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LONG-TERM CARE

Baby Boom Generation Increases Challenge of Financing Needed Services

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Long-Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services

Chairman Grassley, Ranking Member Baucus, and Members of the Committee:

I am pleased to be here today as you discuss the challenges we as a society face in financing long-term care needs. These challenges are formidable already, as an estimated 9 million persons age 18 or older receive long-term care assistance, either at home or in institutions such as nursing homes. While family members provide much care, paying for purchased services presents a significant financial burden for many individuals and for public health care programs. For those needing nursing home or other extensive continuous care, the costs can be substantial. On average, nursing home care currently costs $55,000 annually, with many nursing home residents paying much of that out of their own pockets.

Providing and financing long-term care will become even more challenging in just over a decade when the 76 million baby boomers begin to turn 65. Over the next 30 years, the number of elderly individuals is expected to double. Moreover, with baby boomers expected to live longer and greater numbers reaching age 85 and older, this generation is expected to have a dramatic effect on the number of people needing long-term care services, as the prevalence of disabilities and dependencies increases with age. To help alleviate the pressures on public programs and families in meeting the needs of these persons, some advocate a growing role for private long-term care insurance. Several recent congressional initiatives aim to increase the use of private insurance in financing long-term care needs. These initiatives include establishing a program to make group long-term care insurance available to federal employees, members of the uniformed services, and civilian and military retirees; and proposals to provide additional tax subsidies to individuals purchasing long-term care insurance.

In view of these issues, you asked us to provide the Committee information on long-term care insurance to assist you in considering what role it may play in meeting future long-term care needs. Accordingly, my remarks today, which are based on our previous work and other published and ongoing research,[1] focus on (1) the increased demand an aging baby boom generation will likely create for long-term care; (2) an overview of current spending for long-term care, including recent changes in Medicaid and Medicare financing of long-term care; and (3) the potential role of private long-term care insurance in helping finance this care, including

[1]A list of related GAO products follows this statement.

who is likely to buy this insurance, its affordability, and the critical need for consumer protections.

While my focus will be on financing the projected increase in the need for long-term care for the elderly, long-term care needs of younger persons should not be overlooked. Disability and dependency have no age boundaries, and the long-term care needs of the nonelderly and the burden of satisfying them can be profound. How to better meet these needs and distribute the burden deserves our attention. However, the potential for private long-term care insurance to assist those whose disabilities or dependencies begin at younger ages may be very limited.

In summary, the confluence of the aging baby boom generation, longer life expectancies, and evolving options for providing and financing long-term care services will require substantial public and private investment in long-term care and the development of sufficient capacity to serve this growing population. Spending for long-term care, including post-acute and chronic care in nursing homes and home and community-base care, was about $134 billion in 1999. Medicaid and Medicare paid for nearly 58 percent of these services in 1999, contributing about $59 billion and $18 billion, respectively. Medicaid funds primarily go to nursing homes and other institutional settings of long-term care, but home and community-based services receive a growing share. Medicare primarily covers acute-care services and thus plays a lesser role in financing nursing home care—by paying only for short-term stays following a hospitalization. While the Medicare home health benefit had grown to play a significant role in covering long-term care, the new BBA-mandated payment system may reduce the provision of such services. Medicaid, which is a jointly funded federal-state program, poses a large burden on states' budgets, creating pressure on their capacity to absorb additional costs associated with the growing need for long-term care services over the coming decades.

Private long-term care insurance is viewed as a possible way to reduce catastrophic financial risk for the elderly needing long-term care and to relieve some of the financing burden now shouldered by public long-term care programs. Yet private insurance, including both traditional health insurance and long-term care insurance, represents only about 10 percent of long-term care spending—about $14 billion in 1999. Less than 10 percent of the elderly and an even lower percentage of the near-elderly have bought long-term care insurance, although the number of individuals purchasing long-term care insurance increased during the 1990s. Questions remain about the affordability of policies and the value of the coverage relative to the premiums charged, and while many states have adopted standards for long-term care policies, it is uncertain whether

these fully assure consumer confidence in the reliability of long-term care insurance. If long-term care insurance is to have a more significant role in addressing the baby boom generation's upcoming chronic health care needs, the policies offered must be viewed by consumers as reliable, affordable products with benefits and limitations that are easy to understand.

Background

Long-term care includes many types of services needed when a person has a physical or mental disability. Individuals needing long-term care may have difficulty performing some activities of daily living (ADL) without assistance, such as bathing, dressing, toileting, eating, and moving from one location to another. They may have mental impairments, such as Alzheimer's disease, that necessitate supervision to avoid harm to themselves or others or require assistance with tasks such as taking medications. Although a chronic physical or mental disability may occur at any age, the older an individual becomes, the more likely a disabling condition will develop or worsen. Nearly one-seventh of the nation's current elderly population—an estimated 5.2 million—have a limitation in either ADLs; instrumental activities of daily living (IADL) such as preparing food, doing housekeeping, and handling finances; or both. More than one-third of these people have limitations in two or more ADLs.

