extremely likely to investigate the product concept further.
- Retirement Plus scored well on clarity and uniqueness – 69% and 58%, respectively.

The research showed a potential reduction in Medicaid spending of 48%.

Potential Future Research

Some companies and states are interacting to potentially turn these concepts into products for consumers. Revisions to some state laws and regulations may be necessary for the products to be offered on the

market. On the federal level, the Retirement Plus type of products will require federal tax law revisions related to the contributions or benefits.

As new LTC insurance ideas continue to be developed and refined, including the two concepts resulting from the LTC Think Tank and other hybrid products, it is likely that additional objective research will be necessary. One potential research project to consider, per recent discussions, is exploring the offering of these new products through employer benefit packages. The SOA stands at the ready to engage in further discussion and to assist with research to aid policymakers with their analysis of prospective legislation/regulation centered on improving the financial LTC well-being of the US population.

Sincerely,



Ann Weber
Director Government Affairs
Society of Actuaries

CC: Gregory W. Heidrich
Executive Director
Society of Actuaries

R. Dale Hall, FSA, MAAA, CERA, CFA
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From: Cain, Steve <Steve.Cain@LTCIPartners.com>
Sent: Tuesday, August 13, 2019 8:47 AM
To: LTCITaskForce
Subject: Submission | Federal Interagency Task Force on Long-Term Care Insurance
Attachments: NAHU LTC Position Paper.pdf

Good morning.

I chair NAHU's Working Group on LTC Insurance. Here's something that we put together on the subject.

To respond to the aging of America and the increasing number of individuals who will need LTSS, NAHU recommends:

1. Enforce Medicaid estate recovery, extend the Medicaid look-back period, limit the home exemption and educate the public about LTSS risks and State LTC Partnership programs.
2. Allow funds in an individual's retirement plan to be favorably accessed to buy LTCi.
3. Change Title 26 of U.S. Code to include LTCi as an allowable IRS Section 125 benefit.

Thanks,
Steve

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Long Term Care Position Paper

January 2016

The National Association of Health Underwriters (NAHU), a leading professional trade association for health insurance agents, brokers and consultants, represents more than 100,000 benefit specialists. Our members work on a daily basis to help millions of American individuals and employers purchase, administer and utilize health insurance coverage. Long term care insurance is an important topic; many NAHU members provide products and advice with regards to family LTC planning as an adjunct to retirement and estate protection.

THE LONG TERM CARE SITUATION

The long term care (LTC) system in the United States faces significant challenges as it prepares for an increasingly aging society. The number of people over age 65 is projected to grow to 98 million of the total population by 2060.¹ Thus, many individuals will require long term care services and supports (LTSS) to manage the many health conditions that develop due to aging. While the need for LTSS is not just for the elderly, those ages 65 and older are eight times more likely to need care than those under 65.² Furthermore, with life expectancy of men at 86.6 years and women at 88.8 years,³ it is no surprise that approximately 133 million Americans are living with at least one chronic condition, which can eventually lead to the need for LTC. By 2030, that number is projected to increase to 171 million.⁴

More than 50% of recipients of LTSS in the U.S. partially self-insure their expenses by using savings, depleting retirement assets and/or relying on family caregivers. In fact, 75% of people needing care rely solely on unpaid caregivers. It should also be noted that caregivers die earlier than non caregivers yet also need more LTC themselves because of the mental and physical burden of being a caregiver.⁵ After age 65, it is highly likely that a person will need at least one year of care.⁶ Due to the high cost of care,⁷ many people are pushed into poverty and dependency on Medicaid, yet few Americans are currently covered by LTCi—less than five percent.⁸

Many Americans incorrectly believe that their private health insurance or Medicare will pay LTSS costs. However, the primary burden of providing these services falls on family members. The person needing care and their family then engage in spend-down of savings or other depletion of savings and assets until the person requiring care can meet state-based eligibility criteria for Medicaid. Unless we successfully encourage people who can afford to do so to take personal responsibility for their LTC needs, Medicaid will be hard-pressed to have the funds necessary to care for the truly needy.

¹ Aging Statistics, ACL (Administration for Community Living), U.S. Dept. of Health and Human Services, www.aoa.gov/aging_statistics.

² Derived by Claude Thau using July 2015 population numbers (below age 65 vs. 65+) from www.cia.gov/library/publications/the-world-factbook/geos/us.html#Energy; and a June 2007 estimate of the percentage of LTC recipients under age 65 ("nearly 41%") from Georgetown University Long-Term Care Financing Project. "Long-Term Care Financing Policy Options for the Future," June 2007, as cited at www.ltcfed.com/start/aboutltc_what.html. An update to Georgetown's 42% statistic should cause the ratio stated in the text to increase.

³ Society of Actuaries, Retirement Plans Experience Committee, June 2015, update of the mortality improvement scale, mp-2015.

⁴ "The Growing Crisis of Chronic Disease," www.cdc.gov/nccdphp/publications/AAG/chronic.htm.

⁵ "Risk of Death Can Soar When Spouse is Sick." Robert Roy Britt, news.yahoo.com/s/space/2006215/sc_space/riskofdeathcansoarwhenspouseissick.

⁶ Kemper, Komisar, Alecxih. Long-Term Care over an Uncertain Future: What Can Current Retirees Expect? Inquiry 42:335-350; winter 2005/2006.

⁷ Genworth 2015 Cost of Care Study; April 2015.

⁸ Robert Wood Foundation, Policy Snapshot, Health Issue Brief, February 2015.

Potential caregivers also need to be educated about the significant mental and physical burden of being a caregiver. This results in caregivers dying earlier than non caregivers. They also need more LTC themselves.⁹

As policy-makers look for solutions to the ever growing LTC crisis in the U.S., an important consideration and strong justification for everyone to consider purchasing LTCi is that individuals using LTCi benefits at the end of life have lower medical costs. A recent study confirmed this and found that total medical costs were 14% lower. The breakdown of the 14% savings showed pharmacy 13% lower, inpatient admission 35% lower and outpatient visit costs 16% lower. Hospital admissions were eight percent fewer and inpatient days were 10% less.¹⁰

NAHU is pleased to offer three proposed solutions that, if implemented, will facilitate:

1. Preservation of government safety net programs for people who need them and for future generations.
2. More employers offering LTC education and LTCi as an employee benefit.
3. Increased acceptance of personal responsibility by Americans for their long term care.
4. Additional purchases of LTCi, which will add stability in the LTCi marketplace and generate additional taxes, increasing state and federal revenues.

An important part of these proposed solutions will be the establishment of public and private educational programs to encourage and assist Americans to fully understand the:

1. High probability that LTSS will be needed.
2. Financial, physical and emotional burden on loved ones to provide LTSS.
3. Limited coverage available under Medicare.
4. Complex rules and regulations associated with receiving benefits under Medicaid.
5. Need to plan adequately for their own LTC needs.
6. Importance of considering purchase of LTCi as a part of overall retirement strategy.

The results will mitigate the lack of financial preparedness among far too many U.S. individuals and their families.

FIRST PROPOSED SOLUTION: MEDICAID REFORMS

Medicaid was created in 1965, as Title XIX of the Social Security Act, to provide healthcare coverage for the neediest. Most Americans share in the belief that Medicaid should provide a basic safety net for current and future Americans in need. Unfortunately, Medicaid is already over-extended and too often provides LTSS coverage to people who are not destitute.

The rapidly growing need for LTSS will exacerbate Medicaid's ability to provide needed care since its funding is not infinite. Thus, every effort should be made to find ways to preserve Medicaid and ensure its financial solvency. If policies and programs were available to incentivize more consumers to purchase LTCi or use reverse mortgages, Medicaid could provide better care to the neediest rather than being a refuge for those who can afford to cover their LTSS needs. Changes made to Title XIX in 1993 require states to recoup costs of Medicaid LTC-related services from the estates of deceased recipients (some deferrals exist to protect family members). However, many states have been lax in doing so,

⁹ <https://www.caregiver.org/women-and-caregiving-facts-and-figures>.

¹⁰ "Long-Term Care Benefits May Reduce End of Life Medical Care Costs"; S. Holland, MD, S.R. Evered, PhD, B. A. Carter, PhD, POPULATION HEALTH MANAGEMENT; Volume 0, Number 0, 2014.

discouraging people from accepting personal responsibility. Far too many people believe that the government will take care of them for free.

The Long Term Care Partnership program, implemented by 43 states, is a federal and state program to preserve Medicaid. It encourages the purchase of Partnership LTCi policies, thereby greatly reducing the risk that those people will need Medicaid funding for LTSS. Statistics demonstrate extremely few people who own LTC Partnership policies end up relying on Medicaid. The most recent reports from each of the four original LTC Partnership Program states advise that only 7.2% of claimants who owned Partnership-approved policies have accessed Medicaid. The California Department of Health Services calculated that, as of the first quarter of 2013, the LTC Partnership plan had saved them \$46 million. New York state officials reported a savings to their Medicaid program of \$34 million through 2014.¹¹

In contrast to Medicaid, when individuals purchase LTCi that meets state LTC Partnership policy requirements, they can receive LTSS in their place of choice (at home, assisted living facility or nursing home), paying for it with their LTCi and possibly some of their income and assets. Rather than immediately beginning depletion of savings and assets to become eligible for public assistance, they know that if their income and insurance benefits are insufficient, they spend-down assets only until their remaining countable assets match (equal) the total benefits they received from their policy. The disregarded assets are permanently protected from estate recovery.

NAHU supports the Long Term Care Partnership program and encourages all states to adopt this federal-state hybrid initiative. However, adoption of the program is not enough. For states to have a successful program, states must also educate their citizens about the program. This should also be a joint federal-state effort.

When a person buys a Long Term Care Partnership policy, Medicaid is not the primary payer of LTSS. Thus, in addition to avoiding payment of Medicaid benefits, states reduce expenses for determining eligibility, administering benefits and recovering estates. Also, fraud potential is reduced due to fewer incentives for individuals to attempt to game the system by hiding or transferring assets. Furthermore, the sale of LTCi and reverse mortgages generates several sources of tax revenue, including from LTSS providers, whose revenues go up because of a higher percentage of private-pay clients.

Two additional important recommended steps to ensure it will be more difficult for individuals to obscure their assets and finances to qualify for Medicaid are:

1. Change the federal Medicaid eligibility regulations to reduce the ever-increasing home equity exemption, which in 2016 can be up to \$828,000 (for ALL assets in England INCLUDING home equity no more than \$32,250 assuming \$1.50 to the English pound).¹²
2. Extend the look-back period on transferred assets from five to 10 years.

Changes like these would result in federal and state governments having better control of their Medicaid programs to better ensure only individuals absolutely needing public help receive it.

¹¹ Derived by Claude Thau from the following reports, which were the most recent he found for each state in November 2013: California Partnership for Long-Term Care Quarterly Report, 1st quarter, 2013 (www.dhcs.ca.gov), Connecticut Cumulative Program Statistics as of June 30, 2015 (www.ct.gov/opm/cwp/view.asp?a=2995&q=474136&opmNav_GID=1814), Indiana Long-Term Care Insurance Program Report Quarter 1-2012 Report (www.in.gov/fssa/iltcp) and NYS (New York State) Partnership for Long-Term Care Quarterly Update, 4th Quarter 2014 (www.nyspltc.org).

¹² Adrian Walker, "Logical Step? Using Equity Release to Pay for Long-Term Care," Professional Advisor, August 18, 2015.

SECOND PROPOSED SOLUTION: PERMITTING FUNDS IN EMPLOYER AND INDIVIDUAL RETIREMENT PROGRAMS TO BE ACCESSED PENALTY- AND TAX-FREE TO PURCHASE LTCi:

Retirement planning has changed dramatically. Now most employer-based defined-benefit pension plans have changed to defined-contribution plans. More than 100 million Americans currently participate in 401(k), 403(b), 457 and/or Individual Retirement Account (IRA) plans.¹³ These programs are a very important step to help individuals ensure their financial security and have proven increasingly popular. Unfortunately, early-withdrawal penalties and an additional 10% tax on withdrawals before age 59.5 discourage individuals from withdrawing funds to purchase LTCi. Waiving taxes and penalties on money removed from such accounts in order to purchase LTCi would allow people to use a small portion of their retirement assets to protect the balance of their retirement assets for their and their spouse's intended uses.

NAHU believes allowing funds from retirement accounts to be accessed to purchase LTCi will benefit our nation in the following ways:

1. Individuals and families will be better prepared and experience less drain on savings and fewer burdens managing their daily lives if LTSS becomes needed.
2. Individuals with LTCi will receive better quality of care, including choice of caregivers and place to receive care.
3. Coverage will reduce burnout and protect the health of family members by facilitating hiring commercial caregivers and providing care-coordination services to help guide them through necessary decisions and arrangements.
4. LTC facility providers will receive private-pay reimbursements rather than the much lower Medicaid reimbursements. This will allow more innovation and competition in the LTC provider industry. The increased income will also result in facilities being able to pay low-income LTC workers higher wages.
5. States will save money on Medicaid benefits paid and processing costs for eligibility determinations and estate recovery.
6. The federal and state governments will receive more tax revenue from insurers, insurance agents and providers.

THIRD PROPOSED SOLUTION: IRS SECTION 125 REFORMS

More than 145 million Americans are a part of employee benefit plans.¹⁴ However, too few of these plans offer LTCi plans.¹⁵ Employers should be encouraged and incented to offer LTCi plans. Employers should also be incented to contribute toward the premium costs. Having LTCi offered as a benefit would demonstrate the value of taking personal responsibility for likely LTSS costs in the future. Employees who enroll gain yet another layer of financial security for their retirement planning.

A significant incentive to employees to enroll in an offered plan will occur if employees are allowed to purchase LTCi through their employer's IRS Section 125 plan. This allows reduced cost to employees by allowing pretax dollars to pay for premiums. Employers benefit by not having to pay payroll taxes on income an employee sets aside on a pretax basis. LTSS planning education, a vetted program and the ease of paying premiums through payroll deduction bring additional value to employees. The educational material should include encouraging LTSS planning for self and with family.

¹³ Vanguard, "How America Saves," June 2014. www.fa-mag.com/news/how-much-do-people-really-have-in-iras-10914.html,2012.

¹⁴ The Henry J. Kaiser Family Foundation, 2014 Employers Health Benefit Survey 9/10/14.

¹⁵ The 2012-2013 Sourcebook for Long-Term Care Insurance Information. "At the end of 2011, there were approximately 12,000 employers sponsoring group LTCi coverage in the US.," p.13.

This recommendation can be implemented by changing Title 26 of U.S. Code, Subtitle A, Chapter 1, Subchapter B, Part III, which states, “Such term shall not include any product which is advertised, marketed or offered as long-term care insurance.” Striking this line would easily remedy the prohibition and be in line with tax policy for benefits, such as Health Savings Accounts.

It is understood that the change would not benefit persons purchasing LTCi outside of an employer-sponsored plan since IRS Section 125 only offers tax preference to employer-sponsored benefit plans. However, those individuals could receive improved tax benefits if changes made to IRS 1040 tax deductions.

All LTCi policies are fully portable. This allows employees to have freedom and flexibility to change jobs or retire and maintain their same LTCi coverage. At time of purchase, policies offer options to increase coverage over time so benefits remain meaningful as the cost of care increases. The younger the age of a person purchasing LTCi, the less expensive the cost will be. Furthermore, if the three percent annual compounding of benefits option is chosen, 10 years later, an insured person will have 34% more benefit amount when he or she needs care. Making LTCi as attractive a purchase as possible to working Americans is a significant way to decrease the number of Americans who end up relying on Medicaid.

CONCLUSION

To respond to the aging of America and the increasing number of individuals who will need LTSS, NAHU recommends:

- 1. Enforce Medicaid estate recovery, extend the Medicaid look-back period, limit the home exemption and educate the public about LTSS risks and State LTC Partnership programs.**
- 2. Allow funds in an individual’s retirement plan to be favorably accessed to buy LTCi.**
- 3. Change Title 26 of U.S. Code to include LTCi as an allowable IRS Section 125 benefit.**

These recommendations have been developed by health insurance professionals who understand the LTCi marketplace and have unique insights gained from assisting consumers enrolling in LTCi coverage. Therefore, we feel confident that our recommendations, if implemented, will:

1. Encourage and enable individuals to better plan for the potential of needing LTSS, allowing increased financial security.
2. Increase state and federal revenues while reducing financial expenditures so Medicaid can now and in the future focus on our most-needy populations, as intended.
3. Improve the health of America’s seniors and health and productivity of people who would otherwise be family caregivers.
4. Benefit all Americans by allowing both federal and state governments to achieve a stronger financial condition due to reduced LTSS expenses and increased revenues by generating a higher volume of taxes.
5. Result in a more competitive, healthy, stable and diverse LTSS marketplace, which benefits care recipients and their families.
6. Result in a more competitive, healthy, stable and diverse LTCi marketplace, which will increasingly permit less dependence on government-funded LTSS.

From: Sally Leimbach <Sally.Leimbach@tribridgepartners.com>
Sent: Friday, August 30, 2019 4:53 PM
To: LTCITaskForce
Subject: Invitation for Public Comment re: Federal Interagency Task Force on Long Term Care Insurance
Attachments: Final Report Submitted to Governor.pdf; NAHU_PositionPaper_LTC.pdf

Please find the two attachments above that will be of interest to the Task Force as they continue their effort:

1-Report to Maryland Legislature and Governor Hogan by the Task Force on LTC Education and Planning in Maryland. This 154 page report contains much information including 10 recommendations made by the Task Force for improvement of education and planning for LTC Education and Planning by the residents of Maryland. It outlines Public/Private efforts that would contribute to a better outcome for the State of Maryland and its residents regarding the ever increasing crisis created by the aging of Americans. The report was written with the hope that it could also assist other states as they wrestle with this common problem among states. The report includes discussion of long term care insurance as a viable planning option. This report includes a section NAIC recommendations to the federal government. The report also includes a detailed index of resources for information that the Federal Interagency Task Force will find useful in their efforts.

2-Position Paper of NAHU (National Association of Health Underwriters) that recommends to the federal government three areas of action by the federal government that would assist U.S. residents to be encouraged to plan for LTC and for them to more favorably consider LTC insurance as a part of their planning.

I served on the Maryland Task Force that produced the first attachment and also Chaired the committee that wrote the NAHU Position Paper. I am happy to discuss any aspect of either or both with this Task Force.

Respectfully Submitted

Sally Leimbach



Sally Leimbach CLU®, ChFC®, CEBS, LTCP, CLTC
Senior Long Term Care Insurance Consultant
One East Pratt Street, Suite 902
Baltimore, MD 21202
[410-659-3702](tel:410-659-3702) Direct Dial

October 26, 2018

The Honorable Larry Hogan
State House
100 State Circle
Annapolis, MD 21401

The Honorable Thomas V. "Mike" Miller, Jr.
President
Senate of Maryland
State House, H-107
Annapolis, MD 21401

The Honorable Michael E. Busch
Speaker
Maryland House of Delegates
State House, H-101
Annapolis, MD 21401

Re: Report of the Maryland Governor's Task Force on Long Term Care Planning required by SB 696/Ch. 212, 2017 and HB 953/Ch. 213, 2017 (MSAR # 11102)

Gentlemen:

Enclosed is the report detailing the Task Force's findings and recommendation on education methods that will help "ensure that no Maryland resident reaches the age of 50 without having received complete information about the risk of needing long-term care and the private options available to pay for long-term care; and include information about the Maryland Medical Assistance Program (Maryland Medicaid), how the Program is funded, and whom the Program is intended to serve."

Education about long-term care options will help Marylander's plan for these costs. During their lifetime, one quarter of Maryland's 1.5 million Baby Boomers will require long-term care costing at least \$100,000. Many residents do not understand that they cannot rely on the State and federal government to pay the costs for long-term care. They may also be under the misconception that the Maryland Medical Assistance (Medicaid) program and other state programs will cover these costs.

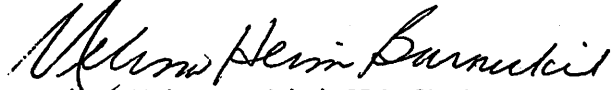
The Task Force is providing recommendations that can create a sound foundation of vital long-term care education for the residents of Maryland using established infrastructure and cost effective techniques within relatively short implementation timelines. Implementing these recommendations will benefit both the public and private sectors of Maryland and all Maryland residents.

The Honorable Larry Hogan
The Honorable Thomas V. "Mike" Miller
The Honorable Michael E. Busch

2

October 26, 2018

Sincerely,

A handwritten signature in black ink, appearing to read "Melissa Heim Barnickel". The signature is fluid and cursive, with the first name "Melissa" being the most prominent part.

Melissa Heim Barnickel, CPA, CLTC
Task Force, Chair

cc: Sarah Albert, Department of Legislative Services (5 copies)

Maryland Governor's Task Force on Long Term Care Education and Planning

Learn your options

Take the time, it's important!

Create a plan for you and your family

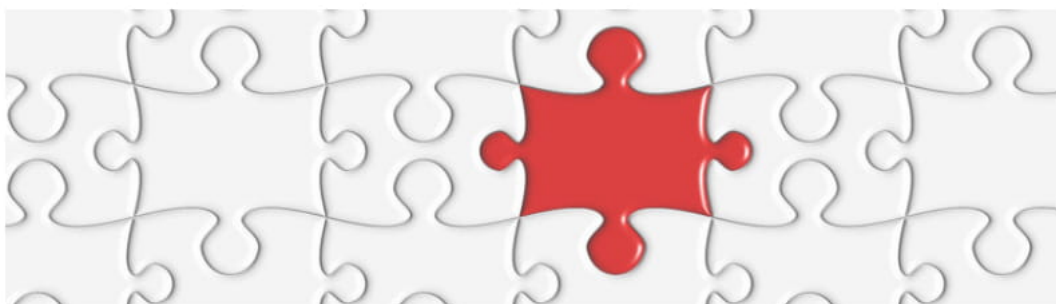
Put the "pieces" in place

Look to Public/Private Resources for Assistance

Action is key

Now is the time!

Every Piece Of Information Helps!



MARYLAND TASK FORCE ON LONG TERM CARE EDUCATION AND PLANNING



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Section 1:

Executive Summary

EXECUTIVE SUMMARY

The purpose of the Task Force has been to consider options to educate and make recommendations regarding education methods that will “ensure that no Maryland resident reaches the age of 50 without having received complete information about the risk of needing long-term care and the private options available to pay for long-term care; and include information about the Maryland Medical Assistance Program (Maryland Medicaid), how the Program is funded, and whom the Program is intended to serve.”

The reason that this education of Maryland residents is needed is that the population of Maryland includes over 1.5 million Baby Boomer. One quarter of this number will, over their lifetime, require long term care costing at least \$100,000. Many Maryland residents do not understand that they may not rely on the State and federal government to pay the costs for long term care. Also, many Maryland residents may be under the misconception that the Maryland Medicaid Assistance program and other state programs will sufficiently cover the cost of their long term care needs.

A recent CMS report projects that nationwide, Medicaid spending over the next 10 years will grow at an average annual rate of 5.7%. CMS Administrator, Seema Verma said, “The status quo is simply unsustainable. We must slow the growth in Medicaid spending so that it will be around to serve those who truly need it.” Government needs to find ways to slow the growth. This and additional facts and figures can be found at; Administrator Seema Verma Twitter handle @SeemaCMS.

The makeup of the Task Force deliberately includes public and private sector representatives. In putting together, the verbiage that was then drafted into legislation that has become law, the intent is to have a clear message come with one voice from both the public and private sectors. Too often in the past there have been confusing, conflicting, changing messages that have made the information misinterpreted and often ignored altogether. The easy alternative is to ignore the need to have a long term care plan. However, “a failure to plan is a plan to fail”.

This report is divided into 14 sections for easy reference. Backup information including Law 953 and information about Task Force members are found in Sections 2-6. Sections 7-10 create the foundation for the 10 Recommendations found in Section 11. An extensive Appendix is found in Section 13.

States have already reached out to Task Force members for information on Maryland's efforts. An overview of other state initiatives is found in Section 8. All states share similar problems in the area of the negative impacts that result of increasing Medicaid budgets and states are eager to share and learn.

National organizations have already said they are willing to work with Maryland. Examples of this appear under Recommendation 6," Reach Out and Include Private Organizations and Entities."

This Task Force is providing recommendations that can create a sound foundation of vital education regarding LTC for the residents of Maryland, using established infrastructure, cost effective techniques, and relatively short implementation timelines. Embracing these recommendations will be a win-win for the public and private sectors of Maryland and all Maryland residents.

Section 2:

Appreciation

APPRECIATION



The entire Governor's Task Force on Long Term Care Education and Planning would like to thank the United Seniors of Maryland, Jessica Goughnour, Jessica Talley, Amna Sassy and Mariam Davies for their active support throughout the course of the project.

Thank you!

Section 3:

Law HB 953 Creating Task Force

LAW HB 953 CREATING TASK FORCE

LAWRENCE J. HOGAN, JR., Governor

Ch. 213

Chapter 213

(House Bill 953)

AN ACT concerning

Task Force on Long-Term Care Education and Planning

FOR the purpose of establishing the Task Force on Long-Term Care Education and Planning; providing for the composition, chair, and staffing of the Task Force; prohibiting a member of the Task Force from receiving certain compensation, but authorizing the reimbursement of certain expenses; requiring the Task Force to study and make recommendations regarding certain matters; requiring the Task Force to report its findings and recommendations to the Governor and the General Assembly on or before a certain date; providing for the termination of this Act; and generally relating to the Task Force on Long-Term Care Education and Planning.

Preamble

WHEREAS, Baby boomers represent 15% of the U.S. population and Maryland is home to 1.5 million baby boomers; and

WHEREAS, About one-quarter of the 1.5 million baby boomers in the State will require long-term care that will cost at least \$100,000 over the course of their lifetimes, with nearly two-thirds of this population having to pay for this care out of pocket; and

WHEREAS, A number of Maryland residents may not understand that they may not be able to rely on the State and federal government to pay for their long-term care needs; and

WHEREAS, Many Maryland residents may be under a misconception that the Maryland Medical Assistance Program and other State programs will sufficiently cover the cost of their long-term care; and

WHEREAS, Maryland residents are in need of education regarding the cost of and need for planning for long-term care; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
MARYLAND,

That:

Ch. 213

2017 LAWS OF MARYLAND

- There is a Task Force on Long-Term Care Education and Planning.
- The Task Force consists of the following members:
 - ~~one member of the Senate of Maryland, appointed by the President of~~

~~the Senate;~~

- ~~(2) one member of the House of Delegates, appointed by the Speaker of the~~

~~House;~~

- (1)the Secretary of Aging, or the Secretary's designee;
- (2)the Secretary of Health and Mental Hygiene, or the Secretary's

designee;

- (3)the Maryland Insurance Commissioner, or the Commissioner's

designee; and

- (4)the following members, appointed by the Governor:

- one representative of the Maryland Association of Certified

Public Accountants;

- one representative of the Maryland State Bar Association;

- one representative of the Financial Planning Association of

Maryland;

- one representative of the Maryland Association of Health

Underwriters;

▪ one representative of the National Association of Insurance and Financial Advisors of Maryland; ~~and~~

▪ one representative of the Maryland Association of Private Colleges and Career Schools; ~~and~~

▪ one representative of the Health Facilities Association of Maryland; and

▪ o
ne LAWRENCE J. HOGAN, JR., Governor Ch. 213
representative of a long-term care insurer or a trade association that includes long-term care insurers.

(c) The Governor shall designate the chair of the Task Force.

(d) ~~The Department of Aging~~ United Seniors of Maryland shall provide staff for the Task Force.

(e) A member of the Task Force:

(1) may not receive compensation as a member of the Task Force; but

(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) The Task Force shall:

(1) examine the status of long-term care education in the State;

(2) consider options for improving efforts to educate residents of the State about planning for long-term care; and

(3) make recommendations regarding long-term care education, including recommendations regarding education methods that will:

(i) ensure that no Maryland resident reaches the age of 50 without having received complete information about the risk of needing long-term care and the private options available to pay for long-term care; and

(ii) include information about the Maryland Medical Assistance Program, how the Program is funded, and whom the Program is intended to serve.

(g) On or before December 1, 2017, the Task Force shall report its findings and recommendations to the Governor and, in accordance with 2-1246 of the State Government Article, the General Assembly.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2017. It shall remain effective for a period of 1 year and 1 month and, at the end of June 30, 2018, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

Approved by the Governor, April 18, 2017.

Section 4:

**Report to Governor Hogan
December 1, 2017**



United Seniors of Maryland
Elizabeth Weglein, President
P.O. Box 1094
Sparks, MD 21152
410-608-7966
ew@elizabethcooneyagency.com

December 1, 2017

The Honorable Larry Hogan
State House
100 State Circle
Annapolis, Maryland 21401

The Honorable Thomas V. "Mike" Miller, Jr.
President
Senate of Maryland
State House, H-107
Annapolis, Maryland 21401

The Honorable Michael E. Busch
Speaker
Maryland House of Delegates
State House, H-101
Annapolis MD 21401

RE: Report required by SB 696/Ch. 212, 2017 and HB 953/Ch. 213, 2017
(MSAR # 11102)

Gentlemen:

The Task Force on Long Term Care Education and Planning respectfully submits our December 1, 2017 interim report. The Task Force began meeting in October 2017 through June 30, 2018. Meetings are held at the Heritage Complex 2664 Riva Road Chesapeake Room, Annapolis, Maryland every 3rd Monday monthly from 10am-12pm.

The Task Force was appointed by the Governor's Appointments Office for its composition, chair, and staffing. A membership list is located in the addendum.

