MINUTES OF THE
LEGISLATIVE SUBCOMMITTEE TO STUDY
LONG-TERM CARE IN NEVADA
January 13, 2000

A meeting of the Legislative Subcommittee to Study Long-Term Care in Nevada (created as a result of Senate Concurrent Resolution 4 – 1999) was held at 9:30 a.m. on January 13, 2000, at the Legislative Building, 401 South Carson Street, Room 4100, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, 555 East Washington Avenue, Room 4412, Las Vegas, Nevada. Exhibit A is the Meeting Notice and Agenda; Exhibit B is the Attendance Roster.

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Senator Mike McGinness, Chairman
Senator Raymond Rawson
Senator Terry Care
Assemblywoman Sheila Leslie
Assemblywoman Kathy McClain

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblywoman Merle Berman

STAFF MEMBERS PRESENT:

Steve Abba, Senior Program Analyst, LCB Fiscal Division
Thomas Linden, Principal Deputy Legislative Counsel, LCB Legal Division
Ann Iverson, Deputy Legislative Counsel, LCB Legal Division
Sherie Silva, Secretary, LCB Fiscal Division

Chairman McGinness called the meeting to order at 9:45 a.m. Following the roll call, he noted there was a spelling correction to be made in the November 9, 1999 minutes. There being no other changes, Senator Rawson moved to approve the minutes with the one correction; Assemblywoman Leslie seconded the motion; motion passed unanimously.

Senator McGinness thanked those in the audience for attending the meeting. He remarked that the committee has severe limitations placed upon it by time. Even though there is an 18-month period between legislative sessions, it really is not much time to thoroughly look at issues. There is also a limitation by virtue of the fact the members are citizen legislators, and trying to find time is very difficult. He noted the committee is budgeted for only five meetings. At the last meeting a member asked if the committee could break out into subcommittees, which he thinks would be a great idea if there were time—unfortunately there is not. The last meeting will be utilized to bring everything together to try to develop legislation to send to the 2001 Session.

As a reminder of the purpose of the interim study of long-term care in Nevada, Senator McGinness reviewed the committee's mandates:

1. To identify alternatives to institutionalization;

2. To analyze the costs of those alternatives;

3. To determine the positive and negative effects and methods to provide long-term care services on the quality of life of persons receiving those services;

4. To determine the personnel required for those services;

5. To determine realistic methods for funding;

6. The evaluation of possible waivers from the federal government to integrate and coordinate acute care services through Medicare and Medicaid; and

7. An evaluation of the possibility of waivers from the federal government to eliminate the requirement of impoverishment as a condition of receiving assistance.

Senator McGinness said the committee will attempt to follow the mandates of the committee throughout the hearings. It would be possible to divert in a number of different directions, but it is his job to keep everyone on the path.

Chairman McGinness announced the meeting would be long in order to take the opportunity to hear some excellent speakers from near and far. He asked committee members to keep their questions current to the topic, and unless clarification is needed, questions should be kept to a minimum during the presentations in order to afford the speakers plenty of time. He apologized in advance to the Las Vegas contingent for not supplying copies of all handouts to them, and he announced that in the future, handouts should be submitted to the Legislative Counsel Bureau Fiscal Division in advance so that they may be provided to the Las Vegas audience. He then introduced the first speaker.

Robert Mollica is the Deputy Director of the National Academy of State Health Policy. He conducts policy research and provides technical assistance to state health policy leaders on a range of issues that include access and the uninsured, long-term care, and Medicaid managed care. The National Academy for State Health Policy is a non-profit organization located in Portland, Maine. Dr. Mollica has spoken widely on state health reform, assisted living, long-term care, and Medicaid managed programs during the past eight years. He has co-authored case studies of Medicaid managed care programs for elders in Arizona, Florida, Oregon and Utah, and policy papers on dual eligibles and managed care based on interviews with officials in Arizona, California, Oregon and Tennessee. Dr. Mollica has 23 years of policy program development and legislative relations experience in long-term care. Prior to joining the Academy, he held an appointment as the Assistant Secretary for Policy and Program Development in the Massachusetts Executive Office of Elder Affairs. He worked for eight years in the Governor's Office of Federal Relations in Massachusetts. He has a doctorate in counseling and a master's degree in social work from Boston University. He earned his undergraduate degree in psychology from Villanova University.

Dr. Mollica remarked he was enjoying his first visit to Nevada. He stated that long-term care is a tremendously important issue. The resolution that created the Nevada interim committee (SCR 4) identifies the reasons it is an issue in Nevada and an issue across the country. He would be presenting some slides that profile Nevada and its neighboring states that will give the committee information on how Nevada compares with other states in similar areas. He noted that it is difficult to compare statistics when looking at Medicaid spending, because one state may be high relative to another for no apparent reason other than "it's just different." In other instances, there may be real reasons for the differences. Dr. Mollica said after the slide presentation, he would discuss ways to look at redesigning long-term care systems, the potential roles for assisted living (one of the emerging important components of long-term care systems), and then managed care issues. He noted that a number of slides were included primarily for background and later reference—it would not be possible to get through all of them in the time allotted.
Long-term care comprises a major piece of all Medicaid spending. Nationally, it was 35 percent in fiscal year 1997, and Nevada was slightly lower than the national average at 25 percent. Dr. Mollica said no Medicaid program can ignore the long-term care piece. Many states have controlled Medicaid spending by enrolling adults and kids in a tiered program, and they are now trying to determine how they can get control of long-term care spending. When looking at state Medicaid spending, most of the expense for older people is for long-term care and not acute care, which is readily explained by the fact that the vast majority, 95 to 98 percent, of older Medicaid beneficiaries are also Medicare beneficiaries, and Medicare pays for the acute care and Medicaid pays for the co-insurance. However, with regard to long-term care, Medicare doesn't pay much at all and Medicaid becomes the primary payor for long-term care services.

Dr. Mollica said it is intriguing that people who do not receive SSI are costing states far more than an SSI beneficiary.

Nevada provides people with institutional services up to 300 percent of the federal SSI benefit, and those individuals would be included in the long-term care category.

Referring to a slide which illustrates Medicaid spending in the states of Colorado, Nebraska, Nevada, Idaho, Montana, Utah, and Wyoming, as well as nationally (Exhibit "C"), Dr. Mollica explained the data is from 1995, and the number for Nevada (27 percent) is now different. He noted there are significant variations in the array of acute and long-term care spending across the states in this part of the country. He cautioned that whenever data is reported from Health Care Financing Administration (HCFA) there are always some caveats about how it may vary from what the state itself reports or what the state might report separately, and there is no explanation as to why the reporting differs. Dr. Mollica suggested when it comes to making policy decisions, the state is probably better off relying on the data provided by its own state Medicaid agency, as it is more likely to be related to what is actually being spent in relation to the budget than what might be presented at the federal level.

Another problem with compiling comparative data across the country is the significant lag time, and the scenario can change dramatically between the last date of reporting and the current date. However, Dr. Mollica noted that Nevada's spending is heading in the right direction, i.e., nursing home spending is declining and home- and community-based spending is increasing.

With regard to long-term spending per elderly beneficiary, Dr. Mollica explained that in 1995 the data was based on spending per beneficiary actually using the service in FY 97, and the 1997 data was calculated based on all of the elderly Medicaid beneficiaries. Consequently, in Nevada the 1997 number is slightly lower than it was in 1995. Most of the other states, with the exception of Oregon, were a slight bit higher. Oregon, which is widely known for its expansive community-based system, spends $5,600 (updated 1997 figure) per elderly beneficiary of long-term services. Montana spends $12,456, the high amount explained by the fact they rely a great deal on nursing homes as their major service.

Dr. Mollica explained the supply of nursing homes is a critical factor in looking at long-term care systems. He feels most states would be envious of Nevada's low nursing home supply (21.6 beds per 1,000), which means the state is not faced with the struggle of shifting resources from institutional to community care. There are opportunities to do so, but he said it is much easier to build a system when working off of a relatively lower base of supply of nursing homes. Some of the other states with 63 or 76 beds per 1,000 are faced with the dilemma of closing nursing homes and reducing nursing home bed supply, which has proven to be a very difficult thing to do in most states. Dr. Mollica pointed out that in the days when there was a certificate of need required for building a nursing home, the system must have been faulty, considering Nevada has 21.6 per 1,000 and Nebraska has 76 per 1,000. He does not think those figures could be attributable to a formula that accurately measures need. In today's climate, Dr. Mollica thinks a certificate of need would be even less useful. In the 1970s and 1980s it was possible to count more readily how many people qualified to be in a nursing home. Whether they would actually enter one was a separate issue. However, when counting people now they can qualify to be in a nursing home, adult foster care, assisted living, or in their own home receiving home health or other Medicaid waiver services. It is not possible to count them in every place, so developing a need-based formula to predict the supply needed in any given area is nearly impossible.

Continuing with his slide presentation, Dr. Mollica explained that occupancy rates are another important measure of how well a state is doing. Nevada's occupancy rate more recently is down from 92 to 87 percent, which is close to the national average. Oregon was down to 83 percent in 1996, which is surprising because they too have a very low supply of nursing homes. Even with that low supply, one would expect Oregon to have a higher rate. However, because they have invested so much money in home- and community-based services, their occupancy rates are considerably lower.

Nursing home use figures indicate how many residents per 1,000 people 65 years of age and older are using nursing homes. Dr. Mollica noted that again Nevada's figure of 19.2 fares quite well in terms of the use. This is obviously a function of how many nursing home beds per 1,000 there are available, or maybe people are less likely to enter a nursing home and instead are using family members and other caregivers or accessing other long-term services. He had learned earlier in the day that Nevada has some services that focus primarily on Medicaid through county and other federal sources that are not measured in any state profiles.

With regard to home health beneficiaries and home health spending, Dr. Mollica said the figures are interesting because they show how states try to maximize Medicare for home health utilization whenever possible, and relative to Medicaid utilization, most states will have a much higher enrollment of people using home health services under Medicare than they will under Medicaid. The Balanced Budget Act dramatically shifted how much Medicare is spending on home health services in many states. Recent reports indicate a large increase in referrals and spending for Medicare, and states that offer state-funded home- and community-based services report a significant increase due to the cutbacks in Medicare for those services as well.

Dr. Mollica then moved to a slide on residential care facilities, saying that if states are interested in creating a balanced long-term care system, residential care is certainly an important piece. It is particularly important for people who cannot live alone at night or on week-ends when caregivers might not be available or there are not any family members. Even if there are paid services available, it is difficult to find providers that are available week-ends and nights. There are people who just cannot stay at home alone any longer, and residential care presents an excellent option for those folks. Dr. Mollica said he always encourages Medicaid programs to look at their Medicaid waivers to try to determine the number of people who left the waiver to go into a nursing home, and to look at the situation that precipitated that move to see if covering services in residential settings might have been able to prevent it.

Dr. Mollica then moved to a chart reflecting the number of nursing facility residents who have assisted daily living (ADL) impairments, both nationally and in Nevada (Exhibit "D"). The significance of the chart is that it suggests that people with 0, 1, 2, and maybe even 3 ADL impairments are good candidates for home- and community-based services. Dr. Mollica said the statistics may hide the fact that some persons with no ADL impairments might have significant medical conditions that require nursing home residence. However, it is important to look at those with low ADL impairments to see if other options might be available or appropriate for them.

Dr. Mollica then referred to a slide prepared by Ladd, Kane and Kane in 1999 entitled "State LTC Profiles – State Rankings" (Exhibit "E"), which he said is somewhat controversial. Dr. Ladd had gone through a host of variables collecting data both from HCFA and the states, and he ranked states on a number of those variables. In the tabulation of the figures, Nevada appears to be making significant strides in balancing the system compared to where it ranked four or five years ago. Because of some of the measures of the number of people 85 years of age and over, i.e., the growth rate of 85 and over, the number of people living alone, the number of minorities, and the number of people under 65 with disabilities, Mr. Ladd found that Nevada ranked fairly low on those ratings, and perhaps relative to other states, Nevada has a lower future demand for long-term care services than other states. Dr. Mollica suggested committee members study the tabulations and make their own determinations as to whether the statistics fairly characterize where Nevada stands now. However, he added, if the figures are correct they help to address some fears that if Nevada offers services that are more attractive to people, a real drive on spending may be created. This is often referred to as the "woodwork" effect. The implications of the statistics are that maybe the future demand may not be as great as states fear when looking at expanding services.

Nevada's low nursing home supply and high occupancy rate is a plus, but Dr. Mollica noted as Senator McGinness had mentioned earlier, there are lots of competing pressures and demands for available state resources and allocations to long-term care. Even though the state may not have a vast amount of resources to divert from nursing homes, as difficult as that might be, it doesn't make it any easier to find where that money is going to come from. The data does suggest that a number of people with ADL impairments in nursing homes, as well as a number of people that the state's Medicaid agency reports, have more than two ADLs and are below levels of Medicaid ICF payment. This suggests to Dr. Mollica that a really well-designed program for residential care facilities might offer opportunities to actually relocate people who are now in nursing homes and prevent people with low ADL impairments from entering them. The bottom line, he summarized, is that there is an opportunity to expand and build, without necessarily rebuilding, the system. However, he added, the challenges are certainly there to do so. The resolution (SCR 4) which created the committee has some excellent statements that would form some good goals on how to proceed. Offering a full range of services is critical to developing a well-balanced system, and once the difficult decisions and choices as to how to finance them are made, then actually delivering them, finding people who are available and willing to work for lower pay than might be available in other occupations, is also difficult. Once something is covered, it does not mean it can always be delivered if the workers are not available. Reimbursement rates are clearly an important piece of how well any program will be able to attract people to deliver long-term care services.

Dr. Mollica explained the woodwork effect means that if services are offered that are attractive to people as opposed to just nursing home care, which individuals will try to avoid, then spending is going to increase. The experience in some states suggests that doesn't always occur as people fear. A study done by AARP looked at three states and showed when the states expanded their long-term care systems, the participation and spending did not increase as fast as the growth in population of 75 years and over that are more likely to use long-term facilities, or people with disabilities who are under 65 years of age.

Budget staff and committees might say that they are not necessarily going to tie planning to growth in the population that might use the services—instead they would look at the current number of people served and not build in any additional growth. Dr. Mollica said this creates a different type of discussion, but still one that lends itself to an argument that the system can be rebalanced. He thinks that if only one aspect of a system is expanded, the program is vulnerable to unanticipated spending. If the total system is analyzed, and attempts are made to try to reshape it in line with types of services offered, it would more likely be possible to address the concerns of those worried about the woodwork effect. Dr. Mollica said if a system relies solely on nursing homes, the result will be much higher spending trends than if there is a better mix of services. A good mix of services along with an increase in the supply of nursing homes will result in more stable spending. If the supply of nursing homes is maintained or reduced and other options are expanded, it is likely less money will be spent than if more nursing homes are relied upon.