Long-term care encompasses a wide array of care settings and services, not only institutional care provided by nursing homes for individuals with more extensive care needs but also home and community-based care. Nearly 80 percent of the elderly requiring assistance with ADLs or IADLs live at home or in community-based settings, while more than 20 percent live in nursing homes or other institutions. The majority of long-term care is provided by unpaid family caregivers to elderly individuals living either in their own homes or with their families. However, a growing minority of the elderly receives paid assistance from various sources. For example, state Medicaid programs have increased significantly the number of beneficiaries receiving in-home or community services. In addition, alternatives to nursing home care, such as assisted-living arrangements, are developing that have long-term care services available.

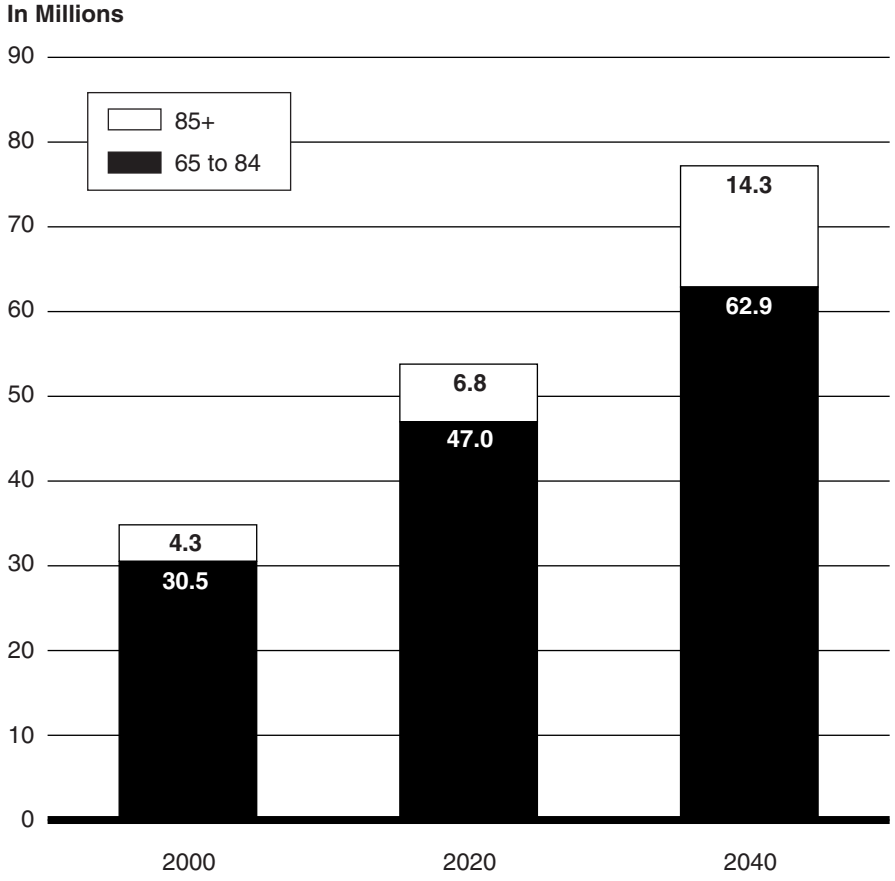
Long-term care needs are an especially significant concern for women. Women represent 7 of 10 unpaid caregivers, three-quarters of nursing home residents 65 years and older, and two-thirds of home health care users. Given their longer life expectancies and the fact that married women usually outlive their spouses, many women face a greater risk of needing long-term care by a paid caregiver.

The Baby Boom Generation Will Greatly Expand Demand for Long-Term Care

The baby boom generation, about 76 million people born between 1946 and 1964, will contribute significantly to the growth in the number of elderly individuals who need long-term care and in the amount of resources required to pay for it. The oldest baby boomers are now in their fifties. In 2011, the first of the baby boomers born in 1946 will turn 65 years old and become eligible for Medicare. The Medicaid program, which pays for many health care services for low-income elderly, including nursing home care, will also begin to be affected. Baby boomers are likely to have a disproportionate effect on the demand for long-term care because more are expected to live to advanced ages, when need is most prevalent. The first baby boomers reach age 85 in 2030.

In 2000, individuals aged 65 or older made up 12.7 percent of our nation's total population. By 2020, that percentage will increase by nearly one-third to 16.5 percent--one in six Americans--and will represent nearly 20 million more seniors than there are today. By 2040, the number of seniors aged 85 years and older will more than triple to 14 million (see fig. 1).