Composition of the Task Force:

Secretary of Aging, or the Secretary's designee

Secretary of Health, Secretary's designee

Maryland Insurance Commissioner, or the Commissioner's designee

- one representative of the Maryland Association of Certified Public Accountants;
- one representative of the Maryland Bar Association;
- one representative of the Financial Planning Association of Maryland;
- one representative of the Maryland Association of Health Underwriters;
- one representative of the National Association of Insurance and Financial Advisors of Maryland
- one representative of the Maryland Association of Private Colleges and Career Schools
- one representative of the Health Facilities Association of Maryland
- one representative of a long term care insurer or a trade association that includes long term care insurers
- United Seniors of Maryland is providing staff to the Task Force.

Special Note: The Maryland Association of Private Colleges and Career Schools did not respond to repeated outreach from the Governor's Appointments Office and the United Seniors of Maryland.

The Task Force is prohibiting from receiving certain compensation, but it is authorized receive reimbursement of travel expenses.

Baby boomers represent 15% of the U.S. population and Maryland is home to 1.5 million baby boomers. About one-quarter of the 1.5 million baby boomers in the State will require long term care that will cost at least \$100,000 over the course of their lifetimes, with nearly two-thirds of this population having to pay for this care out of pocket. A number of Maryland residents may not understand that they may not be able to rely on the State and federal government to pay for their long term care needs. Many Maryland residents may be under a misconception that the Maryland Medical Assistance Program and other State programs will sufficiently cover the costs of their long term care.

The Task Force will examine and study:

- (1) Examine the status of long term care education in the State;
- (2) Consider options for improving efforts to educate residents of the State about planning for long term care; and
- (3) Make recommendations regarding long-term care education, including recommendations regarding education methods that will:

- ensure that no Maryland resident reaches the age of 50 without having received complete information about the risk of needing long-term care and the private options available to pay for long-term care; and
- Include information about the Maryland Medical Assistance Program, how the Program is funded, and whom the program is intended to serve.

The purpose of the Task Force is to consider options to educate and make recommendations regarding education methods that will “ensure that no Maryland resident reaches the age of 50 without having received complete information about the risk of needing long term care and the private options available to pay for long term care; and include information about the Maryland Medical Assistance Program (Maryland Medicaid), how the Program is funded, and whom the Program is intended to serve.

The makeup of the Task Force deliberately includes public and private sector representatives. In putting together the verbiage that was then drafted into legislation that has become law, the intent is to have a clear message come with one voice from both the public and private sectors. Too often in the past there have been confusing, conflicting, changing messages that have made the information misinterpreted and often ignored altogether. The easy alternative is to ignore the need to have a long term care plan. However, “a failure to plan is a plan to fail”.

The Long Term Care crisis at the federal and state level can no longer be responsibly ignored. The impacts of the ever swelling Medicaid budgets are increasingly smothering other necessary state responsibilities such as education, transportation, and infrastructure. Maryland, with bipartisan support, has created the opportunity, a conduit, not for a complete answer but for a necessary step to assist finding answers, by education through clear messaging with one voice of the Public and Private sectors in unison.

If successful, Maryland can be providing a model for other states to follow. Assistance from the federal level could be most helpful, and it is hoped that success at the state level will spill over to having the federal level aid be able to achieve higher levels of success. Then there will be the opportunity for a crisis to evolve to a manageable program.

For this Task Force to function there had to be administrative support. United Seniors of Maryland was designated staff for the crucial responsibility for the Task Force to function. United Seniors of Maryland is a non-partisan consortium of organizations and individuals that help promote senior issues, causes, laws and programs representing 3 million Maryland seniors.

Our initial discussions focused on:

- What is the current level of knowledge in various age groups?

- What goals should be created to meaningfully reach various age groups so they all will have had the opportunity to receive complete information by age 50 regarding:
 - Risk of needing long term care
 - Private options available to pay for long term care
 - Understanding the Maryland Medical Assistance Program including how it is funded and who it is intended to serve.
- How can Public Sectors be reached to consider and incorporate effective messaging to relay to the residents of Maryland the importance of understanding LTC risk and the importance of LTC Planning.
- What is the Department on Aging already doing?
- See if the MD CASH Program could be a conduit for information somehow.
- How to address the teenagers or young 20's who do not realize the impact that it has on some family members such as parents with work related stress, financial contributions and not having time for themselves. Parents often do not discuss these important impacts trying to shelter children.
- How to promote LTC terminology into financial literacy at the High School age as a beginning.
- Maybe children's books with theme of multigenerational interaction and the need for care giving for young and old.
- How do you get people to listen? Perhaps by including in a financial incentive.
- What is the best way to introduce to a group?
- When professional sits down to review a 401K, there just is not enough time to also include LTC planning.
- What Programs in MD currently exist?
 - Dept. of Health Transitional unit re genetics
 - Dept. of Aging targets age 50 plus
 - MD Access Points (MAP) which is a referral for resources should be studied. Provides information about existing state programs to enable people to stay at home longer.
 - Check the Federal educational web sites. One site is www.longtermcare.gov.
 - EAP programs
 - Chamber of Commerce's to reach employers. Ask Chambers how they are preparing their members for LTC.
- Use "Long Term Care Choices" as well as "LTC Planning".
- How to encourage Associations to spread the need for LTC planning to members.
- Could Maryland try to implement for LTC something like the 501K for college education savings? Even if only one year with a sunset."
- Maryland is starting a 529A plan for those disabled by the age of 26 with a limit of \$14,000 per year contribution.

- How to educate the veterans? They do qualify for Aid and Attendance Veterans Allowance Pension if have served during a period of war even if no disability from that service.
- Need to compile a list of possible assets available to MD residents e.g. from Dept. of Veterans Affairs and the Dept. of Health and Mental Hygiene.

FEDERAL ASSISTANCE TO STATES

- From 2005 through 2010, there was strong federal support for LTC awareness education. The federal government offered to states, with some funding, the “Own Your Future” campaign. Twenty-six states participated at various levels. During this time, the federal government created a web site, www.longtermcare.gov. This website continues to provide a broad focus on planning with insurance treated as one option for planning.
- “Own Your Future” materials are in public domain. Perhaps the Task Force should access to see if items could be modeled to assist Maryland in an education campaign.
- However, other activities at the federal level including research, and consumer education, have ceased. ACA activities have created a HUGH diversion over the period of the last several years.
- Maryland was one of the 26 states who did use aspects of the “Own Your Future” campaign. Namely a letter was sent out from then Governor Ehrlich’s office in 2006. Unfortunately, instead of being perceived as a strong message from the public sector that residents of Maryland need to accept personal responsibility and have a plan for long term care, it was looked on as a political in an election year or ignored due to lack of additional support activities.

STATES ACTIVITIES ON THEIR OWN

Prior to 2005, four states pioneered the concept of LTC Partnership programs, California, Connecticut, Indiana, and New York. The federal government then froze this program again allowing it to expand under the Deficit Reduction Act of 2005.

HAWAII

- Hawaii has had an effort since 2008 with the establishment of the State of Hawaii Long Term Commission. It is unclear at what stage the Hawaii effort has reached. Follow up is needed with three contacts in Hawaii, two at the U of Hawaii at Manoa and one with the Maui County Office on Aging.
- However, through available material, “The highest level of concern seemed to be weighted toward a lack of public awareness of the upcoming LTC crisis”. “The community must wake to the problem”. “Hawaii must convince the public that long

term care will affect their future and “warn the community that a train wreck is coming.”

- Kakuna Caregivers Act – enacted 2016 – up to \$70 a day from the state.

MINNESOTA

- Minnesota has continued on with “Own Your Future” consumer awareness since 2013. The state is using social media and traditional outreach as well as grassroots partnerships.
- In addition, Minnesota is actively working on finding a product component to add to the awareness campaign. Minnesota is in the testing phase for two innovative products: 1-LifeStage Protection 2-Adding enhanced home care into Medicare supplement plans.
- MIA may model off of MN since they have approval for a test market.

NEBRASKA

- Nebraska tried a one of a kind savings plans to end Jan. 1/2018 due to low participation. Created by the legislature in 2006, the program was intended to give Nebraskans “another option in considering their future health care needs and hopefully encourage more Nebraskans to plan ahead”.

NEW YORK STATE

- New York State established their program in 1989 to encourage more New Yorkers to purchase LTC Insurance and become less reliant on the Medicaid system. As of December 31, 2014, 71,925 persons “were enrolled” in NYS LTC Partnership. 346,286 “were enrolled in non-Partnership Policies. Actual factors of successful marketing are not available on the Internet. Goal to contact the NYS department who manages the program for further information.

WASHINGTON STATE

- Washington has explored the financial impact of a mandatory front-end program funded through small employer paid payroll tax. The effort has included stakeholder interviews and actual modeling. To date, Industry has informally supported. The next step for moving forward is to get support for a legislative proposal.

RESEARCH STUDY BY GENWORTH –The Long Term Care LTC Ripple Effect –

- Fear of lack of money, loss of independence, inability to care for yourself, not having loved ones to help take care of you and finally not being able to stay in your home.
- Important to not just consider insurance as the only way to plan –
- Personal cost of insurance – Only 11% own their own insurance, 18% believe government will pay costs and 54% don't act due to their perception that cost of insurance too high.
 - 2017 Genworth Cost of Care Study.
 - NAIC has a publication
 - Shoppers Guide on LTC (currently being revised).
 - Note: Al Redmer, Commissioner, Maryland Insurance Commission, is on Task Force for NAIC

Task Force Subcommittees

The Task Force formed four subcommittees. Each Task Force member is to serve on one of these committees, excluding Logistics. The four are:

- 1-Communication and Advocacy
- 2-Education
- 3-Logistics
- 4-Research

Advocacy Workgroup

- Identify the stakeholders – For example: government agencies (Office on Aging, branch to community and non-profits, Chambers of Commerce, Professional organizations and Associations, Young Professional Groups of various organizations, Labor organizations, etc.
 - Messaging is key
- Age groups – younger the better – progression by age – limited to greater so by age 50 understand topic

Communication Workgroup

- What tools to be used – all types of social media – YouTube, newsletters, news media, public service announcements, presentations to various groups, get celebrity to be spokesperson, APP for phone
- Website – with links to get information
- **Local MAPs** – Gateway for individuals to obtain information, assistance, referral, and access to public and private resources for long term services and supports in Maryland. Options counseling is available to individuals and caregivers to help make informed decisions about long term care needs. How can we use it for people to get information before they need care? In 2016 data in ages – 18-59 (disability) – 5000, ages 60 plus reached 3500.

- **MarylandAccessPoint.info** - an online, searchable resource directory with links to long term care information. Additional links to more long term care information can be added.
- SHIP – Individuals that already have a need – not reaching the right population for Task Force.

Education Workgroup

- What has been done in the past for Own Your Future campaign
- Research existing videos available to educate
- Limitations of Medicare and Medicaid –

Logistics Workgroup

- Comprised of the United Seniors of Maryland and Task Force members to successfully support the Task Force

Research Workgroup

- Look at national and state activities for developing and existing information.
- Identify potentially helpful research relating to State of MD.
- Identify potential funding partners to help launch the effort
 - Robert Wood Johnson Foundation
 - Johns Hopkins University
 - U of MD
 - How did other states fund programs?
- Develop research to pass the messaging after it is created to test messaging and content of campaign. The Task Force will continue its mission and study from December 2017 till the end of June 2018. A full report and its recommendations will be provided in July 2018. The Task Force is committed to make a positive impact on Maryland's citizen to better prepare for their Long Term Care needs.

A special thanks to Sally Leimbach and Melissa Barnickel for their initial development of the legislation, documentation, leadership, and expertise.

Respectfully submitted,

Elizabeth Weglein, President
United Seniors of Maryland

Section 5:

Task Force Roster

GOVERNOR APPOINTEE TASK FORCE MEMBERS

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Section 6:

Biographies of Task Force Members with Overviews of Organizations Represented

BIOGRAPHIES

Melissa Barnickel, CPA, CLTC

Founding Principal Baygroup Insurance LLC

For over the last 25 years Melissa has specialized only in LTC issues and LTC insurance. Melissa's financial career includes public accounting, chief financial officer of two insurance brokerages and now as an independent insurance broker and small business owner. Melissa has been active in professional organizations in the financial, insurance and senior industries. These professional organizations include: Maryland Association of Health Underwriters, Maryland Association of CPAs, Financial Planning Association of Maryland, Baltimore Estate Planning Council, SOA-LTCI Section, Baltimore County Provider Council, and others. Since the fall of 2016, she has been a member of the MIA LTCI Workgroup. Also, currently, Melissa is the member of Joint Legislative Committee for NAIFA-MD and MAHU. She is a member of the NAHU LTCI Working Group. Governor Hogan appointed Melissa to the Task Force to fill the slot for MAHU-MD and she was elected chair by members of the Task Force.

OVERVIEW of both MAHU-MD and NAIFA-MD also represented on the Task Force (see Sally Leimbach Bio.)

MARYLAND ASSOCIATION OF HEALTH UNDERWRITERS (MAHU); NATIONAL ASSOCIATION of INSURANCE and FINANCIAL ADVISORS OF MARYLAND

MAHU and NAIFA-MD are professional trade associations. Both of these associations strive to assist their members to maintain high standards of proficiency, competency, and ethical behavior when working with Maryland residents. MAHU and NAIFA-MD combined have over 700 members across the state of Maryland. Members include health insurance and employee benefits specialists, financial advisors, financial planners, multiline agents, both captive and independent advisors, new to the business, industry leaders and everyone in between.

The work performed by association members includes analysis of needs, recommendations and implementation of life and health insurance products. As pertains to planning for long term care (LTC), these products include life and health insurance products such as: long-term care insurance (traditional model), Long term care insurance (hybrid or combo models combining life insurance or annuity with long term care and/or chronic illness riders), disability, short-term care, and critical illness.

MAHU and NAIFA Maryland jointly operate the Joint Legislative Committee (JLC). The JLC exists to advocate for legislation that protects both the consumers who purchase insurance products and the industries in which these products are created and to assure a continuing high level of quality and choice regarding their needs for health and life insurance products.

JLC members have always recognized the need for a public-private effort to provide a voice to communicate to all Marylanders the importance of long term care planning for themselves and those for whom they feel responsible. During the 2017 Legislative Session,

with the help of lobbyists Bryson Popham and Joan Smith, the JLC spearheaded legislation that was signed into law as HB953, which created a task force on long term care education and planning. Educating Marylanders about long term care planning will help them to avoid having to plan in a crisis and will assist to mitigate the increasing strain the Maryland Medicaid expenditures are placing on the State budget.

Maryland Insurance professionals are already providing education about long term care planning tools including several options in addition to LTC insurance such as: own income and assets, reliance on family and friends, home equality, Veterans benefits, and continuing care retirement communities (CCRCs), as well as education regarding often misunderstood facts about Medicare and Maryland Medicaid. Association members also explain and offer Maryland LTC Partnership policies that can be of great advantage and affordability to middle class Marylanders, not just the upper class and wealthy. According to the latest available NAIC LTC Experience Report (data from end of 2016), there are approximately over 147,000 (traditional model) LTC policies in force in Maryland. No state specific data is available regarding hybrid/combo products. However, it should be noted that the popularity of hybrid models is documented nationally with rapid placement of policies.

Priscilla Campbell, CPA, CFP

Priscilla has been a CPA since 1986 and a CFP since 2013. She has worked in public accounting for over 30 years preparing financial statements and tax returns for businesses and individuals. She has been advising businesses and individuals on tax and retirement issues throughout her career. She currently has her own small accounting and tax practice as well as being a part-time CFO for a small consulting firm. Governor Hogan appointed Priscilla to the task force to fill the slot for MACPA

OVERVIEW of MACPA

The Maryland Association of Certified Public Accountants (MACPA) was founded in 1901 after helping the state of Maryland pass the Certified Public Accountancy Act into law. Today it has over 10,000 members. The general purpose of MACPA is to advocate for CPAs. From the MACPA website:

“We are a “community of success” where CPAs turn to cultivate their professional growth. We exist to help our members **CONNECT** in strategic ways, **PROTECT** their professional interests, and **ACHIEVE** in their careers. In so doing, we also protect the public interest as we uphold the value of CPAs and their commitment to ethical and professional standards”

CPAs are trusted financial advisors whose goals are to help the public -

1. Understand financial information
2. Improve their financial position
3. Comply with current tax laws
4. Plan for future financial needs

The public perception of CPAs is that we prepare tax returns. CPAs do much more than just tax returns. We help business prepare financial statements that will further their

businesses. We advise clients on starting businesses, detection, and prevention of fraud in their companies, business mergers and acquisitions, succession planning and more. For individuals, we help them understand their current financial situation, help them plan for future needs and estate planning.

Many CPAs specialize in specific areas such as tax or audits of financial statements and other areas including elder financial issues. Elder financial issues include planning for retirement, disability (short and long-term), and long term care. By focusing on the needs of seniors, CPAs can help them through the period in their lives that include the time for retirement through end of life.

CPAs work closely with other professionals including attorneys, actuaries, financial planners, insurance providers, brokers, and other business consultants to help clients achieve the goals they desire. It is a joint effort with other trusted advisors to help the public with financial needs throughout the various phases of their lives.

Because CPAs work closely with the financial needs of their clients, they are in a unique position to advocate for long term care family planning. This might be a way to further the agenda of this Task Force. Through MACPA, CPAs should be encouraged to discuss family meetings around long term care planning with their clients.

**Susan A. Coronel, Executive Director, Product Policy
America's Health Insurance Plans (AHIP)**

Susan Coronel has been with AHIP for over twenty years and is currently Executive Director in its Product Policy Division. Susan has found the niche of her interests in Elderly Health Care Issues, specifically Long Term Care Insurance. She is considered one of the leading experts on Long Term Care Insurance market trends in the country. She conducts and supervises research and analyzes the Long Term Care Insurance market regularly. Ms. Coronel is the author of the most recent ten volumes of "Policy & Research Findings on Long Term Care Insurance Market Trends." She staffs the insurance industry's Long Term Care Policy Committee that formulates industry public policy positions on long term care issues.

Ms. Coronel has written numerous articles and is a frequent speaker at various conferences and media events on elderly health care issues. Susan has appeared on CNN and Bloomberg Financial News, been interviewed on numerous radio stations, and quoted in numerous publications, including the Wall Street Journal, Washington Post and Smart Money Magazine. She is continuously designing and administering studies and surveys to keep up with the public pulse and opinion. Governor Hogan appointed Susan to represent an insurance company trade association that includes long term care insurance insurers.

OVERVIEW of AHIP

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services. Through these offerings, AHIP

improves and protects the health and financial security of consumers, families, businesses, communities, and the nation. AHIP is committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

Shaun Eddy, CFP, MSFA, AIF

Shaun Eddy, CFP, MSFA, AIF, representing the Financial Planning Association of Maryland, has over 28 years of experience in financial planning and is past president of the Financial Planning Association of Maryland. The Financial Planning Association of Maryland represents Financial Planners and Consumers in the area of Financial Planning. Long Term Care needs, if unattended, represent a large threat to the success of long term financial planning. As financial planners, it is our goal to help individuals recognize and plan for these needs earlier so that adequate time remains to implement successful planning.

OVERVIEW of FPA-MD

FPA-MD is the professional association of Financial Planners in Maryland. The Financial Planning Association of Maryland is the premier community that develops and supports financial planning professionals and elevates the financial planning profession in Maryland. The Financial Planning Association® (FPA®) is the largest member organization for CFP® professionals in the U.S. and also includes members who support the financial planning process.

Owen T. Gardner, MPH, NHA

Owen T. Gardner has been working in the healthcare industry for over 20 years. He has vast experience in various aspects of healthcare administration, project management, health education as well as Epidemiology.

Mr. Gardner has been a licensed nursing home administrator in the state of Maryland and Commonwealth of Virginia. During his tenure as an administrator he has won various awards for outstanding clinical and financial leadership and was able to help lead his team with two deficiency free federal and state surveys and has won the Delmarva Award for Most Improved Clinical Quality Indicators. He has also been recognized within his organization as one of the top executive directors.

During his career in administration Mr. Gardner has specialized in taking over the operations of troubled nursing facilities and turning them into clinically sound, profitable centers. As an administrator Mr. Gardner prides himself with being blessed to serve in healthcare. Mr. Gardner currently works as the Regional Executive Director of Operations overseeing skilled nursing facilities in Maryland as well as Virginia. He has recently been appointed by the Governor of Maryland to sit on a task force to assist with reshaping the course of LTC in Maryland.

Owen has been an active member of The Health Facilities Association of Maryland (HFAM) for the past 18 years.

OVERVIEW of HFAM

HFAM has been a leader and advocate for Maryland's long term care provider community for more than 60 years. HFAM members provide care for 72% of all Maryland Medicaid long term care beneficiaries.

Joy Hatchette, Associate Commissioner Consumer Education & Advocacy, Maryland Insurance Administration

Joy Hatchette was MIA commissioner Al Redmer's designee to sit on the Task Force.

OVERVIEW of Maryland Insurance Administration (MIA)

The agency's goal is to provide efficient, effective service to both the consumers of insurance products and the insurance industry. The MIA best serves its core constituents by assuring fair treatment of consumers. This consumer protection begins by regulating the availability of insurance coverage at fair prices and extends to issues of solvency and fair sales, claims and settlement practices.

The agency strives to increase public understanding of the vital role insurance plays in the daily lives of Maryland residents and businesses. Insurance is the principal means of managing risks. While it is not possible to eliminate risks arising from poor health, auto accidents, home damage and other unexpected occurrences, you may minimize its impact by purchasing appropriate insurance coverage.

Though the MIA cannot recommend a particular policy or insurance company, we can help Maryland consumers learn what types of coverage are available, at what cost, and assist if there is a complaint about how an insurance company responds to a filed claim.

MIA's commitment to the insurance industry, including agents, brokers, and insurers, is no less than our dedication to consumers. We are, for example, committed to fairness in licensing and to the expeditious review of proposed new products and other filings. A viable, competitive insurance industry is essential to our mission of consumer protection. Our regulatory and enforcement efforts strengthen the environment in which the insurance industry operates in Maryland and we hope they encourage the insurance industry to find more and better ways to protect the residents and businesses of Maryland. Rigorous enforcement of all applicable statutes and regulations fosters a positive economic environment by assuring that those who comply with the law are not disadvantaged by those who evade compliance.

Overview of MIA Responsibilities

- Protect Maryland consumers by regulating the state's insurance companies and producers.
- Investigate complaints consumers have about their insurance coverage, including, but not limited to, life, health, automobile, and homeowners.

- License insurance companies and producers operating in Maryland.
- Conduct financial examinations of insurance companies to ensure solvency.
- Conduct market conduct examinations to ensure compliance with Maryland's insurance laws.
- Investigate acts of insurance fraud.
- Review and approve rates and contract forms.

For additional information about the Maryland Insurance Administration, please visit the Maryland Manual Online:

<https://msa.maryland.gov/msa/mdmanual/00front/html/title.html>

Morris Klein, Esq.

Morris Klein practices law in Maryland and the District of Columbia, concentrating in elder law, special needs law and estate planning. He holds the prestigious title of a “Certified Elder Law Attorney” from the National Elder Law Foundation. Governor Hogan appointed Mr. Klein to represent the MSBA.

Mr. Klein is a member of the Board of Directors of the National Academy of Elder Law Attorneys (NAELA) and co-chair of its Public Policy Steering Committee. He is also a NAELA Fellow and a member of the NAELA Council of Advanced Practitioners. He is a founding member and past president of the Maryland/DC Chapter of NAELA. He is also a member of the Board of Directors of the Special Needs Alliance, a select group of attorneys who advise on special needs issues.

Mr. Klein is named a "Top Lawyer" in elder law by Washingtonian Magazine and a “Super Lawyer” in Maryland and Washington, D.C. He is the co-chair of the Montgomery County Bar Association Elder Law Section. He served twice as the Chair of the Maryland State Bar Association Elder Law Section and continues to serve on its Section Council. He was also a Co-Chair of the Steering Committee of the District of Columbia Bar Estates Trusts and Probate Law Section. He was also on the Board of Directors of the Alzheimer’s Association National Capital Chapter.

OVERVIEW of MSBA and MSBA Elder Law & Disability Rights Section

The Maryland State Bar Association (MSBA) exists to effectively represent Maryland’s lawyers, to provide member services, and to promote professionalism, diversity in the legal profession, access to justice, service to the public and respect for the rule of law.

The MSBA Elder Law & Disability Rights Section brings together MSBA members with a shared interest in elder law; promotes the continuing legal education of the Bar in the field of elder law; sponsors elder law publications for the benefit of the Bar and the public; works on a cooperative basis to improve the law and promote the interest of the public and members of the Bar in elder law; and promotes the delivery of free or reduced-fee legal services to the low-income elderly.

Mark A. Leeds, Director**Long Term Services and Supports, Maryland Department of Health**

Mark Leeds is the Director of Long Term Services and Supports Administration for the Maryland Medicaid Program. Programmatic responsibility encompasses Medicaid policy and regulations for coverage of services in home and community-based settings as well as in institutions. Programs are funded with federal and State funds and are provided for individuals who meet medical, technical, and financial criteria.

OVERVIEW of LTSS for Maryland Medicaid Program

Long Term Services and Supports for Maryland Medicaid Program target individuals over 65, individuals with physical disabilities, individuals with intellectual disabilities, chronically ill children, and individuals eligible for both Medicaid and Medicare (“dual eligible”). Medicaid covers certain services available to these participants based on medical necessity and technical and financial eligibility.

Long Term Services and Supports are provided in home and community-based settings, as well as in institutions. Institutional settings include nursing facilities and intermediate care facilities for individuals with intellectual disabilities. Home and community-based services vary by program and may include, but are not limited to, personal assistance, nursing, nurse monitoring, medical day care, case management, transportation, medical supplies, and medical equipment. Long Term Services and Supports are mostly paid fee-for-service and are not covered by Health Choice managed care organizations.

For the over 42,000 individuals receiving Long Term Services and Supports, Maryland Medicaid is dedicated to providing choice and autonomy in the provision of services. The Centers for Medicare and Medicaid Services recently issued new rules to ensure individuals receiving Long Term Services and Supports have choices regarding their setting, services, and service providers. The rules aim to guarantee rights of privacy, dignity, and respect, by optimizing autonomy and independence in making life choices, and ensuring that participants in home and community-based service programs are able to fully participate in their communities to the extent that they desire and are able.

In service of these goals, Maryland Medicaid has adopted a person-centered planning approach to Long Term Services and Supports administration, which is designed to promote not only optimal health outcomes, but also greater independence and better quality of life for participants. To that end, Medicaid is increasingly moving away from institutional-based care toward home and community-based services.

The Affordable Care Act established the Community First Choice program option to make it easier for Medicaid participants who require institutional-levels of care to receive services in home and community-based settings. Maryland was one of the first states to implement Community First Choice. Under Community First Choice, Maryland is more efficiently managing personal assistance services, and enhancing the means to provide services in the community.

Sally Huff Leimbach, CLU, ChFC, CEBS, LTCP, CLTC

Senior Consultant, Long Term Care Issues and Insurance for TriBridge Partners LLC

Sally has specialized only in LTC issues and LTC insurance for over the last 25 years. For most all of her 39 years as an insurance professional, Sally has been a member of relevant professional organizations which currently include: NAIFA-MD, MAHU, SFSP-Baltimore, Baltimore Estate Planning Council, and SOA-LTCI Section. Since the fall of 2016, she has been a member of the MIA LTCI Workgroup. Also, currently, Sally is the designated reference person on LTC matters for the Joint Legislative Committee (Lobbyist, Bryson Popham), for NAIFA-MD and MAHU. She is the past chair and current member of the NAHU LTCI Working Group. Governor Hogan appointed Sally to the Task Force to fill the slot for NAIFA-MD.

OVERVIEW of NAIFA-MD-see Overview of MAHU and NAIFA-MD under Melissa Barnickel Bio.

Linda Warr, Chief of Long Term Care Services, Maryland Department of Aging

Linda Warr has worked for the Maryland Department of Aging (MDoA) for more than 16 years. She began her career at MDoA in the Housing Services Division, which later became Long Term Services and Supports, as a program specialist and later as the manager for the Older Adults Home and Community-Based Services Waiver and Money Follows the Person Options Counseling (MFP OC) program. In 2014, the Older Adults Waiver program transitioned to the Maryland Department of Health (MDH) and merged with the Living at Home Waiver to become the Community Options Waiver, while the program's case management/supports planning service remained at MDoA. Linda was the administrator for the Area Agencies on Aging Medicaid Supports Planning Service until it transitioned to MDH in 2016. That same year, Linda assumed responsibility for the Veterans Directed Care program. Currently, Linda is the Division Chief of Long Term Services. Her division includes the MFP OC and VDC programs, and Maryland Access Point (MAP), Maryland's Aging and Disability Resources Center. The 20 local MAP sites are designated as Maryland's gateway for individuals to plan, identify, connect, and assist with accessing private and public resources for long term services and supports. The Secretary of MDoA designated Linda as the department's representative on the LTC Education and Planning Task Force.

OVERVIEW of the Maryland Department of Aging

The Maryland Department of Aging (MDoA) helps establish Maryland as an attractive location for all older adults through vibrant communities and supportive services that offer the opportunity to live healthy and meaningful lives. MDoA's vision for all Marylanders is to "Live Well, Age Well".

Maryland's aging population provides multiple opportunities to engage residents and partners towards the collective goal of a high quality of life for older Marylanders in a fiscally responsible manner. Between 2015 and 2030, Maryland's 60+ population is

anticipated to increase by 40%, from 1.2 million to 1.7 million older adults. As advances in health and medicine are allowing citizens to live longer, the need for caregiving and other long-term services and supports will increase dramatically.

Maryland's Aging and Disability Resource Center, Maryland Access Point (MAP), has established itself as a national model integrating multiple human service agencies and serving as the gateway to Medicaid and other community long-term services and supports. Older adults, individuals with disabilities, and their family members can connect to MAP to reach a variety of programs to meet individual needs. The signature Options Counseling planning service provides a proactive, prevention-focused initiative to increase consumer contact with and use of the health and human services network prior to crisis situations.