Some states, such as Washington, Dr. Mollica continued, have made a conscious decision to reduce the supply of nursing homes by offering more options. Washington also realized that the people in nursing homes are likely to be less appropriate for some of the options and will be more expensive to care for. Thus the payment rates were raised for people in nursing homes because the residents are sicker. This was possible to do, while at the same time shifting a significant amount of funding to home- and community-based options and maintaining spending on a path that is consistent with the state's legislative projections.

Dr. Mollica said there is even less fear about the woodwork effect when it comes to assisted living, particularly for Medicaid beneficiaries. If individuals are in their own homes, they do not want to move no matter what. If they are already eligible for the Medicaid waiver, they will not get anything new by going to assisted living if it were covered. Dr. Mollica has always considered Nevada to be one of the states that pays for services in residential settings, even though it is not called assisted living, i.e., Nevada's residential group facilities are equivalent to assisted living in other states. So, he added, people do not have to move to a residential group facility or a facility that markets itself as assisted living in order to get something that they could not get in their own homes. If a person moves to a residential setting, it is because he/she really needs to.

Another issue is that states can control waiver spending. Dr. Mollica explained a state determines how much it wants to spend on a waiver, submits that figure to the federal government in a formula, and identifies how many people will be served. When the plateau is reached, a waiting list is created. Therefore, the woodwork effect is again less of an issue when spending can be controlled in that manner. Another advantage of the waiver is it allows states to serve people who, without the waiver, would only be eligible for Medicaid long-term care services in an institution. The waiver allows those people to be served in a community and kept from entering nursing homes.

Moving to the subject of strategies being used by states in their long-term care systems, Dr. Mollica listed a full range of options:

- Build community options
    - Home care
    - Personal care
    - Residential alternatives

- Continue to limit NF bed growth
    - CoN/Moratorium
    - Convert nursing facilities to assisted living
    - "Buy backs," bank beds

- System management
    - Single point of entry
    - Eligibility
    - Targeted activity

In addition, Dr. Mollica noted that a number of states have developed foster care, but it is a difficult program to recruit providers for. Some states allow relatives to care for people who are low-income; Medicaid will reimburse the relatives, who sometimes will care for one or two other low-income Medicaid beneficiaries. Limiting the nursing home supply is an important component, and some states with an excess capacity have actually created incentives for facilities to convert to assisted living. A few states have issued certificates of need and have offered to buy them back, or they allow facilities that have licensed beds to close them, de-license them, but bank them in the event in five or ten years those beds may be needed again. This would involve facilities with low occupancy rates. The state may have a penalty for occupancy—if the occupancy threshold drops below a certain amount, state Medicaid will no longer approve payments for some of the capital costs. In order to get the rates higher, the facility will agree to close a certain number of beds in order to lower the occupancy rate to the threshold in order to receive a higher rate.

If a state does not have a balanced supply of services, it must have a way of managing entry into them. Dr. Mollica said usually states that do not have single-entry systems contract with a range of providers. How a person gets to a particular provider will depend on what information he receives or who referred him to a service. In many states, Dr. Mollica explained, there is not just one place to call for information regarding all services. Single-entry systems are a good way of managing access to long-term care services.

Private activity is also an important area where states have tried to develop resources to enable nursing home residents to move back into the community. They can also focus on hospital discharge planners, because often the pressure is so great to get someone out of the hospital as soon as possible and nursing home placement is a quick replacement, particularly if it is not known if there is a waiting list for home- and community-based services. Targeting the people who are most likely to need services is a very important aspect of developing entry systems.

Dr. Mollica said discussion usually takes place as to whether to use a health model or social services model. Most long-term care systems that develop in the community want to stay away from physicians controlling access to services. A number of states are pioneering systems that create roles for geriatric nurse practitioners that blend both the health and social services approaches in order to recognize that people have both sets of needs. The other problem is to find providers that offer a full range of services and how to create that diversity without creating broader fragmentation within the system, which makes access much more difficult. States that have turned to comprehensive entry points as a way to accomplish this are:

- Incremental reform – Maine
- Medicaid managed care – Arizona
- Managed LTC – Wisconsin

Dr. Mollica said that in many of the states it is either an area agency on aging, which does not exist in Nevada, or a county department of human services, social services, or department of health that functions as the entry point. When Colorado was building a single-point entry system, they basically said, “Here is what we want these organizations to do and here are the criteria that we will use to select them.” It could be a home health agency, a county agency, a community organization—as long as the agency could meet the criteria and fulfill the function it could be designated as the single entry point. Dr. Mollica explained these organizations provide the following services:

- Information & referral
- Case management
- Nursing home pre-admission screening
    - Medicaid
    - Private pay

He further explained that many states not only screen people who are Medicaid-eligible, but also people entering the nursing home as a private pay, primarily because they want to ensure people know what their options are. The state is concerned that an individual may enter as a private-pay and spend down, then in three or six months apply to Medicaid, at which point it is hard to get them out; there are other options that they could have considered.

Case management functions performed by states utilizing comprehensive entry systems include:

- Assessment
- Care planning
- Authorization
- Coordination
- Monitoring
- Reassessment

Dr. Mollica said there are a number of ways states have approached redesigning their systems. Maine decided to do a more incremental approach, which was by no means easy. Arizona designed a Medicaid managed care system in 1989 for all acute and long-term care services. Wisconsin used counties to deliver home- and community-based waiver services, and now they are going to move to a capitated system which will provide a single payment to the county for all nursing home and home- and community-based services—the county will be enabled to manage all of the services. This system allows people to make decisions about whether nursing home money can be spent on home- and community-based services without going to the line item for home- and community-based services. There is greater flexibility in shifting money. Dr. Mollica said there are also a number of dual eligible managed care demonstrations that states are looking at to improve the delivery of not only long-term care, but acute care as well.

Dr. Mollica continued, saying that about four or five years ago Maine faced tremendous budget shortfalls, and their response was to first cut back on long-term care spending, and then to redesign their system in order to create a system they wanted rather than one they were stuck with by default. One action they took, which states have a difficult time doing, was to raise the threshold. Dr. Mollica said raising the threshold makes it more difficult for people to enter nursing homes, but it also becomes more difficult to receive waiver services. Generally, he thinks states are more interested in leaving the nursing home eligibility criteria as flexible as possible. He added Nevada's criteria is quite flexible in that regard.

Maine also tightened its nursing home bed supply and created incentives to change from nursing homes to residential care facilities. They implemented some Medicaid eligibility changes and further consolidated the single-entry system. Instead of designating five agencies around the state, they contracted with one agency to do it statewide. In looking at Maine's total system, they were actually able to reduce nursing home utilization by 13 percent and nursing home expenditures by 17 percent. Dr. Mollica remarked there are only a few states that have been able to reduce nursing home spending, although it appears Nevada has been able to do so since the early 1990s. Maine not only managed to reduce spending, but they significantly increased the number of people served, the greatest increase being those in their own homes.

Dr. Mollica explained another aspect of reshaping a system is helping people make a transition from the nursing home back to the community. A lot of times when a person goes into a nursing home, the long-term care system forgets about him. In Colorado, the single entry point agencies set up criteria for individuals who might be able to move from the nursing home to the community, and they use case management nurses to analyze the data and identify those people and ask them if they are interested. Once an individual is in a nursing home for more than four or five months, he has probably lost his home or apartment. Most states, although they have the authority to do so, do not allow a person to maintain an apartment if residence in a nursing home is anticipated for any period of time. Dr. Mollica said Medicaid law allows a person to exempt income in order to maintain a home or apartment if his/her return is anticipated within six months. The other issue that prevents people from moving out of a nursing home is if they have lost their possessions, and the move to an apartment may require the first month's rent, deposit, furniture, and so on. Unless states have a way of making that money available, the clients are not able to move back to the community.

Colorado actually selected a pilot and looked at 119 people. At the time of reporting 68 of the 119 had moved, and 44

of the 68 had moved to an assisted-living facility. The rest of the people identified had not moved at the time the data were prepared. Dr. Mollica said most people might think that residents with low ADLs are more likely to move than others, and those who have been in for a short time are more likely to move than those in for a long time, but 65 percent of the people who moved had been nursing home residents for less than a year, and 11 percent had been in for 3 years or more. Nearly 51 percent had more than four ADL impairments, which is significant.

Dr. Mollica then cited Washington as a great example of a state that also identifies people and offers them an opportunity to move. Washington also has some financial resources that can be made available. If an individual has income that is being used to spend down nursing home costs before Medicaid pays, that income will be exempted in order to allow the person to maintain a residence or reestablish a residence. Washington has an $800 state-funded allowance for people who have divided income and might be SSI beneficiaries. The program was started in July 1997, and between 200 and 300 people a month have been relocated from nursing homes to the community.

Shifting the discussion to assisted living, Dr. Mollica believes there is tremendous growth in this area, and it provides great opportunities for states to offer people a chance to live independently. Some say there is an oversupply in some parts of the country, but there is more competition, and occupancy rates are falling. Facilities are concerned about people who move into assisted living for two, three or four years, they had modest means and they spent those resources, and now they are having trouble making the monthly payment fee and either have to be subsidized by the facility or move out. However, current state level of care and licensing rules generally allow assisted living facilities to offer a much higher level of care than they have historically under older rules. States obviously have a greater incentive to reduce and convert nursing home supplies to prevent people from entering facilities that are more expensive.

The limitations of assisted living are:

- Private demand is still quite strong, and as long as a facility is maintaining its occupancy rate at adequate levels, it is not so interested in participating in Medicaid.

- In many states the rates that Medicaid pays are not adequate to cover what a private facility charges, i.e., in the $1,500 to $2,500 range, which when compared to what a state might pay for nursing home care, still may be an affordable option.

- Facilities are not always interested in offering a higher level of service, particularly in states that have a high medical basis for entry into a nursing home.

- The industry in general is afraid that if Medicaid becomes a primary payor it is going to lead to more government regulation.

With regard to current trends Dr. Mollica reported that 39 of 40 states now cover services under Medicaid. Most use waivers, but a few use state plan services. Nevada, which covers personal care, could extend personal care to residential group facilities and pay for people who might not qualify for a nursing home to enter those facilities. There is a significant range of Medicaid rates, and in many states where they have low participation, Dr. Mollica believes it is by and large because the rates are so low. For now, and probably for the next five years or so, he thinks people will compare how much Medicaid pays in a residential facility or assisted living to costs of a nursing home. Over time, the comparison may break as the comparability between the two populations may tend to weaken, and people in nursing homes will most likely be far more impaired.

Dr. Mollica then reviewed some current assisted living issues:

- **Market rates and level of care**
  What are facilities charging in Nevada and other states, and are they offering a level of care that would fit with what a person on Medicaid under the waiver will require?

- **Family supplementation**
  Will a state allow family supplementation? There is no prohibition in Medicaid law

for family members to supplement a person's contribution for room and board in assisted living. In a nursing home, states cannot supplement anything that is covered in the Medicaid rate, but in assisted living, Medicaid cannot pay for room and board. If they do not pay for it they can (but they don't have to) prevent families from supplementing what the resident might pay. For example, if the facility rate is $2,000, and of that room and board is $1,000 and the beneficiary only has $500 or $600 a month in income, Medicaid could pay the service rate of $1,000, and if the facility is willing it could take the $500 or $600 for room and board. If the facility is not willing to accept that rate and a family member is willing to supplement the income, the individual would then be able to move into an assisted living facility.

- **Aging-in-place**
  One of the great expectations is that assisted living will allow people to move in when they have long-term care needs and stay there, perhaps moving into a nursing home only when they have high medical needs. Not all facilities are meeting this expectation, particularly those that may also own nursing homes. If an entity owns a nursing home and an assisted living facility, it may be desirable to use the assisted living facility as a referral source for the nursing home and limit the services received there.

- **Medicaid eligibility "fast track"**
  States need to look at ways of fast-tracking eligibility. Often decisions about where to go are made very quickly and if a living facility does not know for sure if the person is going to be Medicaid eligible, it might be less likely to accept him. It is much easier in a nursing home to determine whether a person is going to be Medicaid eligible and whether Medicaid will pay. Determining eligibility quickly is very important.

- **NF relocation options**
  Offering residents an opportunity to move is an important issue, and several states have shown there is a great potential to do this.

- **Separating the room and board and service components**
  One of the difficult aspects is to separate how much the room and board component is from the service component. Medicaid cannot pay for room and board in these settings, and not only do the rates for the service have to be appropriate, but the room and board piece and how it will be paid must be known. In Nevada, the SSI supplement brings it up to $850, which is generous compared to other states. Washington only allows slightly over $500 a month for room and board. However, their service payment is more generous and the facilities may be covering some of the room and board with the service side.

Dr. Mollica then moved to the subject of reimbursement practices for assisted living. Most states use flat rates, but tiered rates create incentives for facilities to take people who need more care. If a person does not need more care than a flat rate was predicated on, then the facility will accept him. However, as the person develops more needs, he will be asked to move elsewhere because the rate will not cover the increased services. Tiered rates are a method to cover the additional costs. Reimbursement is also based on geographic variations. Dr. Mollica said it is difficult to compare rates in different states because the markets are different.

With regard to the Medicaid state plan and waiver coverage, Dr. Mollica said that states are generally reluctant to use the state plan because they cannot control spending. There are 32 states that cover personal care under the state plan, and only 5 of those states allow that to be used in assisted living, although the flexibility exists to do so. Under the state plan services and entitlement, anyone who qualifies has to be served and it is available statewide, whereas a waiver is not an entitlement, spending can be controlled, it does not have to be statewide, and people with annual incomes of up to $18,000 can be served as long as they meet the nursing home level of care criteria.

The state of Nebraska developed the Health Care Trust Fund as a method to try to reduce the supply of nursing homes. Grants were made to 61 projects in the amount of $40 million, which will create 800 new assisted living units and de-license at least 600 nursing home beds. Dr. Mollica remarked this program may not apply in Nevada; however, if nursing homes are developing low occupancy rates and assisted living becomes an option, both for coverage and

expanded coverage in the state, Nebraska's experience might be useful to look at.

The final area Dr. Mollica wished to discuss was managed care. He said 6 states have operating programs and 4 other states' programs are pending. Five years ago he thought at least 30 states would have operating programs by now, but these are very, very difficult programs to get up and running. One of the basic difficulties is that they are voluntary. Under Medicaid managed care, it can be mandated that people enroll. When talking about a dual-eligible person where most of the acute care costs are paid by Medicare, it cannot be mandated that he join an HMO for Medicare services. If the Medicare HMO chooses to participate in a state managed care program, or if the person chooses to join the HMO, that's fine—but it cannot be mandated.