Figure 1: Estimated Number of Elderly Individuals in 2000, 2020, and 2040



Source: Bureau of the Census, "Projections of the Total Resident Population by 5-Year Age Groups and Sex With Special Age Categories: Middle Series," selected years 2000 to 2040 (Jan. 2000).

Projecting the number of baby boomers who will need long-term care services is complicated by several factors. While experts agree that the growing elderly population will increase the number of disabled elderly needing long-term care over the next several decades, no consensus exists on the size of that increase. Projections of the number of disabled elderly who will need care range between 2 and 4 times the current number. Researchers also disagree about the effects of better health care and healthier lifestyles on the baby boomers' need for long-term care. Some contend that medical advances have increased life expectancy but have not changed the age of onset of illness and that therefore the need for

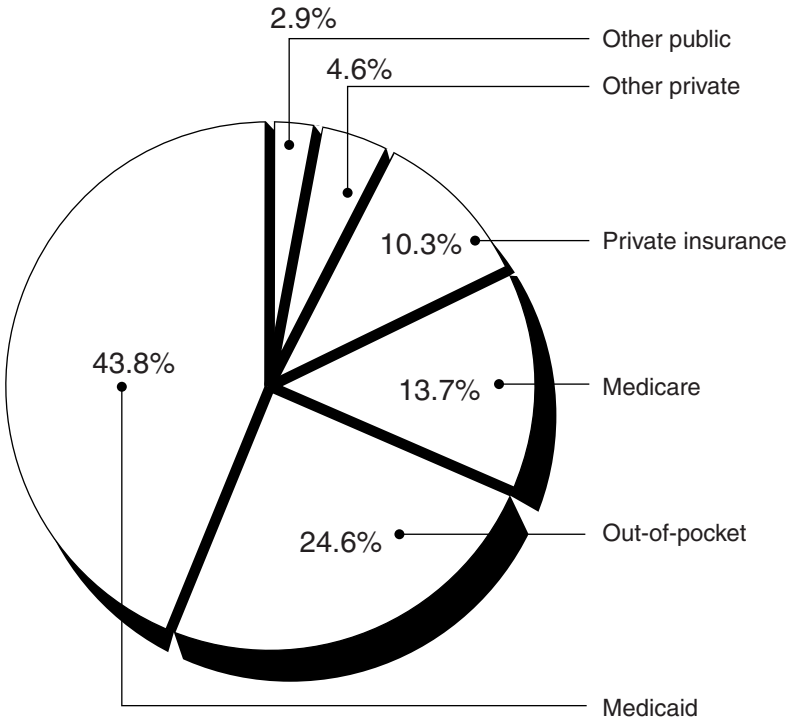
long-term care may have increased. Others contend that better treatment and prevention could decrease the time period at the end of life when long-term care is needed.

Baby boomers may also have a disproportionate effect on the demand for paid services. Many baby boomers will have fewer options besides paid long-term care providers because a smaller proportion of this generation may have a spouse or adult children to provide unpaid caregiving. This likelihood stems from the geographic dispersion of families and the large percentage of women who work outside the home, which may reduce the number of unpaid caregivers available to elderly baby boomers.

Public Programs and Out-of-Pocket Spending Predominantly Finance Long-Term Care Services

In 1999, spending for nursing home and home health care was about $134 billion. Individuals needing care and their families paid for almost 25 percent of these expenditures out-of-pocket, public programs (predominantly Medicaid and Medicare) funded 61 percent, private insurance (including long-term care insurance as well as services paid by traditional health insurance) accounted for about 10 percent, and other private sources paid the remaining 5 percent (see fig. 2). These amounts, however, do not include the many hidden costs of long-term care. For example, they do not include wages lost when an unpaid family caregiver takes time off from work to provide assistance. An estimated 60 percent of the disabled elderly living in communities rely exclusively on their families and other unpaid sources for their care.

Figure 2: Percentage of Expenditures for Nursing Home and Home Health are, by Source of Payment, 1999



Note: Also includes Medicaid expenditures for home and community-based services, which are considered as part of "other personal health care" in the Health Care Financing Administration's (HCFA) national health care accounts.

Source: Department of Health and Human Services, HCFA, Office of the Actuary, National Health Statistics Group, Personal Health Care Expenditures, 2001.

Medicaid

Medicaid, a joint federal-state health financing program for low-income individuals, continues to be the largest public funding source for long-term care. Within broad federal guidelines, states design and administer Medicaid programs that include coverage for certain mandatory services, such as skilled nursing facility care, and other optional coverage, including home and community-based services. Long-term care services under Medicaid are not limited to adults—about 1 million children with special needs also receive long-term care services from Medicaid. Although most Medicaid long-term care expenditures are for nursing home care, in the last two decades the proportion of expenditures for home and community-based care has increased. By fiscal year 1998, the number of Medicaid recipients receiving home health or home and community-based services was similar to the number of Medicaid recipients receiving nursing facility services. How much service Medicaid provides varies among states, and Medicaid financing can be vulnerable to shifts in state revenues.