Level funding at both the state and federal levels requires that MDoA evaluate and develop new solutions to continue providing low cost community based care while increasing the focus on health promotion and disease prevention to avoid costly nursing home institutionalization. New strategies are needed to ensure Baby Boomers have access to health promotion and long-term services and supports to help them remain independent. Partnerships between the Aging Network and health care providers including the development of fee-for-service programs can expand services to the growing population.

MDoA's key goals will continue to direct its efforts to serve the target population through 2020:

- Advocate to ensure the rights of older adults and their families and prevent their abuse, neglect, and exploitation.
- Support and encourage older adults, individuals with disabilities, and their loved ones to easily access and make informed choices about services that support them in their home or community.
- Create opportunities for older adults and their families to lead active and healthy lives.
- Finance and coordinate high quality services that support individuals with long-term needs in a home or community setting.
- Lead efforts to strengthen service delivery and capacity by engaging community partners to increase and leverage resources.

Elizabeth Weglein

Elizabeth Weglein is the CEO of the Elizabeth Cooney Care Network which provides comprehensive and complex home care services throughout Maryland since 1957 contracting with individuals, private and public entities. The Care Network has been providing Trust, Integrity and Excellence as its mission for over 61 years. She represents the third generation female in her family owned and operated home care business. Elizabeth is proud to continue her grandmother's legacy of excellence in caregiving. Elizabeth is the President of the United Seniors of Maryland which is a non-profit umbrella coalition senior advocacy organization representing over 3 million seniors in Maryland. She was appointed as the Governor's Chair of the Maryland Caregivers Support Coordinating Council overseeing all caregiving issues in the state for ten years. She is involved in various other boards and organizations throughout the state and nationally. Her company won two national awards of excellence. Elizabeth was awarded the Brava Award from SmartCEO and The Daily Record Maryland Top 100 Women Award. Elizabeth serves as legislative assigned staff for the Task Force.

OVERVIEW of United Senior of Maryland

USM United Seniors of Maryland is providing administration for the Task Force. USM is a non-profit coalition of individuals and organizations that includes almost three million Marylanders. USM advocates to preserve and to maintain the physical, mental, and financial well-being of Maryland seniors. The senior population in Maryland is expanding rapidly. USM recognizes that we are continuing to operate under competing needs, but we believe that we must ensure that the most vulnerable seniors among us are protected.

Section 7:

**History, Current Status and
Future Prospects of Long
Term Care (LTC) in Maryland**

History, Current Status and Future Prospects of LTC in Maryland

The history of LTC in Maryland has paralleled the evolution of LTC in the United States.

A century ago, it was very much considered a matter for the women of families to address. Family members lived close to one another. If a woman was widowed with children, it was not unusual for an unmarried sister, sister-in-law, aunt, or a female family friend to move-in to assist with child rearing and, in turn, expect family members to take care of them through their aging years. Children were expected to take care of their parents.

The majority of women did not work outside the home and they expected to take care of parents and in-laws as they aged. Life spans were shorter, and the period of needing care prior to death was usually not extended. If someone was seriously ill, they died quickly. In wealthier households, there would have been domestic servants to take on the role of caregiving.

For those without families who were destitute, community or county based, or religious based charitable organizations played a role. Fraternal organizations such as the Masons were known to build facilities and provide services to take care of their own in need. In the 1930's, this responsibility began to shift to the state and federal governments. This encouraged the advent of private, for profit nursing homes in addition to the religious and not-for-profit nursing homes.

In more recent times, people left the farms and their families, and moved to the populated areas. They also lived increasingly longer: average life expectancy 1900 47 yrs., 1925 58 yrs., 1944 66 yrs., 1965 69 yrs., 1990 75 yrs., 2016 78.7 yrs. This resulted in increasing need for non-family assistance to help the aging manage their day-to-day needs, because their children were no longer there to attend to them. The Henry J. Kaiser Foundation published in 2015 a piece giving concise information in time order from 1935-2015, "Long-Term Care in the United States: A Timeline".

<https://kaiserfamilyfoundation.files.wordpress.com/2015/08/8773-long-term-care-in-the-united-states-a-timeline1.pdf>

Nursing homes became acceptable to families as a preferable way for families to address the need for care for their aging member.

A Maryland family example of this is Edna Thompson Huff. Born and raised in Maryland as three generations of her family before her, Edna was a 1906 graduate of Eastern High School in Baltimore, MD. In 1910, Edna married Walter Henry Huff, a 1902 graduate of Baltimore City Collage. They settled in Baltimore to begin their family of two boys. When Walter's mother became an invalid in Philadelphia, PA, Walter arranged a transfer from the Baltimore office of the Adams Express Company to the Philadelphia office and moved his family to Philadelphia so that Edna could take care of her mother-in-law. This Edna did

until her mother-in-law's death. When in 1963 Edna needed care, she was widowed and her bachelor son who lived with her was unable to care for her. Her other son had a thriving business in Baltimore and three children. She was urged to come to Baltimore and live in a brand new private nursing home. When she refused, she was placed in a new private nursing home outside of Philadelphia until her death in 1971. Her son and family visited faithfully as they could. The cost was paid privately from her savings.

While Edna Huff was able to cover the costs of her nursing home from savings, many were not. As the costs of LTC have escalated over time whatever the venue, more and more families have found themselves in crisis - unprepared, trying to address what to do for a family member needing care immediately. With no pre planning, they suddenly are faced with how to meet the needs of the person to receive LTC and how to pay the associated costs.

From 1950 to 1980, America experienced for the first time the elderly population, ages 65 and older, increasing faster than the population as a whole.

On July 30, 1965, President Lyndon B. Johnson signed the Social Security Amendments of 1965 creating both Medicaid and Medicare. Medicare provided federal hospital and medical insurance for persons over age 65, financed through a payroll tax. Medicare did not include coverage for custodial care. Medicaid, administered by states with some variation in financial and medical eligibility requirements, could provide financial assistance for nursing home care only. The intention was to provide a safety net for the poor, after a person no longer had funds to pay for themselves.

The Medicare - Medicaid dichotomy had several unintended consequences. First, financial assistance was determined in part by the disease one had - an open heart surgery received significant subsidization from Medicare, but custodial care necessitated by Alzheimer's disease did not. Second, patients increasingly expected the government to help pay for their health care and assumed Medicare would help with LTC expenses, so there was little interest in planning for LTC. Third, the dichotomy encouraged persons to seek nursing home care, as it was the one venue where Medicaid might help pay for care.

As government assistance was not to be available for LTC until a patient spent all of their assets, the private marketplace for LTC insurance first appeared as nursing home only coverage in the late 1970s. By the 1980's, in response to patients' desire to "age in place," the LTC insurance policies evolved to cover care also given in the home or in the just emerging Assisted Living Facilities. With Assisted Living Facilities came the new concept of a place where one could receive "graduated" care, meaning more or less care (with more or less cost) depending on need.

In the same time period, Medicaid eligibility broadened, allowing Medicaid, beginning in 1981, to pay for care in limited circumstances in "home and community based settings," to exempt a residence from the spend-down, to protect spouses and disabled persons from

impoverishment, and to allow persons with disabilities to hold assets for care needs supplemental to what Medicaid pays. Medicare could pay for skilled nursing home care for a limited number of days for care needed after a hospital discharge.

However, since LTC insurance was relatively new, there was concern among the states that there needed to be more uniformity and consumer protection among the policies and this resulted in the National Association of Insurance Commissioners (NAIC) producing model legislation for states to consider for adoption. The State of Maryland did adopt this NAIC model in the mid 1990's. In fact, all sales of LTC insurance policies were halted in Maryland until an insurance company wanting to sell LTCI in Maryland had refiled policy forms that reflected the NAIC model adopted by Maryland legislature. In 2002, Maryland also adopted a later NAIC model to assist in providing rate stabilization for LTCI policies sold on forms approved after that adoption. This regulation was again strengthened in 2014 as the Maryland legislation adopted an enhanced NAIC model regulation for rate stabilization.

The Health Insurance Portability and Accountability Act (HIPAA) enacted into law in 1996 allowed a taxpayer who purchased LTC insurance to claim a portion of the premium as a medical expense deduction. The law also clarified that most LTC insurance policy payments could be paid out tax-free, if one purchased a "Tax-Qualified" LTC insurance policy as defined in HIPAA. The State of Maryland passed legislation in 2000 allowing up to a \$500 state tax credit for the first year a Maryland resident purchases a tax qualified LTC insurance policy.

The federal Deficit Reduction Act of 2005 (DRA) tightened Medicaid eligibility rules but expanded the availability of Medicaid home and community-based services. Additionally, the DRA included important reforms that allowed states to implement LTC Partnership programs. These state-based programs allow people who purchase an approved LTC insurance policy to keep some of their assets that they otherwise would not be allowed to have and qualify for Medicaid. Maryland has established a LTC Partnership program.

LTC IN MARYLAND TODAY

MORE PEOPLE WILL NEED LTC

In 2016, U.S. life expectancy was 78.7 years (FORTUNE Magazine, Grace Donnelly, 2/02/18). Life expectancy in Maryland in 2016 was 79.2 (The Journal of the American Medical Association, 4/12/18). A recent Daily Record Newspaper article (3/23/18) referred to the "graying of Maryland," saying that by 2030, 25% of Marylanders will be over age 60. The article went on to say that the fastest growing age segment in Maryland is between the ages of 80 and 85.

This increased life expectancy, although generally considered to be a good development, has potential negative consequences including the older one lives, the greater the chance of the need for LTC assistance. According to the Alzheimer's Association, the likelihood of

developing Alzheimer's doubles about every five years after age 65. After age 85, the risk reaches nearly 50 percent. A 2005 study ("Long Term Care over an Uncertain Future: What Can Current Retirees Expect?" by Peter Kemper, Harriett L. Komisar, and Lisa Alecxihit, INQUIRY: The Journal of Health Care Organization, Provision, and Financing, November 1, 2005) estimated that 58% of men and 79% of women aged 65 and older would need long term care at some point, and that average lengths for care were 2.2 years for men and 3.7 years for women. It was also estimated that 38% of men and 63% of women will require care for one year or longer, while 11% of men and 28% of women will need care for at least five years.

LONG TERM CARE IS EXPENSIVE

The Genworth Cost of Care Survey for 2017 (published every year by Genworth Financial, an insurance company), reports the average cost to have paid caregivers to come into the home as \$23 per hour, and \$300 per day for a private nursing facility. In an urban area like D.C., it is about \$350/day for a nursing home, about \$5,000/month for assisted living, and about \$25/hour or \$600/month for 24/7 home care.

FAMILIES ARE ILL PREPARED

As stated above, many families have little or no information about planning for LTC. Moreover, critical decisions are often made at a time of crisis; for example, when the hospital informs a person who was hospitalized after breaking a hip that they are to be discharged within a few days to a nursing home. This often leaves the person and their family in a quandary as to what to do.

Many families, even if they can prepare, can do little about cost. According to a Federal Reserve Report in 2018, forty percent of American adults do not have enough savings to cover a \$400 emergency expense such as an unexpected medical bill, car problem or home repair. More than a quarter of adults skipped necessary medical care last year because they could not afford it. (Source: "The alarming statistics that show the U.S. economy isn't as good as it seems" by Heather Long, Washington Post, May 25, 2018.)

The problem is not going away. By 2060, those 65 and over will make up approximately one quarter of the U.S. population. (SOURCE: Fact Sheet: Aging in the United States. Population Reference Bureau (PFB). popref@pro.org).

OPTIONS FOR CONSIDERATION

1-Use your own income and assets or look to family and friends for assistance.

2-LTC insurance can help if one has the foresight and income to purchase a policy. It cannot be purchased at a time of crisis, or at a time after the applicant has encountered an illness, depending on projected medical outcome. To qualify, usually the applicant must meet medical underwriting standards and can be declined for coverage. Like other insurances

such as health insurance, premiums must be paid for many years, with possible risk of increases along the way.

3- Home equity including Reverse Mortgages for persons over 62 can be used to finance LTC. However, setting up a Reverse Mortgage can be expensive and complicated to initiate.

4-The Veterans Administration can offer modest subsidies (from about \$1,100 to \$2,300/month) for veterans and their spouses.

5-Continuing Care Retirement Communities (CCRCs) can be explored.

6- Medicaid will pay for services and supports if a person meets medical, technical, and financial eligibility criteria which sometimes requires asset spend down. Services are often provided in a nursing home setting. Maryland also provides community long term services and supports to over 20,000 people. However, Maryland has an extensive waiting list for persons with higher incomes to receive home and community based care, or to receive Medicaid coverage for assisted living facilities.

7-Medicare will AT MOST pay for 100 DAYS of services in a nursing facility and only after a 3-day hospital stay. It does not cover community-based LTC services and supports. It MAY pay for home health-care services when medically necessary for a limited period of time for skilled caregiver – usually two or three visits per week.

Aside from finances, providing LTC has additional adverse impact on the population. It has been said that the very backbone of LTC in the United States is unpaid caregivers. A New York Times article in January of 2017 cited that the value is \$470,000 billion dollars annually (New York Times, “Who will Care for the Caregivers,” Dhruv Khullar, 1/19/2017). Currently in Maryland, 771,000 Marylanders are providing unpaid caregiving. The unpaid caregiver suffers emotionally, physically, and financially, especially if they have been forced to take on this new role without forethought. Caregivers become distracted at their jobs, promotions are missed and a “Caregiver Glass Ceiling” settles in. Depression and other adverse health conditions often follow. The lifetime cost to caregivers has now been calculated, including lost and reduced wages, 401ks and pensions, and lost Social Security wages is equal to \$303,880. (“The MetLife Study of Caregiving Costs to Working Caregivers, June 2011”) This does not include out of pocket expenses that can often be more than \$5,000 per year.

Maryland employers also suffer; loss of productivity of distracted or resigned employees and increased healthcare costs of caregiving employees. The National Society of Human Resource Management (SHRM) endorsed as their national project in 2017 education about and support for working caregivers as a part of “The Aging Workforce: Leveraging the Talents of Mature Employees.” It is estimated that the loss to U.S. businesses due to caregiving employees in 2014 reached \$33.6 billion dollars. Of that, \$13.4 billion was due to increased health care costs of the caregiving employees. ((MetLife (2011)) “The MetLife

Study of Caregiving Costs to Caregivers, retrieved (Jan. 2015) The employment workplace is a perfect place for the message about LTC family planning to resonate and employers can implement policies and practices that support, not punish, the working caregivers. According to the 2009/10 U.S. Census, 44.27% of 5.8 million Marylanders are between the ages of 18 and 49, many of whom are employed. Employers can be a significant resource to successfully educate Marylanders about the need to plan for LTC. Not only will this be a tremendous benefit to employees, employers will benefit by having a healthier and more productive workforce.

PROSPECTS FOR FUTURE OF LTC IN MARYLAND

Maryland residents need to be educated that at the present time there is no politically or economically viable State or federal program to cover LTC available as an entitlement. However, a consensus of misunderstanding and confusion by the public does exist. Increasing numbers of families are living the LTC crisis instead of implementing their LTC plan. A plan that could have been devised years before and updated at appropriate periodic times.

Maryland offers many helpful programs and vital information. The State employs many dedicated employees ready to aid Marylanders needing information about services for LTC. Unfortunately, far too many residents are unaware of how to access or who to call. When the crisis comes, there is a “crash course” of piecing together what needs to be done. If there had been a plan, much of the panic would be eliminated and appropriate actions could quickly be set into place, instead of by trial and error.

The debate of whether there can or will be more state and federal monies available to assist families/individuals will continue. However, a joint Public/Private effort by the State of Maryland, legislators, knowledgeable citizens, professional advisors, and organizations, can alleviate the current confusion and misunderstandings by educating Marylanders about the facts. There is no “Silver Bullet” to provide and pay for LTC. There needs to be education followed by planning.

The planning will not be effective unless addressed by family units. If no family, individuals need to seek out those they would look to if they need LTC. This could include friends, their employer, a religious community, or their financial planner, CPA, attorney, and insurance advisor. It could be a State agency such as the Maryland Department of Health, the Department of Human Services, or the Maryland Department of Aging.

Perhaps at some future date there will be assistance for all from state and federal means. However, no informed, responsible person should make their plans or “bank their future” based on something that does not exist now and is not seen as politically or financially viable for the near future.

An important responsibility of the State of Maryland is to be sure residents are informed about what they can expect from the State including for safety, education, infrastructure, and potential health hazards such as smoking, opioids, and alcohol. Maryland also has the responsibility to be sure that by age 50, all Maryland residents are educated about the risk of needing LTC, the private ways to address that risk, and what the Maryland Medicaid system is, how it is funded and who it is intended to serve. This is paramount for residents, so they can avoid crisis LTC planning.

To quote Benjamin Franklin, “If you fail to plan, you are planning to fail.”

Section 8:

LTC Initiatives in Other States

LTC INITIATIVES IN OTHER STATES

INTRODUCTION

Maryland is not unique among states to be exploring education as a basic component for residents to take more personal responsibility for preplanning for LTC for themselves and for others for whom they feel responsibility (family and friends). To date 27 states, going back to 1999 have engaged in a federally introduced model known as “OWN YOUR FUTURE”. Initially, the federal government provided some funding but no longer does. Maryland has tried two previous statewide efforts to raise awareness of the problem and, as a third, has even provided a tax credit incentive to reward Maryland residents for purchasing LTC insurance.

However, Maryland is unique to now be exploring a Public/Private Partnership to provide education to Marylanders about the need for all Marylanders to have a LTC Plan. This “grass roots” effort with the assistance of the State could well result in a model for other states to embrace, as all states are experiencing rapidly aging populations who are living in large numbers to older ages than experienced in the past.

PREVIOUS EFFORTS BY MARYLAND

Maryland participated in the “OWN YOU FUTURE” campaign in 2006. The federally initiated program allowed states to opt in. Twenty-seven states have participated with Minnesota having the longest participation duration. There was great flexibility as to how much time and energy a state wanted to put into the program. Maryland chose to have the then current Governor mail a letter to all Marylanders ages 50 through 70 urging them to NOT assume that Maryland would be able to provide their LTC. Maryland residents were urged to create a LTC plan. A return card was enclosed to request a CD be sent to provide ideas as to how to go about planning. Other states did far more than Maryland. For example, Minnesota to this day has used the “OWN YOUR FUTURE” campaign as the springboard for state initiated programs that continue and evolve into additional initiatives. This includes product development due to the decline in the traditional LTC insurance market.

A second proactive move to provide residents of Maryland with better LTC insurance planning tools was the adoption of the Maryland LTC Partnership program. Allowed under the Deficit Reduction Act of 2005, this program is between the state and private insurance companies. Partnership approved policies protect assets from Medicaid spend down by matching dollar for dollar what policyholders receive from their policies in insurance benefits. Although the MIA did produce an excellent pamphlet explaining Maryland LTC Partnership, unfortunately that has been the only effort by the State to publicize that this potentially attractive LTC planning tool exists. Few Maryland residents, including professional advisors, have heard of LTC Partnership policies. The MIA pamphlet is now in

need of updating and can only be obtained on line, due to budget constraints. The link is here...

<http://insurance.maryland.gov/Consumer/Documents/publications/longtermcare.pdf>

A third effort became effective on 7/01/2000. Maryland began to allow a one-time state tax credit of up to \$500 for tax-qualified LTC insurance policy for insureds that are the following: self, spouse, parent, stepparent, child or stepchild and a resident of Maryland and not covered by LTC before 7/1/2000 and not claimed the credit for the insured by another tax payer year of purchase, nor any other year. At the time, the action was applauded, but not widely publicized. In fact, it was barely publicized at all. In retrospect, there is no evidence that the tax credit did anything to increase the purchase of LTC insurance policies. Other states have had similar tax incentives and none of them have seen an increased call to purchase as a result. It is often stated that tax credits for purchasing LTC insurance are a “reward” and not an incentive.

All three of the above examples point out that the State has made moves to recognize that Maryland, like the rest of the United States, has an oncoming LTC crisis, but failed to clearly communicate to residents why the actions were initiated and how they could assist Marylanders. Nor has the State looked to the private sector for assistance as a joint effort.

WHAT OTHER STATES ARE CURRENTLY DOING TO RAISE AWARENESS AMONG RESIDENTS

HAWAII-Enacted the “Kupuna Caregivers Act” in 2016. Kupuna is a Hawaiian word that can be interpreted to mean revered or respected when referring to senior citizens. It made Hawaii the first state to enact a program that was intended to provide money to caregivers who work full time (30 hours or more per week). Hawaii has 154,000 unpaid caregivers. There is reference to \$600,000 being available at the startup of the program which was 7/2017. However, no follow up information was found to determine what the current status of funding and participation is. The law directed “the Executive Office on Aging to establish caregivers’ program “to assist community members in obtaining care for elders while remaining in the workforce”. The funding portion of the law allowed “wiggle room” for **not** funding by the legislature with Department on Aging funds if not available and to receive funds from other agencies “that may be available”. It is suspected that, to date, funding has not been available to go forward with the intent of the law.

MAINE-Ballot question for upcoming November 2018 election to fund the “Act to establish Universal Home Care for Seniors and Persons with Disabilities” initiative. Annual amount to be raised is \$350,000 by 3.8% employee tax on portion of income above amount subject to Social Security tax and employer tax of 1.9 % on the same amount (\$128,000, 2018). Some discussion regarding constitutionality has emerged.

MICHIGAN-HB (4674) 5/30/1017 introduced to have the Michigan Department of Health and Human Services contract for a feasibility study and actuarial model of public, private, and public-private hybrid options to help individuals prepare for, access, and afford long

term services and supports (LTSS) that they need. The original request was for the State of Michigan to fund \$200,000 of the effort with expectations that advocates raise the same amount from private and philanthropic sources. However, the final version reduced state funding to \$100,000. As of 6/26/18, nothing has yet gone forward.

Please note in comparison, that the Task Force recommendations in this report are not asking for any such amounts and expect outcomes that are expected to be favorable to both Maryland residents and the State in a relatively short period of time.

MINNESOTA-Has been most proactive since the “OWN YOUR FUTURE” campaign in 2006. The State has continued the initiative to educate residents about LTC and about the need for families to plan for LTC. October of 2017, the Minnesota Office on Aging released “Policy Brief: Caregiving”. Highlights of the report include the intent for Minnesota to continue to:

- 1- “Educate family and friend caregivers about LTSS options in effort to divert/delay use of assisted living and facility based care.”
- 2- “Train caregiver consultants to assist family and friends with finding and using various technologies to assist caregiving.”
- 3- “Raise employer awareness of caregiving and older workers.”
- 4- “Establish measurable outcomes for programs to document return on investment (ROI) for caregiving support systems.”

Beginning in 7/2019, Minnesota will offer “self-directed budgets for family and friends of certain individuals in the RTC (Return to Community) program to test new ways of support to family and friend caregivers.”

Minnesota stresses that in providing “Central Access Points” where caregivers and seniors can access information from a “trusted central resource that serves as a visible place for understanding aging in place services”, both the residents and the State benefit.

Minnesota received two prestigious national recognitions this year for the outstanding efforts and successes in supporting residents of Minnesota in the areas of LTC education, access to valuable information to use in planning and access to services: Harvard’s Ash Center Bright Ideas Innovation in American Government and the SCAN Foundation Pacesetter Prize for Support of Family Caregivers.

In accepting the SCAN award on October 6, 2017, the Minnesota spokesperson, Emily Piper, Human Services Commissioner, said that the program supporting unpaid caregivers are important to the persons needing care and also the State budget.....” saving Minnesota alone an estimated at \$7.9 billion per year. That is more than Minnesota’s annual Medicaid costs for nursing homes and other long term services and supports.”

Minnesota is now working with consultants to develop a life insurance product that at age 65 turns into benefits for LTC, mirroring an effort funded by the Society of Actuaries to model something similar. Minnesota is also looking at a possible expansion of home care to be provided in Medigap policies, which also has seen comparable work by the Bipartisan Policy Center and the Commonwealth Fund. This addition to supplemental products would include Medicare Advantage plans which have recently been given permission by CMS programs beginning in 2019 (most observers do not believe there will be significant activity in this area until 2020).

NEBRASKA-Tried a unique savings plan intended to encourage Nebraskans to plan for LTC. Created by legislature in 2006, the program ended 1/01/18 due to low participation. Cited as a major factor, was lack of information to the public that such an option even existed.

RHODE ISLAND-Rhode Island Jobs with Justice (Labor Union) has launched (9/2017) a coalition to enact RhodyCare to address universal family care needs by expanding access to child and eldercare and disabled for all those working. No legislation has yet been filed.

WASHINGTON STATE-Has explored the financial impact of a mandatory front-end program funded through small employer paid payroll tax. The benefit would allow up to \$100 per day to working caregivers for up to one year. The effort is to avoid or delay the need for more intensive Medicaid-funded services. The State has hired the actuarial firm, Milliman and other consultants to assist. To date, the effort has included stakeholder interviews and actual modeling and Washington State industry has informally supported. However, the process was slowed by AARP questions as to the definition of the caregivers to receive the benefits not being sufficiently defined. The program is under the auspices of Washington State Department of Social and Health Services who developed “a new state eligibility category and benefit for people “at risk” of needing future Medicaid Long Term Services and Supports”. The program started as a five year pilot. If program shows effectiveness and cost savings results by the end of 2021, the Washington model could become a model for other states. Washington State is receiving \$180 million of federal funds to set up and test the program until 2021.

CONCLUSION

It is important for Maryland to continue to follow the efforts and outcome of these initiatives by other states. Although the professionals in LTC needs and services at the state and private levels are aware of the growing crisis of LTC for citizens and the burden that this puts on their states, it is not clear that the citizens are educated as to how to assist themselves and therefore their states. Education of residents about options and planning is not the answer, but an important and cost effective first step for Maryland. Other states are now watching Maryland as we watch them. One thing that will certainly resonate is the economical way Maryland is pursuing a sound foundation on which to perhaps build other,

more costly efforts. Other states are proposing new taxes, some on businesses while others on the wealthier residents.

If initial recommendations as found in this report are implemented and results analyzed, Maryland will have a much clearer idea as to the most cost efficient, least complicated, and effective path to follow for maximum desired results. Time is of the essence as the aging process stops for no one.

Section 9:

Risks of Not Planning for Long Term Care (LTC)

RISKS OF NOT PLANNING FOR LONG TERM CARE

Many people underestimate their likelihood of needing LTC and how much that care will cost. The prospect of becoming disabled and needing LTC may well be the most daunting risk that Maryland seniors face today. According to the U.S. Department of Health and Human Services, over half of all 65-year-olds will need substantial amounts of LTC at some point in life, and about 15 percent of people who do, could need care for more than 5 years, (<https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>). Although older people use most LTC services, a young or middle aged person who has been in an accident or suffered a debilitating disease may also need LTC. In fact, 40 percent of people receiving LTC are between the ages of 18-64, (National Clearinghouse for Long-Term Care Information, www.longtermcare.gov).

LTC is a range of services that people may need to meet their personal care, including eating to dressing to bathing to moving from one place to another. It can be the result of a chronic illness or disability that leaves them unable to care for themselves for an extended period of time.

LTC is often the largest financial risk for the elderly and their families. In Maryland, median cost of care in a nursing home is over \$109,000 per year in 2017. The median cost of care in an assisted living facility is \$49,800 a year, and over \$50,000 a year for home health aides, (<https://www.genworth.com/aging-and-you/finances/cost-of-care.html>).

According to an AHIP report (<https://www.ahip.org/who-buys-long-term-care-insurance/>), people underestimate the cost of LTC services. About 3 in 5 underestimates how much nursing home care costs. People age 50 and over guessed nursing home stays in their community cost 27 percent less than the actual average cost.

In addition, not only do individuals underestimate the costs of LTC, but they also mistakenly believe these costs are covered by the government through Medicare, Medicaid or by their private health insurance.

Generally, Medicare does not cover LTC. People over 65 and some younger people with disabilities have health coverage through the federal Medicare program. Medicare pays for not more than 100 days of short-term skilled nursing home care following a minimum of a 3-day hospitalization. Medicare also pays for some skilled at-home care, but only for short-term unstable medical conditions and not for the ongoing assistance that many elders or injured people need.

Medicaid covers LTC but is intended for Americans who have exhausted their resources, until they reach the level allowed by Medicaid to apply. One can qualify for Medicaid to pay for LTC, but only by giving up financial independence and accumulated assets. Medicaid qualification also requires meeting stringent levels of disability that states are

able to change. In addition, people who go on Medicaid may have limited care choices—some nursing homes and many assisted living facilities, do not accept Medicaid patients or limit the number, so a person might not be able to enter the facility of their choice. Access to Medicaid home and community-based waiver services is limited, so a nursing home may be the only option for many people needing care. However, Maryland is one of the few states that have implemented the Community First Choice option as a State Plan entitlement, which has greatly enhanced access to home care for Medicaid-enrolled individuals.

Private health insurance usually does not cover LTC services. Many people mistakenly believe that the health insurance they have either on their own or through their employer covers LTC services. Health insurance helps pay doctor and hospital bills if one gets sick or injured. It does not protect against the significant financial risk posed by the potential need for LTC services in one's home, community, assisted living, or in a nursing home.

For the most part, people who need LTC services pay the bills, and/or have assistance from family for financial and care needs. Planning for this health and financial risk requires considering different options.

For those with very limited income and assets, Medicaid may be the only option. However, for the vast majority of Marylanders who are able to plan ahead, various options are available and need to be considered. Consulting with a trusted financial advisor and family members is an important step to take. LTC insurance is an option for protection against the financial risk posed by the potential need for LTC services. Using savings or investments to cover the cost of LTC should also be considered. Perhaps assistance from family and friends will be a part of the plan. These and additional options are discussed also in Section 7 of this report.

Keep in mind that males need LTC for an average of 2 ½ years and females for over three years. With average nursing home costs at \$109,000 per year, that translates to needing to have current savings of over \$270,000 for 2 1/2 years of care. When saving for future expenses, one must keep INFLATION in mind. Current costs for care will be more than double in 20-25 years.