Dr. Mollica said changes over the last few years through the Balanced Budget Act have really created some shifts in the Medicare market, and lots of plans are pulling out. Nearly ¾ million people this year and last year have had to change HMOs. The benefits that attracted them are changing, and fewer HMOs are offering prescription drug coverage, or they are reducing benefits or charging higher co-payments. The result is lower enrollment rates for Medicare beneficiaries. Dr. Mollica said as long as the Medicare climate is murky and Medicare is going to implement its risk adjustment, there will be a lot of hesitancy about whether to continue in this market. It is not a real good time to develop a managed care program. He suggested that an existing PACE program or social HMO that is committed to stay in business is a resource that should be considered.

Maine spent a lot of time working with providers and when they issued an RFP, nobody bid. They have now taken a step back and are going to tie the long-term care system case manager to a physician's office, and through a primary case management program, try to improve the coordination between the two services. They will be contracting with two sites soon and are working with three other interested sites. Dr. Mollica noted this project is interesting because it is happening primarily in rural parts of Maine, and it is a realistic step given where the managed care market is.

In summary, Dr. Mollica thinks the state of Nevada, because of its low nursing home supply, is in an enviable position to support future growth in home- and community-based services. It will not be necessary to fight with a provider group as hard as some other states in order to get money to finance the program. Securing new funding is questionable because it is never an easy challenge. He thinks the major challenges are how to build a system that avoids more fragmentation and creates a real scope of services. Some states have a list of services, but those are not always flexible enough to meet a person's needs. A few states have said they will pay for whatever is appropriate and cost effective, which makes it unnecessary to even have to think about all the services a person might need, but instead allows flexibility to fund something they may have not even thought about.

Dr. Mollica said if the state is interested, a single entry system is a way to tie together all of the fragmentation. When individual providers are funded and delivering, every provider has its own case manager and no one is in charge overall. Home health agencies may not make referrals to the adult day care center or to a professional care or assisted living provider because it means they are going to have to give up their client and their source of revenue. He suggested a case management system agency that is more independent might be a way to build a system.

Senator McGinness thanked Dr. Mollica for his presentation and assessment of the state's position. He said it is good news to learn that Nevada is in an enviable position, but living in the state probably makes it impossible to see the forest for the trees.

Dr. Mollica said it is also difficult to make comparisons with other states, and when it comes down to it, the state must come back to its own context and pressures and make decisions based upon what is happening in Nevada.

Chairman McGinness then introduced Dr. Lawrence J. Weiss, Director and Associate Clinical Professor, Sanford Center for Aging, University of Nevada. Dr. Weiss' professional experience over the past 25 years encompasses health and aging services administration, research and management, as well as program planning, process evaluation, and program development. His experience has primarily focused on issues relating to health and human services and the best methods for achieving cost effective, quality public and private delivery systems. His current responsibilities include the administration of aging-related educational activities, research, and service programs for the University of Nevada. The Sanford Center for Aging is designed to benefit all seniors in Nevada through the exploration of innovative

strategies to enhance successful aging.

Dr. Weiss received his M.A. and Ph.D. in Health Psychology at the University of California, San Francisco. He has been an Assistant Clinical Professor with the Institute on Health and Aging and formerly in the departments of Physiological Nursing and Family and Community Medicine at the University of California, San Francisco. He also co-authored (with Dr. Evashwick), Managing, The Continuum of Care, Aspen Publishers, Inc.; Rockville, Maryland, July, 1987.

Dr. Weiss remarked that one of the important issues is the language used. Long-term care has many images and stereotypes and has primarily focused on nursing home care. He prefers to use the term "chronic care" because it refers more to a spectrum of integrated services that assists people with chronic health conditions in living fuller lives. It refers to a continuum of care required over a prolonged period of time for people who have lost functional abilities. A continuum assures a person receives appropriate, accessible, and efficient care across time, place, and disciplines. Dr. Weiss referred the committee to a document in the meeting packet entitled "Chronic Care in America: A 21st Century Challenge" (Exhibit "F", original on file at Legislative Counsel Bureau). The document was prepared by the Institute for Health and Aging, University of California at San Francisco, for the Robert Wood Johnson Foundation in August, 1996. He remarked the document provides some ample information as to the incidences and degree of severity of the crisis being discussed. The report projected that in the year 2000, there will be 100+ million people with chronic conditions in the United States, costing over $500 billion. Twelve million of those people are unable to live independently. By the year 2050, the report projects, there will be 167 million people with chronic conditions, costing over $900 billion, with 42 million of them unable to live independently. Dr. Weiss noted those projections reveal this is not just a problem of today—it's a problem of tomorrow.

Dr. Weiss referred to Exhibit "G," on which he said he had provided testimony in January of 1998 for a U.S. Senate Special Committee on Aging field hearing. He said the document contains issues surrounding integrating care and developing an integrated delivery system. The document contains four major issues in the establishment of an integrated delivery system:

1. Expand the definition of long-term care, incorporate the concept of "continuum of care" which treats the person across settings and over time;

2. Enhance the role of the consumer and market forces to develop a new model of care;

3. Employ service integration techniques, especially focused on acute and chronic care;

4. Conduct research which aids the legislature and the Department of Human Resources with informed decision-making information and data through various types of experimentation and demonstration, that includes not just cost issues, but even more importantly, quality of care outcome issues.

Dr. Weiss said he had just received a document from Dr. Charlene Harrington from the University of California at San Francisco. About a year earlier, Dr. Harrington had conducted a national study for the Health Care Financing Administration, for which she selected Nevada as one of five states to look at. He read the introduction to the study, which outlines some of the issues around Medicaid home- and community-based care in Nevada:

> Nevada is a small state with a rapidly growing population. Nevada has been one of the most conservative states in the nation in its Medicaid program. The state ranked last in the nation in terms of its total Medicaid expenditures per capita, $302 per capita; 50th in per capita nursing facility expenditures, $40 per capita; and 38th in expenditures for intermediate care facilities for the mentally retarded in 1998. The state Medicaid program had goals of expanding its home- and community-based services as alternatives to institutionalization. To this end, the state had developed a small personal care services state option plan with 853 participants in 1999. In addition, the state had developed four 1915C home- and community-based waiver programs that provided services for individuals with mental retardation and related conditions, the aged in the community, and the aged in group homes, and

individuals with physical disabilities. Even though these waiver programs had grown to 1,515 participants, Nevada ranked 44th in waiver participants per 1,000 in 1997. At the same time, expenditures for the home- and community-based waiver programs increased substantially over the past six years. Nevada ranked 46th in the country in its home- and community-based waiver expenditures per capita. Not surprisingly, the state had a sizable waiting list for home- and community-based services in three of its four waiver programs. Advocates complained that home- and community-based services were not available to meet the demand for care by the severely disabled. These problems were exacerbated in the past two years because Nevada had experienced a general state budget crisis and took substantive measures to reduce the Medicaid budget, including freezing provider reimbursement rates and new admissions to the waiver programs. Thus the fiscal crisis dominated the Medicaid home- and community-based waiver program decisions and implementation.

Nevada had other potential barriers to the expansion of home- and community-based services waiver programs discussed in this report. These include restrictive eligibility limits on the program, conservative administration of the Medicaid program, political opposition to expanding home- and community-based services, service cost controls, expanding nursing home beds, shortage of home- and community-based service providers, low Medicaid long-term care provider reimbursement rates, and limited advocacy activities.

Dr. Weiss reminded committee members that he had read only the introduction to the report, but it reflects the flavor of the contents of the 30-page report. He said he would like to address some specific recommendations—some deal with the issues in Dr. Harrington's report, others do not. It was his hope his comments would address the intent of the established legislative resolution, SCR 4.

Little is known really about the use and need of the health and human service systems. Dr. Weiss said it is difficult to assess if the current systems are appropriate, responsive, and financially viable, or to determine what new systems may be needed. He said his proposed ideas encompass research and data projects, demonstrations, training programs, and policy initiatives important to the state and to the mission of the Sanford Center for Aging at the University of Nevada. The goals of his proposals are:

1. To support individual autonomy, decision-making, quality of life, and independent living for Nevada's chronically ill seniors;

2. To provide information and data through research, demonstrations, and other ways of testing ideas for state policy development related to aging, health and long-term care or chronic care services;

3. To assure that an adequate supply of trained professional gerontologists, geriatricians, and other health professionals, as well as paraprofessionals, is available to meet the needs and support the service needs of Nevada's seniors, especially those that are chronically ill;

4. To assure that Nevada's seniors receive the highest quality of chronic care services available; and

5. To facilitate and maximize the use of private, Medicare, and other federal resources to support the aging, health, and long-term care services for Nevada's seniors.

Dr. Weiss provided a brief summary of his recommendations, along with rough cost estimates (see Exhibit "H" for detailed information).

1. Research and Demonstration Entity (Cost: $300,000 - $500,000/year)
The state needs to take a proactive and exploratory approach and identify a research body to work with the Department of Human Resources and its constituent divisions.

2. Planning and Policy Development (Cost: $50,000 - $100,000/project)
Develop a planning model for long-term care that projects the need for institutional and home care services.

3. Planning and Policy Development (Cost: Unknown)
Develop a long-range plan for health and human service system for seniors and disabled based on data obtained through state-of-the-art technology.

4. Research and Policy Development (Cost: $100,000 - $250,000/year)
Develop a cross sectional longitudinal panel study of older Nevadans. This study would generate information about demographic, health, social support structures, service use, and needs across community and institutional settings.

5. Quality of Care (Cost: $75,000 - $150,000/project)
Evaluate client satisfaction with Medicaid-eligible groups.

6. Cost Benefit Research and Policy Development ($100,000/project)
Evaluation of the interface or duplication between Medicare+Choice plans and state aging programs.

7. Consumer/Self-Directed Care (Cost: $100,000/year)
Consumer or self-directed care maximizes the consumer's role and decision-making abilities and creates partners in wellness.

8. Caregiver Burden and Quality of Life Study (Cost: $150,000/year)
Eighty percent of the care for disabled chronically-ill persons occurs through the informal support system.

9. Quality of Care in Group Homes (Cost: $100,000)
Group homes and assisted living facilities throughout the state should be surveyed to evaluate satisfaction levels of residents, employees, and families.

10. Long-Term Care Manpower Development Training
(Cost: $300,000 - $700,000/year)
All aspects of health care manpower for chronically ill elders must be enhanced. The state is currently grappling with a severe shortage of adequately trained personnel.

11. End of Life Ethical Care (Cost: $250,000/year)
Given that approximately 80% of the cost of health care occurs in the first and last years of life, some attention on how to curb these expenses needs to be explored.

12. Home and Community-Based Long-Term Care Alternatives to Institutionalization
(Cost: Depending on scope)
The state's CHIP program needs to be enhanced. With a waiting list of over 800 persons for both the state and the Medicaid programs, the CHIPS program needs to at least double in size.

13. Integrating Assisted Living and Medicaid Long-term Care Services
(Cost: Unknown; demonstration - $400,000)
Affordable housing with services must be developed for those who do not have $40,000 annual income. Low- to moderate-income elders need access to assisted living settings.

14. Medicare/Medicaid Integration Program (Cost - $0)
The state has a unique ongoing federal Medicare demonstration program through the Health Plan of Nevada, the Social Health Maintenance Organization (Social HMO). The state Medicaid program needs to learn about the Social HMO, which provides a package of traditional acute care and long-term care benefits.

15. Community Integration Plan (Cost: Unknown)
Per the recent Supreme Court "Olmstead" ruling on Title II of the ADA, states are required to provide community-based services for persons with mental disabilities. In order to accomplish this, Nevada must develop a Community Integration Plan that a) assures anyone applying for Medicaid is told they have an option to live at home and use Medicaid money for services; b) those in nursing homes or other institutions have the same option; and c) has a reasonable time table for accomplishing these objectives.

16. Volunteer Programs (Cost: $100,000/year)
Both federal and state programs currently fund volunteer efforts in working with the chronically ill and disabled elders through such programs as RSVP or Senior Companion. Enhancement efforts need to tap into the volunteer community and develop programs like the Special Advocate for Elders (SAFE).

In making the sixteen different recommendations, Dr. Weiss said he tried to cover the various components of the state resolution, everything from manpower to utilization of current resources to establishing quality programming to manpower issues. He said he does not necessarily have all of the answers, but he believes the Sanford Institute for Aging has the resources to find the answers and explore and test various approaches. He feels change should be implemented incrementally and with as much information as possible.

Senator McGinness thanked Dr. Weiss for his presentation. He asked for questions from the committee.

With regard to Recommendation 11, curbing expenses during the last year of life and a "good death," Senator Care asked if there is a way to tie in the expression "good death" with curbing expenses during the last year of life. Dr. Weiss replied health professionals are trained to cure, they are not trained to comfort. Hospice is an example of how to provide comfort care and pain management, and is a more ethical care—it is a care that focuses on the individual choices of the person rather than what the health professionals are trained to do. If people are given the ability to make those decisions and the format to make those decisions, and then communicate with their families, significant others, and health care providers, in many cases they do not choose aggressive interventions of acute care. Dr. Weiss said this would curb many of the costs alluded to.

Chairman McGinness again thanked Dr. Weiss for appearing before the committee. He then moved to Item VI of the Agenda, Presentation on Affordable Assisted Living for Older Nevadans.

Jon Sasser, Washoe Legal Services, said he was one of five witnesses who will outline a concrete proposal which encompasses many of the ideas and recommendations previously presented. It is his hope the committee will take action on the proposal and move it forward to the next session of the legislature. He distributed written testimony for the record (Exhibit "I"), which he said he would not read but would instead provide a brief overview. Details of the project will then be discussed by the other four presenters.

Mr. Sasser explained the group's goal is to offer a proposal that will fill a critical gap in the needed continuum of services in Nevada—the lack of affordable assisted living care for Nevada's lower-income seniors. He noted that Dr. Mollica and Dr. Weiss had emphasized the need for this assisted care. Currently the state has the ability to pay for someone in a nursing home whose income is up to $1,500 a month, at an average cost to the state of about $2,600 per recipient, or to serve some of those people outside of the nursing home in their homes. This service takes place in a couple of different ways: If the client has a low enough income, i.e., less than $500 per month, to be on the SSI program, he gets Medicaid coverage, and as part of that coverage he gets access to personal care and home health services that can get him out of the nursing home and into his home. However, if an individual's income falls between $500 and $1,500 a month, there is basically nothing available in the community, with the exception of two waivers, both of which have long waiting lists. Mr. Sasser described the two waivers:

1. The CHIPS waiver for individuals who can be cared for outside of their homes with incomes up to $1,500 a month, and who can benefit from the following services:

    - Case Management

- Homemaker
- PCA
- Day Care
- Companion
- Respite
- Chore
- Personal Emergency Response System
- Nutrition (starting 7-1-00)

One problem with Medicaid and the CHIPS waiver is it does not pay for room and board. There are two reasons the CHIPS waiver does not keep people out of nursing homes once they reach a certain level of need:

- They may need more care than the CHIPS program offers. For example, they may need access to services 24 hours a day rather than the few hours a day provided under the CHIPS program.

- They may need assistance with a roof over their heads, especially those people who are leaving a nursing home and trying to come back to the community. Medicaid presently cannot pay for room and board.

Mr. Sasser said their proposal would be to web together two independent sources of government funding with the participation of the private sector to address this gap. The two sources of funding would be a Medicaid waiver that would provide the medical services to people needing assisted living, coupled with funds from the federal low-income or affordable-housing programs, which would provide the bricks and mortar to build apartments or residential units that people will live in. He explained under the present system neither of the two programs can do the job alone. Medicaid cannot do the job because it cannot pay for room and board, and the federal housing programs cannot do the job because they cannot pay for medical services. Mr. Sasser noted these two arms of government do not help each other at all.

The proposal, Mr. Sasser continued, is to provide a waiver in which developers of housing can apply for currently existing federal funds, which will be described in much more detail by Eileen Piekarz, to put together the bricks and mortar for places for people to live, and then through a Medicaid waiver, the services needed by those folks in the assisted living facility would be provided Medicaid dollars. Mr. Sasser said this would be a way to maximize the leveraging of funds, and it can probably be done within existing resources as a way to cover the existing gap in the present service system that pushes people into nursing homes before they need to be.

2. The Group Care waiver provides room and board. However, this waiver has severe limits, the main one being that it is available only to individuals on SSI, i.e., people who are disabled or aged and who, if they live independently, would only have a monthly income of $500. He said the state pays a supplement to the SSI payment to bring the total payment up to $850 per month if they live in a group care home. The $850 goes to room and board, with a small amount kept for personal needs. They are also allowed to be eligible for the Medicaid program, for which they will receive personal care and case management services.

   The disadvantage, Mr. Sasser explained, is that a more typical Social Security recipient on disability, who is living independently and has an income of $600, $700, or $800 a month, cannot take advantage of the Group Care waiver.

At this point, Mr. Sasser said he would like to turn the presentation over to the other witnesses to provide a more in-depth view of federal housing programs, other trends throughout the country, some description of the need in Nevada, and specific details of the group's proposal.

Eileen Piekarz, Executive Director of the Affordable Housing Resource Council in Reno, said she was appearing before

the committee to provide information on some of the existing affordable housing programs in use in Nevada and why these programs alone cannot provide affordable assisted living. She said the group is not asking for any additional housing dollars through its proposal, but is asking for a Medicaid waiver that would be used in conjunction with affordable housing programs. She noted that Dr. Mollica had mentioned that family supplementation of income is often necessary to cover the housing portion, even in states where there is a Medicaid waiver to cover the services portion. Affordable housing programs would be a way to reach the same goal. She then provided the following testimony:

> Housing is defined by federal and state (NRS 319.510) governments as affordable when the household is paying no more than 30% of its gross income for housing costs, which would cover utilities as well as housing. Households paying more than 30% of their income for housing costs are considered to be overpaying for housing, leaving less money available for other necessities such as food, clothing, transportation, health care and education.
>
> The majority of programs that provide financing for affordable rental housing are restricted to developments that serve households earning no more than 60% of the Area Median Income (AMI) as determined by the U.S. Department of Housing and Urban Development (HUD). In Washoe County, a one-person household at 60% of AMI would have an income of $23,220 annually. The Medicaid waiver being proposed would target folks up to $1,500 a month, or $18,000 a year, about 45% of AMI. This level cannot be served, as far as the housing costs, by the open market—subsidies are typically required.
>
> Affordable housing programs that provide monthly rent subsidies to produce affordability are not very rare. What is most common is that affordable housing is developed with a combination of conventional lender financing and capital from subsidy sources, so that the overall debt service is reduced compared to market rate housing. This lower debt service allows for property owners to charge lower, affordable rents. However, these capital subsidy sources only support the cost of the building and cannot pay for ongoing services such as personal care and case management associated with assisted living facilities.
>
> Some of the common capital subsidy sources in use in Nevada administered by local and state governments are:
>
> **HOME Investment Partnerships Program.** Commonly known as HOME funds, this federal program is typically given out as grants or low-interest loans and is designed to fill the gaps between the debt the project can support and what it needs to construct the building. The program is administered by the Nevada Housing Division and three local government consortia (Clark, Washoe, Western Nevada).
>
> **Low Income Housing Trust Fund.** The Low Income Housing Trust Fund, a state-generated program, operates very similar to the HOME program, and is funded by transfer taxes on real property. This program is also administered by the Nevada Housing Division and the local government consortia.
>
> **Low Income Housing Tax Credits.** The Low Income Housing Tax Credit is an IRS program, administered by the Nevada Housing Division, which generates equity in the property in trade for tax credits an investor can use over time.
>
> **Tax Exempt Bond Financing.** Tax exempt bond financing is one of the larger sources and is more appropriate for larger developments, 150 units and up. This program is administered and allocated by both local governments and the Nevada Housing Division.
>
> **Rent Subsidy Programs.** The few affordable housing programs that provide rental subsidies include Section 8, administered by public housing authorities, and two specific programs, Section 811 which provides housing for the disabled, and Section 202 which provides housing for the elderly. The rental subsidies associated with all three of these programs can be used only to pay for housing costs and, again, cannot pay for services such as personal care and case management associated with assisted living facilities.

There is a recognizable need for affordable assisted living among the affordable housing community. The Draft Housing and Community Development Needs Assessment for Washoe County found that in the Reno/Sparks area, the typical monthly charge per person in an assisted living facility ranges from $2,800 to $3,200. On an annual basis these charges amount to $33,600 to $38,400, far more than being proposed under the Medicaid waiver. The same study found that 1,540 frail elderly with personal care limitations in Washoe County fall below the $35,000 per year it takes to get into an assisted living facility. Reducing housing costs through the existing affordable housing programs takes care of half the battle in meeting the needs of the low-income frail elderly, but there is also a piece needed to pay for the costs associated with other assisted living services. The Medicaid waiver being proposed for assisted living facilities would provide that missing piece for those Medicaid eligible elderly persons whose incomes are below $1,500 per month.

Coordination with state and local agencies will be necessary to make sure that affordable housing programs can be successfully linked on the right kind of timeframe with any new Medicaid waiver program. There is already a recognition of the need for affordable housing for elderly, frail elderly and disabled populations among the three counties in local government consortia and the Nevada Housing Division. Furthermore, the Housing Division already has in place a priority for senior housing, including assisted living, for their bond program, and is launching a study of the current supply and demand for senior housing and the existing supply in Nevada, including assisted living.

It will be up to advocates for affordable housing, seniors and the disabled to work with these various funding agencies to ensure that the right priorities are submitted at the right time so that when a Medicaid waiver can be enacted, the funding is also available from the capital end to build the facilities. Given that this is already a growing concern, I am confident that we can work that out.

Chairman McGinness thanked Ms. Piekarz for her presentation. The next speaker for the project was John Rimbach, A.F. Evans Company, Inc.

Mr. Rimbach said in 1993, as a result of a grant from The Robert Wood Foundation, he was involved in launching a program known as “Coming Home,” which had the objective of figuring out the “how to” of developing models of assisted living that would be affordable to low and very low income individuals. To meet this objective, the Coming Home program addressed a number of issues, including:

- How to work with third-party payors who pay for support services such as Medicaid, targeting the low-income population;
- How to develop cost-effective and efficient ways to develop and operate the assisted living facilities;
- The methodology and process for pursuing and completing development of projects using local community-based sponsorship; and
- How to secure and structure financing that reduces the overall project’s costs of capital to a level that is supportable by the affordable rent levels that are necessary to reach this population.

Mr. Rimbach has been involved in development projects in the states of Arkansas, California, Colorado, Connecticut, Illinois, Iowa, New York, New Jersey, Oklahoma, Oregon, and Virginia, all focusing on this issue. Specifically, he has worked with Arkansas, Iowa, Illinois, and Oklahoma to create programs for facilitating Medicaid reimbursement of assisted living. He said he is currently working with the states of Connecticut and Virginia to adopt their programs, and he hopes to be working with the state of Nevada also.

Mr. Rimbach said assisted living is a fairly recent phenomena, coming into existence about five or six years ago. He thought if operators of assisted living facilities were present, they would talk about their product being affordable, based on their target market. People in the private assisted living business do not develop a product that is not affordable to

this segment of the population.

Generally, Mr. Rimbach continued, individuals will spend anywhere from 75 to 80 percent of their disposable income for assisted living. Nationally, the average an individual pays for assisted living is slightly over $2,000 a month and in Washoe County, the average is about $2,500 to $2,800 a month. This translates into a qualifying income of about $35,000 a year needed to afford today's assisted living product. Actual income of residents living in assisted living today is only about $30,000. Of the 10.2 million seniors age 75 years and older, approximately 65 percent have incomes under $25,000, so today's assisted living product is definitely being targeted to the upper-income group, and there are very few choices for individuals at the $25,000 and less level.

Mr. Rimbach reviewed some of the reasons affordable assisted living is needed:

1. It is a proven consumer-friendly, cost-effective long-term care environment. This has been indicated by the demand in the private pay marketplace.

2. Assisted living has very high occupancy rates. There has been a decrease in nursing home occupancy rates since the advent of assisted living.

3. Case studies will show that there is improved health condition of individuals residing in this long-term care setting.

4. Assisted living can generally be provided in the private pay marketplace for about 75 percent of the skilled nursing facility lease rates.

Mr. Rimbach said another component of assisted living is the "age wave effect," which will produce 20 million people age 85 and over within the next 50 years. Twelve million of those people will have incomes of less than $25,000. He emphasized it is necessary to focus on and deal with this problem today so it doesn't hit all at once down the road.

The reason Mr. Rimbach advocates assisted living is that most people do not want to enter the existing long-term care system that has been set up. A bureaucratic administrative decision was made back in 1965 to institutionalize long-term care in this country. Seniors are institutionalized for having needs that are similar to those of 3-year-olds, but we would never institutionalize a 3-year-old having the same needs. Some seniors eek out an existence; they postpone entry into a quality long-term care environment because they do not want to enter a nursing home. As a result, there is a greater incidence of advanced acute care. Mr. Rimbach said that just monitoring an individual's nutrition, hydration, and medication in a quality long-term care environment can go a long way toward improving his health condition.

For the poor elderly, Mr. Rimbach continued, substandard housing is a cause for many health problems, both psychological and medical. Obviously, the need for affordable assisted living is because the federal and state governments find themselves in the business of funding long-term care. Existing skilled nursing facilities in operation are just not able to keep up with consumer demands for choice and the fiscal responsibility of government to cover those costs.

Mr. Rimbach reviewed some of the barriers facing assisted living:

1. State and federal budget constraints are first and foremost. Any proposal needs to be fairly budget controlled.

2. These programs and projects are essentially nursing home diversion programs. The critical component is case management and an integrated entry system, providing screening, assessment, and assistance with placement of individuals in the appropriate long-term care setting.

3. Another barrier is because of what was instituted in 1965, 80 percent of existing nursing home residents receive public-pay assistance. The nursing home industry has been created, although it is not as big an issue in Nevada as in other states. However, this really bothers nursing home lobbies and providers, and a public decision needs to be made as to whether the state has the political will to change its long-term care system and

provide seniors in the community with a choice of long-term care options.

4. Targeting the $25,000 and less income group results in focusing on a pricing point that cannot exceed roughly $1,400 a month, which goes back to spending 70 to 80 percent of disposable income for care and services. Operating expenses for assisted living run somewhere between $850 and $1,675 a month (the service component only, not the shelter component).

Mr. Rimbach said assisted living is a combination of a housing option and a service need, and it is the combining of the shelter component with the services that really brings assisted living to the forefront of long-term care. He also noted there is a lot of confusion about what assisted living actually entails, and he gave the committee his definition:

> Assisted living is a residential environment where services are provided, and those services have the presence of hands-on care provided by staff within the facility. The presence of hands-on care for assistance with ADL limitations, i.e., activities of daily living such as bathing, dressing, ambulation, hygiene, etc., is the difference between assisted living and other forms of congregate care. It is the absence of true medical care that differentiates it from the nursing home or skilled setting.

Mr. Rimbach explained that in order to reach this population, it is necessary to rely on public sector programs and public sector dollars. Currently there is a very fractured delivery mechanism for these public sector dollars. Referring to Dr. Mollica's earlier testimony, Mr. Rimbach said the Medicaid dollars will not pay for housing—they pay for services. The housing dollars cover housing—they do not cover services, and if services are provided, the program is penalized in terms of what an individual can be charged.

Mr. Rimbach noted the group is not necessarily looking for any great modifications in existing programs. With some modifications, the existing programs available in Nevada can be used to replicate what has been done in some other states. He was involved in a Coming Home program in Illinois in 1996, when the state came up with the idea of changing its long-term care environment. The Illinois Department of Public Aid, which administered Medicaid, was paying for about 56,000 individuals in nursing homes. The department spent about $1.3 billion a year for those 56,000 individuals, roughly $1,935 a month each, but the department quantified, based on their own determination of need, that about 30 percent of those residents did not have medical needs or require 24-hour nursing care. Thus, Mr. Rimbach surmised, they were expending a lot of dollars to serve a population that was basically being institutionalized when it didn't need to be.

Illinois decided to develop a program similar to that being discussed today, basically a demonstration program under the home- and community-based waiver for supportive services in a residential environment; they called it the Preferred Provider Program. Combining Medicaid dollars with a small portion of state match dollars to pay for meal service, which Medicaid does not usually cover, provided the mechanism to pay for a full complement of assisted living services in a residential setting. Today, the average reimbursement is about $952 per enrollee in the program.

Mr. Rimbach was involved with a project in Ullin, Illinois, a town with a population of 550 people. The project consisted of a 40-unit assisted living facility, which was fully leased within 45 days of opening its doors. The first fifteen residents in the facility came directly out of a nursing home. Therefore, Mr. Rimbach remarked, the state was saving $1,000 a month per individual by placing clients in a more appropriate residential setting. As of today, he has been involved in development of 180 units now operating in southern Illinois delivering assisted living services to a very low-income population.

Noting that the $952 per person pays for the services component, Mr. Rimbach said the next issue is how to pay for the shelter component. All of the units in the Ullin facility are available to low and very low-income residents, and using public sector supplemental payments, the rent level is reduced to an affordable price based on their SSI income, which was $407 per month average for this project. The SSI supplemental program in Illinois provides $625 per month, so there is even a retained amount for personal needs. Mr. Rimbach explained two different housing financing programs were combined, a conventional loan for about $700,000 and $500,000 in Illinois Trust Fund loans, along with accessing the low-income housing tax program, which is the primary funding vehicle in the country for the production of affordable housing.