Regardless of the option one chooses, it is paramount to plan for your family's LTC needs. Given the likelihood and costs associated with LTC, not planning is too great a risk.

Section 10:

**National Association of
Insurance Commissioners
(NAIC) Activities to Assist
States with Financing LTC**

NAIC ACTIVITIES TO ASSIST STATES WITH FINANCING LONG TERM CARE INNOVATIONS (B) SUBGROUP:

INTRODUCTION

As part of the NAIC's Retirement Security Initiative and ongoing focus on LTC insurance issues, the NAIC's Long Term Care Innovations (B) Subgroup ("the Subgroup") held 14 open calls and meetings during 2015 and 2016, and continues such outreach, to gain insights from stakeholders on various approaches to financing LTC. The goal of this work is to identify and develop actionable, realistic policy options for consideration by state regulators, state legislators, the NAIC as a body, federal agencies, and Congress, that could increase the number of affordable asset protection product options available for middle-income Americans, potentially paving the way for the private market to play a more meaningful role in financing the LTC needs of our society.

Broadly speaking, some of the issues and questions the subgroup examined include the role for the private market in assisting people in financing their LTC needs; the steps that could be taken to encourage more participation by insurance companies or other innovators in this market; the future design of LTC insurance (LTCI) products; other asset protection products and the role they can and do play in financing LTC; the types of products most appealing to consumers; the types of products insurance companies would be interested in selling; the role employers should play in terms of offering products to assist in financing LTC services; the legal and regulatory barriers that may need to be overcome and any federal or state actions that could be taken to increase the number of options available to consumers to help them finance their potential LTC needs.

Although the focus of the Subgroup is on the private LTC insurance market, it is important to understand that no one is suggesting that private LTC insurance is the answer to the problem of how we as a society are going to finance the LTC needs of our citizens. We still expect Medicaid LTC costs to continue growing and recognize that many of the solutions being discussed by the Subgroup will not fully address long duration LTC needs. But, we believe the private market can be part of the solution.

The following is a list of federal policy changes compiled in June 2016 that have been raised by various stakeholders, submitted to all Subgroup members for a 30-day comment period, vetted in the Subgroup during a 2-hour open conference call and reviewed by NAIC staff. The Subgroup believes these federal policy changes could help to increase private LTC financing options for consumers. Ultimately, any final recommendations to the federal government will need to be approved by the NAIC's Government Relations Leadership Council. The federal laws primarily identified by stakeholders that would require changes include the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Deficit Reduction Act of 2005 (DRA).

Federal Policy Options to Present to Congress (released in April 2017)

- **Option 1: Permit retirement plan participants to make a distribution from 401(k), 403(b) or Individual Retirement Account (IRA) to purchase LTCI with no early withdrawal tax penalty.** Related considerations include whether premium payments should be made directly from the retirement plan to the insurer; allowing purchase of combination or hybrid products as well as traditional LTCI; whether premium payments would be counted for purposes of satisfying the minimum distribution requirements; and permitting tax-favored contributions and distributions to pay for LTC services and supports or LTC insurance including allowances of LTCI as a plan investment.
- **Option 2: Allow Creation of LTC Savings Accounts, similar to Health Savings Accounts (HSAs) and/or Enhance Use of HSAs for LTC Expenses and Premiums.** HSAs are tax-advantaged medical savings accounts available to taxpayers who are enrolled in a high-deductible health plan (HDHP). The funds contributed to an account are not subject to federal income tax at the time of deposit. Advantages of HSAs include: 1) the account is tax-advantaged, meaning that money goes into the account before tax, thereby incenting savings; 2) the funds roll over from one year to the next; 3) the money can be invested in order to gain returns from stocks or other financial instruments, which helps the account grow more quickly; and 4) money withdrawn (including any investment growth) for approved expenses (which include LTCI premiums under current law) is tax-free. Consideration should be given to stand-alone accounts which could be used for LTC expenses and LTCI premiums. Such accounts should not be conditioned upon having a HDHP, since health insurance coverage generally does not cover LTC costs. Consideration also should be given to enhancing use of HSAs such as allowing an additional contribution (similar to a “catch-up contribution”) to HSAs for owners of LTCI.
- **Option 3: Remove the HIPAA requirement to offer 5% compound inflation with LTCI policies and remove the requirement that DRA Partnership policies include inflation protection and allow the States to determine the percentage of inflation protection.** In an LTCI policy with inflation protection, the LTC benefit increases each year at a specified rate; the aim of inflation protection is to ensure that the value of the benefit keeps up with inflation. Inflation protection substantially increases LTCI premiums. For tax-qualified policies and those governed by the NAIC Model Regulation, a 5% inflation protection option must be offered, although a purchaser may choose not to take it. However, if the purchaser is under 75, they must accept inflation protection in order for the policy to be Partnership qualified. For group coverage, this option must be offered to the group policyholder (usually an employer), but it is not generally required that it be offered to each individual group member, although some states require this as well. Removal of the requirement that insurers offer 5% compound inflation with LTCI policies and the

requirement that Partnership policies include inflation protection would increase insurer flexibility when designing products and could lead to lower premium costs. At the same time, consideration should be given to requiring an offering of some type of inflation protection to ensure consumers continue to have the option to protect themselves against increasing LTC costs. [Note: this would require both federal changes, changes to the NAIC models, and adoption of revised NAIC models by states.]

- **Option 4: Allow flexible premium structures and/or cash value beyond return of premium (HIPAA and DRA).** Flexible premium policies with clear consumer disclosures and protections built in could increase consumer choice and flexibility by allowing prefunding for LTC needs under a variety of premium payment patterns. Cash value or cash surrender value is the amount of money the insurance company pays a policyholder or beneficiary when they terminate a life insurance policy or annuity contract that has a cash value feature. Federal law (HIPAA) prohibits tax qualified LTCI policies (but not hybrid products) from containing a cash value feature. Prohibiting cash value creates a “use it or lose it” design for LTCI, because a policyholder only receives a benefit from their policy if they need LTC services. [Note: some flexible premiums structures may be permissible under current federal law, but they are limited by the prohibition on cash value.]
- **Option 5: Allow products that combine LTC coverage with various insurance products (including products that “morph” into LTCI).** Many stakeholders emphasized the need for regulatory changes at the federal level to allow for LTCI innovation and market expansion. One consistent view of stakeholders is the need to expand products that can address a consumer’s needs over time. Products that offer life, disability, critical illness, supplemental, and other benefits could be allowed in various combinations with or for conversion to LTCI, such as after the policyholder reaches a certain age. Legislative changes specifically allowing this type of product would be required for pertinent federal tax and NAIC governing documents.
- **Option 6: Support innovation by improving alignment between federal law and NAIC models (HIPAA and DRA).** HIPAA and the DRA require that LTC policies comply with specific provisions of outdated versions of the NAIC model act and regulation. The NAIC regularly updates its models, and this may result in confusion as the NAIC models evolve while federal law continues to reference old models. Therefore, it may make sense for federal law to reference and require compliance with pertinent provisions of the “current” version of the NAIC model for newly issued contracts (with appropriate transition rules to address model amendments) rather than require compliance with specific provisions of a specific version of the model. This would allow federal law to evolve as the NAIC, a collaborative body with active involvement of consumer and industry representatives, updates the models as needed. This would increase the flexibility of federal law to adapt to

the evolving LTC market and regulatory requirements and reduce confusion and possible inconsistencies between state and federal law.

- **Option 7: Create a more appropriate regulatory environment for Group LTCI and worksite coverage (HIPAA and DRA).** Ideas for consideration could include addressing concerns that may prevent an employer from providing LTCI on an opt-out basis by a) providing a safe harbor to limit the employer's fiduciary liability and b) allowing an employer to offer expanded "catch-up" contributions; and/or permitting LTCI to be available for purchase through cafeteria plans.
- **Option 8: Establish more generous federal tax incentives.** Ideas for consideration include allowing a full federal tax deduction for LTCI premiums (rather than for expenses over 7.5-10% of Adjusted Gross Income) each year an LTCI policy is in force and/or allowing purchases of LTCI under cafeteria plans and from FSAs (consideration may be given to whether tax incentives should be income-based or means tested to focus on lower and middle-income Americans who may not otherwise purchase a LTCI policy); and/or allowing shorter maximum benefit plans (<1 year) to be tax qualified to incent market expansion through lower-priced, shorter duration products.
- **Option 9: Explore adding a home care benefit to Medicare or Medicare Supplement and/or Medicare Advantage plans.** Medicare provides extensive acute care coverage but more limited post-acute coverage (home health and skilled nursing facility care). Medicare Advantage and Medigap plans fill the gaps in Medicare. But most LTC services are not covered by Medicare, leaving a considerable gap in coverage for post-acute care. The most comprehensive Medicare Advantage and Medigap plans do not cover LTC services, other than the daily Medicare co-payment for the 21st to 100th day of Medicare covered skilled care; they do not cover intermediate care, assisted living, Alzheimer's, custodial or adult day care. Medigap and Medicare Advantage plans only supplement Medicare covered nursing home care on a temporary basis and help with hospice coverage. There has been discussion of adding either something akin to a LTC benefit or, less extensive, new home and community based benefits either to Medicare (which would affect supplemental carriers) or to Medicare Advantage and/or Medigap plans. If new benefits were provided in supplemental coverage it could make those products more expensive, though that increased cost might be offset by savings from delaying or preventing the use of more expensive institutional care. [Note: this would require federal changes to Medicare, changes to the NAIC models governing Medigap benefits, and adoption of revised NAIC models by states.]
- **Option 10: Federal education campaign around retirement security and the importance of planning for potential LTC needs.** The federal government could provide funding and partner with states to provide education to consumers about retirement security. Such a campaign would focus on encouraging people to think about their future retirement and

LTC needs and provide education on the array of private products available to help finance these costs.

Section 11:

Recommendations

RECOMMENDATIONS

INTRODUCTION

The Task Force through a journey of many months absorbing education and pondering issues resulting in ever increasing knowledge and awareness, submits the following 10 Recommendations. They are presented here in a deliberate order to assist the reader to comprehend how one recommendation builds on the next. However, implementation can take an order different than presented here. Please also consider that the implementation of several of the recommendations can happen simultaneously. Recommendations 1-5 are seen by the Task Force as Phase One. Recommendations 6-10 are being called Phase Two. Recommendation 6 can be seen as a part of both Phases.

The Task Force recognizes that time is of the essence for implementation. The Task Force also recognizes that the State of Maryland, with limited resources and overwhelming directions calling for attention, must prioritize for the best results for the citizens of Maryland. Addressing the ever increasing needs of residents to prepare themselves and their families for the risk of needing LTC has reached paramount proportions. The projected increases for the Maryland Medicaid budget are known. "Kicking the can down the road" can no longer be considered a responsible option for the State of Maryland to take.

In reviewing the following recommendations, do know that the Task Force welcomes new ideas for recommendations and/or modification of these 10 Recommendations.

RECOMMENDATION #1

Execute Surveys to Measure Level of Knowledge Marylanders Have on LTC

For the State of Maryland to successfully implement an educational program of any nature, it is paramount that the State understands what level of knowledge exists before the program is begun. The accepted method to do this is by survey. A survey can be tailored to the task and the Task Force has identified necessary parameters to address in a survey to ascertain the level of knowledge that Marylanders under age 51 currently have about LTC risk, ways to address that risk using tools from the private sector, and the understanding of the Maryland Medicaid program. It is important the initial survey be undertaken to be followed at periodic times with follow up surveys to assess the effectiveness of the educational program and establish benchmarks. This allows an established program to be appropriately modified without delay to be able to move effectively and efficiently toward the ultimate goal of having all Marylanders by age 50 have the knowledge as mandated in (HB) 953. It is also the only way to be able to measure ROI (return on investment) of effort and money invested.

The Task Force Recommendations #2 and #3 described in the next recommendation sections, include reaching out to two initial target groups to achieve the goal: 1- education of high school students through already established Maryland State Standards for Personal Financial Literacy Education, Financial Literacy Standards and 2- working through private Maryland employers and the State of Maryland to reach Maryland employees.

The initial survey mechanism being recommended is to reach Maryland residents employed by Maryland businesses. The survey will be geared to include four distinct regions of Maryland identified as: 1-Eastern Shore 2-Western Maryland 3-Southern Maryland 4-Central Maryland. This will provide a credible cross section of Maryland residents in the most time and cost efficient manner.

The survey will recognize all size employers and be available in more than just the English Language. The survey is user friendly to employers as they have no in-house work to do regarding the survey, but to be supportive of the effort by Maryland in urging any of their employees who do receive the random survey, to promptly complete and return it as instructed. To minimize disruption to State of Maryland Departments, it is suggested that at least the initial survey be managed by a private firm experienced in this type of survey. It is recommended that a credible survey can be accomplished by surveying 750-1000 Maryland residents employed by Maryland businesses. One thousand can reflect approximately a 5% sample of the Maryland population, and the survey will be targeted to reach ages 18-50. A professional in the survey field has advised that this will provide a 95% degree of confidence and that it is not difficult to be able to identify this specific "pool" to be surveyed. The timeline for a survey as needed for this effort is relatively short; three months from beginning to final presentation. The two most unpredictable aspects of a survey for this purpose are; 1-going through the vendor selection process and 2-having

available for the process the appropriate State of Maryland representatives. This includes, after vendor selection, the need to meet with the selected vendor and sign off on research objectives and subsets of information expected to be included in the final report. The three month timeline for this process is as follows: Month 1- Define research objectives, design survey questionnaire, review and finalize survey form and sample specifics. Month 2- Program survey and test for predictable results accuracy, conduct survey (7 to 14 days), scrub data, ready data files to be delivered to analyzer. Month 3-Prepare data files for analysis, conduct analytics, write report, and present findings.

FUNDING FOR THE SURVEY

The cost for an initial baseline survey for a project such as this can range from \$22,000 to \$65,000. It is expected that a credible vendor can be found to do the project for a fee in the neighborhood of \$22,000-\$27,000. The Task Force is optimistic that if necessary a private source can be found to fund this critical, pioneer foundation of this vital educational effort that is crucial to the welfare of Maryland residents and the State.

Periodic surveys recommended to follow, although most important to measure success, are expected to be much less costly.

RECOMMENDATIONS #2 & #3

Recommendations for Initial Target Groups to Receive Education

Educating all Marylanders so that none will reach age 50 without having been educated as directed by (HB) 953, is a tall order! The Task Force realized this at the first meeting. To understand realities and options, guest speakers have presented to the Task Force on a variety of subjects. This has led to the recommendation that the State of Maryland during the first phase, focus on two segments of Marylanders that are more easily defined and offer established structures for the education to happen:

- 1- High School students
- 2- Employees of Maryland employers who are residents of Maryland.

RECOMMENDATION #2

Target Maryland High School Students to Educate on LTC Issues and Structure a Plan To Implement LTC Education of Maryland High School Students

Dating back to 2008, Maryland has initiated legislation and programs that are geared to ensure that Maryland students are educated about Financial Literacy. Senate Bill 533(Chapter 186) and House Bill 1242 (Chapter 187) resulted in legislation creating the “Task Force to Study How to Improve Financial Literacy in the State”. The State Board of Education accepted the Task Force’s report. As a result, for grades K-12, the Maryland State Department of Education established Financial Literacy Standards. Financial Literacy is defined as “the ability to use knowledge and skills to manage financial resources effectively for a lifetime of financial well-being”.

The State Standards were adopted into COMAR by the Maryland State Board of Education in 2010 and became effective September 2011. Although the regulation “requires that each local school systemprovide an instructional program in personal Financial Literacy (K-12), it is up to each local school system to determine how it is done” (The Maryland State Standards for Personal Financial Literacy Education, 2016, provided by Patrick A. Fleming, Director of Education, Policy and Government Relations, Maryland Dept. of Education). While there is no stand-alone graduation requirement, local school boards can decide to include financial literacy as a local graduation requirement, or not.

As recently as the 2018 MD legislative session, Delegate Walker, House Ways and Means Committee introduced legislation to require that the State Board of Education develop

curriculum content for a semester-long course in Financial Literacy and make it a requirement for graduation by all high schools in MD. The bill Adjourned Sine Die.

As of January 2018, seven MD counties have chosen to write their own curriculum and also require at least a one semester course as a requirement for graduation. Three of the seven require a two semester requirement for graduation. These seven counties are Alleghany (1), Calvert (1), Caroline (2), Carroll (1), Charles (2) Frederick (1) and Garrett (2).

In reviewing the State Standards, the Task Force found six categories of standards. In Standards 6, Manage Risk and Preserve Wealth, types of risk are taught and the appropriate insurance types to protect against that risk associating with Life cycle. In fact, in the definition section describing major types of insurance, LTC is included and defined. What is actually taught under this concept is not provided by the Standards but determined by the local school boards. The school boards must sign off periodically that they are adhering to State Standards. As quoted from The Maryland State Standards for Personal Financial Literacy Education (page 7), “State Standards define what students should know and be able to do in each grade band”.

The Task Force recommends that the Standards be broadened to include more than just the mention of LTC in the glossary (page7) when defining major types of insurance. In addition, include knowledge that can be expanded under risk management and/or Financial Planning, Family Risk Management (Standard 6). The lack of family planning for LTC leaves not just the person needing care at financial risk, but also the working family members who must now arrange, finance, or actually provide care. This, in turn, affects the State of Maryland if the family must look for assistance from the Medicaid system.

A second recommendation regarding educating high schoolers is to look to one or all of the seven counties that already have a Financial Literacy course requirement, to suggest implementing a pilot program to include the need for LTC Planning for all families. It is recognized that students must see relevance to learn and retain knowledge. At the high school age, perhaps a 15 minute video is all that is necessary, introducing vocabulary and concepts using a real life situation or situations. Maryland teachers are hardworking and dedicated. The Task Force does not want to add to burdens but instead provide an easy but effective way to not have LTC be a “foreign language” to any Maryland high school graduate.

Therefore, it is recommended that as a Public/Private effort, the Maryland Public School System, perhaps with assistance of funds from the private sector to produce a short educational film or a computer oriented learning module, could update State Standards. For local systems, their Financial Literacy curriculum could be updated to include the importance of family planning for LTC. This will go a long way to meeting the goal to educate Maryland high school students about this important issue that is or will be affecting their families.

RECOMMENDATION #3

Target Employees Who Are Maryland Residents to Educate on LTC Issues and Structure a Plan to Implement LTC Education of Employees of Private and Public Maryland Employers

Employers have obligations/mandates to educate their employees about many federal and state rules and regulations. Most of these are to protect employees' rights under federal and state laws. This means that employers are accustomed to disseminating information to their employees in an effective fashion. Even small businesses have a designated person or persons to provide all things that are related to Human Resources. Larger companies have dedicated departments to do this.

Employees at a business entity today usually range in age from 18 to over age 65. Since HB 953 dictates finding a way to educate all Maryland residents by the age of 50 regarding LTC and Maryland Medicaid, the employee population is an ideal first phase target, recommended by the Task Force. After a survey has been completed (Recommendation #1) and using the Maryland employee population as an initial target group, a Starter Kit, titled "PLAN NOW Starter Kit" described in Recommendation #4 of this report, will be finalized, and prepared for distribution to all employers in Maryland. The State of Maryland will inform employers of the purpose of the "PLAN NOW Starter Kit" and suggest ways for it to be distributed to employees. Efforts of outreach will also have been made to the Maryland professional organizations for Human Resource professionals (SHRM and IFCEBS). This outreach is to make them aware of the purpose and suggested ways to introduce "PLAN NOW Starter Kit" to their organization members, who in turn can assist their companies in implementing with employees.

PLAN NOW Starter Kit should not come as a surprise to employees as it is recommended that there will be media information released by both the Public and Private sectors before release of the kits. This will be another Public/Private effort to have Maryland residents know that the message is unified and the same. **FAMILIES MUST PLAN for LTC NOW.**

The kits will contain information as to where Marylanders can go to obtain information from State sources such as websites for MAP (Maryland Access Point) and MHCC (Maryland Health Care Commission) described in Recommendation #5 of this report. However, this is not a one shot deal. Every new Maryland resident employee will at time of employee orientation, receive a copy of "PLAN NOW Starter Kit". The employer person responsible to give out this information will also ask if that employee and their family have a plan. If not, the HR acting person can point out how the kit will be helpful and why it is important to initiate a plan.

Targeting Maryland employees through their employers is another cost efficient way to work toward achieving the goal of HB 953 as quickly as possible.

Reaching Employees of the State of Maryland

Likewise, all employees of the State of Maryland will receive a “PLAN NOW Starter Kit” and then new employees during employee orientation. Additionally, The State of Maryland has a well-established program that can provide education regarding the importance of LTC family planning; “State of Maryland Pre-Retirement Planning Program.” This program is offered through the Community College of Baltimore County, Center for Retirement Education. As portions of the 80,000 State employees come within 10 years of retirement, they are invited (urged) to attend this program. However, as the program is currently written, only one paragraph of Chapter III, Financial Planning-Other Sources of Income (page IIIiii-28) is devoted to LTC. That paragraph does say that “All retirees with \$50,000 or more of assets should consider Long Term Care (LTC) Planning”. The paragraph goes on to say, “Everyone needs a LTC plan, but not everyone needs to buy LTC insurance policy.” If this information is expanded to include “PLAN NOW Starter Kit”, all Maryland pre-retirees will be much better prepared and have the tools they need to customize plans for their families. The employees will have previously received the kit. However, now the message is reinforced by the course instructor and if questions are asked, they can be immediately addressed.

Reaching Maryland Residents Who Are Federal Employees

The Task Force is still exploring how best to reach the Maryland residents that are federal employees. One avenue would be working with, National Association of Active and Retired Federal Employees (NARFE).

RECOMMENDATION #4

Develop and Distribute PLAN NOW Starter Kit

PLAN NOW Starter Kit is an educational piece developed by the Task Force to serve as THE PIECE Maryland Residents will receive to assist them with their LTC family planning. A “mock up” of this piece is included beginning on the next page.

This pamphlet is envisioned as approximately 6” by 6” with the title “PLAN NOW Starter Kit” on the front cover and will be able to be accessed in hard copy or on line. It will be available in at least two languages (English and Spanish) and more if there is need. There are nine pages, or five pages, front to back printing. These pages first introduce the purpose, importance, and uniqueness of the Public/Private effort. Included will be information about how to do successful family planning for LTC with areas to be filled in for customization. The final version of the pamphlet will also include websites and phone numbers for Public and Private Organizations to contact for assistance.

The State of Minnesota, currently ranked #1 by the AARP SCORE biannual program judging LTC success by states in several different categories, uses a similar pamphlet in their “Own Your Future” campaign. This Task Force has modified from Minnesota (and with thanks to Minnesota), a piece titled for use in Maryland, “PLAN NOW: Guidelines to Assist Long Term Care Planning”, that will allow customization by each family.

As explained in Recommendation #3, Maryland employees will receive access to “PLAN NOW Starter Kit” through their employers. In Recommendation #7 Phase Two, it is explained how this information will become available to all Marylanders.

MARYLAND PLAN NOW Starter Kit WHAT'S YOUR FAMILY'S PLAN?

Learn your options

Take the time, it's important!

Create a plan for you and your family

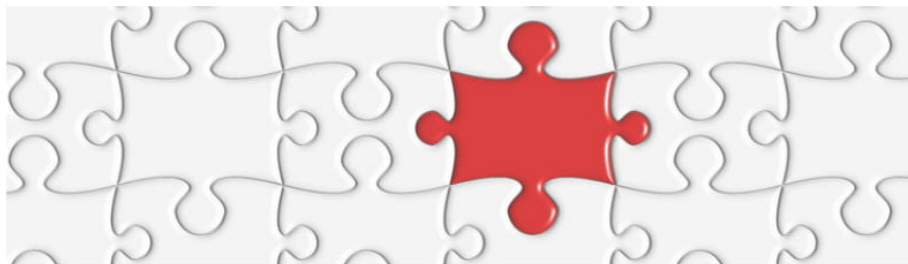
Put the "pieces" in place

Look to Public/Private Resources for Assistance

Action is key

Now is the time!

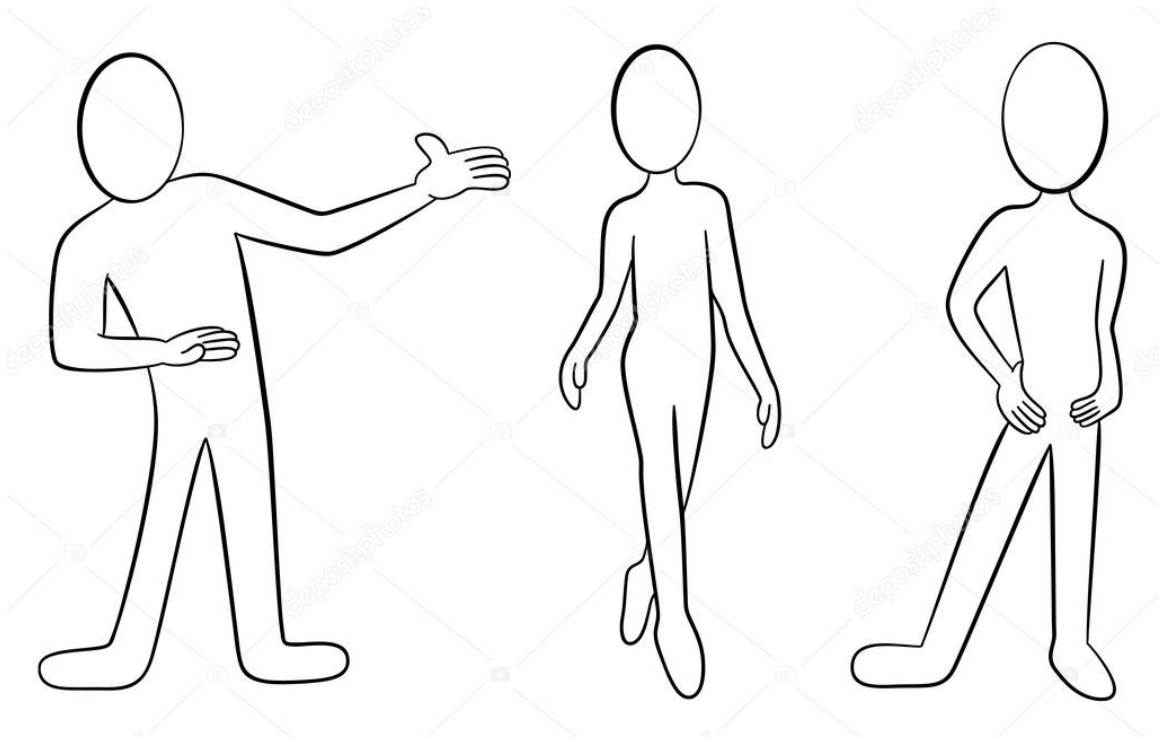
Every Piece Of Information Helps!



A STARTER KIT FOR DISCUSSIONS ABOUT LONG TERM CARE (LTC)

What happens if Grandma falls and breaks her hip? How will she be cared for? Will Mom have to quit work to care for her Mother? How will the bills be paid if she can't work? Do we have enough financial resources to pay for care? Severe unexpected injuries can happen at any time to anyone.

Questions like these and others should be addressed in multi-generational family meetings. The Governor's Task Force on Long Term Care and Education has prepared a Starter Kit to help families begin the discussion about long term care planning.



Did you know that:

70% of adults age 65 will need long term care in their lifetime.

20% will require long term care for more than five years.¹

¹ <https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html>

Why Planning for Long Term Care Matters

One of the wisest things anyone can do to prepare for their financial future is learn about long term care services long before they're needed. Knowing and understanding the choices puts you in a better position to make wise decisions and avoid stress if care is needed. Consider the following facts:

- The financial impact from a long term care event is massive: Approximately one-third of caregivers provide 30 hours – or more – of care per week. Half of those who do so estimate that they lost around one-third of their income. If a long term care event lasts an average of three years, that's potentially a full year's worth of income lost in the course of a single long term care event.
- Understand cost of care in your area. See page 6 of this Starter Kit.
- Options to address long term care, can be a combination of options:
 - Own income and assets
 - Family and Friends
 - Home equity (reverse mortgage)
 - Continuing Care Retirement Community
 - Long Term Care Insurance
 - The top four reasons individuals purchase of long term care insurance:
 - Not wanting to be a financial burden on family²
 - For financial security/peace of mind
 - To cover the cost of LTC services in the future
 - To protect assets
 - Private social programs
 - Public social programs

Long term care will be a necessity for many Marylanders. In order to overcome some of the obstacles, conversations on planning within families should begin early and should include as many as possible family members. The older family members should find comfort knowing they do not have to face these issues alone.

Purchase of long term care insurance to cover some or all of the cost for long term care is available in multiple forms. Knowing the desires of an individual in need of care is paramount. Knowing the willingness of family and friends and their financial and time capabilities is necessary for long term care planning.

² <https://ltcconsumer.com/ltc-facts/statistics/>

Rules of Engagement

The Discussion

A family meeting to discuss long term care should begin before the need arises and should be open for everyone, and all ideas should be heard. However, the family meeting may happen for the first time when someone in the family needs long term care. It may be very emotionally difficult for some, so be aware of everyone's feelings. A final decision on a plan is not necessary for the discussion to be successful. It may take regrouping at a later date after everyone has considered the information presented in the first meeting. If you don't know how to start the conversation, here are some ways you could break the ice:

"I need your help with something"

"I was thinking about what happened to ____, and it made me realize..."

"Even though I'm okay right now, I'm worried that ____, and I want to be prepared."

"I need to think about the future. Will you help me?"

NOTE: Family meetings should happen at certain intervals when circumstances change. Examples are graduation from school, marriage, divorce, retirement, unemployment, unexpected health issues. As we pass through the various phases of our lives, our ability to care for ourselves changes. In addition to discussions on long term care, other family issues can be discussed at the same meetings, including end of life issues and medical directives. Suggested follow-up questions may be found on page 7.