Coming Home and the sponsorship of The Robert Wood Johnson Foundation evolved from the initial idea of demonstrating actual projects through development, which is the component in which Mr. Rimbach was involved. Since he left after the completion of the program in May of 1999, The Robert Wood Johnson Foundation has instituted a new program entitled "Coming Home II", which is more focused on the public policy aspects of facilitating the development of assisted living for long-term care.

Once policy decisions are made and guidelines are developed, Mr. Rimbach's focus would be to work with providers within the state to implement the program and deliver the services to the constituents to be served. One of the most important issues affecting development will be sponsorships, their objectives, their operating philosophy, and their dollar resources. He said in today's environment it is difficult to take existing providers who may be providing housing and services in the community and get them to adapt to a program which is focused on the population the program is looking to serve. Mr. Rimbach said the capital structures of their buildings, their financing, and their operations do not necessarily facilitate the best mechanism for serving scarce state and federal resource dollars. Consequently, they have developed models which work for their private pay marketplace. Even though there will be new sponsorships, buildings and services still cost money. However, he continued, reducing or subsidizing those operating costs that are generally supported by resident rents is the key to creating affordable assisted living. It is truly an issue of public policy debate. There are so many interested parties, but there must be collaboration and compromise between different state agencies who might influence this program to make them work together. Mr. Rimbach said he would advocate that in terms of drafting a program, there be a concise and consistent state policy regarding using all the resources available to the state to bring together something that will work for low-income seniors in Nevada.

Karen Mabry, Director of Washoe County Senior Services, introduced the project consultant, Bruce Arkell, who has a background in state and county experience. Ms. Mabry said she was delighted to hear the previous testimony—she has thought she has been living and breathing something on her own, but the previous presentations validated the reason she is appearing at this meeting. She explained the reason she titled her presentation "Nobody Fits into a Box" is because Washoe County Senior Services has been providing assistance to individuals over the age of 60 for over 20 years. Because of the complex needs, wants, and desires of clients, she is acutely aware that client problems are not resolved by a "one size fits all" quick-fix approach. Ms. Mabry said Washoe County Senior Services has been working for several years on the Washoe County Eldercare Project, which is basically a pilot project that will meld all housing, medical, and community services using public-private partnerships in order to affect and enhance the quality of life in Washoe County.

Ms. Mabry said because of their experience during the past three years, Washoe County Senior Services has been exploring the possibility of creating a program designed to address the social, health care, and housing needs of low-income seniors. The objective is to develop a safe, secure, and home-like campus of continuing care featuring affordable assisted living and group care options that promote resident independent living through a system of programs currently offered by the department, as well as the addition of preventative health care.

In addition, Ms. Mabry said many services will be available to residents in the general community. Patterned after the PACE model (Program of Auspice Care for the Elderly), which is now a permanent waiver program, the concept was expanded from a primarily medically based focus that targeted only those who are nursing home eligible. The proposal adds housing and broadens the target to include those who are at risk of placement. By expanding the target, Ms. Mabry said it was felt that if at-risk seniors were identified early and steps taken to assist them before they become critical, they may never need acute or nursing home care.

With regard to the delivery system, Ms. Mabry said the current system is composed of many public and private agencies, and it is not uncommon for a single elder to have multiple case workers. The unfortunate reality of the scenario is:

- The client may receive contradicting care;
- The agencies do not communicate effectively and frequently enough to ensure that service is being provided or monitored appropriately;

- Clients become confused;
- Clients begin to play one worker against another;
- Agencies may be working at cross purposes as a result of their respective policies and procedures;
- Multiplicity of case workers becomes invasive; and
- Duplication of effort results.

Ms. Mabry explained the Eldercare Project calls for a different delivery system, which would include one care coordinator to work with an inter-disciplinary team to address clients. The team may be composed of representatives from multiple agencies through contractual arrangements, but the care plan would be under the direction of a single entity.

In putting together the project, Ms. Mabry said there are many pieces to the puzzle which need to be brought forward. Because of the complexity, there are many serious issues. To be effective and successful, all of the pieces must come together, and she said that in itself has been no easy task. She reviewed a slide which reflects the various pieces:

- Program Participants: The current data base of program participants represents individuals with incomes below $15,000.
- Private Sector: From the private sector, assistance would be sought from the private non-profit corporation, which is Senior Alliance for Support Services. Medical providers, private foundations, and the congregate housing piece would also be required.
- Local and State Government Services: These services are the challenging issues and include Aging Services, Reno Housing Authority, Washoe County Senior Services, Nevada Health Care Financing, other local and state agencies, and other Washoe County Divisions.
- Federal Government: Medicare/Medicaid, Veterans Affairs, HUD, and other federal programs.

Ms. Mabry remarked that one thing that needs to be recognized in pulling the pieces together is that as a public partnership, it is critical each agency or party member brings to the table a combination of, not only their expertise, but their resources as well.

The project is expensive, Ms. Mabry continued, and the following potential funding sources have been identified:

- Existing state, county, and local budgets;
- Medicare/Medicaid waivers;
- State and local medical assistance funds currently in use but might be rerouted;
- State and federal housing funds; and
- Many private foundation grants.

In putting a project together of this complexity, Ms. Mabry said many obstacles are anticipated, some of which are:

- Change from the status quo;
- Turf issues – both public and private;
- Timing of federal and state approvals;
- Funding;

- Time to implement; and
- Legislation.

Ms. Mabry said her group feels they have a concept and that justification has been presented, and they would appreciate some serious consideration in terms of assisting with their effort. She said a full complete report including a specific and very fine-tuned financial analysis will be brought back to the committee at a later date.

Once again reviewing the delivery system, Ms. Mabry pointed out that the end result of the proposed project will be a change to the delivery system. It will no longer be the traditional approach, but a non-traditional approach offering a system that is more humane and a community-based approach to care. It offers better cost control and, more importantly than anything else discussed, it offers better client and family satisfaction with regard to the needs of older adults.

Ms. Mabry suggested that as an outcome, it is anticipated that the proposed project will result in an initial 10 to 12 percent savings if institutionalization can be avoided or postponed for at least two-thirds of the targeted population within the first year. She noted this is consistent with Dr. Mollica's earlier presentation.

Ms. Mabry summarized her presentation by saying if serious consideration is to be given to any alternatives to the present long-term care issue, policymakers and service providers must begin to think out of their respective boxes.

Chairman McGinness thanked Ms. Mabry for her presentation. She remarked a longer presentation had been planned, but reiterated that a complete formal report will be submitted to the committee at a later date.

Assemblywoman McClain asked which agency would be the appropriate one to serve as the single point entry agency. Should it be local or should it be on the state level? Ms. Mabry feels it should be the county because it is closer to the population. Also, most county agencies are charged with direct services, whereas many state agencies are charged with only administration and supervision.

Assemblywoman McClain wondered about the problem of funding, saying it would stand to reason if the responsibilities go to a different level, then the funding would need to follow.

Senator Care asked if the profile of the senior community in Washoe County is similar in Clark County. Ms. Mabry said the data had been recently secured as the result of an assessment process the County Human Services Consortium agency has gone through. She was not familiar with the data for Clark County.

Ernest Nielsen, Washoe County Senior Law Project, said all of the consortiums now are going through a five-year review in which they are doing updates on their needs assessments, so the director of Clark County's Home Consortium would have profile information.

Mr. Nielsen then thanked the committee for the opportunity to present the project information. He believes there is a substantial gap in need between the services provided by the CHIPS waiver and the nursing home services. He said this gap can most readily be filled by matching the Medicaid waiver with the state's existing affordable housing programs. He referred to a handout in the meeting packet (Exhibit "J") which describes the concept, and asked the members to read it at another time. Hopefully, Mr. Nielsen continued, the presentation has convinced the committee that there is a need for a waiver to fill this population gap, and that members understand that affordable housing programs cannot provide affordable assisted living without something else. Without the waiver, there will be no affordable assisted living for people whose monthly incomes are between $500 and $1,500. Mr. Nielsen said the waiver would serve both the state's interest and the clients' interests. He asked the committee to consider developing a waiver for presentation to the 2001 Legislature, and perhaps requesting the Governor to include a waiver of this sort in his budget.

Mr. Nielsen said the development of this proposal is not going to come about without much more additional work. He said there are a number of issues the committee may wish to take on, some of which are basically just number crunching, others being basic policy decisions. For example:

- Should an existing waiver such as the CHIPS waiver be amended, or should a new one be created?
- Should there be restrictions on who can receive the benefit of the waiver, or should it be available to all Medicaid-eligible elderly persons?
- Should a waiver be structured so that it would include Medicaid reimbursements for disabled persons as well?
- Is additional staffing at the state level needed to develop and administer a waiver of this sort? Perhaps through the work of this committee, the Executive Branch, and the community, an application could be fashioned to The Robert Wood Johnson Foundation's Coming Home Program.
- How many people currently in nursing homes would be better suited to residential assisted living and would wish to go there?
- Does there have to be additional statutory definition versus putting these facilities in regulations?
- How many people, as Dr. Mollica had discussed, are in the woodwork? Is a formal needs assessment required to determine what that number is?
- What are the projected long-term savings for the state if a Medicaid waiver associated with affordable housing is adopted?
- What is the perfect mix of services?

Mr. Nielsen said a big issue is whether the waiver should be structured as a pilot, where a limited number of slots are funded and affordable housing developers throughout the state are allowed to develop assisted living through the waiver. A pilot approach would allow development of the housing side of the formula and then evaluation of both budgetary impacts and quality-of-life issues with respect to the pilot to help determine the long-term direction desired. Time would also be allowed to develop systems which are needed to provide quality services implemented within the assisted living facilities.

Mr. Nielsen said there certainly should be some money associated with this type of pilot program. An important question is whether the Governor would be willing to budget the waiver in his next budget. He thought the committee may have some ability to communicate with the Executive Branch to see if that is a possibility.

Referring to Chairman McGinness' earlier statement that there would be no subcommittees, Mr. Nielsen remarked that development of the waiver is going to take a substantial amount of work by Executive Branch officials, perhaps some legislators, and many people in the community. He wondered if the chairman would be willing to sanction a working group that would be able to develop the concept with the Executive Branch and others to assure that by the time the committee is finished with its work, it will have a fairly concise and concrete waiver to propose to the Governor and to the Legislature. Mr. Nielsen thanked the committee for the opportunity to testify.

Chairman McGinness thanked Mr. Nielsen for his presentation, and asked if there were any questions from the committee.

Assemblywoman Leslie wanted to disclose that she works in the Washoe County Manager's Office and has done some work on the consolidated plan development; however, she has no ties to any developers and will not personally benefit from any decision made. As the grants administrator for the county, she had just received information on the Coming Home program, and she noted that only one application per state is accepted and must come from the State Medicaid Office. The deadline is March 1, 2000 for a letter of intent. Ms. Leslie was intrigued by some of the possibilities for funding, including an $8 million revolving loan fund to provide predevelopment capital. She wondered if there is any

movement in the community or at the state level to apply for the program.

Mr. Rimbach replied during the application process for Coming Home I, it was realized that it required a consolidated effort of the various state agencies coming together with their respective roles and respective funding to make the program work. The one application referred to is basically the state pulling its resources together to set up a foundation for the promotion of assisted living development within the state. There are no efforts under way currently to apply for participation in the program, only because it needs to be facilitated from a representative state agency, i.e., the Medicaid agency, the housing agency, or the Governor's Office.

Ernie Nielsen said there has been some discussion with the Division for Aging Services about this particular grant, so there is interest and the Executive Branch should be pulling together, perhaps with some assistance from the community, and putting forward something for the foundation.

Mr. Sasser suggested a letter from the committee to the Executive Branch making that recommendation might be very helpful.

Mr. Rimbach said the March 1 deadline is just for a letter indicating an interest in submitting a proposal; he thought maybe the Long-Term Care Committee could facilitate that letter from the Governor's Office by March 1.

Assemblywoman Leslie assured the committee there was no collusion—she had just received the Coming Home information the day before, and she would be willing to share it with the committee. She would hate to see the state lose the opportunity to apply for funding. Senator McGinness said copies of the information booklet would be made during the lunch break for the committee members' review.

Ms. Leslie said the idea of a waiver has come up with every discussion in the meeting, and she liked the idea of a demonstration pilot project because the costs can be contained. Everyone is concerned about costs when additional services are added in state government. She said she is confused as to exactly what it takes to develop a waiver. Recent newspaper articles have criticized the state for not having adequate resources to develop another waiver. She wondered if a future meeting could include a precise description of what is involved in the development of a waiver.

Carla Sloan, AARP Executive Director, testified from Las Vegas. She commended the contingent from Washoe County for their work on a highly innovative project. She offered the resources of AARP for research and background information for the project in order to meet the March 1 deadline for the letter of intent for The Robert Wood Johnson Foundation. Ms. Sloan said the project firmly supports AARP policy and the work of the AARP State Legislative Committee.

Senator McGinness thanked Ms. Sloan for her comments, as well as everyone else for their presentations.

Following a break for lunch, Senator McGinness resumed the meeting. He welcomed Steffani Crawley, Director of Government Relations for AEGON Insurance Group from Bedford, Texas.

Ms. Crawley said she was speaking on behalf of the American Council of Life Insurance, which represents approximately 500 life insurance companies in the United States. Her topic for the meeting would be the background of long-term care insurance, where it has been and where it is today, and how long-term care insurance can help in the upcoming funding crisis for long-term care in the future, as referred to by several of the morning speakers.

Back in the early 1970s there were some long-term care policies for sale, but according to Ms. Crawley, they were not really long-term care policies—they were along the line of nursing home only policies, since that was generally all they paid for. There were not very many insurers in the market at that time—there were only a handful of carriers. The market was relatively unknown, the risk was relatively unknown for paying for nursing home care, and there was not a lot of data on which to base pricing. Also, Ms. Crawley said in the 70s Medicare paid for a lot of skilled care in the hospitals. At the time Medicare's structure was such that a patient could stay in the hospital for a lot longer period of time, providing a longer period of time to recover from whatever illness he/she had; Medicare would continue to reimburse the hospitals. However, that changed in the 1980s. Given that Medicare would pay for the patients in the

hospital for such a long time, there was not much interest in long-term care insurance in the 1970s.
Also in that decade, Ms. Crawley said the family caregivers were much more closely concentrated; they were not as spread out as they are today, i.e., children had not moved away from their aging parents as much as they have today.

In the 1980s the policies available for sale were very similar to what there was in the 70s, but the development of the diagnostic-related groups (DRGs) under Medicare really changed the picture of financing for long-term care. The DRGs established a certain period of time that Medicare would reimburse hospitals for certain types of care, based upon whatever the diagnosis was, thereby severely cutting back on the amount of money that Medicare would pay the hospitals for patient care. The result was "quicker and sicker" discharges, meaning that patients were discharged a lot sooner than they had been before, and they were not as well recovered as they might have been previously.

Ms. Crawley said the private insurance market at the time offered only limited policy benefits. They were still covering mostly nursing home care; there was not much home health care coverage at the time, and there was definitely no inflation protection in the policies like there is today. There were also several restrictions to the benefits:

- 3-day hospital stay trigger – If a patient was in the hospital for at least 3 days, he could be discharged to a nursing home and still receive reimbursement from Medicare if he was discharged to the nursing home for the same reason. Long-term care insurance policies included that 3-day hospital stay trigger in their policies. This became a problem in dementia cases, because generally speaking, dementia patients are generally cared for at home, and there was no reason to put that person in the hospital. So when it became necessary to enter a dementia patient into a convalescent care or nursing home, the 3-day hospital stay would be bypassed, which meant the patient could not receive benefits from the nursing home policy because the trigger was not met. This requirement has since been removed.

- Waiting periods, also known as elimination or deductible periods – The policies in the 1970s and 80s usually had at least a 30-day elimination or waiting period, whereas today there are policies with zero day elimination periods, meaning benefits can start on the first day of nursing home care.

- Facility definitions were very strict—the nursing facilities had to meet very stringent conditions on the amount of care they provided. They usually had to have 24-hour nursing care available seven days a week.

- In the 1980s there was not very much in the way of insurance regulations to provide guidelines for nursing home policies or to provide for consumer protection. The result was some marketing abuses of the sale of nursing home policies. Fortunately, the insurance industry has regulated itself on this issue, as well as being regulated by the insurance department.

Ms. Crawley said in the late 1980s and early 1990s, the amount of regulations increased, which has been a good thing for both the insurance companies and the consumers. Also, the 3-day prior hospital stay was eliminated from most policies; it was eliminated from any new sales, but on existing policies that still had the 3-day prior hospital stay, most companies offered to eliminate the 3-day trigger through the purchase of an additional rider. Many policyholders took advantage of the offer.

The policies of the 1990s were called guaranteed renewable, meaning that the carrier could not cancel the policy for any reason whatsoever, unless the policyholder has not paid the premiums. In the 90s, home health care minimum standards were developed which outlined the minimum benefits that could be offered, generally at least 50 percent of the nursing home benefit. Also, it became required by regulation to offer an inflation protection rider, which was very much needed because medical care costs go up every year, and the inflation rider helps the policyholders' benefits keep up with inflation. The rider generally covers 5 percent compounded inflation.

Ms. Crawley said another consumer protection provision resulting from the 1990s regulations was the unintentional lapse protection, which means if the policyholder forgets to pay the premium for whatever reason, the company will notify him that he forgot to pay it and he has a 30- or 60-day grace period to pay the premiums. Also included is a 5- or 6-month period in which the policy can be reinstated by paying back premiums due.

The third-party payor notice can be stipulated by the policyholder at the time he purchases the policy. This provides for the designation of a person the company can contact if the policyholder forgets to pay his/her premiums. Other consumer protection provisions included in the 1990s are disclosure provisions and suitability provisions, i.e., making sure the sale of long-term care insurance is appropriate for that person.

Ms. Crawley reviewed the various products available in today's market:

- Nursing homes.
- Assisted living, residential care, domiciliary care.
- Home health care benefits.
- Adult day care benefits.
- Non-forfeiture benefits, i.e., if the policyholder allows a policy to elapse, a portion of the long-term benefits will be awarded if the non-forfeiture benefit had been purchased.
- Inflation protection—there are only two forms of inflation protection, simple or compound. Compound is more expensive, but is more beneficial to the consumer.
- Unlicensed caregivers—a home health aid can be allowed to come in and help with bathing, dressing, or eating.
- Alternative care provisions – if a policyholder is receiving benefits in a nursing home, then the policyholder, his physician, and the company can get together and discuss whether there is a more beneficial form of care that can be given to the policyholder. Sometimes this can result in home modifications such as wheelchair ramps or handrails, allowing the person to move from the nursing home back into his own environment.
- Caregiver training—a lot of today's policies will pay for informal caregiver training.
- Bed reservation benefit—keeps the nursing home bed "on hold" if the policyholder has to go into the hospital from the nursing home.
- Durable medical equipment.
- Respite care benefit—someone who is caring for their loved one can place the person in a nursing home to provide respite care for a few days or a week, up to 14 or 21 days per year.

Ms. Crawley said today's benefits are triggered based on an inability to perform activities of daily living. There are six standard activities of daily living (ADLs):

- Bathing
- Dressing
- Continence
- Toileting
- Eating
- Transferring

These activities are generally standard in all of today's policies, and the general trigger is the person has to be unable to perform at least two activities of daily living. Ms. Crawley said the nice thing about the activities of daily living trigger

is that it is an objectively measurable trigger.

The other policy benefit trigger is cognitive impairment. If the policyholder is cognitively impaired and unable to care for himself, policy benefits will be triggered.

Ms. Crawley cited statistics from a 1994 Health Insurance Association of America (HIAA) buyer's survey, which is the most recent data available:

- Average age of purchaser is 69 (now closer to 67)
- 61% of the purchasers are female
- 62% are married
- 79% have incomes over $20,000
- 82% have assets over $20,000
- 65% have some college education

Ms. Crawley then reviewed the characteristics of the typical benefits purchased:

- 61% are comprehensive, meaning they cover nursing home and home health care
- 5.1 years is the average for benefits
- $85 per day for daily benefits (this number is higher today)
- $1,500 average annual premium

Reviewing the impacts of baby boomers in the past, Ms. Crawley said in the 1950s and 60s the boomers had an impact on the schools—it was necessary to build lots of new schools to accommodate the school-age children coming through. In the 60s and 70s, more boomers were going to college than ever before—there was a greater college population. In the 1990s, the boomers have really affected the stock market—they have had a good impact.

Ms. Crawley then asked, what is next for the baby boomers? Hopefully retirement she said, and hopefully the retirement years will be filled with enjoying hobbies and doing things they were unable to do while raising children. However, as the boomers move in their 70s and 80s, their health and whether they can take care of themselves becomes a major issue.

Ms. Crawley said most of the statistics cited come from an American Council of Life Insurance (ACLI) study entitled "Who Will Pay for the Baby Boomers' Long-Term Care Needs?" (Exhibit "I", original on file at Legislative Counsel Bureau). The current national demographics of the boomers are:

- There are 35 million over 65 years of age today;
- By 2030, there will be 70 million;
- Average life expectancy is about 86 years.

In Nevada 585,000 baby boomers are expected to turn 65 years of age by the year 2030; the 65+ population is expected to increase 400 percent by 2030 (national average is only 119 percent); and 10 percent of Nevada residents will be 85+ by 2030. Ms. Crawley said in the year 2030 the demographics for Nevada will look more like Florida than they do today.

Nationally, the costs of long-term care range from about $70 to $100 billion. Ms. Crawley said the costs are expected to increase to $330 billion by 2030. She noted that today's Social Security budget is $330 billion, so future expenditures for long-term care will equal the amount of today's Social Security budget.

Nevada's long-term care expenditures were $156 million in 1995. By 2030, they are projected to be $2.3 billion (inflation-adjusted). The current long-term expenditures are broken down as follows:

- 13% Medicare
- 33% Medicaid
- 54% Private Pay

Ms. Crawley noted the above figures do not account for the additional county expenditures.

Long-term care expenditures are going to continue to rise due to the ever-increasing elderly population. More and more retirees will be moving into Nevada, and they will be living longer thanks to medical technology. Unfortunately, Ms. Crawley continued, those who are living longer are also more likely to have some sort of disability or cognitive impairment as they grow older. There will also be fewer family caregivers nearby to care for their loved ones because they have moved away from their parents for one reason or another, and the generation directly behind the baby boomers is a much smaller generation. She said it is reported that 21 percent of baby boomers were childless in 1995, so many boomers are not having children, and therefore those people will not have families to take care of them in their old age.

Who is going to pay for long-term care expenses? Ms. Crawley said Medicaid is currently paying the bulk of the expense. Medicaid was originally designed as a health care program for the poor—it was not designed to be a provider of long-term care for everyone. Medicaid and Medicare now pay for over one-half of all nursing home costs—Medicaid pays about 41 percent. Ms. Crawley said the federal government is tightening the controls on qualifying for Medicaid so that Medicaid is available for those who really need it, but maybe not available for those who can afford other options.

At the rate the baby boomer population is growing and aging, state governments will not be able to support their Medicaid budgets without raising taxes significantly or reducing the amount of benefits paid for by Medicaid. Ms. Crawley thinks it is unlikely that states can sustain the growth rate of long-term care expenses at the current tax rates.

Medicare is designed primarily as an acute health care plan—it is not designed to pay for chronic care such as nursing home stays. Ms. Crawley reiterated that Medicare will pay for up to 100 days of nursing home care, but only for skilled care; the patient must have the previous 3-day hospital stay before Medicare will pay; and the patient must be discharged from the hospital to the nursing home for the same reason in order to receive Medicare reimbursement for skilled nursing. She said 8 percent of nursing home stays are currently paid for by Medicare (as of 1996), and more recent reports indicate that amount has increased to 14 percent.

Medicare does pay for some home health care benefits, but generally speaking there must be a medical component in order for Medicare coverage. Medicare will not pay for someone to come in to bathe and dress a person on a daily basis, or even a couple of times a week. Ms. Crawley said if there is a medical component, such as rehabilitation from a surgery or recovery from an illness, then Medicare will cover home care. The Balanced Budget Act of 1997 developed the prospective payment system for home health care, which resulted in even more serious cutbacks on reimbursements for home health care under the Medicare system. Ms. Crawley said the cutbacks were so severe they drove a lot of the home health care agencies out of business, and the prospective payment system is still being debated in Congress today. It may eventually be modified, but Ms. Crawley did not think enough to make much of a difference.

Ms. Crawley added that Medicare and Social Security already have their own funding issues, and those issues are going to continue in the future with the increasing elderly population.

Moving to the issue of insurance, Ms. Crawley questioned if private insurance is a solution for the long-term care funding crisis. Clearly, she said, insurance is not a solution for people below a certain income level. The purpose of Medicaid is to pay for those who cannot afford to pay for the care themselves or cannot afford to purchase insurance. However, the baby boomers who can afford to purchase long-term care insurance are not planning for the future—they do not want to think about it. Most boomers are dealing with other financial issues, such as raising their children, saving for college education, etc. They are not thinking about their own future health care, although they are thinking about retirement, albeit not the financial issues of retirement and health care.

Ms. Crawley said a lot of people do not know who pays for long-term care. Many assume that Medicare is going to pay for all of their health care needs, no matter what they are. People also assume if they cannot afford health care costs themselves or if Medicare will not pay, then Medicaid will pay. She said people do not realize what is necessary to qualify for Medicaid, e.g., spend down nearly all assets ($2,000 in some states). People are just not educated enough about the funding issues of long-term care, which is the reason many boomers have not done anything about it.

Ms. Crawley cited statistics for Nevada regarding who can afford to buy long-term care insurance:

- Nearly 75% of the working age population in Nevada could afford to buy long-term care insurance;
- About 35% of those over 65 years of age could afford long-term care insurance;
- If everyone in Nevada who could afford to purchase a long-term care insurance policy did purchase such a policy, then the Medicaid expenditures in the future could be reduced significantly (national estimate is about 20%).

Referring again to the ACLI study (Exhibit "K"), Ms. Crawley reviewed some assumptions and projections based on who would purchase long-term care insurance and the Medicaid and out-of-pocket savings that could result.

- If everyone 35 years of age purchased long-term care insurance, by the year 2030 nearly 30 percent of long-term care insurance would be covered by private insurance as opposed to the 3 percent covered today.
- If everyone 35 years of age purchased long-term care insurance, the Medicaid expenditures could decline by as much as 9 percent, from 41 percent down to 32 percent, and personal expenditures would decline by about 17 percent, down to 31 percent. The result would be personal expenditures and private insurance would each account for about one-third of long-term care expenses instead of 40 percent and almost 50 percent out-of-pocket. Ms. Crawley noted the savings are significant—Medicaid $28 billion and out-of-pocket $60 billion.

The Health Insurance Portability and Accountability Act (HIPAA) is a tax bill passed in 1996 which was generally designed to provide for the portability of health insurance for employees. Ms. Crawley said also included in HIPAA were some tax provisions and guidelines for long-term care policies. It provided certain minimum standards on benefit triggers and consumer protection provisions that policies had to meet in order to be considered tax qualified. She said this was a huge step for the federal government to recognize that long-term insurance was worthy of granting some tax breaks in order to encourage people to buy long-term care insurance and plan for their futures.

Under HIPAA, premiums for long-term care insurance policies may be tax deductible, depending on whether or not a person itemizes deductions and whether or not medical expenses meet the 7-1/2 percent threshold. Any benefits received under a tax-qualified long-term care insurance policy are not taxable. Ms. Crawley said during 1998 and 1999, there has been growing support, both in the public arena and in Congress, for a full tax deduction for long-term care insurance premiums directly from the adjusted gross income. She said this would be very positive in encouraging people to buy and plan for long-term care, and she compared it to what IRAs did for retirement planning.

Ms. Crawley said the federal government is also considering the development of an employer-sponsored long-term care program for its employees. The federal government is the largest employer in the United States, and adopting a program for its employees would set a very good example for employers across the country. She said the plan is in very early development stages—it has not been legislatively approved. This proposed plan, along with the potential tax deduction for long-term care premiums, is a message that there is not going to be an entitlement program for long-term care. Ms. Crawley reiterated her belief the current tax level cannot support an entitlement program such as Medicare to cover everyone's long-term care expenses.

At the state level, Ms. Crawley noted that Nevada does not have a state income tax, but several other states are creating tax deductions and tax credits as incentives for citizens to purchase long-term care insurance. Another method states can use to encourage people to purchase long-term care insurance is to develop an employer-sponsored plan for state

employees. She said about 18 states currently have employer-sponsored long-term care programs. Most of the details differ between state plans, but for the most part the employee plans are employee-pay-all as opposed to employer-subsidized premiums. Ms. Crawley said she was aware that during the 1999 Nevada Legislative Session, Senate Bill 446 was proposed which would have provided for an employer-sponsored long-term care plan. However, there was a large fiscal note attached to the bill, and it did not pass.