PLAN NOW: Guidelines to Assist Long Term Care Planning (See worksheet on pages 9-10)

Step: 1 Choosing the Type of Care and Estimating Long Term Care Expenses

There are many resources available to care for family and friends. Many faith-based organizations are available to help in planning and in caregiving. There are community groups that can be helpful also. In addition, local, state, and federal organizations are available. The chart below shows the pros and cons of care setting to assist you in developing your plan. Being informed on the costs for care is important in determining the type of care you may want to consider. See page 8 for a suggested worksheet on estimating the costs of each care setting:

Care setting: pros and cons

Type of care	Pros	Cons
At-home care	The care recipient can remain in a comfortable, familiar environment and maintain some independence. Various support services can help provide the needed care.	Depending on the level of care needed, support services can be costly, especially during nights and weekends. At-home care personnel typically are paid by the hour.
Living with a family member	Moving in with a loved one to receive care can be a comfortable, familiar option. Freed up from responsibilities, the individual can enjoy time with family and feel happier and more satisfied.	Family members who provide care may become emotionally and financially burned out, especially if they also work full time and or are also caring for children and grandchildren in the home.
Adult daycare	This type of care allows the older adult to live at home or with a family member, but also remain engaged, active and safe 8 hours while the primary caregiver works	The individual will need transportation to and from the adult daycare center. A full day of activities may prove exhausting.
Assisted living facility	In this type of facility, the older adult can receive tailored care, with services ranging from assistance with chores to hands- on care. Living near and socializing with others is known to improve well-being and happiness.	Individuals may feel sadness or depression at being separated from their home and loved ones, along with the loss of independence.
Nursing home	Living in a full-time facility ensures immediate access to medical-grade nursing care.	Moving into a nursing home can be a difficult transition. The transition can lead to loneliness, frustration and even depression.
Hospice care in a facility	Full-time, supervised care provides much-needed comfort in the final stages of life, lesser amount of care is available in the home setting.	Hospice settings are for individuals who are terminally ill.

Step: 2 Review of Family and Financial Resources

In any family, funds and time can vary greatly. One family may have a non-working spouse that is willing and able to give help. Another family may have more financial resources and be willing to contribute more funds. Knowing the financial and time resources available is a starting point towards planning. See page 9 for suggested breakdown of financial resources to consider.

Step 3: Collect Important Information

It is important that before the end of the family meeting that pertinent contact information be provided to all adult members who have agreed to help. A form is included in this kit for entering the information. This should include:

1. Phone numbers and email addresses of all involved.
2. Names and phone numbers of the doctors and medical professionals that will be attending to the individual with long-term needs.
3. Names, phone numbers, email addresses of other professionals such as attorneys, insurance professionals, financial advisors, accountants, and many more.
4. Places where important information are kept such as wills, medical directives, securities, deeds. They may be kept in a safe deposit box. If so, who has the keys and authorities to get to it? They could be in a drawer in the bedroom. If information is online or in a computer, user names and passwords will be needed.

Follow-up Questions after Considering Care Plan Options

1. If the desire is to stay in own home
 - a. Which family members will be able to assist? Will that family member(s) be compensated in any way?
 - b. Are there friends willing to help and will they be compensated in anyway?
 - c. Will you accept help from professional caregivers to complement care you receive from family and friends? If so, how will this care be paid?
2. If the desire is to stay with family
 - a. Which family members would you prefer to stay with? Will that family member(s) be compensated in any way?
 - b. Would you be willing to stay part of the year with one member and part of the year with another member of the family?
 - c. Would you be willing to go to Adult Day Care during the day?
3. If the desire is to stay with friends
 - a. Will the friend agree to help with care? Will that friend(s) be compensated in any way?
 - b. Would you be willing to stay part of the year with one friend and part of the year with another friend?
 - c. Would you be willing to go to Adult Day Care during the day?
4. If the desire or need is to stay at an Assisted Living Facility
 - a. Would you prefer it to be located near a friend or family member?
 - b. How will the facility be paid?

Cost should also be a factor to consider when choosing a long term care setting. It is helpful to know the Maryland (or where you are receiving care) median costs for extended care, which vary by state and are increasing steadily. Anticipated inflation can also affect the decision-making process.

Type of Care	Annual Median Cost- Maryland
Homemaker services*	\$49,700
Home health aide*	\$52,300
Adult day care	\$20,100
Assisted Living Facility	\$49,800
Semiprivate room in a nursing home	\$109,500
Private room in a nursing home	\$119,000

Source: , <https://www.Genworth.com/costofcare> and is current as of September, 2017

*Based on 44 hours per week by 52 weeks a year

CONGRATULATIONS!

You have had “the conversation” hopefully, the first of many. You can use the following questions to collect your thoughts about how you first talk went, and to think about what you’d like to talk about in future conversations.

- ❖ Is there something you need to clarify that you feel was misunderstood or misinterpreted?

- ❖ Who do you want to talk to next time? Are there people who should hear things at the same time (like siblings who tend to disagree)?

- ❖ How did this conversation make you feel? What do you want to remember? What do you want your loved ones to remember?

- ❖ What do you want to make sure to ask or talk about next time?

PLAN NOW: Guidelines to Assist Long Term Care Planning

Step 1: Choosing the Type of Care and Estimating Long Term Care Expenses
(For most recent cost by state and region, see www.genworth.com/costofcare)

	Median Monthly Cost	Anticipated Length of Time Needed (Months)	Anticipated Total for Care
Nursing Home (Private Room)	\$	X	=\$
Nursing Home (Semi-Private Room)	\$	X	=\$
Assisted Living Facility	\$	X	=\$
Home Health Aide (4 hours/day; 7 days/week) If 4 hours/day; 7 days/week is not correct for your planning, change figures to meet your estimated needs	\$	X	=\$
Homemaker (4hours/day; 7 days/ week). Adjust same as above.	\$	X	=\$
Adult Day Care (5 days/week)	\$	X	=\$
	Anticipated Total Need:		\$

Step 2: Review of Family and Financial Resources

	Today's Value	If you anticipate this value to increase or decrease over time, indicate your best guesstimate at age 80.
Personal savings	\$	
Insurance benefit (life or long term care insurance)	\$	
Annuity contracts	\$	
Home equity	\$	
Health savings account	\$	
Other funding sources	\$	
Total Resources Available	\$	

Compare Expenses and Assets

Estimated Costs (step 1)	\$
Less Total Resources (Step 2)	\$
Difference	\$

Step 3: Collect Important Information**This is LTC Plan for:****Current Age:****Date:**

Notes

RECOMMENDATION #5

Revamp and Streamline State LTC Information Available to Maryland Residents

In reviewing current State of Maryland websites available from several departments, it has been observed that there is a void of depth of information and nothing to educate how one can go about family planning for LTC. It was also found that one website refers observer to go to another website. The referred to website refers the observer right back to the original website!

The following websites were studied: Department of Aging, MAP (Maryland Access Point), Maryland Department of Disabilities, Maryland Department of Health, MHCC (Maryland Health Care Commission), and MIA (Maryland Insurance Commission). The MIA website does offer important information under Long Term Care Insurance. In fact, the MIA website in this area has significantly improved over the last four years. However, information is appropriately geared around LTC insurance and not family planning for LTC.

OBSERVATIONS/RECOMMENDATIONS

Following are observations/suggestions where the MAP, Department of Disabilities and MHCC websites with some manipulation recommendations that could both be updated, streamlined, and made complimentary to each other to become valuable resources to Maryland residents:

[Maryland Access Point, http://aging.maryland.gov/accesspoint/Pages/default.aspx](http://aging.maryland.gov/accesspoint/Pages/default.aspx)

Task Force recommends:

PLAN NOW Starter Kit

1. Starter Kit be included under “Staying Healthy and Prepared”, sub section- Plan and Prevent, Get Ready for your Planning Session as #1 (first point to be listed). PLAN NOW Starter Kit. The Starter Kit could be included here.
2. Move current Check List, “How to Prepare for Your Options Counseling Session”, to become # 2 (second point to be listed).
3. “Explore Your Options” link – modify insurance link on left menu to be, “Long Term Care Planning”.
4. Review current Maryland Health Care Commission under link for “Consumer Guide to Long Term Care” and also “MAP” websites for accuracy, completeness, and redundancy to make information easier for consumers.

[Maryland Department of Disabilities, http://mdod.maryland.gov/Pages/Home.aspx](http://mdod.maryland.gov/Pages/Home.aspx)

Task Force Recommendations:

1. Adding a link to the left menu for Long Term Care Planning and then a page with PLAN NOW Starter Kit. (move with PLAN NOW to be under Adding)
2. Link to State website that is the repository of all information.

[Maryland Department of Health – Maryland Health Care Commission](#)

Task Force recommendations:

1. Add a Financial Planning Tool to estimate LTC expenses and financial resources to determine the shortfall to plan for. Example:
<https://www.mn.gov/ownyourfuture>, page 19.

RECOMMENDATION #6

Reach Out and Include Public Organizations and Entities to Participate in Public/Private LTC Education Effort

Law HB953 formed a Public/Private Task Force to look for Public/Private solutions to educating Marylanders about LTC and LTC Planning. In Recommendation #5, the Task Force has focused on the Public Sector (State of Maryland) in recommending changes and enhancements to already existing State information outlets (websites). In Recommendation #6, the focus is on outreach and inclusion of the Private Sector.

During the nine official meetings held by the Task Force, various speakers from private organizations shared their knowledge and aided the Task Force through their organizations. Discussions prompted by the presentations brought to mind other organizations that could also become important allies to the cause.

The appendix of this report names these potential resources. Several have already been contacted and have agreed to assist. Others, to be strategically approachable for the best outcome, should be approached soon after a positive acceptance of this report.

The Alzheimer's Association Greater Maryland, Program Director Ilene Rosenthal, made an impressive presentation that conveyed to the Task Force the existence of a national outreach platform that the Association has tailored to the needs of Marylanders. This Association wants Marylanders to do family pre planning around the high possibility that one or more family members will be diagnosed with Alzheimer's and need special care. This care must be tailored to the multi phases that this disease must receive in order for best outcomes for the afflicted and for their family members. Program Director Rosenthal offered that there could possibly be inclusion of the Maryland educational effort on LTC and LTC family planning. This could possibly include having a section of the Power Point presentation used throughout the State of Maryland as a part of the Alzheimer Association presentations, focused on family planning for LTC and the distribution of PLAN NOW Starter Kits. She also offered to share the recent experiences and perspectives that the Association has gained in trying to effectively reach all Marylanders. The Alzheimer's Association effort is available in several languages and is well aware of the distinctions that must be considered to effectively relate to the different demographic and cultural areas of Maryland.

A second organization that has generously offered to assist Maryland is AARP. This association has also recently launched a new national platform of education and outreach in several area of the aging process. Planning is also a focus.

A third example of a cooperating private organization is the Society of Actuaries (“SOA”). SOA is an educational, research, and professional organization dedicated to serving the public and Society members. The SOA, LTC Section has in the recent past assisted Maryland when asked by MIA to make presentations in several open hearings on the facts behind the compilations of premiums for LTC insurance and what caused rate increases. SOA, LTC Section has granted permission for the appearance of an effective one page infographic on family planning that can be found in the Appendix. The SOA, LTC Section is expecting to publish an article in their Fall/Winter newsletter on the experiences of the Maryland Task Force formed by HB953 about how the Maryland experience. This article will include information that could assist other states in facing their aging tsunami of residents and the adverse effects on their Medicaid programs.

A partial list of other organizations that the Task Force believes will consider assisting the State of Maryland, either via funding aspects of the project and/ or offering services of other kinds, can be found in the Appendix.

RECOMMENDATION #7

Launch Phase Two: Continue Efforts and Enhance Experience for Initial Target Groups and Expand Outreach to all Marylanders Age 50 and Under

Recommendations 1-5 have all dealt with Phase One of implementing education on LTC and LTC Planning so that all Marylanders will have knowledge and family LTC plans by age 50. Recommendation #6 is a part of Phase One and the HB 953 mandate to recommend ways for funding the education of Maryland Residents as outlined in the law. It is possible that funding/assistance can come from the Private sector to assist with Phase One as well as Phase Two. The ability to partner with AARP and the Alzheimer's Association Greater Maryland will actually better fit the efforts of Phase Two than Phase One.

Phase One has focused on setting a foundation with Recommendation #1 Survey and then using existing infrastructures already in the State of Maryland to reach the youngest target of Phase One, High Schoolers, and the largest, most easily reached population of Maryland employees via their employers (Recommendations #2 and #3). Both of these targets will provide "spill over" to the other Marylanders up to age 51 that HB953 directs need to be reached. Phase One targets have been chosen to be the largest easiest to reach groups with the least effort. This in no way means it will not take concerted effort to reach these two groups, but they are the quickest to be able to reach with existing infrastructure to do so.

However, additional efforts to be implemented in Phase Two will be focused on 1- Continuing the effort for the first two target groups and enhancing from experience gained and 2-Reach out to all other Marylanders fitting the goal to be sure that they are educated and have the tools to create a family LTC plan as well as understand the Maryland Medicaid program. Many of these people will have received information from their high schooler, or employed spouse, or parent, etc. It is still important to be sure that the Public/Private uniform message with tools to follow through with planning, permeates to all Marylanders.

The ability for Phase Two to be effective will be impacted by acceptance of Recommendations #9 and #10. It is recommended that Phase Two will first activate the Maryland State Board of Education Financial Literacy Standards for not just High School, but for K-12. The Standards directed to be mastered are divided by grades K- 5, 6-8, and 9-12. Secondly, it is recommended that partnering be fostered with other organizations to reach out to Offices of Aging, Chambers of Commerce, Ethnic/Cultural Organizations, etc., and as identified during Phase One, underserved populations for receiving the message.

During Phase One, identification of committed partners will take place. Perhaps grants will be written or identified partners will apply for grants on behalf of this effort to enhance funding. Outreach will continue to the media so that the message becomes ingrained into everyday life.

RECOMMENDATION #8

Distribute Report to Additional States and Others

Although other states are working on projects to address their aging crisis and expanding Medicaid budgets, none are implementing a program such as Maryland as defined in HB953. Maryland's project specifically addresses implementing a Public/Private effort to educate the residents of Maryland by age 50 to understand all the private options to consider when planning for LTC, exactly what is the state's Medicaid program, how it is funded and who it is intended to serve, and to have a family plan for LTC that is periodically updated.

What other states are doing can be helpful for Maryland and current efforts can be found in this report in Section 8. It is interesting to note that most of these efforts involve significant funding and /or additional taxes. Although the Maryland effort will have associated costs, none are in the range of what other states are spending. However, it should be noted that Minnesota, who has experienced the most success to date and has invested substantial financial resources from taxpayers and grants, is finding that their early investment is now resulting in enough saving to cover their Medicaid cost for nursing homes and other costs associated with long term services and supports.

This report should be distributed to states as a model for them to consider and to allow Maryland to receive back comments.

National Association of Insurance Commissioner (NAIC) has a Senior Issues Committee that has a subsection on LTC and LTC Insurance. They will certainly be interested in learning about the Maryland initiative especially since MIA has been represented on the Task Force. NAIC's mission is educational. They may see an opportunity to produce an educational component on the importance of LTC family planning that can be used by all the states. One of the ten 2017 recommendations for federal policy changes by the LTC/LTCI subcommittee (see Section 10) was to provide better education to U.S. residents. The very basis of the Maryland initiative is better education to the residents of Maryland.

Likewise, the Society of Actuaries' ("SOA") has a mission of public education and the SOA, LTC Section has a Think Tank committee with new ideas for, and testing of, possible new products to better assist consumers with affordable planning tools to use in their LTC planning (><https://www.soa.org/sections/long-term-care/lctthinktank/>). SOA LTC Section is expecting to include an article in their Fall/Winter newsletter on the Maryland experience in creating the Task Force under HB953, Task Force experiences, gathering information for this report, and the reception of the report by Governor Hogan.

AARP and the Alzheimer's Association Central Maryland are looking forward to reading this report and partnering with Maryland for parts of implementing recommendation.

The insurance industry represented by AHIP, NAIFA, and NAHU are all eagerly waiting for the release of this report and offering support to Maryland for implementation and also, through their national and other state connections, want to be able to use the Maryland initiative as a role model. They also are looking to publish information directed to their members about this report.

The MSBA, MACPA, FPA-MD, HFAM, and USM will be disseminating information to their members about the work of this Task Force.

There are Think Tanks including SCAN, the Bipartisan Policy Center, and The Urban Institute, who are wrestling with how to advise and what to do about the LTC crisis in the United States that will find the Maryland effort of interest.

Effective distribution to a wide audience of this report will be helpful to others, but also can serve to promote interest in aiding and/or funding assistance for Maryland during implementation of recommendations.

RECOMMENDATION #9

Invest State of Maryland Funds across Sister Agencies to Implement Recommendations

The State of Maryland already has in place the infrastructure to make HB953 successful in the near future and as an ongoing endeavor. With cooperation between the State Departments of Education, Aging, Health, and MIA along with the private sector, the goal of HB953 can be implemented, sustained, and economically funded. If Maryland is successful in the goal of HB953, there potentially can be savings to the Medicaid budget such as seen by Minnesota. One way to view potential savings is to equate that for every year delay that a Maryland resident does not need to look to the Maryland Medicaid program for a nursing home bed, it will save the program approximately \$82,735 (based on the projected average cost to the Medicaid program for nursing home services for Fiscal Year 2019).

What must be accomplished as outlined in most of the ten recommendations is a natural fit for the above departments. Nothing needs to be created but rather reworked, improved, and/or expanded depending on which recommendation is being addressed.

The Survey (Recommendation #1), which is the foundation for implementing a successful sustainable program, has been recommended to be done by a private concern for the least disruption of the hard working State of Maryland departments that would need to be involved, and to provide the quickest turnaround time to implement the important beginning of HB953. It is suggested that perhaps private funding be sought for this effort. If there can be state funds readily available, it would speed up the process. Or perhaps, to allow a quick start up time, the State put forth funding for the Survey with the expectation of being reimbursed all or in part by the private sector. It is not known by this Task Force if this is allowable.

RECOMMENDATION #10

Empower an Ongoing Entity to continue the work of this Task Force. Expand the next Entity to Include Additional Public/Private Representation.

This Task Force is aware of the precedent to establish ongoing commissions to assist in implementation of programs, and to provide ongoing overview and institutional knowledge. It is recommended that such a commission be appointed by Governor Hogan to assist in carrying out the recommendations of this Task Force.

Although the Public/Private members of this Task Force worked together exceptionally well, it is noted that it would have been helpful to have a member representing the extensive and nationally acclaimed higher educational institutions found in Maryland, and equally as helpful to have had a representative from the community colleges of Maryland. Also missing was a representative from the State Department of Education as well as from the Chambers of Commerce. In addition, a representative of the Maryland Hospitals Systems, additional health related organizations, and perhaps other areas yet to be suggested.

All of these entities are Stakeholders in what HB 953 is endeavoring to accomplish. All that served on the Task Force are Stakeholders. In fact, all Marylanders are Stakeholders in the importance of being educated regarding LTC, understanding options for planning, having a plan for our families, and understanding the Maryland Medicaid program, how it is funded and who it is intended to serve.

Section 12:

Reports and Agendas

TASK FORCE MEETING DATES

October 16, 2017

November 20, 2017

December 18, 2017

January 8, 2018

February 12, 2018

March 12, 2018

April 16, 2018

May 21, 2018

June 18, 2018

AGENDA

October 16, 2017

10am-12pm

2664 Riva Road, Chesapeake Room, Annapolis, MD

10am Welcome

10:10am-10:30am Introductions

10:30-10:45am Review of Legislation: Task Force on Long Term Care Education and Planning and Hand Out Materials

10:45-11:15am Speaker: Sally Leimbach, TriBridge Partners, LLC, Task Force member

11:15-11:45am Review of Suggested Education Goals:

- Develop or locate ways to identify the level of background knowledge in a variety of age groups as a means of planning instruction.
- Create goals for various age groups related to LTC planning. Some will be relevant to high school students, some to beginning workers, some to middle aged individuals, and some to seniors. Goal by age of 50.
- Define messages, sources, and means to inform various public sectors about the nature and needs for effective long term care planning.

11:45am-12pm Public Comment

12pm Commence

Next Meetings for 2017:

November 20, 2017 Speakers:

AARP National LTC Educational Campaign

Alzheimer's Association National LTC Campaign

December 18, 2017 Speaker:

The Gray Report, Dr. Memo Diriker, Salisbury University

Governor's Report Due by December 1, 2017, First Report

REPORT

Governor's LTC Task Force on Long Term Care Education and Planning Minutes for October 16, 2017

2664 Riva Road, Chesapeake Room, Annapolis, MD

Prepared by: Sally H. Leimbach, TriBridge Partners LLC, Task Force member appointed by Governor Hogan to represent NAIFA-MD (National Association of Insurance and Financial Advisors of Maryland).

The purpose of the Task Force is to consider options to educate and make recommendations regarding education methods that will “ensure that no Maryland resident reaches the age of 50 without having received complete information about the risk of needing long term care and the private options available to pay for long term care; and include information about the Maryland Medical Assistance Program (Maryland Medicaid), how the Program is funded, and whom the Program is intended to serve.”

The makeup of the Task Force deliberately includes public and private sector representatives. In putting together the verbiage that was then drafted into legislation that has become law, the intent is to have a clear message come with one voice from both the public and private sectors. Too often in the past there have been confusing, conflicting, changing messages that have made the information misinterpreted and often ignored altogether. The easy alternative is to ignore the need to have a long term care plan. However, “a failure to plan is a plan to fail”.

The LTC crisis at the federal and state level can no longer be responsibly ignored. The impact of the ever swelling Medicaid budgets are increasingly smothering other necessary state responsibilities such as education, transportation, and infrastructure. Maryland, with bipartisan support, has created the opportunity, a conduit, not for a complete answer but for a necessary step to assist finding answers, by education through clear messaging with one voice of the Public and Private sectors in unison. If successful, Maryland can be providing a model for other states to follow. Assistance from the federal level could be most helpful, and it is hoped that success at the state level will spill over to having the federal level aid be able to achieve higher levels of success. Then there will be the opportunity for a crisis to evolve to a manageable program.

For this Task Force to function, there had to be administrative support. United Seniors of Maryland stepped up to this crucial responsibility for the Task Force to function. United Seniors of Maryland is a consortium of organizations and individuals that help promote senior issues, causes, laws and programs for Maryland seniors. Members in Maryland include NARF, AARP, MD Department of Aging and all 23 Maryland counties Departments of Aging, including all Senior Centers, all Commissions on Aging, and entities on aging. This voluntary organization is made up of a 21 member Board of Directors.

The head of this organization currently is Elizabeth Weglein. Elizabeth is well seasoned in the intricacies of Task Forces as she has served on many and been in charge of a few. Elizabeth is also experienced in Grant Writing as are other members of United Seniors.

There has been a slow start to having Governor Hogan appoint the representatives to the private sector seats on the Task Force. The organizations that were to have appointees were not aware they had been included in the law. When finally made aware, there still remains a formal process to have an individual apply and be accepted as a prospect to be considered by the Governor for appointment. Most Maryland residents and organizations have never been educated about this process. In addition, there are three public sector positions on the Task Force that select within their government department to choose who will represent that department on the Task Force.

So, at the first Task Force meeting, the three Maryland government department representatives were in attendance: MIA, Department of Aging, and Department of Health and Human Resources. From the private sector in attendance was the representative of the Maryland State Bar Association, Morris Klein, Esq., past president of Elder Law Section, Financial Planning Association of Maryland, and NAIFA-MD, Sally Leimbach, TriBridge Partners LLC. MAHU representative Melissa Barnickel, Baygroup Insurance LLC, was traveling out of the country. Trade Association that includes LTCi insurers is thought to be Susan Coronel, AHIP. Also missing were the appointees to represent Health Facilities Association of MD, MACPA (MD Association of CPA's), and MAPCC, MD Association of Private Colleges and Career Schools. All but MAPCC have identified recommendations to the Governor to be appointed and are expected to attend the next Task Force meeting.

Elizabeth Weglein explained that there are four subcommittees of the Task Force. Each Task Force member is to serve on one of these committees, excluding Logistics. The four are:

1-Logistics

2-Education (defined as creating the message. Nuts and Bolts of the content).

3-Communication and Advocacy (defined as spreading the message. Recommending Legislation can be a part of this).

4-Research (defined as ferreting out what already exists that could be helpful to the goals of the Task Force. For example, compiling a list of what is already available as resources/education in Maryland. What other states are trying to educate residents about LTC and LTC Planning? How are they going about this?).

Thirty minutes was spent discussing ways to understand:

- What is the current level of knowledge in various age groups?

-What goals should be created to meaningfully reach various age groups so they all will have had the opportunity to receive complete information by age 50 regarding:

1-Risk of needing long term care

2-Private options available to pay for long term care

3-Understanding the Maryland Medical Assistance Program including how it is funded and who it is intended to serve.

-How can Public Sectors be reached to consider and incorporate effective messaging to relay to the residents of Maryland the importance of understanding LTC risk and the importance of LTC Planning.

Following are comments and ideas offered by the Task Force members to address the three points above:

What is the MD Dept. on Aging already doing?

See if the MD CASH Program could be a conduit for information somehow.

Never too early to have heard about the need. Certainly, by high school. By then many families have seen a family member needing care. But perhaps the teenagers or young 20's do not realize the impact that it has on some family members such as parents with work related stress, financial contributions and not having time for themselves. Parents often do not discuss these important impacts trying to shelter children.

Get the LTC terminology into financial literacy at the High School age as a beginning.

Maybe children's books with theme of multigenerational interaction and the need for caregiving for younger and older.

How do you get people to listen? Perhaps by including in a financial package.

What is the best way to introduce to a group?

When professional sits down to review a 401K, there just is not enough time to also include LTC planning.

What Programs in MD currently exist?

-Dept. of Health Transitional unit re genetics.

-Dept. of Aging targets age 50 plus so could be a disconnect for what Task Force trying to accomplish.

-MD Access Points (MAP) which is a referral for resources should be studied. Provides information about existing state programs to enable people to stay at home longer.

-Check the Federal educational web sites. One site is www.longtermcare.gov.

-EAP programs used by employers.

-Chamber of Commerce's to reach employers. Ask Chambers how they are preparing their members for LTC.

-Use "Long Term Care Choices" as well as "LTC Planning".

-How to encourage Associations to spread the need for LTC planning to members.

PUBLIC COMMENTS TIME (last 15 minutes. There were about 10 none Task Force related people in attendance).

- "Maryland should try to implement for LTC something like the 501K for college education savings. Even if only one year with a sunset."

-Maryland is starting a 529A plan for those disabled by the age of 26 with a limit of \$14,000 per year contribution.

-How to educate the veterans? They do qualify for Aid and Attendance Veterans Allowance Pension if have served during a period of war even if no disability from that service.

-Need to compile a list of possible assets available to MD residents e.g. from Dept. of Veterans Affairs and the Dept. of Health and Mental Hygiene.

MEETING CONCLUDED 12:10 pm., Next two meetings 11/20 and 12/18.

AGENDA

November 20, 2017

10am-12pm

2664 Riva Road, Chesapeake Room, Annapolis, MD

10am Welcome

10:05am Introductions

10:15 Review Minutes

10:20-10:25 Review of Legislation: Task Force on Long Term Care Education and Planning

10:25-10:45 Speaker: Sally Leimbach, Task Force member, Review of Other States

10:45-11:15 Work in Subcommittees

- Education
- Communication
- Advocacy
- Research

Review of Suggested Goals:

- Develop or locate ways to identify the level of background knowledge in a variety of age groups as a means of planning instruction.
- Create goals for various age groups related to long term care planning. Some will be relevant to high school students, some to beginning workers, some to middle aged individuals, and some to seniors. Goal by age of 50.
- Define messages, sources, and means to inform various public sectors about the nature and needs for effective long term care planning.

11:15-11:30 Report Preliminary Goals in each subcommittee

11:30-11:40 Elect Chair

11:40-11:45 Review First Governor's Report due December 1, 2017

11:45am-12pm Public Comment

12pm Commence

REPORT

Governor's LTC Task Force on Long Term Care Education and Planning
Minutes for November 20, 2017
2664 Riva Road, Chesapeake Room, Annapolis, MD

Elizabeth Weglein brought meeting to order at 10:07 am

ANNOUNCEMENTS

1-Deadline – 12/1/17 –Report to Governor Hogan. Notification to Governor of Task Force goals. Elizabeth will email to Task Force to review prior to submission.

2-Task Force meetings will be held 3rd Monday of each month – 10 to noon – until June 2018. Martin Luther King holiday may impact scheduling.

3-Task Force has been invited to be the guest attendees at the next BEPC meeting 12/05/17 at Radisson Timonium 7:30-10 am. RSVP to Elizabeth by 12/01/17. If enough interest, a meeting session with speaker Eileen Tell will follow. Eileen presenting “New Prospective on a Persistent Problem: Financing for Long Term Care (LTC) Needs”.

WHAT IS CURRENTLY BEING DONE IN OTHER STATES – presented by Sally Leimbach (see Sally Leimbach’ report as attachment sent with report.). Discussion around the report included the following:

- Sally recommended reviewing the www.longtermcare.gov . On the site are several YouTube videos...the documents are now public domain so may be good to review and determine what we can use.
- Susan Coronel will obtain metrics that document the impact of Own Your Future campaign in MD.
- NY – significant program established in 1989 to encourage NY residents to purchase LTC–
- MN – Social Media and grassroots partnerships; two innovative products - “LifeStage” term life/LTC hybrid Protection and 2nd – adding enhanced home care in Med Sup plans.
- Joy Hatchette, MIA If MN has approval for a test market, it would be very nice.
- Melissa Barnickel, MAHU, brought up that the plans are national, so if MN gets HHC included in a greater way, it would impact the national.
- Susan Coronel brought up that since Task Force is aiming at people to plan from age 50 and Med Sup is for those ages 65 and after, we may not want to put all our eggs in one basket.
- Wash State – explored employer paid tax for front-end funding, next step getting support for legislation.
- Hawaii –identified the risk that is looming, the community needs to be warned that a train-wreck is coming.
- Sharing by - Morris Klein, Esq. - Kakuna Caregivers Act – enacted 2016 – up to \$70 a day from the state (not sure of limits).
- NE – 2006 legislation created a savings plan for LTC but will end 1/2018 due to low participation.