Ms. Crawley said Maryland has an excellent plan for educating its citizens. She knows the person in charge of the Maryland Outreach Program and will be happy to share that information. The thrust of the Maryland Outreach Program is to educate consumers so they know that they need to plan somehow for their long-term care needs, whether it is by purchasing long-term care insurance, self-funding, investing, etc. They are not particularly promoting any specific type of funding or purchase; their goal is just to educate people about the need to plan for their futures.

In summary, Ms. Crawley remarked that in order to make private long-term insurance work, education is the key in averting the long-term care funding crisis.

- The general public must be educated about the limitations of Medicare and its qualification requirements;
- More employer involvement in long-term care planning must be encouraged;
- Financial planners need to be encouraged to include long-term care as an important part of retirement planning;
- Younger people need to be encouraged to buy long-term care insurance, and they need to be educated as to the huge premium savings resulting from purchasing at an earlier age.

Ms. Crawley exclaimed the bottom line is education, education, education! She applauded the committee for taking on the long-term care study, remarking it is a big step forward. The next step is to educate the consumers, insurers, and agents. She said the insurance industry is continually educating themselves and watching the marketplace to see how it changes and develops in order to offer current and flexible products that will be useful in the coming years.

Chairman McGinness thanked Ms. Crawley for her presentation and asked if committee members had any questions.

Assemblywoman Leslie remarked that as a baby boomer she could relate to Ms. Crawley's remarks. However, as a single working mother who has to pay for her daughter's health insurance, she said she could also relate to why people do not purchase long-term insurance. When she looks at her whole insurance package, she needs to take care of her daughter's current needs before she can take care of her own needs when she turns 80. She agreed with Ms. Crawley that education is the key.

Ms. Leslie asked if Ms. Crawley has ever seen instances where long-term care insurance is incorporated within a regular health insurance package rather than a separate policy. Ms. Crawley replied she has not seen such a policy, but that does not mean it doesn't exist. Generally long-term care is a separate policy because it is a separate type of care designed for chronic care as opposed to general health care needs such as hospital and physician visits.

Assemblywoman Leslie wondered if it is possible to ever get past the issue of people having a hard enough time paying for health insurance today to be able to afford long-term care coverage. She remarked she would be willing to pay more for the whole package.

Ms. Crawley said when individuals purchase their health insurance plan, usually from their employer, they expect to use it. On the other hand, homeowners' insurance is something that is basically required, but it is a policy the insured hopes he never has to use. Between health care and homeowners, Ms. Crawley said long-term care would be more similar to a homeowners' policy—it is an insurance policy a person might buy but hopes he will never have to use.

Senator Care asked if Ms. Crawley was aware of any jurisdictions in which an employer is offered some incentive for offering long-term care. She replied she did not know of any.

Senator Care then asked if she was aware of any state similar to Nevada in which there is no state income tax but there is still some sort of tax break for those individuals who enroll in long-term care insurance. Ms. Crawley responded that Texas does not have a state income tax, but as far as she knows, there is no tax incentive to purchase long-term care insurance.

Senator Rawson remarked if Nevada wanted to investigate an incentive for the purchase of long-term care, the property tax would be the most likely tax considered. He asked Ms. Crawley if she had any information regarding premiums in various age groups. She replied that 1994 data disclosed an average annual premium over all age groups of $1,500. She said she thought there were some sample premiums included in committee members' meeting packets.

Senator Rawson said the state had talked to New York Life Insurance concerning creation of a long-term care product for state employees, and it seemed to him that the premium was under $200 a year for all employees. He recalled that the overall population of state employees was younger, thereby allowing the lower premium. Senator Rawson said it costs $44 million for a 1 percent raise for all state employees, including teachers, and he wonders if it would be realistic to provide state employees with long-term care insurance.

Ms. Crawley said she would be surprised if the premiums were the same for all ages of state employees. Senator Rawson said they had asked New York Life to create a product for the state with the idea it would include all state employees, and New York was given the actuarial data in order to calculate the ages. He said he did not know if the information is still valid, since the bill did not pass; however, he would like to pursue the possibility again. He is not overly optimistic that state employees would voluntarily purchase long-term coverage if it were offered.

Senator Rawson asked if the federal government would possibly pick up any portion of long-term care costs. Ms. Crawley replied she did not see how it would be possible with current tax rates; a new payroll tax or something similar would have to be created to fund it. There is still speculation whether Medicare and Social Security are going to remain solvent.

Assemblywoman McClain said she realized that large employers such as the state and Clark County will be able to negotiate good rates for their employees down the road, but she wondered what possibilities exist for small- and middle-size businesses. With all of the bundling of financial services, i.e., banking, insurance, financial planning, etc., she asked Ms. Crawley if the insurance industry has pursued tax deferred premiums or similar incentives for the everyday employee of smaller companies. Ms. Crawley replied there were some incentive provisions attached to a rather large tax bill passed by Congress in August 1999 and subsequently vetoed by President Clinton. The bill package had included the ability of long-term care insurance to be offered as part of a cafeteria plan and the premiums could be tax deferred. The insurance industry, she added, is definitely pushing for the cafeteria plan ability and full premium tax deduction.

Senator McGinness again thanked Ms. Crawley for her excellent presentation. He then asked Guy Perkins, Chief Insurance Examiner, Nevada Division of Insurance, to make his presentation.

Mr. Perkins stated that long-term care insurance is not a widely owned insurance product in this country. Most adults carry some sort of life insurance. Approximately 80 percent of the population carries medical coverage and 42 percent of the people on Medicare have additional coverage over and above traditional Medicare by either enrolling in a Medicare HMO or by purchasing a Medicare supplement insurance plan. However, long-term care insurance is held by relatively few Americans and even fewer Nevadans.

Mr. Perkins reviewed the long-term care demographics in Nevada:

- A small portion of the population (1.1%) owns long-term care insurance in the United States. While the use of long-term care insurance nationally is low, in Nevada the incidence of long-term care insurance is even less (.27%, or ¼ of the national average). In 1997, Nevada had a population of 1,675,581. At that time only 4,529 people were covered by private long-term care insurance.

- The actual loss ratio in 1997 was 32% nationwide and 23% in Nevada. Mr. Perkins explained that a loss ratio is the dollars an insurance company pays out compared to the dollars it brings in. Therefore, for every dollar an insurance company collects, so many pennies are supposed to be paid out in claims. Standards range from 40% up to 85%. In Nevada the regulation for individual coverage is 60%. Therefore, very little return is being made on the premium dollar invested by insurers. These ratios may not reflect lifetime loss ratios since most of these policies were less than 10 years old, and it takes an insurance policy a certain period of time before it matures and reaches its target loss ratio. However, health insurance policies mature fairly early, about the third or fourth year, so the Division of Insurance expects a loss ratio of 55%. Mr. Perkins noted Ms. Crawley had mentioned earlier that long-term health policies are a unique product, and it is probably the closest health product to a life insurance policy. People buy life insurance policies because they know at some point they are going to die, but they may buy that product at an age with an expectation that death will not occur for many years or decades. He said the same is true of long-term care—it is something one buys with the anticipation that it is not going to be used for some time, as opposed to HMO coverage or a major medical policy.

- The cost of a long-term policy insurance policy increases significantly with age. The cost for the same coverage increases by over four times if purchased at age 70 versus age 40. If a person waits until retirement to consider a LTC policy, the cost may be prohibitive because people are on limited or restricted budgets.

- In Nevada over 800 insurance companies have licenses to issue health insurance, which would allow them to also sell approved long-term care insurance. Of these 800 companies, 65 have filed with the Division their intention to sell LTC insurance. In 1997, 42 insurance companies had LTC insurance policies in effect. Of those, two companies represented 47 percent of all in-force policies in Nevada.

Mr. Perkins then referred the committee to a document entitled "A Shopper's Guide to Long-Term Care Insurance" (Exhibit "L", original on file at Legislative Counsel Bureau), which he explained is a publication issued by the National Association of Insurance Commissioners (NAIC). Nevada law requires the guide to be provided to each prospective applicant for long-term care insurance. Mr. Perkins summarized the guide as follows:

1. Defines long-term care, explains the costs associated with long-term care, and shows how these costs have been paid;

2. Explains who would need long-term care and who would need long-term care insurance;

3. Explains what "federally qualified" means as defined by the 1996 HIPAA law;

4. Describes the types of long-term care insurance;

5. Describes how long-term care insurance policies pay benefits:

    a. Expense incurred versus indemnity,
    b. What services are covered (nursing facility, home care, assisted living, adult day care, etc.),
    c. Exclusions and limitations,
    d. Amounts of coverage (benefit limits),
    e. Types of triggers (Activities of Daily Living – bathing, continence, dressing, eating, toileting, and transferring plus a separate mental cognitive trigger),
    f. Policy elimination periods,
    g. Inflation protection, and
    h. Optional benefits, i.e., third-party notice, waiver of premium, restoration of benefits, premium refund at death, non-forfeiture benefits;

6. Describes problems when buying a policy:

a. Health conditions, and
b. Pre-existing conditions;

7. Explains guaranteed renewability;

8. Explains the cost of long-term care insurance;

9. Switching LTC insurance plans;

10. Shopping tips;

11. Lists of state agencies and SHIP offices; and

12. Sample worksheets to compare long-term care policies.

Moving to current Nevada regulations, Mr. Perkins cited the regulation definition of long-term care:

> A policy or rider that covers diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services in a setting other than an acute care unit of a hospital.

Nevada, like many other states, requires a minimum benefit period of 24 months. Times less than that are considered long-term stays and involve other issues. Also, benefits must be paid on an expense incurred, indemnity or prepaid basis.

Mr. Perkins said the regulations also require an offer to purchase inflation protection, which must be made to every applicant. Individual policies must be "guaranteed renewable," and rate increases due to policy duration and increasing age beyond 65 are prohibited. The regulations also place limitations on pre-existing conditions; an insurance company cannot look back more than six months in an applicant's medical history, and if there is a medical history during those six months, it can be excluded for six months after the policy begins. There are limitations on exclusions for home health care and community care, and conditioning benefits on prior hospital confinement. The expected loss ratio in Nevada is 60 percent for individual policies.

Mr. Perkins said in general, Nevada bases its long-term care insurance regulations on the Long-Term Care Model by the National Association of Insurance Commissioners (NAIC). Following the changes to LTC insurance brought about by HIPAA, the NAIC began revising its model. The new model is in the final stages of completion—a part of it was approved at the association's December meeting. It is the intention of the Nevada Division of Insurance to revise its regulations when the changes have been completed. This may be accomplished in 2000. The revised regulations will include at least:

1. Definitions of benefit triggers, which conform with federally qualified requirements and minimum benefit triggers for non-federally qualified requirements. Benefit triggers are Activities of Daily Living. To receive federal tax qualification, the plan must trigger the inability to perform 2 of 5 or 6 ADLs without substantial assistance. Benefit triggers also include cognitive definitions;

2. More restrictive disclosure requirements; and

3. Requirements for an offer of non-forfeiture benefits and contingent non-forfeiture benefits when the applicant rejects the offer. Mr. Perkins noted that having the luxury of a savings account in the product does cost more money; it is not something provided gratis by the insurance company. So what is generally considered an expensive product becomes more so with non-forfeiture benefits.

Moving to the cost of long-term care insurance in Nevada, Mr. Perkins said the top 11 companies writing long-term care insurance, representing 84 percent of the market share in Nevada, were contacted by the division. As of January 11,

2000, responses had been received from 6 of the 11 companies. The 6 companies represent 67 percent of the policies sold in Nevada in 1997. The companies were asked to price a sample long-term plan when purchased at three different ages (40, 60, and 70). The plan included the following characteristics:

1. Federally qualified (could not include non-forfeiture benefits);
2. Both nursing home and home care included;
3. 30-day elimination period;
4. Benefit period of 3 years;
5. 5% simple interest inflation protection;
6. The example be male; and
7. Coverage of $100/day for nursing facility care and $50/day for home care.

The result of these 6 companies indicated the following average annual premiums:

1. $402/year if purchased at age 40 (ranging from $179 to $560),
2. $859/year if purchased at age 60 (ranging from $631 to $1,240), and
3. $1,773/year if purchased at age 70 (ranging from $973 to $2,540).

Mr. Perkins referred committee members to Exhibit "M", a chart reflecting the breakdown of responses received from the long-term care survey conducted by the division.

Upon the conclusion of Mr. Perkins' presentation, Chairman McGinness asked for questions from the committee.

Ms. Leslie complimented Mr. Perkins on a very useful presentation. She observed one of the problems appears to be difficulty in obtaining information; she wondered who is responsible for providing the Shopper's Guide to the buyer. Mr. Perkins replied the law requires the guide be provided to the consumer once he/she indicates an interest in completing an application. There is also a 30-day grace period to look over the policy and decide whether to keep it.

Ms. Leslie asked if the Insurance Division makes an effort to disseminate the Shopper's Guide to consumers, and Mr. Perkins replied the division keeps a very large supply on hand, and its distribution is part of its Outreach Program and health fair participation.

Ms. Leslie remarked it is disturbing that only ¼ of one percent of people in Nevada have long-term care insurance. Mr. Perkins agreed, noting that education is a very large component, as well as its affordability. As previously indicated by Ms. Crawley, long-term care insurance is a low priority in comparison to other types of insurance such as health and life.

Mr. Perkins added that the figures being discussed do not take underwriting into consideration, and someone 70 years of age who is not in perfect health probably has some health conditions, so the numbers will rise considerably as a result.

Senator Rawson requested that Mr. Perkins provide similar demographics for the current state employee population. Since he assumes that retired employees cannot afford to buy long-term care insurance, he would request that retirees also be included. Senator Rawson said he is estimating a cost of $3 to $5 million per year to provide long-term care coverage, and he cannot help but feel that it is imminently possible if enough interest can be generated. He is aware that the younger employees are not interested in LTC as a benefit; it is only after the 50s and 60s and/or experiencing a health care issue that individuals start really thinking about the devastating consequences.

Mr. Perkins told Senator Rawson he could provide those numbers, and he noted that the figures presented in today's meeting certainly do not contemplate groups of 26,000 to 37,000. Insurance companies are much more willing to negotiate when the discussion involves groups of that size.

Senator Rawson said he would prefer to exclude underwriting—the full group should include the whole group without various exclusions. Mr. Perkins replied the insurance laws of the state would prohibit underwriting. The insurance company would conduct an enrollment of the entire group with very few health questions; the Insurance Division would

allow the company to price the group, but would not allow any exclusions.

Finally, Senator Rawson asked Mr. Perkins to provide the committee with his honest and frank opinion of the information obtained, and Mr. Perkins agreed to do so.

Senator McGinness thanked Mr. Perkins for his presentation. He then introduced Craig Hartung, a long-term care insurance consultant. Mr. Hartung was a consultant in design, marketing, sales, and general administration for the CalPERS Long-Term Care Program in California. He noted that Mr. Hartung is also a native Nevadan.