REVIEWED RECENT RESEARCH STUDY BY GENWORTH –The Long Term Care LTC Ripple Effect –

- Fear of lack of money, loss of independence, inability to care for yourself, not having loved ones to help take care of you and finally not being able to stay in your home.
- Important to not just consider insurance as the only way to plan –

- Personal cost of insurance – Only 11% own their own insurance, 18% believe gov't will pay costs and 54% don't act due to their perception that cost of insurance too high.

Additional resources – 2017 Genworth Cost of Care Study. NAIC has a publication – Shoppers Guide on LTC (currently being revised).

Al Redmer is on Task Force for NAIC Senior Issues. Joy will share updates on this in the future.

BROKE INTO FIVE WORK GROUPS (each Task Force member chose work group to join).

Workgroups – 30 minutes – Charged with identifying short-term (obtainable) goals to be done by next meeting Dec. 18, 2017.

Research Workgroup (Sally Leimbach on this group)

- Look at national and state activities for developing and existing information.
- Identify potentially helpful research relating to State of MD.
- Identify potential funding partners to help launch the effort
 - Robert Wood Johnson Foundation
 - Johns Hopkins University
 - U of MD
 - How did other states fund programs?
- Develop research to pass the messaging after it is created – via intern to test messaging and content of campaign
- Conference call among workgroup members 12/11/17 10 am to check what has been accomplished and what else need to be done prior to 12/18/17 meeting.

Advocacy Workgroup

- Identify the stakeholders – For example: gov't agencies (Office on Aging, branch to community and non-profits, Chambers of Commerce, Professional organizations and Associations, Young Professional Groups of various organizations, Labor organizations, etc.
 - Messaging is key
- Age groups – younger the better – progression by age – limited to greater so by age 50 understand topic

Education Workgroup (Melissa Barnickel on this group)

- What has been done in the past for Own Your Future campaign
- Research existing videos available to educate
- Limitations of Medicare and Medicaid –

Communication Workgroup (Joy Hatchette of MIA on this group)

- Agencies, AARP, NORC, churches, employer groups, VA Dept., Community Associations, and Homeowner's Associations, etc. ...- piggyback marketing.
- What tools to be used – all types of social media – YouTube, newsletters, news media, PSAs, presentations to various groups, get celebrity to be spokesperson, APP for phone
- Website – with links to get information

Linda Warr, MDOA Update from Last Meeting

- MAPP – one portal gateway – how can we use it for people to get information before they need care.

- MarylandAccessPoint.info Options for counseling at the time of need - reached 2016 in ages – 18-59 (disability) – 5000, ages 60 plus reached 3500. Provides options for counseling on site.
- SHIP – Individuals that already have a need – not reaching the right population for Task Force.

ELECTION OF TASK FORCE CHAIR

Melissa Barnickel was elected chairperson

Public Comment –

- “LTC can be the destroyer of family fabric”
- Suggestion to get outside expert support on how to do PR and communication –
- Multi-cultural communications, not just English
- Regions of the state are very different – needs vary across the state and Task Force needs to address this in efforts.

Next meeting 12/18/17

Guest speaker Dr. Memo Diriker, Salisbury University, The Gray Report

Meeting adjourned at 11:57 am, by Elizabeth Weglein

AGENDA

December 18, 2017

10:03 a.m.

2664 Riva Road, Chesapeake Room, Annapolis, MD

Special Guest Speaker

Dr. Memo F. Diriker, Director BEACON

Business, Economic & Community Outreach Network, consulting unit of Franklin P. Perdue
School of Business, Salisbury University

Presenting:

The Gray Report

Dr. Memo Diriker is the Founding Director of the Business, Economic, and Community Outreach Network (**BEACON**). **BEACON** is the premier business and economic research and consulting unit of the Franklin P. Perdue School of Business at Salisbury University.

BEACON is home to the award winning Community Visioning, ShoreTRENDS, GraySHORE, ShoreENERGY, GNAppWorks, and Bienvenidos a Delmarva initiatives and a proud partner of the GeoDASH initiative.

Dr. Diriker currently serves on the boards of the Salisbury Area Chamber of Commerce, the Maryland Chamber of Commerce, the Maryland Chamber of Commerce Foundation, Leadership Maryland, Inc., and the United Way of the Lower Eastern Shore. Dr. Diriker is a Past President of the Salisbury Sunrise Rotary Club and the Salisbury Area Chamber of Commerce. He has also served as the President of the American Marketing Association in Boston, Massachusetts. During his AMA Presidency, he was also a senior advisor to the Board of Directors of the Sales and Marketing Executives of Greater Boston, Inc.

Internationally, Dr. Diriker has served in many capacities on the board of the Network of International Business Schools for over 20 years, including as the organization's Vice-President and has been awarded the *Board Member Emeritus for Life* designation in 2014. Diriker said he and BEACON first noticed the aging population issue while studying data being compiled for the 1990 U.S. census. The percentage of older adults on the Shore is projected to increase over the next couple of decades, which could leave a gap both in services for the elderly and the economy, he said. The data made those at BEACON wonder if the Shore was ready for the changes that come with an aging population. BEACON deduced the Shore was not ready, he said, considering the infrastructure that was in place at the time — things like elder care, elder shelter, and the economy.

REPORT

Governor's LTC Task Force on Long Term Care Education and Planning
Minutes for December 18, 2017
2664 Riva Road, Chesapeake Room, Annapolis, MD

Minutes Prepared by Melissa Barnickel, Chair & edited Sally Leimbach, Task Force Member
& Elizabeth Weglein

Meeting opened at 10:03 am

Minutes approved from November 2017

Guest Speaker: Dr. Memo F Diriker, Director, Beacon – Business, Economic and Community Outreach Network consulting group of the Franklin P Perdue School of Business, Salisbury University presenting The Gray Report. Beacon created in 1988 as a part of Salisbury University

Use of 1990 Census Findings; Profile of demographics of nine E. Shore counties showed they were changing differently than the rest of the State of Maryland. So, began to track ages 50 plus as early indicator of what would happen at older ages.

Demographics on the Eastern Shore indicated- **in migration**, different than other parts of state. Also showed that people on the E. Shore are living longer due to quality and access to health services. Increasingly were coming to retire... but more young people were leaving the Eastern Shore.

However, after married plus 2 kids, natives moved back to Eastern Shore – babysitting by grandparents, etc. But after the 2008 Recession, this hasn't been happening as quickly. Tough to sell homes and move back. So, after the Recession, natives moved back older and for different reasons, such as being divorced.

After the 2005 Census, the Gray Shore Initiative was launched. As of now, 225 organizations are represented. There is an Annual summit. One result has been the Gray Shore Report. The last summit was Oct. 2017.

The recent report indicates the in-migration from age 65-85. At age 85, when one spouse deceased, there is out-migration – moving back to where family is located when LTC is needed.

Worcester, then Talbot Counties have the fastest growing percent of population ages 65 and over.

If 1/3 outside of workforce (over age 65), the county cannot sustain itself. They must import workers from elsewhere. This indicates unintended consequence of the aging on the Eastern Shore. A problem which compounds problem of importing workers is that there are limited major arteries, which impacts commuters. 38% Somerset County residents work outside the county. 39% of those that work in Somerset don't live in county.

3 reasons for requesting Welfare subsidies on the Eastern Shore – 1. Childcare, 2. Elder Care and 3. Transportation (longer commute and can't afford reliable vehicles).

INTERESTING SOLUTIONS

There exists an incredible volunteer community on the Eastern Shore. There are a large number of well-educated retirees willing to volunteer. So, a movement titled "SHORE WISDOM" has been created that connects volunteers to volunteer jobs that can use their expertise. The movement works on increasing the effectiveness of volunteerism. The object is to match knowledge opportunities with existing challenges.

However, a problem is that per capita resources are declining faster on Eastern Shore than the rest of Maryland as aging population increases.

LONG TERM CARE ON the EASTERN SHORE

On Eastern Shore –If LTC needed, a family member stops working to care for family needing care. A large number of ages early 20's to middle 30's is dropping out of the work force to take care of Grandparents. Then they go on Medicaid or other social services.

82% of services in hospitals on Eastern Shore – relate to the age 65 and over.

Requested universal design principals for zoning of new construction – no action has been approved

Organizations to delivery training – non-profit, United Way, universities need infrastructure to connect to those in need.

HEALTH LITERACY CAMPAIGN JUST BEGUN

A piece titled "Welcome to Delmarva" was just launched in four counties.

A campaign operating in Spanish and English – possible Creole to be added.

It is important to get jargon out of the training materials – SIMPLIFY to effectively reach the most people.

(Get full report and extract data points to see if can be helpful to the Task Force).

Average household income is under 40K, too much to be eligible for help.

ADDITIONAL RESOURCES TO FIND INFORMATION OF POSSIBLE HELP TO TASK FORCE

Alice Report – United Way – basic living expenses, cannot even make bills -

<https://www.unitedwayalice.org/maryland>.

Dashboard for quarterly (possibly) – update Gray Shore Report

Other resources for studies include the following:

University of MD – leading expert in state although tends to be more academic then practical

Frostburg University

Towson University- Regional Economic Studies - Dr. Irani

University of MD – College Park – curriculum research

St. Mary's – had a professor who concentrated in state data (?)

U. of Delaware (might have info).

UMBC- Dr. Gray

Montgomery County – number 1 source of IN Migration for the Eastern Shore.

Where do the seniors that move from the shore when they need LTC go? Where do they receive services for LTCi?

Task Force Elderly Migration - Governor – Task Force should check out the following:

<http://msa.maryland.gov/msa/mdmanual/26excom/defunct/html/13elder.html>

Governor's Aging Conference mentioned. Task Force should find out when and where.

Dr. Diriker feels that Japan does it best – tremendous cultural respect for elderly. Ireland has trained community outreach services. Central America has Day Care for elders.

There are three levels of solutions: 1-Federal level 2-State level 3-Local level. All good cures start with education about the matter. At the state level, universities could be the leaders. ONCE IDENTIFY PROBLEMS, RANK INTO IMPORTANCE AND SOLVABILITY. What is the priority of each identified problem?

There are not enough private sector resources on the Eastern Shore at this time. On the Shore, the majority of money for LTC services comes from Medicaid.

Must educate Millennials that their inheritance is about to go away!

NO FORCASTER IS SAYING THAT (LTC) COSTS ARE GOING DOWN.

Question: Since we are focusing on the under 50 crowd, how do you reach them and get them to engage?

It is hard to reach young people, but when you do they are sponges – very malleable!

END OF DR, DIRIKER PRESENTATION

REPORT ON EILEEN TELL PRESENTATION FOR BEPC 12/05/17-Sally Leimbach

Task Force invited guests and six did attend.

Eileen Tell – presented Long Term Care Financing; How It Evolved and What is the Future The Task Force and members of the Maryland LTC Roundtable then meet afterward with Eileen, Key ideas from that meeting included:

- Don't present problems without solutions
- Every family needs to have a family meeting
- MOLST form – end of life planning – necessary, possibly have something similar for family LTC planning
- Support of MD educators in this effort
- Education can work, if consistency of message
- Focus on successes in other states
- Education in simplicity of solutions
- Eliminate bills and whistles
- Suggestion - Packet of educational materials be given to every new hire
- State and Federal notice s possibly a notice on LTC planning...
- HR – SHRM, CEBS, assist in educating employees
- Direct high school – volunteer hours in senior community
- LTC IQ tool to measure what have known or don't know
- Spread word – affinity groups, libraries
- Measure ROI for success – pre and post survey –
- Consider one control group – members of MD Legislators, they can assist their constituents.

Subcommittee –

Education – Info from Own Your Future CMS, AARP and Let’s Talk materials from Genworth
– we agreed to come back with 5 sound bites to distribute to those under 50

Communication – success w PSAs – some states were successful based on Eileen Tell,
billboards, metro..., local celebrities as spokesperson

Advocacy – who is out there that better reaches this audience – get organizations to re-
think

Research try to develop and analyze national research on LTC, look at research specific to
MD, develop list of future funders for launching the MD education, MD based education
institutions, MD based business (Under Armour, AARP, MD based LTC providers, Office
Research of data – State Dept. of Education) – Next steps – good list – Base level of
awareness by age groups –

Public Comment

None were shared.

Meeting adjourned at 11:50 am.

AGENDA

January 8, 2018

10:10 a.m.

2664 Riva Road, Chesapeake Room, Annapolis, MD

Meeting to order 10:10 am

In light of the absence of Chairperson Melissa Barnickel and Elizabeth Weglein, United Seniors of MD., Sally Leimbach stepped in to serve as Acting Chair.

9:20am-9:40am Review Minutes

The meeting minutes from December was reviewed regarding the discussion from the presentation with Dr. Memo F. Diriker, Director.

An interesting suggestion brought to the Task Force that information about importance, etc. of LTC planning could be included with every Maryland driver's license renewal package! During the meeting Joy found on the internet on marylandpubliceducation.org that a Maryland law was passed and effective 9/2011 requiring "financial education" in grades 3 through 12.

12:10-12:15pm Next Steps

12:15pm-12:30pm Public Comment

12:30pm Commence

REPORT

Governor's LTC Task Force on Long Term Care Education and Planning

Minutes for January 8, 2018 10:10 a.m.

2664 Riva Road, Chesapeake Room, Annapolis, MD

Minutes Prepared by Sally Leimbach

Maryland Governor's LTC Education and Planning Task Force (rev. 1/10/18)

1/08/18 Meeting; Next Meeting 2/12/18 10 am; same location; Speaker Howard Gleckman, Urban Institute

Attendees: TASK FORCE members-Priscilla Campbell MACPA, Joy Hatchette MIA, Shaun Eddy MD FPA, Morris Klein MSBA, Mark Leeds MDH, Susan Colonel AHIP, Sally Leimbach NAIFA-MD

Non Task Force-Jannette Wundraw AARP, Jim Duls USM/NARFE #251, Carla Duls AARSPA, Wanda R. Twigg MRSPA, Claisses Jackson Public

Report/Meeting Minutes prepared by Sally Leimbach, representing NAIFA-MD on Task Force

Meeting to order 10:10 am

In light of the absence of Chairperson Melissa Barnickel and Elizabeth Weglein, United Seniors of MD., Sally Leimbach stepped in to serve as Acting Chair.

The report Melissa Barnickel and Sally had prepared as their report of the December meeting 12/18/17, was used as a track to proceed with discussions for the meeting.

Dr. Diriker Presentation 12/18/17- Comments in retrospect by the Task Force

The presentation by Dr. Memo F. Diriker, Director, Beacon, Salisbury University, was first discussed. His personal family experience of finding that LTC insurance did not meet their needs. Group discussed that perhaps the insurance plan design had met what original need was foreseen but was not reviewed to keep up. It was mentioned that Dr. Diriker had wished he had saved the premiums paid instead. Comment made that this is certainly a choice to be considered when planning for LTC. Unfortunately, hard to save "enough" whatever that turns out to be.

Another choice used by a member of the attending group is to pay a family member to provide the care, which is certainly another option that families can consider.

A quote from Dr. Diriker of which the group was reminded is "need to solve tomorrow's problems. It is too late to save today's problems."

Then there evolved a discussion regarding zoning and housing codes. Legislation and laws/regulations can be one way to influence that housing is more user-friendly for aging. However, there is a big "push back" from builders and contractors if forced to do something. If builders "required" there is push back. BUT builders are willing to offer choices. Consumers need to be educated that including choices in a home that can allow "aging in place" will increase the value of their home and make it more user-friendly for them. Also, all need to pay attention to the Big Picture that having housing

accommodations that allow people to stay in their homes for example for an extra five years, can create a significant savings for health care costs. So, in providing LTC planning considerations, home design choices either as being built or as modifications later, should be something the Task Force considers in our messaging package.

After Eileen Tell Presentation Meeting 12/18/17 –Comments in Retrospect by the Task Force

Several bullet points that appeared in the Report by Melissa and Sally were then discussed. MOLST form. Could it be modified for LTC planning?

What age to begin educating about LTC planning?

Problem of elderly that have too many assets, but they are not liquid.

An LTC Plan needs to include what steps to take in progression, importance of a discussion with Person at State Board of Education came back with recommendation not to do anything specific with Power of Attorney documents, need to educate when appointing a Trustee is important and importance of Successor Trustee.

Perhaps coming up with an inexpensive and easy way to establish an LTC guardian.

Family Conversations regarding LTC planning MUST be PROACTIVE, not reactive!

National Conversation Project was brought to the attention of those attending. One of this project's objectives is to have families have an LTC plan. Susan Coronel is checking out this project.

An interesting suggestion brought to the Task Force that information about importance, etc. of LTC planning could be included with every Maryland driver's license renewal package!

Including LTC planning in Health Education discussed not to try to do anything specific with especially the younger students. Parents are very protective and dislike this. After some back and forth discussion, a consensus of the Task Force was reached that the lowest age we should be planning to reach with education is High School.

It was also suggested that there should be a focus on educating Human Resource departments. However, whatever the message, it should be "easy". Do EPA's have as a part of the resources they provide?

In the past there is a piece "Employers Guide to Long Term Care Insurance". Susan Coronel kindly offered to see if she can find a copy. Also, we should look on the OPM website to see what is there. (Susan has sent since the meeting some additional information which I will forward on).

During the meeting Joy found on the internet on marylandpubliceducation.org that a Maryland law was passed and effective 9/2011 requiring "financial education" in grades 3 through 12. We all need to look at this.

It was brought to the attention of the group that NPR via the Bipartisan Policy Committee has had advertising spots regarding LTC Planning. Susan Coronel has contacts there with whom she will check.

Also mentioned is that perhaps this is "Elder Abuse" month and points are being made that a silent result of bad or no LTC family planning is in fact elder abuse.

The Education committee chaired by Melissa had gathered "sound bites" for consideration since the Dec. meeting that were read to the group. Several were compatible with the four identified areas of consensus reached at this meeting

Meeting Conclusions

It was agreed by all Task Force members in attendance that we do not want to have a “half baked” report at the end of the Task Force in June. We all are aware that we must pick up the pace to focus on what can be done.

Four areas of consensus reached:

- 1-FAMILY MEETING MESSAGE (not just one but periodically to be sure plan still viable).
- 2-Target age for education is High School to age 50
- 3-Human Resource Depts. Need focus
- 4-Lots of really good information already created. Task Force needs to select, customize, and get permission to use, if necessary.

Task Force needs to decide within the focus of an initial consensus:

- 1-What to present
- 2-To whom to present
- 3-How to present

Homework for the Task Force is to consider these minutes and decide if we have an initial consensus. Do we need to add or subtract things? Also, consensus of Task Force to request receipt of the following:

- 1-Roster of Task Force: name, title, organization representing on Task Force, email, phone number, business address
- 2-Interim Report sent to Governor
- 3-Minutes as soon after meeting as feasible
- 4-Next meeting reminder with agenda a week before the meeting

Public Comments

Jannette Wundraw: Reminder of United Senior of Maryland Conference. 1/17/18.

Annapolis Miller Building. 8 until 2. Then each district goes to separate rooms to meet with their legislators.

Clairese Jackson: There exists a group “Maryland Care Planning Council”.

caremaryland.org One of posted missions is to educate the public about LTC. Task Force agreed we should check on this.

MEETING ADJOURNED 12:03 pm

AGENDA

February 12, 2018 10am-12pm

2664 Riva Road, Chesapeake Room, Annapolis, MD

- I. Chair's Opening Remark
- II. Review Minutes
- III. Guest Speaker: Howard Gleckman is the author of *Caring for Our Parents* (St. Martin's Press) and is a Senior Fellow at The Urban Institute, where he is affiliated with both the Tax Policy Center and the Program on Retirement Policy.
- IV. Howard Gleckman: Question/Answer Discussion with Task Force
- V. Task Force members working collaboratively on
 - a. Short Term Goals from Subcommittee Work with Timelines and Defined Outcomes
 - b. Long Term Goals July/2018, 2019, 2020 for Educating & Planning by Age 50
- VI. Governor Report 12.2017
- VII. Public Comment
- VIII. Commence

Howard Gleckman's Reference Sources:

<https://aspe.hhs.gov/system/files/pdf/106211/ElderLTCrb-rev.pdf>

<http://www.convergencepolicy.org/wp-content/uploads/2016/02/LTCFC-FINAL-REPORT-Feb-2016.pdf>

<http://www.convergencepolicy.org/wp-content/uploads/2015/07/LTCFC-Vision-070215.pdf>

REPORT

Governor's LTC Task Force on Long Term Care Education and Planning

Minutes for February 12, 2018

10:00 am to 12:00 pm

2664 Riva Road, Chesapeake Room, Annapolis, MD

Meeting was called to order by Melissa Barnickel, Chair at 10:03 am

Minutes were reviewed. Shaun Eddy made motion Jan and Dec minutes with corrections brought up by Morris Klein for approval and Priscilla Campbell seconded the motion. Minutes were approved 2nd. Minutes are unanimously approved with corrections noted.

Howard Gleckman – Guest Speaker

- Howard is author of “Caring for our Parents”, resident fellow at The Urban Institute, and writes a tax and budget blog, TaxVox which can be read at Forbes.com.

Points Made by Mr. Gleckman

- LTC for older adults – 40% LTC provided to those under 65, solutions must include these people.
- Life expectancy past age 65, there is a good chance will live to age 85.
- Public health and medical technology
 - From 1989 TO 2015 – mortality for breast cancer has dropped 40%.
 - Health care system is set up for acute conditions, not chronic.
- Need of personal assistance
 - 10% age 70 to 74
 - 44% 75-89
 - 66% 90 or older
 - 2/3 of people will need assistance before they die.
- For those that reach age 65, 50% of adults would qualify for long term care insurance by triggering benefits, or Medicaid, if financially qualify.
- Average cost for LTC in facility is 138k, however for paid caregivers the average cost is \$266K.
- Average duration of LTC claim 2 yrs. Among those that develop a disability, average duration increases to 4.4 years for women and 3.2 for men. Many more require assistance prior but not significant need that would qualify for claim w LTCi
- 14% will need care 5 years or more
- 57% of women are likely to develop a chronic disability, 18% of those will need at least 5 years of care (only 9.8% of men will need care over 5 years).
-

Trends Pointed out by Mr. Gleckman:

1-Living a long time -at age 65, Men have a 19.6 years life expectancy vs 22.2 for women

2-Fewer and fewer family caregivers

3-Funding LTSS comes from – savings, insurance, home equity and Medicaid.

4-Medicare does not pay for all care – premiums, co pays, deductibles. Pays only up to 100 days for custodial long term care in facility.

5-Home equity loans and Reverse Mortgage – not yet cost efficient but can be a resource for LTC plan.

LTC insurance carriers – premiums increased, carrier shrinkage, less sales in past few years.

5-Medicaid \$158 billion spent – almost all growth in home and community-based care – 60% of Medicaid spending. However, funds are limited and waiting list very long.

6-Controversy – who receives benefits – no research that it is wide-spread.

SOLUTIONS cited by Mr. Gleckman

Most will receive care in the home.

Start with care recipients and their families

- Stay Home Considerations
 - Safe place to live.
 - Capable ([program JH School of Nursing](#)) – nurse, handyman and OT – \$2800 for 5 wks.
 - Transportation – volunteer services (senior villages) – public does not work well for frail elders – dedicated transportation, can range from UBER to public transportation.
 - Good nutrition – good meals programs. We need to know who needs it and get them on list. These tend to be people not on Medicaid and aren't found before crisis hits.
 - Social support – senior villages and faith communities.
 - Challenge of suburbs – cost of delivery more money than cost of meals. Gov't supports single family, suburbs.
 - Role of community-based organizations – deliver the care that is funded by gov't.
 - Organization bears Adm. cost – should include collecting data and analysis.
 - Are the programs effective?
 - Support community-based organizations and health systems.
 - Language differences.
 - Financing differences.

- Housing, health, and community
 - [SASH](#) program good example – Vermont based -support for seniors – Medicare Waiver – federal and state funded. Now 140 locations – Medicare waiver – apartments and neighbors of the apartments, reduces overall cost – keeps people out of hospital.
 - [PACE](#) – MD – support and services around adult day care program – at Johns Hopkins Hospital.
- Zoning issues can stand in way of home sharing.
- Home health aides – state laws may be difficult to deal with – e.g. eye drops = must be RN.
- Senior Villages support – don’t limit creativity – regulations can create hurdles.
- Funding Options being purposed
 - Mark Cohen, PhD, respected LTC researcher - Proposing a program to enhance and supplement private LTCi –
 - Universal catastrophic coverage to kick in after 3 years of receiving care.
 - Tie waiting period to income -lower income has 1 year wait, highest income has 4 year wait.
 - Financed by 1% increase in Medicare payroll tax - cost per employed person about \$500 a year.
 - Encourage private LTCi– standardize insurance, reform premium. Have vehicle similar to 401k to save for LTC or to use to pay premiums for LTCi.
 - Fully integrate.
- [Chronic Care Act](#) - Federal just passed budget that would allow Medicare Advantage plans (option to choose carrier)– could provide non-medical services, tailor to needs of members, signed by President. Eff date 2020. Regulations need to be written. Case management will be an issue. Will need to measure quality.

SUGGESTIONS on how to Educate Marylanders to Plan for LTC from Mr. Gleckman:

- Challenges- no foresight, too often with retirement planning, don’t think about frail old age,
- Being able to compare LTCi policies
- Understand importance of planning prior to crisis
 - Talk to family – financial, legal, medical, care, physicians to encourage families to have these conversations.
 - Engaging faith communities to encourage congregants to have these conversations – “Good chance you will have to deal with LTC– so talk with your family!”

- Fewer and fewer children to care for parents and do not live near.
- With resources – hire care manager, faith communities – food delivery.

CONSENSUS from Task Force members:

- Include in health insurance curriculum.
- Financial literacy – current law for MD public schools– However, no funding, few legs as of now.
- Culture shift – being an LTC Administrator as career path – could give some conversation, Nurse in a nursing home – not just home health and assisted living...
- High School students interested in college, not thinking about family planning LTC.
- Family conversation with up to 50s –need easy simple messaging.
- Curriculum and family meeting. Try for High School target.
- May be difficult to get the message into colleges.
- If we get someone at age 45, little trickle effect – more responsive at that age point.
- HR – great place to touch lots of people as employees, with help of employers – perhaps a nuisance would be to hire people to:
 - Work with SHRM (national organization for Human Resource professionals with state and local chapters) – advocate and voice give training and voice. Northrop Grummen
 - EAP – Employee Assistance Programs – can be tied into SHRM.
- Not reinvent wheel – collect and make it work very well.
- Website –
 - [MD Health Care Commission](#) – website – links to all counties – Clarise found this.
 - [MD Access Point](#) – check website – good resources.
 - Perhaps enhance the MD Access Point website.
 - [Maryland Commission of Caregivers](#) - launching website.
 - Maryland based resources - MD LTC – navigation website and point to resources? – Is this a goal to be considered? Launch a program to launch conversation.

Public Comment: NONE

Meeting adjourned at 11:55 am.

AGENDA

March 12, 2018 10a.m.-1p.m.

2664 Riva Road, Chesapeake Room, Annapolis, MD

10am Welcome by Chair & Introductions

10:05am-10:10am Review Minutes

10:10am-11am Guest Speaker: Tracy Imm, Communication Expert, Maryland Insurance Administration, speaking about Task Force marketing strategies and opportunities

11am-11:20am Task Force: Question/Answer Discussion with Task Force

11:20am-12:10pm Task Force members working collaboratively on Review of First Draft Goals

- Short Term Goals from Subcommittee Work with Timelines and Defined Outcomes
- Long Term Goals July/2018, 2019, 2020 for Educating & Planning by Age 50
- Identify Strategies and Timelines to Implement Goals

12:20pm-1:40pm Begin Discussion for Framework of Governor Final Report

11:40-11:45 April & May Speakers

12:45am-1pm Public Comment

1pm Commence

REPORT

Governor's LTC Task Force on Long Term Care Education and Planning

March 12, 2018

2664 Riva Road, Chesapeake Room, Annapolis,

Minutes prepared by Melissa Barnickel and edited by Sally Leimbach

Meeting was called to order by Melissa Barnickel, Chair, 10:10 am.

GUEST SPEAKER PRESENTATION-Tracy Imm

Our guest speaker was Tracy Imm, Director of Public Affairs for MD Insurance Administration. She has a vast amount of expertise in Public Relation, Marketing and Communication from various organizations both public and private; adjunct professor; familiar with financial planning and long term care-both on a professional and personal level. Tracy was invited to speak to us about Task Force marketing strategies and opportunities

Tracy's Update on MIA –

- Short Term issues – existing policies – building out web page – additional feedback on MIA website is welcome.
- Distribution list to receive updates is determined by those who go to website and sign up.

Imm's Recommendations to Task Force:

Step 1 – Do Market Research to help identify Challenges/obstacles; Clearly define the current state and future state

Narrow scope of initial campaign – For example, identify individuals 50 and above who don't have a plan. However, with discussion among attending Task Force members. (This is not what the law requires us to do. We are to address those under age 50.)

Pilot communications campaign that targets a smaller subset first – For example, leave High School segment to target later.

Target research of people that fit in that category to help identify challenges/obstacles; clearly define the current state and the desired future state – this can be done in phases

Step 2 Really get very specific in business objectives.

Layer communications and layer on the stakeholders – leverage all outlets that they already have.

Inventory what is available – insurance companies and stakeholders – cut through clutter and clearly define what we are trying to do in the marketplace. (Task Force waiting on responses to request sent by Elizabeth Weglein last fall).

Step 3 Segment/Target Audience

by demographics –i.e. Millennials (e.g. use phone app). Some groups may need high touch in person. Each group may need a different approach

Step 4 Develop overarching strategy to include situation overview, communication objectives, budget/resource, and metrics (ways to reassure reaching goals).

Situational overview needs to include for example what is going on now –Why/how it is catastrophe without a plan –

Communication spectrum – awareness to acting on information.

Have a survey or focus group to get feedback in the process.

Be mindful of team of people and budget for each – copywriter, social media, videography, marketing calendar...

In the report set forth a recommendation – indicate these portions will have a cost and Governor's office will determine if they want to proceed and decide on how to get done. Indicate we want to have private sector to be involved. (Task Force must be mindful that the law charges us with coming up with ways to fund the effort.)

Step 5 -Key messages – informing, directing to another place for additional information.

Step 6 Timeline – schedule to phase in the tactics, messaging, test messaging.

Step 7 – Define review and approval process for material.

What is reviewed, approval process for material– who has final signoff, approval timeline.

Step 8 identify tactics, consider surveys/focus groups to inform your messaging and tactics.

Step 9 Implement the plan.

Step 10 Measure effectiveness/have system to evaluate.

e.g. Social Media are posts shared, retweets, etc.

Discussion of other task force that was successful in getting resources to implement recommendations. Opioid Group – State, local and federal funding with NO private funding. Strategic partners have evolved. If strategic partner has been introduced, the group pivots to encompass them.

WBAL did a year-long documentary – access to subject matter experts, task force pitched them; <http://www.wbaltv.com/article/documentary-highlights-dangers-of-opioid-addiction/6952867>

Discussion then ensued among Task force attendees on what should be included in our final report.

Agreed –1. Families must plan is core message –2. Identify place for people to go for resources---3. Employers at time of hire to provide message to employees make them aware about the need to plan for LTC.

Do we have stats and demographic – people who are between 50 and 65? How many are going to have to go on Medicaid? AARP can get stats. Elizabeth has contact.

Prescription Drug – market research – how fast people spend down to Medicaid when on a specific drug. Report compelling **stats that this is an urgent need.**

[Families USA](#), advocacy consumers group regarding health care–3/25/18 senior fellow coming into MD – Elizabeth will be meeting with him.

Breakout recommendations by bands of demographics – stats for each and how to deliver information

Special needs -

Don't just have state pay for Public Consumer Announcements consider. Consider **5-year viewpoint.**

FOR EXAMPLE, INCLUDE IN THE REPORT:

10 million American's turn 65 every day.

What is the average cost for CCRC?

What is cost of assisted living?

What is cost of independent living?

What is the cost of home care?

Report must spell out both short term and long-term goals in marketplace;

Have specific recommendations. Have a report that shows a result that can get the media interested.

Helpful to have a media partner to implement awareness.

Financial Literacy –we need to work with school districts, maybe pilot Baltimore County, in one school. Measure those results before going statewide.

Phases -Add recommendation for a long term care planning account such as an ABLE Account.

The more data included in the report the better.

Tracy suggests we Structure the report as follows: 1-state problem –2- assume readers of the report do not know anything -3-Stress how big the problem is and what the realities are-4-include lots of statistics-4-offer solutions-5- offer possible strategic process to use to reach goals.

How many producers, financial planners in MD? MIA didn't have any stats on how many licensed health agents were qualified to write LTCi. Sally has checked with MAHU previously and they didn't have the data either.

Do legislators know what Office on Aging does?

The Task Force members thanked Tracy and gave her a round of applause. Very beneficial information was shared! The Task Force is grateful for this assistance by MIA by providing Tracey Imm the time to share her knowledge with the Task Force,

MEETING AFTER THE SPEAKER

Minutes were reviewed– Sally Leimbach made motion that Feb minutes be approval and Shaun Eddy seconded the motion. Minutes are unanimously approved.

Review of First Draft Goals and develop framework for the final report – See photos of white board attached

Averages are useless for the individual – What is your date of death? Will you need long term care?

Helpful to look nationally what is being done

- **Eileen Tell**– two states most success – MN – ongoing **Advisory Council** (local AARP, John O'Leary (private consultant), Eileen Tell (paid consultant), started in 2012
- **Washington State** – just got caboshed – additional tax on Medicare, provide \$100 a day for 1 year, AARP came out and would not support. Don't know the qualification of caregivers would be who would be paid \$100/day
- **Hawaii** agency on each island – University of Hawaii will be at the ILTCI – call number is provided to obtain a list of what resources are available. Form can be completed by inquirer and then analysis done, and matching done with what services are available.

Advisory Council – frequently – volunteers, state agencies (staff)

Framework of report

Focus – demographics – State more concerned about Medicaid budget. So maybe 40-50-year-old a good place to start. Employers will be a good way to reach many ages. Someone whose parents' health is failing.

Age band within a part of state?

Resources do not solve a problem – you can google long term care, but many don't plan.

Goal – focus and build out framework

Executive Summary –

Background statistics – don't assume the reader knows anything.

Include verbiage from initial memo to form the legislation for HB953.

Mandate requirements - Medicaid – what is it and what it is not and for whom it is to provide care? – Mark Leeds should lead this portion of the report.

Make the case – Why the need for education and LTC planning

- baby boomers – data – more people needing caregivers, known stresses on Social Services and other public and private resources.
Double decker sandwich generation.

Stats

- ID who has not planned and why not? If financially can't purchase insurance, still need to understand the dynamics and resources to research your options; despite resources, need a plan.
- Benefits of planning
- Plan Checklist - - Not just about the money, Benefit of Planning Peace of Mind (equates to dollars, control, quality).
- Impact on State
- Quality of life, Peace of Mind
- Have people plan early – by doing early – Peace of Mind

Short term

- Starter kit
- High school test market
- 40/50-year-old
- **Marketing plan – consistently survey for effectiveness**

Long term

- Demographic
- Alliances/resources
- Identify timeline
- Next steps – who takes over implementation of report recommendations?

Marketing Plan

- Tracy Imm document is an excellent resource.

Survey – to be done

- What do people know about long term care?
 - Follow up survey along the way to determine if approach is working.
-

What do we want the people to know?

What are the resources?

For example, the Maryland Health Care Commission – consumer guide to long term care, paying for it, alternative resources

How do we point Marylanders to have the conversation? – “It is FREE to have the conversation. Can equate for some to winning a lottery with a Huge Benefit!”

Priorities

- 40-50 yr. old – why do we want this to be our target?
 - SHRM/EAPA/Employers/Chambers/ Rotary
 - Renew driver’s license
 - MOLST mandate
 - Department of Planning – Joy to follow-up
 - census data
 - income levels
 - how many own homes?
 - MDOA – Linda Warr
 - What stats does this have?
 - MD Healthy Families – may have stats
 - Melissa to forward AARP public Policy report – Medicaid: A Last Resort...LTSS fact sheet and Who relies on Medicare...

Messaging – touchy, feely

Protect your families for long term care –

- Caregivers, economic impact on family
- Informal or paid caregivers
- Physical impact on caregivers
- Jobs – market impact on productivity, loss of tax base, loss of workforce (ties to caregiving), FMLA, sick leave 2/1/18 (15 or more employees with paid), jobs at risk, if people are not working, they may qualify for social services
- Positive – have a plan and not reaction crisis, have a conversation – think and talk about it
 - Examine what will be needed – housing? Caregiving? Services?
 - Document the plan – identify and match resources, support systems,
 - Peace of Mind – control, quality of life,

Catastrophic outcomes of not planning

- Impact on person who needs care, family (financial and emotional) and State of MD (social services, transportation, stress on budgets, healthcare, more \$ on Medicaid less money for schools and roads, Medicaid
- Financial Literacy – add LTC planning to current curriculum pilot one county and one school

ACTION ITEM

Each Task Force Member - Read through minutes and other resources – Come up with relative information stats for group they represent i.e. Melissa MD Health Underwriters (MAHU) – Paragraph from each group represented on the Task Force.

Insurance Producers – how many are Partnership qualified for LTC? –this stat is not known by MAHU nor MIA

Public Comment – Only Task Force members were present so no public comments.

Meeting adjourned at 12:55 pm.

Update: Next meeting is 4/16/2018 – 9:30 am to 12:30 pm

2664 Riva Road, Chesapeake Room, 2nd FL, Annapolis, MD

AGENDA

April 16, 2018

9:30 a.m. – 12:30 p.m.

2664 Riva Road, Chesapeake Room, Annapolis, MD

9:30am Welcome by Chair & Introductions

9:40am-9:45am Review Minutes

9:45am-10:15am Guest Speaker: Ilene Rosenthal, Program Director, Alzheimer's Association presenting new national Legal and Financial Planning Advocacy Program-advocating for planning for long term care

10:15-10:30am Ilene Rosenthal: Question/Answer Discussion with Task Force

10:30-12:00pm Task Force members working collaboratively on:

Building Platform for Governor's Report

- Short Term Goals with Timelines and Defined Outcomes
- Long Term Goals July/2018, 2019, 2020 for Educating & Planning by Age 50

12:00-12:10pm May & June Speakers

12:10-12:15pm Next Steps

12:15pm-12:30pm Public Comment

12:30pm Commence

REPORT

Governor's LTC Task Force on Long Term Care Education and Planning

Minutes for April 16, 2018

9:30 am to 12:30 pm

2664 Riva Road, Chesapeake Room, Annapolis, MD

Motion to approve March minutes– By Joy Hachette and 2nd Priscilla Campbell

GUEST SPEAKER-ILENE ROSENTHAL

Ilene Rosenthal, Program Director, Alzheimer's Association of Maryland presenting new national Legal and Financial Planning Advocacy Program – advocating for planning for long term care. It is one of 10 programs developed by the Alzheimer's Association for national roll out and use. In 2016, the Association received a grant to encourage planning when not in crisis.

Two handouts – standardized slide deck – imbedded videos- volunteer experts – legal and financial - Information is proprietary. Task Force members were given copies of the PowerPoint handouts, but not the teacher's guide or PowerPoint.

Document – [Centers of Disease Control and Alzheimer's – the Health Brain Initiative](#) – 35 action items that can be taken on the local and national level. MD Health Dept did receive a grant – they used it to encourage people to do advanced planning – during that year they did 35 to 40 seminars

Target – people early stage or care partners – content general and can be geared to general population.

Prior to crisis – take-action. Encourage people to understand the legal and financial issues. 2 ½ hours for both legal and financial parts with a break in-between. Can be done separately. Legal by itself takes about an hour and has 11 issues to cover. The Financial covers 15 issues. Not intended as a replacement for professional advice, but instead to stimulate the conversation. These can be included in conferences as well.

Goals –

1. Importance of planning
2. Importance of involving the person while they are still capable
3. Identify steps – legal and financial
4. Identify documents to put in place

Tips for putting plans in place

24- Hour hot line – initial screening – for example ask if VA eligible. Advise caller that Medicare has compassionate allowances.

Curriculum for presenter- copies of video notes, tells how to engage audience.

Tips document – can be given to attendees, info on how to make plans early, what needs to be created **or** updated. List of people to talk to. Links to other websites and resources.

Definition of terms. Can fill in your state specifics.

Checklist provided. Needs to be a family conversation to:

- 1-Create
- 2-Update
- 3-Creating LTC Budget
- 4-Formal and Informal assistance alternatives
- 5-Verterns Benefits
- 6-Medicare
- 7-Medicaid

Alzheimer's does have database – searchable for: elder law attorney, neurologist, professional mediation, personal resources to think through, think about formal and informal care, Medicare benefits, Medicare Advantage Plans, Medicare Supplement, criteria Medicaid, exploring VA benefits.

Ilene, "We do share your (the Task Force's) interest. The MD Alzheimer's Chapter covers all of MD but DC area including Montgomery and Prince Georges Counties and Southern MD." The Alzheimer's Association does rely on Volunteers and do need legal and financial experts as volunteers.

Sometimes it works well to but this seminar as a part of a conference, for example the MD State Bar Annual Conference in Ocean City which is held each June.

Interested in offering the class? List of Classes can be found on <https://www.alz.org>

Contact Ilene Rosenthal, 410-561-9099 ext. 201, irosenthal@alz.org –

- Who is the audience?
- Where it will be?
- If have audience but need someone to do the seminar, ask if a presenter can be provided.
- Not less than 10 people, ideally more than 10 people.
- Budget – no charge other than rental fee for room and refreshments
- Time to implement – ideally more than a 1 month prior – to give time to prompt

Good Venues for presentations include Senior Centers, provider councils, retirement community, hospital, Baltimore County Government Employee meeting, i.e.: Employers, law firms, Churches, professional education, banking companies

Alzheimer's workplace alliance – if you employ a lot of people, there are employees dealing with this. Employers don't know, and employees keep such problems to themselves for fear of adversely affecting their employment.

General discussion in a school – what is dementia and how to deal with it e.g.

Grandparents with Alzheimer's.

How to deal with behaviors of dementia – Alzheimer's Association giving program at Good Samaritan Hospital later this month.

Online seminar could be used

NO cost to agency/organization presenting nor attendees

Alzheimer's Mission – families with dementia, so not directly our target audience – to age 50

Suggestions to the Task Force:

- Light a fire – accept responsibility,

Series of messages/ways of messaging –

- Why the message is important.
- How to connect people to resources. Provide community forum where people can drill down to get this information.
- Create Partnerships and Collaborations such as with our Task Force.

Partnership and Collaboration –

- Possibly using Alzheimer's Assn format for Task Force messaging, would this be something we can aspire to? –Consensus from attending Task Force members is yes.
- Alzheimer's Association is very data driven - where served, where gaps are, community forums in the next year...informed planning for future
- Possibly for Task Force to consider is partnering with employers to reach demographics Task Force trying to reach.

Anne Arundel County – The future is now –

- Housing, financial...
- High attendance but did not get the population of less than 50
- Couldn't figure out how to get them – Meet at Starbucks, PTA meetings

Other examples of group's initiatives to increase awareness:

- **Purple weekend for June** - Kick-off with Houses of Worship talking points for newsletter, sermons...
- **Law Day** – usually May 1st – Advance Directives but not Financial Powers of Attorney are discussed.

Make is easier to connect with others

[Alzheimer's Care Training Seminars](#) –All the nationally developed programs are free – put in cart, can show them, several are in Spanish as well as English. Latino is greater at risk, family history heart disease, cholesterol, diabetes. - Average age of Latino is 27 years of age.

Ilene Rosenthal does not know the budget or timeframe from concept to launch of developing this outreach effort.

Focus – Early onset Alzheimer's- special support group, planning, messaging – Planning but continue to be involved in social activities, physical activity, healthy diet, can delay symptoms by healthy lifestyles. Generally, starts with a call to help line. Care consultation with social worker – for recent diagnosis - resources available and link to other resources for gaps.

Perhaps Task force recommendations to Governor should include seeking a grant to hire someone to - build relationships around the state, possibly using Alzheimer's Organization to deliver content – Alzheimer's Organization could help identify experts in the state.

Ilene said that the Task Force can use her and her organization as a resource.

Harness the various resources that are already available important to do.

QUESTION: When task force sunsets, who will keep the “ball” rolling? Elizabeth responded to the effect that what the Task Force needs to provide in the report to the Governor is the idea that there is a well engaged and successful program ready to go and willing to incorporate the educational goals that the Task Force was charged to achieve. HOWEVER, the elephant in the room is WHAT IS THE COST?

Ilene said that the Weinberg Foundation has Aging as a primary interest.

Susan Coronel commented that making what we are endeavoring a part of an already established Public Sector organization such as the Alzheimer’s Association’s program seems to offer 80% of what the Task Force needs.

Ilene again said that she is happy to partner with the Task Force to get our message out.

Ilene again stressed that the Alzheimer’s Association is very data driven using zip codes of where are serving and then are able to reach out to the underserved.

Perhaps work with the local Offices on Aging. Could do series of webinars Brown Bags (lunch and learns).

Communicate –start the conversation. For example– with a purposed data –target all employees – team up with Alzheimer’s –not a problem if all ages hear the message –direct visitors to the place of compiled data and employees – start the conversation!

QUESTION TO ILENE: “If Task Force partnered with the Alzheimer’s Association, would it be OK if the Task Force focuses on employers?” Ilene was not sure and suggested that we should talk with her boss about this.

Ilene commented that the Alzheimer’s Association can make Social Workers available for families in tumult.

Task Force member Owen Gardner commented that ComuniCare which specializes on Skilled Nursing, Rehab and Senior Centers (10,000 employees) has implemented a “Purple Day” to focus on employees and their needs and taking care of themselves, not just their clients.

Joy commented that there are MD counties that have a “special day” to emphasize employee awareness of taking care of themselves and their families.

Ilene graciously concluded her remarks by emphasizing that she really respects the work of the Task Force. She said it is a great first step. It is the right thing to do and will save money (for state and families) and mitigate guilt and emotional tumult among family members.

Go to ALZ.org, hit Caregivers prompt, scroll to Educational Programs (they are free).

Several are in Spanish. If there is a need, the Association will find a person to deliver the program in whatever language is needed. Because Latinos and African Americans are more likely to develop Alzheimer’s, the Association would like to do more work both groups.

END OF ILENE’S PART OF THE MEETING

State prospective across many employers –

Step 1-MARKET RESEARCH

Start with Employers (for spreading the message).

Star with companies who already have employee communication programs

SHRM – MD and 4 or 5 local chapters – Start w MD Chapter and see how to get on other programs.

Get input on other Employers we can approach. Sally will research that – 4/18/18 deadline.
Joy's – State of Maryland EEs, County and Municipal employees

- State - Dept. of Budget and Management – controls all the training and HR for State – they do retirement seminars, employee health seminars
- Counties will have their own HR groups – Maryland Association of Counties, Maryland Municipal League (cities and some counties). – Wide range of county officials
- Elizabeth spoke with Executive Director - MML -stable resident base and save money in state.
- [Largest employers of Maryland](#) – Lunch and Learn - Marriott, Allegis Group, Lockheed Martin, Social Security Administration, Laureate International Universities, Johns Hopkins Medicine, HMSHost, Perdue Farm, National Institutes of Health, University System of Maryland
- Workplace Alliance – Alzheimer's already has group set up -contact Ilene
- Program to be given to employees should be 30 to 45 minutes in length
- Dept. of Aging check with Legal Division to look for known State Grants.

Step 2-Inventory what already Available

Inventory what we have on our minutes and review to see what others we have.

Start with employers – see above – get stats as we go through.

Office on Health – genetics – transitional and education – planning for families with members with disabilities.

We need a core messaging center –

- MD Dept. of Aging -MAP website may be a “house” where inventory could reside – 18-59 is not the largest demographics, 60 and above are focus, currently.
- Perhaps find Central resource, not affiliated with one of our entities, non-partisan.
- Talk to MD Dept. of Aging – grants to fund this
- Many, many resources there
- This is probably one of the better ones –
- Link to Alz.org – education section
- Linda Warr will have a casual conversation – will they consider being the “house” for info. – Parameters of who they can link, maintain website for a year, grant writing resource? Linda will try to get us an answer by 4/30/18. She will talk with the Secretary and ongoing funding is an issue. Outside vendor and someone inside uploading and checking links ... SEO.
- Need Platform to upload information
- Have links for Partners we establish also on the platform.
- Must have place that will reach younger ages as well and refer everyone in.

Step 3-TARGET AUDIENCE

- Start by target employers, then “tweak” program to expand the target market.

- Early surveys important so effectiveness of communication can be evaluated on an ongoing basis. (NOTE: Eileen Tell has perfected a method using Survey Monkey to do this “cheaply” so an outreach to her for details is in order).
- Employers should give broad access to all the ages in our 18-50 age targets.

Step 4 Document QA from seminars.

Step 5 - Building a platform.

Sept 6 – Identify a time line must be developed – we won’t be doing so, beyond the scope of the Task Force.

Step 7 – Identify what needs to be done.

Step 9 – Implement plan – Governor can appoint an agency or establish a commission or council or advisory committee – Based on who is to implement, legislation may be necessary.

Step 10 - Implementation Organization, to be identified, will need to do to implementation.

Discussion –

Families must plan – START THE CONVERSATION

- *This is not just an initial conversation and that it is not a one-time thing. –*

Additional information to include in the report

Emotional issues of families not planning – breaks apart families, burn-out....

Impact on employers when employees are dealing with an LTC crisis - person and worksite– Melissa and Sally to provide

Sick Leave Bill – economic impact on families – Elizabeth to get information about this for us.

Elizabeth to handle - Who we consulted with speakers, site resources – profiles of each speaker, Rural prospective from Salisbury University

Elizabeth to handle - Profile of each organization represented on the Task Force – Elizabeth will write for each member. HOWEVER, each Task Force member needs to provide Elizabeth with two or three sentences expressing “who you are, main expertise and focus, and why selected by your organization as their representative on the Task Force”.

Elizabeth to handle - Roster of Task Force

Name, title, focus – expertise

Short Term Goals – Tools in the Toolbox could include

- Starter Kit – Shaun to complete by 4/20/2018
- High School test market – test one school to test messaging.
- Millennials are saving a tremendous amount of money. 24 to 37 years old, short, simple – see notes on Tracy. Anirban Basu, economist, does forecasting for MD and may have information to help the report.

Next Meeting May 21st. By the 21st we will have a rough draft coming thru emails.

Owen Gardner will send link for employees by age in MD - This is the link in ages of employees working in

MD. [https://mwejobs.maryland.gov/admin/gsipub/htmlarea/uploads/Whos%20Working%](https://mwejobs.maryland.gov/admin/gsipub/htmlarea/uploads/Whos%20Working%20in%20MD.pdf)

[20in%20Maryland%20An%20Overview%20of%20the%20States%20Private%20Sector%20Workforce.pdf](#)

Joy Hachette will review census data to get more information

Linda Warr – will get stats on those that access MAP website, # seniors in MD

Melissa Barnickel emailed after the meeting – AARP public Policy report – Medicaid A Last Resort: LTSS fact sheet and who relies on Medicaid.

Impact of needing LTC on the person, their families, and the employers of the person (if still employed), and family members and their employers... financial, physical, mental and emotional.

Priscilla Campbell - Feed the Pig – AICPA –will see if we can get LTC included; How about MACPA financial literacy for high schools – can we have a slide or two for our message?

Elizabeth will build out all the material shared and links...

Elizabeth to review all the single pages received and will ask for more input if needed from the representative.

Remember that Governor Hogan is a big advocate of small to mid-size employers.

Need to reach out to Dept. of Health and Mental Hygiene and see if Mark Leeds staff can lend Task Force a hand.

April 26th – Conference Call AHIP – 866-396-1316, code 202-778-3202

- RSVP is necessary A new Public-Private Partnership: Catastrophic Public and Front-End Private LTC Insurance
- Sally will send out to Task Force

May 21, 2018 Speaker – AARP who like the Alzheimer's Association, has a national platform – meeting time 9:30- 12:30.

June Speaker – June 18th – no speaker 9:30-12:30

No public comment.

Meeting adjourned 12:24 pm.

AGENDA

May 21, 2018,

2664 Riva Road, Chesapeake Room, Annapolis, MD

9:30am Welcome by Chair & Introductions

9:40am-9:45am Review Minutes

9:45am-10:10am Discussion Updates:

- AARP and the LTC Discussion Group LTC Event in May 20, 2018
- AHIP meeting in April
- SOA LTC Section call
- Life Happens Foundation call

10:10am-10:20am Discussion about a Potential Survey and Pilot Funding Options

10:20am-11:30am: Task Force members working collaboratively on:

Building Platform for Governor's Report

- Review of Bio and Contact Information
- Review of DRAFT List of Resources/Appendix
- Review of DRAFT Outline
- DECIDE FINAL Recommendations
 - Educational Objectives
 - Potential Partnerships
 - Funder/Payor Options
 - Pilot Program
 - Media Campaign
- Short Term Goals with Timelines and Defined Outcomes
 - Assignments of Topics to be drafted
 - History of LTC in Maryland
 - Current status of LTC in Maryland
 - Funder/Payor Options
- Long Term Goals July/2018, 2019, 2020 for Educating & Planning by Age 50

12:00-12:10pm Need for June Speakers

12:10-12:15pm Next Steps

12:15pm-12:30pm Public Comment

12:30pm Commence

REPORT

Governor's LTC Task Force on Long Term Care Education and Planning
Minutes for Meeting 5/21/2018, As AMENDED 6/18/2018 NOTE: Next and Last Meeting
June 18, 2018 9:30 am -12:30 pm SAME LOCATION
9:30 AM TO 12:30 PM
2664 Riva Road, Chesapeake Room, Annapolis, MD
Prepared by: Sally H. Leimbach; Edited by Melissa Barnickel

ATTENDEES: Owen Gardner, Joy Hatchette, Pricilla Campbell, Elizabeth Weglein, Sally Leimbach, Mark Leeds on phone.
Sally Leimbach, Acting Chair in absence of Melissa Barnickel

IMPORTANT! PLEASE READ MINUTES CAREFULLY. THERE ARE ACTION ITEMS DUE FROM ALL TASK FORCE MEMBERS TO BE RECEIVED BY ELIZABETH WEGLEIN BY MONDAY JUNE 4TH, 2018.

Priscilla moved that the minutes of the April 18th, 2018 meeting be approved. Owen seconded

There is no speaker today to allow the Task Force to concentrate on the Report to be delivered to Governor Hogan by 7/01/2018. Elizabeth sent the Task force a DRAFT OUTLINE with the meeting reminder. This was garnered from the Kirwan Commission Report also being submitted to Governor Hogan. Elizabeth adapted and reconfigured to be specific to the needs of this Task Force for its report.

Elizabeth stressed that she is not drafting the report. The informational part of the report is the job to be done by Task force members. Elizabeth will do 1-Appointed Task Force Rooster and the 2-Reports section which includes meeting dates, minutes, speakers, member attendance record and will assist with Resources/Appendix section.

Sally reported on some of her "finds" since the last meeting that could prove helpful to the report.

1-Need for Surveys-Task Force needs the ability to measure level of knowledge of target market before beginning education and then at specific times after the education has begun, stressed by Task Force member Susan Coronel and again by speaker from MIA talking about how to effectively do PR. A survey needs to cover the following Maryland areas: Eastern Shore, Southern MD, Central MD, and Western MD. Sally is hopeful that Eileen Tell could assist with this. Sally to call Eileen for estimate of the cost and send to committee as soon as she has it. This is important for the marketing budget. (Sally expecting Proposal and Budget from Eileen Tell 6/04/18).

2-Life Happens Organization. Sally spoke with Ex. Director to see if our Task Force could have access to their information on LTCI (which is currently being updated). The Task Force responded that this group is known for having good you tube videos. Sally to call and see if they would consider including in their updating a video of a Maryland resident telling their personal LTC story. This way the update could feature a Maryland element.

MAP Discussion

Then ensued a conversation of where the Task Force information should be housed and therefore where Links if found in for example "Life Happens.org" would refer people to. The consensus is that it should be on MAP currently found in the Dept. of Aging. Task Force member Linda Warr has already talked to MAP. MAP is currently renegotiating/looking for a new webmaster. Elizabeth is to check with Linda about the status of this. Ideally, the housing of our Task Force information to be found on MAP, would be part of this negotiation. Linda needs to find out what the cost would be to have LTC Education included on MAP. The Task force consensus is to ask the State to pick up the cost of the MAP section. Time is of the essence as the Dept. on Aging will probably complete their budget, by or during June. Elizabeth is checking with Linda.

3-SOA LTCI Section. Sally reported she has the name of the person to ask if we can use already created SOA educational items such as a one pager with cars that encourages planning. Sally will follow up on that. The LTCI Section is expecting Sally to do an article on the Maryland Task Force experience for their Fall/Winter newsletter. The Task Force asked Sally to share that article in some form that can be used for Blogs for AHIP, CPA's, CMS, and NIH.

However, it was decided that no information would go "out" until the Governor's office blesses the report and we have a quote from the Governor to include. We want to work WITH the Governor's office and make it EASY to work with us.

Webinars were then discussed to reach the members of MSBA, MACPA, FPA-MD, etc. In addition to webinars, newsletters, websites, educational conferences, seminars are all ways to reach out to organization members.

Priscilla will speak to Tom Hood, Ex. Director of MACPA.

Owen is speaking to HFAM.

Will ask Morris Klein to reach out to MSBA's EX. Director and to include the Estates and Trusts section as well as the Elder Law section as potential resources to further the goals of the Task Force.

Web content should include a cost calculator.

HISTORY of LTC in MARYLAND-Sally to write the draft.

TIMELINES-Maybe 2020 to complete everything that will be recommended in the report.

Long Term Goals-This is defined as goals to be completed in 2019-20.

Question was asked of Elizabeth- "Can the Task Force continue as a group?" Elizabeth responded, "It depends." Task Force members could contact all candidates for Governor and ask where they stand on this issue (LTC Education and Planning for residents of MD). Mark spoke up he would like to see that this Task force continue in some form. As a committee we can carry on. Owen suggested that the recommendations include that the Task force recommendations be shared as a public document.

Agreed by all "What we do not want is dust to gather on the report". (Because it has been ignored or brushed aside as not important.)

EDUCATIONAL PILOT FOR SCHOOLS

Sally checking to see if Financial Literacy in last Legislative session included “teeth” to get Financial Literacy into the public schools. (Sally has asked Elizabeth to ask Morris Klein to research this.)

Want K through 12 to have family conversations about LTC included. (At an earlier Task Force meeting, there had been a consensus of starting with High School students before “tackling the younger ones.”)

Sally suggested that Calvert County School System might be the correct microcosm to use. She will check with her contacts in the school system as that is where she lives.

ADDITIONAL LINK FOR RESOURCE LIST

Susan Coronel sent Link from Scan about Millennials and LTC. This could be placed in our list of Resources.

ELIZABETH WITH HOUSEKEEPING ITEM-MUST BE TO ELIZABETH BY 6/04/18!!