Referring to earlier questions regarding different types of incentive programs and coordination with health benefits, Mr. Hartung said there are a number of states working on plans. The state of Alaska offered a subsidy of over 30 percent on long-term care insurance for its members, which also includes retirees. There were 7,500 eligibles for the program, and 6,927 are enrolled. Mr. Hartung could not remember all of the specifics, but he recommended the committee contact Alaska for more information.

Regarding the coordination of health and long-term care insurance, Mr. Hartung said the only plan he is aware of is one similar to the CalPERS program, which not only offers long-term care insurance, but health insurance as well. However, the two are completely different types of products. Health insurance is a pay-as-you-go plan, whereas long-term care insurance is a fully funded, long-horizon, hugely investment-return product. He said trying to coordinate those two concepts into one policy is very difficult.

Mr. Hartung said he had received a request for proposal from the state of Texas, which is attempting to combine life insurance and disability, which are actuarially structured similar to long-term care. He assumes that in the future, attempts will be made to hook long-term care and health coverage together.

Mr. Hartung remarked he was glad to have had the opportunity to hear all of the day's presentations. He found them all very interesting. He noted that his mother was born and raised in Carson City, and she had protected him all of his life. He then took care of her in her later years. She never wanted to go into poverty or be on public assistance. Unfortunately, she came down with Parkinson's disease, and by the time she passed away, her medical costs had reached $400,000. Consequently, Mr. Hartung said, when discussing health coverage protection, a person's entire life must be considered.

Mr. Hartung said he had left CalPERS two years earlier and opened his own agency in California selling property casualty and life insurance—he emphasized he does not sell long-term care insurance. He has avoided selling LTC insurance in order to be able to continue providing consulting services to other states.
In 1989-90 when Mr. Hartung started with CalPERS as a researcher, the Assembly Office of Research saw the state of California going broke in the year 2040 if something was not done to offset their MediCal program. It was obvious then that there was no possible federal solution and that there would be no new entitlement programs. A person trying to self-fund long-term care insurance in the year 2010 would have to have at least $1 million in order to protect his/her spouse. Mr. Hartung said Congress has not had a great deal of success addressing this problem.

There are some 20 states looking at programs to offer their state employees. Texas offers long-term care insurance to all public employees, including retirees, which is similar to the CalPERS program, but it is fully funded. There are three kinds of programs available:

1. Self-funded, which is the CalPERS model, in which all of the risks and liabilities and profits belong to the purchasers of the long-term care program; it is under a trust. The risks belong to the CalPERS program.

2. Fully insured. This is the most popular model and is no risk for the state. Of the states considering programs, 95 percent have opted for the fully insured program.

3. Self-funded with reinsurance. This is the preferred program for businesses.

CalPERS chose the self-funded for a number of reasons; they wanted to be able to:

1. Control the marketing;
2. Control the overhead;
3. Control the loss ratio;
4. Control the investments; and
5. Reserve the reserving costs, which translates to a lower premium of about 30 percent below the market.

California also wanted the plan to be flexible, but Mr. Hartung said most of the plans created today have that flexibility, because it is unknown what insurance is going to look like 30 or 40 years from now. He said 14,000 of the CalPERS members were surveyed as to what type of plan they wanted, and the program was designed around them. The members rejected the savings plan due to the additional cost. They can get a better return on their investment if they buy a long-term insurance program and a separate savings program.

Many broad features were built into the program, including an appeals process and alternative care. Mr. Hartung thinks alternative care is going to be a big growth area—a higher level of care for less money, which is a plus in an insurance product. Quality control was another feature built into the program, as well as a free care advisor program, which was probably the most popular feature of the plan.

Mr. Hartung explained the CalPERS program is one of the most successful private insurance programs in the country. It was in 105th spot in 1995, and it is now the 6th or 7th largest long-term program in the United States with 130,000 members. The most popular plans have the broadest coverage, i.e., home care to nursing home care, including everything in between.

Another popular feature is the depth of coverage, which is called the lifetime program; if an individual is in the program for 25 years, he is covered. Nearly 70 percent of the products sold include the lifetime program and inflation protection.

When creating the CalPERS program, the decision was made to keep it simple—only a couple of plans were offered, and those were just plans people really wanted, i.e., no sales gimmicks, features that no one uses, etc. CalPERS was the first program in California to qualify for the Kennedy-Kassembaum Bill, because tax qualification helped to recognize the need for coverage as well as sales.

Mr. Hartung said income levels of public employees in California are not high, nor are the retirement levels. The average retirement level is under $1,000 a month, and the average income is around $32,000 annually. He said products are being sold across the spectrum—the demographics of those purchasing long-term care insurance cannot be determined. Regardless of income, families who recognize the need and understand the problem will purchase long-term coverage.

Mr. Hartung reiterated that over 20 states either have plans or are in the process of developing plans. There is only one self-funded state, Wisconsin, but Mr. Hartung is not familiar with the details. Currently there are two bids out, one of which includes both a fully insured and self-funded program. He said a request for proposal can include a lot of information, and the insurance companies will design a program and put a price on it. An RFP is a good way to have the experts in the industry design a program for very little money and investment.

Mr. Hartung said in the future he expects states to push for more tax relief at the federal level. There are several pieces of legislation to move the issue into the health arena, and there is other legislation to move it into a tax credit, which would certainly help the program. However, Mr. Hartung said just putting long-term care on the deduction list along with health insurance would be a great boon to the program. He feels LTC should be included in the cafeteria plan as alluded to earlier, employers should be shown easier ways to participate in LTC programs, and there should be broader education programs.

Mr. Hartung said he also sees tightening of controls. Financial advisors are taking a stronger role in promoting LTC coverage. He advocates penalties for financial advisors who participate in asset shifting, which is a way of preserving an estate at the expense of the taxpayers.

Mr. Hartung said as an employer, Nevada has the opportunity to stimulate the growth of long-term care insurance, thereby helping to lessen the huge bill confronting the state. The state needs to put together a program that will sell to the public employees, either by a subsidy or some other method, and as a result private sales will be boosted throughout the state. He too feels that education is what will help the program—he reminded the committee that $700 million in less than 30 years is a huge problem to face.

Mr. Hartung concluded his presentation by offering his services pro bono to the state if he can be of any help in developing a program. Copies of the CalPERS plan materials were distributed for the record (Exhibit "N").

Chairman McGinness thanked Mr. Hartung and the other speakers for their contribution to the meeting. He then asked for public testimony.

Eric Sorensen testified from Las Vegas, introducing himself as a native Nevadan and a graduate student preparing for dental school. His testimony follows:

> During the last legislative session and prior to it I was heavily involved in a project to protect the state from the potential future costs of long-term care. With the cooperation and assistance of the Legislative Committee on Health Care, the Segal Company, the Executive Director of the Retired Public Employees of Nevada, and numerous state officials, the team of which I was a part reported actuarial calculations and presented a concise plan to remove a portion of the financial risk from the state and place it on private industry. We focused on the long-term care needs of state and local government employees, members of the PERS retirement system and their families. For our plan, we recommended the New York Life Insurance Company. This company's 10+ years in the long-term care market made them a pioneer in long-term care insurance.
>
> Our proposal was drafted into Senate Bill 446, which I have with me, and presented on the Senate floor on March 15, 1999. It was referred to the Senate Finance Committee, where due to a shortened session and even shorter purse strings, it died. My desire today is to remind this committee that much of the work talked about today has already been done, at least on a smaller scale. A plan already exists that could save the state from a potential financial disaster. However, I refer you all to Senate Bill 446 for further information, and if any of you would like a copy of our proposal, I can make those available to you.
>
> One thing I would like to make clear is Ms. Crawley referred to the large fiscal note that was attached to the bill. In Section 7 of that bill there was a call for $35 million for long-term care coverage for state employees and retirees from state employment. That figure was actually for long-term care insurance for 84,758 people; that combined all state and local government employees and retirees. If we were only talking about state employees and retirees, the number would be more in the area of 16,800 people, which would represent about a fifth of that cost. The plan that we recommended included all state and local government employees, past and present, and also made broad and sweeping discounts available to their immediate family members and loved ones. Thank you.

Chairman McGinness thanked Mr. Sorensen for his testimony, and said the committee would be very pleased to receive a copy of the plan.

The next individual to testify was Harry A. Baut, who resides at 1708 Rio del Mar Drive in Las Vegas. He has been licensed in the state of Nevada since 1997 as a life and health agent and has been both a resident and a taxpayer of Nevada since 1994. Mr. Baut said the reason for his testimony was not on the spur of the moment or out of anger to the Governor or his appointees. His testimony is a result of utter frustration due to the lack of results in dealing with one of Governor Guinn's regulatory agencies, the Division of Insurance. Out of this frustration, he said he was present to place his complaint as part of the public record. Following is his testimony:

> I have here a complete record of all 19 written correspondence, excluding no less than 50 phone calls, for

the period April 6, 1999 through December 14, 1999, a period of nine months. This whole issue with the DOI grew from a very simple notification to the DOI. I notified the DOI on April 19, 1999, as a duly licensed agent, and in accordance with their rules and regulations, of two issues. First issue: A non-Nevada carrier was placing its current subscribers at jeopardy by withdrawing from the Nevada market, and secondly, that as a result of this action I, as a duly licensed agent, was being denied commissions earned. Now one would think that this would be a simple process of resolution to my complaints in a timely fashion. Not so. As the materials will visually represent, the DOI has for whatever reason decided that the Nevada Revised Statutes allows them full discretion. It is this behavior that has placed my family and consumers in harm's way. On May 2, 1999, the pharmacy benefit to our clients, which numbered approximately 1,200 subscribers, was terminated due to a lack of payment by American Medical and Life Insurance Company domiciled in New York. Governor Guinn, you got lucky! Alice Molasky, you got lucky! Fortunately for all concerned parties, a medical tragedy did not occur. Again, one would think that a regulatory agency could easily determine its responsibility and take appropriate action. Again, not so. They must have been too busy with the legislative process, but again, maybe not. I understand that the Nevada Legislature was completed in May. My saga commenced in April and still has not been resolved.

After 8 months I wrote Governor Guinn in December and have been ignored, not only in response to my letter, but to no less than 5 phone calls to his office and staff. I do not know how the committee members or the individuals in the audience make their livelihood, but one could surmise that they could not go for over 9 months in receiving legitimate wages earned through their efforts. This is my current situation. Not only has my family been without income, which is why I am here today, I was served with notice of foreclosure on my residence December 3, 1999. Again, my sole reason for being here today is to place on the public record the total outrage related to the lack of compliance to Nevada Statutes by the DOI and the lack of action to protect both the consumer and myself as a licensed agent. Throughout this entire experience I have been searching for any rationale for the lack of action by the Division of Insurance. After 5+ years as a resident of Nevada, it is now apparent that the little person is being ignored by the Guinn administration. This leads one to only think, would Steve Guinn, also a licensed agent by the DOI, be treated in the same manner as a consumer as I have been since April of 1999? Thank you for your time, and again, I request that this packet be made part of this public record. In addition, Mr. Chairman, I will submit this document to Senator Townsend, who is also aware of this issue, and his response to me was that his hands are tied until session opens. I can assure you that I will be present when the hearings and the session are opened, because this is an outrage, to lose my home over non-compliance of the law. Thank you again for your time. Good day.

Chairman McGinness stated Mr. Baut's problem is obviously not within the scope of this committee, but he thanked him for being present to testify.

Martin Bibb, Executive Director of the Retired Public Employees of Nevada (RPEN) testified that RPEN would like to go on record relative to the topic of long-term care and to thank the committee, witnesses, and guest experts who appeared to discuss this topic. He said long-term care is indeed a complex subject and one which RPEN has been interested in for several years, particularly because of the experience in California. He recognizes that California is a far different state than Nevada, with much larger numbers and the ability to develop a self-insured program of long-term care. However, as alluded to numerous times during the meeting, education is the key and long-term care is a part of the puzzle. Mr. Bibb said LTC is not only for retirees to protect their retirements and hopefully the things they have worked for in their careers, but also because they as taxpayers experience the same impacts as do all the rest of the private public sector relative to indigent care costs and the accompanying tax increases affecting each of us.

Mr. Bibb said one of the concerns of some RPEN members is that tax costs are experienced differently in different parts of Nevada. Certainly in some small counties, a very small number of people going on the indigent rolls can have serious negative impacts on certain other crucial programs, many of which affect seniors. He said this is another prevailing reason to continue the dialogue as the committee noted in the remaining hearings, which will be designed to prepare something for the 2001 Legislative Session.

RPEN has about 7,500 members statewide who worked for PERS-covered employers during their careers (city, county, state, police, fire, etc.), and many of them, because of their age, simply will not be able to profit from the experience of whatever hopefully comes out of future dialogues relative to long-term care. However, that is not really as big an issue for RPEN as one might believe, because members are concerned, as are all Nevadans, with not only the impact on them individually, but on their children and grandchildren as well.

Mr. Bibb again thanked the committee for its hard work and said he appreciates the testimony of those involved. RPEN looks forward to working with the committee towards legislation for the 2001 Session.

Chairman McGinness thanked Mr. Bibb for his testimony. There being no further speakers, public testimony was closed.

The date for the next meeting was set for March 9, 2000, in Las Vegas. There being no further business, the meeting was adjourned at 3:35 p.m.

Respectfully submitted,

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Sherie Silva, Secretary

APPROVED:

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Senator Mike McGinness, Chairman

Date:_____

EXHIBITS:

Exhibit A	Meeting Notice and Agenda
Exhibit B	Attendance Rosters
Exhibit C	Dr. Mollica – Medicaid Spending Graph
Exhibit D	Dr. Mollica – Nursing Facility Residents & ADLs Graph
Exhibit E	Dr. Mollica – State LTC Profiles – State Rankings
Exhibit F	Dr. Weiss – "Chronic Care in America – A 21st Century Challenge"
Exhibit G	Dr. Weiss – Testimony to U.S. Senate Special Committee on Aging
Exhibit H	Dr. Weiss – Testimony and Recommendations
Exhibit I	Jon Sasser – Testimony in Support of Assisted Living Waiver
Exhibit J	Karen Mabry/Ernie Nielsen – Fast Facts – Eldercare Project
Exhibit K	Steffani Crawley – "Who Will Pay for the Baby Boomers' Long-Term Care Needs?" (American Council of Life Insurance)
Exhibit L	Guy Perkins – "A Shopper's Guide to Long-Term Care Insurance"
Exhibit M	Craig Hartung – Long-Term Care Insurance Premium Rate Schedule
Exhibit N	Craig Hartung – "Why CalPERS? CalPERS Long-Term Care Program"

Note: All Exhibits are on file at the Research Library and Fiscal Analysis Division of the Legislative Counsel Bureau.