Elizabeth needs confirmation of the list she prepared and sent to Task Force members a few months back. This will be included in the Report. For each Task Force member, she needs 1- name, address, email, company name and address. Phone number?

2-Also send info on organization representing. This can be as long as a page. Most are already submitted.

3-Also 3 sentence description as to why you were appropriate representative of your organization to serve on the Task Force. This is a short targeted bio, not the one that you may have sent in the past.

MARYLAND MEDICAID INFORMATION

Mark Leeds is investigating how to include information in Governor’s Report as to 1- Definition of Maryland Medicaid 2-How it is funded and 3-Who it is intended to serve. Would also like latest stats on what % of MD Budget goes to the MD Medicaid each year, and how many are related to LTC needs of MD residents.

At 11 am ELIZABETH INVITED NON TASK FORCE ATTENDEES TO FEEL FREE TO ADD IDEAS AND COMMENTS.

PLANNING SECTION OF DRAFT OUTLINE

Question to Elizabeth? What are the recommendations to look like? Few notes for this area of the DRAFT OUTLINE.

- Starter Kits

- language

- Work Force

 - SHRM (Society for Human Resource Management)

 - DLR-has workforce development in each of the Maryland localities the Task Force identified for the Surveys. The Dept. of Labor does a lot of training all over the State.

COMMENT POINTS

Longevity-How long does your family live?

“Education piece is the MOST important thing”. -per Jill

Need Advocacy

Survey to measure knowledge in the beginning needs to happen. Perhaps have Survey age related as well as different sectors of MD be taken into consideration.

Jill going to help Elizabeth with the dissecting of the MD census information to look for meaningful information to include in the Report.

Sally to ask Eileen Tell if separating by age as well as sections/locations is important to the survey being useful.

POTENTIAL PARTNERS to HELP ADVOCATE-include Links to their websites

The Conversation Project

MD Dept. of Veterans Affairs

County Commissions on Aging (under MD Dept. on Aging)

Other State Partners:

- MD Caregivers Commission

- Black Caucus

- MGA- MD Genealogical Assoc.

- Hospice of the Chesapeake (part of the Communications Project).

- MD Chapter of National Association of Social Workers

- Coalition of all Faiths. Perhaps International Association of Ministers and Ministries. Don't forget Unitarians and Quakers. (Sally to check with her minister Tom Blair).

CULTURE PARTNERS OUTREACH

- Casa

- Community Colleges teaching English as a second language

- (Interesting to note the MD State Website has a button to enable changing the language)

- Governor's Office of Community Initiatives (could be a GREAT resource)

FINANCIAL ASSISTANCE

- Annie E. Casey Foundation

- Robert Wood Johnson Foundation

- AHIP

- Various Health Systems e.g. Kaiser and U of MD, Hopkins, Mercy Medical System, etc.

- perhaps identify college Interns and work with colleges such as U of MD System and Johns Hopkins

- MD Health Care Commission is LOOKING for projects to fund IF they WILL result in saving MONEY! Perhaps our survey project component could qualify.

BACK TO SURVEY DISCUSSION

- Eileen Tell will send a quote to Sally by Monday June 4th.

- Task Force must address how to fund and have as ongoing in order to measure impact of the program.

- After survey is analyzed, create Starter Kit. “Don't ask questions if don't have answers”, per Elizabeth.

-Need to set goals for the Survey. 1- Establish what people know and what they do not know. 2-How would they like to receive more information? 3-First round target is 1-High School students and 2-Employers.

ACCEPTANCE OF REPORT DISCUSSION

If the Governor “Buys In” on our report, it will be relatively easy to get a lot of good publicity. Joy rightfully cautioned that acceptance can be dependent on what is going on in the State at the same time. For example, the recent disastrous flooding.

Examples of PR outlets include NPR, WBAL, and Public Service Announcements.

A way to gain better acceptance is for the Task Force to have done as much work as possible to make it easy for the Governor’s Office. Have ready to make available summaries and model press releases.

RECOMMENDATIONS Section of Report Outline

-Potential Pilot Program-Sally exploring possibility of doing with Calvert County.

-Survey-Expecting a budget and outline of steps from Eileen Tell Monday, June 4th.

Original survey will be Employee focused, hopefully using the assistance of SHRM and large employers representing the four regions/sectors of MD. Although perhaps it would be good to have two large employers and three each of medium and small size employers, using the definition of State of Maryland when determining what is large, medium, or small.

Do not need to have polished Links per Elizabeth. That comes under Long Term Goals.

PLANNING Section of Draft Outline for Report

(This section needs to be clarified by Elizabeth)

TIMELINES for the REPORT

Must have requested information back to Elizabeth by Monday June 4th.

By June 18th final meeting, Task Force members will have draft of final report to review prior to that meeting.

RESOURCES AND PARTNERS

Morris reach out to MSBA

Pricilla reach out to MACPA

Shaun reach out to FPA-MD

Melissa reach out to MAHU

Sally reach out to NAIFA-MD

All to reach out and describe back to the Task Force how their organization can assist reaching the goals of the Task Force.

LONG TERM GOALS-2019-20

-Advocating for inclusion in State budget for 2020. Need to start in 2018. Specifically, for the inclusion, implementation, and maintenance of MAP.

-Funding for 2020 for a person or part of a person to coordinate and oversee the process.

-whatever needed to budget for educational unit to be embedded in the Public Schools.

-Where should the initiatives recommended in the report to be "housed"? Should it be 1- Office of Community Initiatives 2-the Health Care Commission, or the Dept. of Health and Mental Hygiene?

-What members of the current Task Force are willing to continue work after July 1st?

Melissa needs to send out for response as to who would be willing to consider continuing a "State of MD Sanctioned Group "or some such title.

Melissa should also ask for additional sectors to be represented in an ongoing effort.

MEETING ADJORNED at 12:30 pm.

AGENDA

June 18, 2018

9:45 a.m.

2664 Riva Road, Chesapeake Room, Annapolis, MD

9:30am Welcome by Chair & Introductions

9:40am-9:45am Review Minutes

9:45am-10:00am Discussion about a Potential Survey and Pilot Funding Options

10:00am-12:00pm: Task Force members working collaboratively on:

Building Platform for Governor's Report

- Bio and Contact Information --- who is missing?
- List of Resources/Appendix --- keep adding to list
- FINAL Recommendations
 - STARTER KIT
 - Needs to be approved and organized
 - Suggested initial implementation
 - Educational Objectives
 - Potential Partnerships – still need to clarify
 - Funder/Payor Options
 - Financial Literacy Pilot Program
 - Media Campaign
- Short Term Goals with Timelines and Defined Outcomes
 - Assignments of Topics to be drafted
 - History of LTC in Maryland
 - Current status of LTC in Maryland
 - Funder/Payor Options
- Long Term Goals July/2018, 2019, 2020 for Educating & Planning by Age 50

12:00-12:10pm Final Process Procedures

12:10-12:15pm Next Steps

12:15pm-12:30pm Public Comment

12:30pm Commence

REPORT

Governor's LTC Task Force on Long Term Care Education and Planning
Minutes for June 18, 2018 9:30 am -12:30 pm
2664 Riva Road, Chesapeake Room, Annapolis, MD

Prepared by Melissa Barnickel and edited by Sally Leimbach

Meeting was called to order at 9:45 am by Sally Leimbach. Melissa Barnickel took over as chair at her arrival a few minutes later.

Attendees: Elizabeth Weglein, Joy Hatchette, Shaun Eddy, Morris Klein, Priscilla Campbell, Melissa Barnickel, Sally Leimbach, Mark Leeds, Susan Coronel and Linda Warr

Owen Gardner was away on business and regretted not being in attendance.

Public attendees – Carla Duls, Jim Duls, Wanda Twigg, Peggy Nicholson, Randy Marshall, Ginny Hardon.

Minutes from 5/21/18 were approved as amended. This included correction of spelling of Hatchette and also deletion of the next to the last sentence in MAP Discussion on page 2., <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3736-ENG>

Sally reviewed draft of Recommendation for Initial Target Groups -1- Explore LTC planning in financial literacy programs in MD high schools and Maryland State Dept. of Education Financial Literacy Standards. 2-Explore using MD employers to assist with reaching MD Residents working for those employers.

MAP is willing to add links for our resources. Linda Warr confirmed this would be negligible cost to MD Dept of Aging. Thank you!

Funding options for both survey and financial literacy -

- LTC planning in financial literacy programs. Funding could come from private/public partnerships
- Notation to appendix Life Happens- done.

Survey as a recommendation – Imperative to determine the level of knowledge of Marylanders when beginning educational program....and to provide a benchmark to evaluate success of the education.

- Review of Initial and Periodic Surveys recommendation in detail
- Where we are at start, periodic to match benchmarks
- Eileen Tell – proposal 27K fee – Omit in report, add in appendix and an LTC Expert
- Recommendation to survey employees as they include MD residents ages 18-50.
- One Benefit from surveys is feedback to be sure education information is working.
- Funding source – open to partnership of private and public funding-could include reaching out to:
 - Robert Wood Foundation
 - Other Non-profits

Add to our final report –

- Include list of potential private and public funding options
- Add as option Speak (easy) Howard – Howard Foundation – added to appendix.

Possible partners – Elizabeth updated us on these

- Add Speak(easy) Howard – Howard Foundation
- Life Happens
- Calvert County Board of Education and/or other County Boards of Education already incorporating Financial Literacy as a graduation requirement.
- SHRM
- IFCEBS
- AARP agreed to be partner
- Women in LTSS
- Member of USM (what does this stand for?)
- USM

(Starter Kit)

Starter Kit – Priscilla reviewed document

- Add pros and cons of each funding resource -Check MIA -LTC Page, Resources - FAQ – printer friendly version -

<http://insurance.maryland.gov/Consumer/pages/LongTermCare.aspx>

- Omit stats, put in links and website addresses for access to MD statistics to have the document be “evergreen”, so updates of starter kit aren’t needed as frequently.
- Caregiving schedule – include in appendix. The one in the back of Step by Step A guide to receiving long term care has all rights reserved and I could not find online without going to agent access portal. After the meeting – Melissa found a The Caregiver’s Notebook – A guide for Organizing and Record Keeping by created by Springwell in Waltham, MA. http://www.springwell.com/docs/Resources/Caregiver_Notebook.pdf.

- Refer to AARP document. Melissa found this link, <https://www.aarp.org/caregiving/answers/info-2017/family-talk-long-term-care-preferences.html>
- Suggest brochure something like Conversation Project - this was circulated among attendees

- Recommendation that the MD brochure be both printed and electronic version available for download.

- Jill Cornish -shared Kaiser Permanente Life Care Planning booklet – similar to the Starter Kit

- AARP Link – Prepare to Care – A Planning Guide for Families – this is in MAP website
 - <https://www.aarp.org/caregiving/prepare-to-care-planning-guide/>
 - First steps
 - Can we find out how many times it was downloaded?
 - 25 pages in length
- Provide Employers with Starter Kit or AARP Prepare to Care booklet to provide to employees during open enrollment
- Recommend a draft of Starter Kit to be included in the final report to the Governor
- Drafted Starter Kit layout – by Task Force Members and the public attendees
 - Title: PLAN NOW for long term care!

Importance of LTC in family discussions

Starter Kit

- Intro paragraph – Why you care and Why you should listen – focus on the reader
 - Universal plan for now and later
 - Severe unexpected injuries can happen at any time to any one – LIFESPAN
- Discussion – value of conversation -Rules of Engagement
- Collection of Information
 - Drs. and medical professionals
 - Professionals – Attys, financial advisor, accountants, and insurance professionals
- Trigger examples
- First Questions –
 - 1
 - 2 – A-F check boxes
- Find solutions
- Keep it Going
 - Want Evergreen discussion to keep from information appearing soon dated - Additional points
- Resources - links
 - FAQ – MIA – payor option
 - Financial plan
- Collection plan

MN – Own Your Future – Plan of Care, <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3736-ENG>

- Cost of Care – website address to Genworth Cost of Care Study, <https://www.genworth.com/aging-and-you/finances/cost-of-care.html>
- We prefer to have link to cost of care study to keep the Starter Kit “evergreen”.

Recommendation of Task Force

Primary recommendation – family discussion about LTC education

- Tools
 - Info on websites
 - Starter Kit
- Method
 - Financial literacy
 - Employers
- Education the landscape

It was decided NOT Hyphenating Long Term Care throughout our final report

Task Force members showed Willingness to continue after seeing the response of the Governor perhaps via conference calls or WebEx, etc.

- MIA does have ability to use WebEX lines – JOY to see if can organize.
- Next meeting toward end of 8/2018.– ½ hour or 1 hour in length is expected.
- Consider future legislation, keep in mind that the budget for 2019 is already done.
- Joy, Priscilla, Shaun, Melissa, Sally agreed to continue meeting after 6/30/18 for 6 month period, - Linda and Mark and Joy need approval for their respective organizations.

Meeting adjourned 12:40 pm

Section 13:

Appendix

APPENDIX

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Section 14:

Speakers and their Biographies

SPEAKERS BIOGRAPHIES

Dr. Memo F. Diriker, Director, Beacon

Business, Economic and Community Outreach Network consulting group of the Franklin Perdue School of Business, Salisbury University presenting The Gray Report. Beacon created in 1988 as a part of Salisbury University.

Howard Gleckman

Howard Gleckman is the author of *Caring for Our Parents* (St. Martin's Press) and is a Senior Fellow at The Urban Institute, where he is affiliated with both the Tax Policy Center and the Program on Retirement Policy.

Tracy Imm, Director of Public Affairs, Maryland Insurance Administration

Tracy Imm, ABC, APR was appointed Director-Public Affairs for the Maryland Insurance Administration in March of 2016. She oversees internal and external communications for the agency to include public relations, social media, employee communications, digital marketing, and external events. She is a business communicator with two decades of leadership and project management experience in a variety of sectors. Prior to her current role, Tracy was the Director-Corporate Communications for Erickson Living, the nation's leader in senior housing. In that role, she was responsible for leading employee communications, diversity, and inclusive and corporate social responsibility.

Tracy has a Bachelor of Arts degree from McDaniel College, a Master of Business Administration degree from the University of Baltimore and a Master of Science degree from Stevenson University. She was named one of The Daily Record's Top 100 Women in 2017 for her mentoring activities, community involvement and professional achievements.

Ilene Rosenthal, Program Director, Alzheimer's Association of Maryland

Ilene Rosenthal, Program Director, Alzheimer's Association of Maryland presenting new national Legal and Financial Planning Advocacy Program – advocating for planning for long term care. It is one of 10 programs developed by the Alzheimer's Association for national roll out and use. In 2016, the Association received a grant to encourage planning when not in crisis.

Eileen J. Tell, ET Consulting, LLC

ET Consulting LLC is a woman-owned business focused on long term care and aging services, policy, and research. Consultant on a variety of LTC projects focused on finance and service delivery reforms. Clients include National Council on Aging (NCOA), US Department of Health and Human Services, Truven Health Analytics, BCBS of Michigan, Washington State Department of Social and Health Services, LTC Section Council Society of Actuaries, and others.



Long Term Care Position Paper

January 2016

The National Association of Health Underwriters (NAHU), a leading professional trade association for health insurance agents, brokers and consultants, represents more than 100,000 benefit specialists. Our members work on a daily basis to help millions of American individuals and employers purchase, administer and utilize health insurance coverage. Long term care insurance is an important topic; many NAHU members provide products and advice with regards to family LTC planning as an adjunct to retirement and estate protection.

THE LONG TERM CARE SITUATION

The long term care (LTC) system in the United States faces significant challenges as it prepares for an increasingly aging society. The number of people over age 65 is projected to grow to 98 million of the total population by 2060.¹ Thus, many individuals will require long term care services and supports (LTSS) to manage the many health conditions that develop due to aging. While the need for LTSS is not just for the elderly, those ages 65 and older are eight times more likely to need care than those under 65.² Furthermore, with life expectancy of men at 86.6 years and women at 88.8 years,³ it is no surprise that approximately 133 million Americans are living with at least one chronic condition, which can eventually lead to the need for LTC. By 2030, that number is projected to increase to 171 million.⁴

More than 50% of recipients of LTSS in the U.S. partially self-insure their expenses by using savings, depleting retirement assets and/or relying on family caregivers. In fact, 75% of people needing care rely solely on unpaid caregivers. It should also be noted that caregivers die earlier than non caregivers yet also need more LTC themselves because of the mental and physical burden of being a caregiver.⁵ After age 65, it is highly likely that a person will need at least one year of care.⁶ Due to the high cost of care,⁷ many people are pushed into poverty and dependency on Medicaid, yet few Americans are currently covered by LTCi—less than five percent.⁸

Many Americans incorrectly believe that their private health insurance or Medicare will pay LTSS costs. However, the primary burden of providing these services falls on family members. The person needing care and their family then engage in spend-down of savings or other depletion of savings and assets until the person requiring care can meet state-based eligibility criteria for Medicaid. Unless we successfully encourage people who can afford to do so to take personal responsibility for their LTC needs, Medicaid will be hard-pressed to have the funds necessary to care for the truly needy.

¹ Aging Statistics, ACL (Administration for Community Living), U.S. Dept. of Health and Human Services, www.aoa.gov/aging_statistics.

² Derived by Claude Thau using July 2015 population numbers (below age 65 vs. 65+) from www.cia.gov/library/publications/the-world-factbook/geos/us.html#Energy; and a June 2007 estimate of the percentage of LTC recipients under age 65 ("nearly 41%") from Georgetown University Long-Term Care Financing Project. "Long-Term Care Financing Policy Options for the Future," June 2007, as cited at www.ltcfed.com/start/aboutltc_what.html. An update to Georgetown's 42% statistic should cause the ratio stated in the text to increase.

³ Society of Actuaries, Retirement Plans Experience Committee, June 2015, update of the mortality improvement scale, mp-2015.

⁴ "The Growing Crisis of Chronic Disease," www.cdc.gov/nccdphp/publications/AAG/chronic.htm.

⁵ "Risk of Death Can Soar When Spouse is Sick." Robert Roy Britt, news.yahoo.com/s/space/2006215/sc_space/riskofdeathcansoarwhenspouseissick.

⁶ Kemper, Komisar, Alecxih. Long-Term Care over an Uncertain Future: What Can Current Retirees Expect? Inquiry 42:335-350; winter 2005/2006.

⁷ Genworth 2015 Cost of Care Study; April 2015.

⁸ Robert Wood Foundation, Policy Snapshot, Health Issue Brief, February 2015.

Potential caregivers also need to be educated about the significant mental and physical burden of being a caregiver. This results in caregivers dying earlier than non caregivers. They also need more LTC themselves.⁹

As policy-makers look for solutions to the ever growing LTC crisis in the U.S., an important consideration and strong justification for everyone to consider purchasing LTCi is that individuals using LTCi benefits at the end of life have lower medical costs. A recent study confirmed this and found that total medical costs were 14% lower. The breakdown of the 14% savings showed pharmacy 13% lower, inpatient admission 35% lower and outpatient visit costs 16% lower. Hospital admissions were eight percent fewer and inpatient days were 10% less.¹⁰

NAHU is pleased to offer three proposed solutions that, if implemented, will facilitate:

1. Preservation of government safety net programs for people who need them and for future generations.
2. More employers offering LTC education and LTCi as an employee benefit.
3. Increased acceptance of personal responsibility by Americans for their long term care.
4. Additional purchases of LTCi, which will add stability in the LTCi marketplace and generate additional taxes, increasing state and federal revenues.

An important part of these proposed solutions will be the establishment of public and private educational programs to encourage and assist Americans to fully understand the:

1. High probability that LTSS will be needed.
2. Financial, physical and emotional burden on loved ones to provide LTSS.
3. Limited coverage available under Medicare.
4. Complex rules and regulations associated with receiving benefits under Medicaid.
5. Need to plan adequately for their own LTC needs.
6. Importance of considering purchase of LTCi as a part of overall retirement strategy.

The results will mitigate the lack of financial preparedness among far too many U.S. individuals and their families.

FIRST PROPOSED SOLUTION: MEDICAID REFORMS

Medicaid was created in 1965, as Title XIX of the Social Security Act, to provide healthcare coverage for the neediest. Most Americans share in the belief that Medicaid should provide a basic safety net for current and future Americans in need. Unfortunately, Medicaid is already over-extended and too often provides LTSS coverage to people who are not destitute.

The rapidly growing need for LTSS will exacerbate Medicaid's ability to provide needed care since its funding is not infinite. Thus, every effort should be made to find ways to preserve Medicaid and ensure its financial solvency. If policies and programs were available to incentivize more consumers to purchase LTCi or use reverse mortgages, Medicaid could provide better care to the neediest rather than being a refuge for those who can afford to cover their LTSS needs. Changes made to Title XIX in 1993 require states to recoup costs of Medicaid LTC-related services from the estates of deceased recipients (some deferrals exist to protect family members). However, many states have been lax in doing so,

⁹ <https://www.caregiver.org/women-and-caregiving-facts-and-figures>.

¹⁰ "Long-Term Care Benefits May Reduce End of Life Medical Care Costs"; S. Holland, MD, S.R. Evered, PhD, B. A. Carter, PhD, POPULATION HEALTH MANAGEMENT; Volume 0, Number 0, 2014.

discouraging people from accepting personal responsibility. Far too many people believe that the government will take care of them for free.

The Long Term Care Partnership program, implemented by 43 states, is a federal and state program to preserve Medicaid. It encourages the purchase of Partnership LTCi policies, thereby greatly reducing the risk that those people will need Medicaid funding for LTSS. Statistics demonstrate extremely few people who own LTC Partnership policies end up relying on Medicaid. The most recent reports from each of the four original LTC Partnership Program states advise that only 7.2% of claimants who owned Partnership-approved policies have accessed Medicaid. The California Department of Health Services calculated that, as of the first quarter of 2013, the LTC Partnership plan had saved them \$46 million. New York state officials reported a savings to their Medicaid program of \$34 million through 2014.¹¹

In contrast to Medicaid, when individuals purchase LTCi that meets state LTC Partnership policy requirements, they can receive LTSS in their place of choice (at home, assisted living facility or nursing home), paying for it with their LTCi and possibly some of their income and assets. Rather than immediately beginning depletion of savings and assets to become eligible for public assistance, they know that if their income and insurance benefits are insufficient, they spend-down assets only until their remaining countable assets match (equal) the total benefits they received from their policy. The disregarded assets are permanently protected from estate recovery.

NAHU supports the Long Term Care Partnership program and encourages all states to adopt this federal-state hybrid initiative. However, adoption of the program is not enough. For states to have a successful program, states must also educate their citizens about the program. This should also be a joint federal-state effort.

When a person buys a Long Term Care Partnership policy, Medicaid is not the primary payer of LTSS. Thus, in addition to avoiding payment of Medicaid benefits, states reduce expenses for determining eligibility, administering benefits and recovering estates. Also, fraud potential is reduced due to fewer incentives for individuals to attempt to game the system by hiding or transferring assets. Furthermore, the sale of LTCi and reverse mortgages generates several sources of tax revenue, including from LTSS providers, whose revenues go up because of a higher percentage of private-pay clients.

Two additional important recommended steps to ensure it will be more difficult for individuals to obscure their assets and finances to qualify for Medicaid are:

1. Change the federal Medicaid eligibility regulations to reduce the ever-increasing home equity exemption, which in 2016 can be up to \$828,000 (for ALL assets in England INCLUDING home equity no more than \$32,250 assuming \$1.50 to the English pound).¹²
2. Extend the look-back period on transferred assets from five to 10 years.

Changes like these would result in federal and state governments having better control of their Medicaid programs to better ensure only individuals absolutely needing public help receive it.

¹¹ Derived by Claude Thau from the following reports, which were the most recent he found for each state in November 2013: California Partnership for Long-Term Care Quarterly Report, 1st quarter, 2013 (www.dhcs.ca.gov), Connecticut Cumulative Program Statistics as of June 30, 2015 (www.ct.gov/opm/cwp/view.asp?a=2995&q=474136&opmNav_GID=1814), Indiana Long-Term Care Insurance Program Report Quarter 1-2012 Report (www.in.gov/fssa/iltcp) and NYS (New York State) Partnership for Long-Term Care Quarterly Update, 4th Quarter 2014 (www.nyspltc.org).

¹² Adrian Walker, "Logical Step? Using Equity Release to Pay for Long-Term Care," Professional Advisor, August 18, 2015.

SECOND PROPOSED SOLUTION: PERMITTING FUNDS IN EMPLOYER AND INDIVIDUAL RETIREMENT PROGRAMS TO BE ACCESSED PENALTY- AND TAX-FREE TO PURCHASE LTCi:

Retirement planning has changed dramatically. Now most employer-based defined-benefit pension plans have changed to defined-contribution plans. More than 100 million Americans currently participate in 401(k), 403(b), 457 and/or Individual Retirement Account (IRA) plans.¹³ These programs are a very important step to help individuals ensure their financial security and have proven increasingly popular. Unfortunately, early-withdrawal penalties and an additional 10% tax on withdrawals before age 59.5 discourage individuals from withdrawing funds to purchase LTCi. Waiving taxes and penalties on money removed from such accounts in order to purchase LTCi would allow people to use a small portion of their retirement assets to protect the balance of their retirement assets for their and their spouse's intended uses.

NAHU believes allowing funds from retirement accounts to be accessed to purchase LTCi will benefit our nation in the following ways:

1. Individuals and families will be better prepared and experience less drain on savings and fewer burdens managing their daily lives if LTSS becomes needed.
2. Individuals with LTCi will receive better quality of care, including choice of caregivers and place to receive care.
3. Coverage will reduce burnout and protect the health of family members by facilitating hiring commercial caregivers and providing care-coordination services to help guide them through necessary decisions and arrangements.
4. LTC facility providers will receive private-pay reimbursements rather than the much lower Medicaid reimbursements. This will allow more innovation and competition in the LTC provider industry. The increased income will also result in facilities being able to pay low-income LTC workers higher wages.
5. States will save money on Medicaid benefits paid and processing costs for eligibility determinations and estate recovery.
6. The federal and state governments will receive more tax revenue from insurers, insurance agents and providers.

THIRD PROPOSED SOLUTION: IRS SECTION 125 REFORMS

More than 145 million Americans are a part of employee benefit plans.¹⁴ However, too few of these plans offer LTCi plans.¹⁵ Employers should be encouraged and incented to offer LTCi plans. Employers should also be incented to contribute toward the premium costs. Having LTCi offered as a benefit would demonstrate the value of taking personal responsibility for likely LTSS costs in the future. Employees who enroll gain yet another layer of financial security for their retirement planning.

A significant incentive to employees to enroll in an offered plan will occur if employees are allowed to purchase LTCi through their employer's IRS Section 125 plan. This allows reduced cost to employees by allowing pretax dollars to pay for premiums. Employers benefit by not having to pay payroll taxes on income an employee sets aside on a pretax basis. LTSS planning education, a vetted program and the ease of paying premiums through payroll deduction bring additional value to employees. The educational material should include encouraging LTSS planning for self and with family.

¹³ Vanguard, "How America Saves," June 2014. www.fa-mag.com/news/how-much-do-people-really-have-in-iras-10914.html,2012.

¹⁴ The Henry J. Kaiser Family Foundation, 2014 Employers Health Benefit Survey 9/10/14.

¹⁵ The 2012-2013 Sourcebook for Long-Term Care Insurance Information. "At the end of 2011, there were approximately 12,000 employers sponsoring group LTCi coverage in the US.," p.13.

This recommendation can be implemented by changing Title 26 of U.S. Code, Subtitle A, Chapter 1, Subchapter B, Part III, which states, “Such term shall not include any product which is advertised, marketed or offered as long-term care insurance.” Striking this line would easily remedy the prohibition and be in line with tax policy for benefits, such as Health Savings Accounts.

It is understood that the change would not benefit persons purchasing LTCi outside of an employer-sponsored plan since IRS Section 125 only offers tax preference to employer-sponsored benefit plans. However, those individuals could receive improved tax benefits if changes made to IRS 1040 tax deductions.

All LTCi policies are fully portable. This allows employees to have freedom and flexibility to change jobs or retire and maintain their same LTCi coverage. At time of purchase, policies offer options to increase coverage over time so benefits remain meaningful as the cost of care increases. The younger the age of a person purchasing LTCi, the less expensive the cost will be. Furthermore, if the three percent annual compounding of benefits option is chosen, 10 years later, an insured person will have 34% more benefit amount when he or she needs care. Making LTCi as attractive a purchase as possible to working Americans is a significant way to decrease the number of Americans who end up relying on Medicaid.

CONCLUSION

To respond to the aging of America and the increasing number of individuals who will need LTSS, NAHU recommends:

- 1. Enforce Medicaid estate recovery, extend the Medicaid look-back period, limit the home exemption and educate the public about LTSS risks and State LTC Partnership programs.**
- 2. Allow funds in an individual’s retirement plan to be favorably accessed to buy LTCi.**
- 3. Change Title 26 of U.S. Code to include LTCi as an allowable IRS Section 125 benefit.**

These recommendations have been developed by health insurance professionals who understand the LTCi marketplace and have unique insights gained from assisting consumers enrolling in LTCi coverage. Therefore, we feel confident that our recommendations, if implemented, will:

1. Encourage and enable individuals to better plan for the potential of needing LTSS, allowing increased financial security.
2. Increase state and federal revenues while reducing financial expenditures so Medicaid can now and in the future focus on our most-needy populations, as intended.
3. Improve the health of America’s seniors and health and productivity of people who would otherwise be family caregivers.
4. Benefit all Americans by allowing both federal and state governments to achieve a stronger financial condition due to reduced LTSS expenses and increased revenues by generating a higher volume of taxes.
5. Result in a more competitive, healthy, stable and diverse LTSS marketplace, which benefits care recipients and their families.
6. Result in a more competitive, healthy, stable and diverse LTCi marketplace, which will increasingly permit less dependence on government-funded LTSS.