State Medicaid programs have, by default, become the major form of insurance for long-term care. About two-thirds of nursing home residents in 1998 relied on Medicaid to help pay for their care, but Medicaid provides insurance only after individuals have become nearly impoverished by "spending down" their assets. Medicaid eligibility for many elderly persons results from having become poor as the result of depleting assets to pay for nursing home care, which costs an average of $55,000 per year.[2] In most states, nursing home residents without a spouse must have less than $2,000 in countable assets to become eligible for Medicaid coverage. An overall increase in wealth among the elderly means that a smaller proportion of elderly individuals will initially qualify for Medicaid—and others will need to become impoverished before they qualify.

States historically limited coverage of in-home services under Medicaid because of concern about the potential cost of covering services for the large number of disabled who were being cared for by their families. However, as part of the Omnibus Budget Reconciliation Act of 1981, the Congress established the home and community-based service waiver program. The waiver program gave states the option of applying for Medicaid waivers to fund home and community-based services for people, including the nonelderly, who met Medicaid eligibility requirements for nursing home care. These waivers also allowed states to restrict the

[2]MetLife Mature Market Institute survey, 2000. This survey also found that nursing home costs vary widely by geographic region, from nearly $33,000 per year in Hibbing, Minnesota, to more than $100,000 per year in the Borough of Manhattan in New York City.

number and costs of eligible individuals served under Medicaid in home and community-based settings. All states now have home and community-based waivers, and more than 200 waiver programs served more than 450,000 individuals nationwide in fiscal year 1998. Medicaid expenditures for home and community-based waivers increased an average of 29 percent per year from 1988 to 1999, reaching over $10 billion in 1999. The extent of services provided varies considerably among the states. Medicaid per capita expenditures for home care in 1999 ranged from a low of about $8 in Mississippi to a high of nearly $230 in New York.[3]

Medicaid is a significant share of state budgets—comprising 20 percent on average. Dependence on state budgets makes Medicaid financing vulnerable to states' fiscal health. States generally must maintain balanced budgets without deficits, and their revenues often decline in periods of low or negative economic growth. A recent fiscal survey of states showed that about one-half of states are expecting declines in revenue growth for 2001 to 2002, and a few states are reducing current-year appropriations and making other adjustments to maintain balanced budgets.[4] At the same time, one-half of the states estimate that Medicaid spending will exceed their current projections. With declining revenue and increasing Medicaid expenditures, maintaining balanced budgets in states may require constraining Medicaid expenditures, including the large share represented by long-term care services.

Medicare

While Medicare primarily covers acute care, in the early 1990s it also became a de facto payer for some long-term care services.[5] However, as spending for both skilled nursing facility services and home health care became the fastest growing components of Medicare, the Congress in the Balanced Budget Act of 1997 (BBA) introduced new payment systems for nursing facilities and home health providers to control this spending.

In contrast to Medicaid, which paid nearly half of total nursing home and other institutional care expenditures in 2000, Medicare plays a relatively small role, paying only about 12 percent of total nursing home and other institutional care expenditures. Medicare primarily covers acute-health-

[3]The range excludes Arizona, which is unique in having a capitated long-term care system.

[4]National Association of State Budget Officers, National Governor's Association, *The Fiscal Survey of States: December 2000 (*Washington, D.C.).

[5]Medicare predominantly covers the elderly, but more than 5 million of the 39 million Medicare beneficiaries are nonelderly disabled individuals eligible for Medicare because they have received Social Security or Railroad Retirement Board disability benefits for at least 2 years.

care costs and therefore limits its nursing home coverage to short-term, post-acute stays of up to 100 days per spell of illness following hospitalization. Medicare nursing home spending increased from $1.7 billion in 1990 to $10.4 billion in 1998 and declined to $9.6 billion in 1999.

Since 1989, Medicare became a significant funding source of home care, financing $8.7 billion in care in 1999—or more than one-fourth of the home care purchased for the elderly. Court decisions and legislative changes in coverage essentially transformed the Medicare home health benefit from one focused on patients needing acute, short-term care after hospitalization to one that primarily served chronic, long-term care patients. By 1994, only about one-fourth of home health visits covered by Medicare occurred within 60 days following a hospitalization. As a result, Medicare, on a de facto basis, financed an increasing amount of long-term care through its home health care benefit. Both the number of beneficiaries receiving home health care and the number of visits per user more than doubled from 1989 to 1996. From 1990 to 1997, the average annual growth rate for Medicare home health care spending was 25.2 percent—more than 3 times the growth rate for Medicare spending as a whole. This increase in the use of these services cannot be explained by any increase in the incidence of illness among Medicare beneficiaries.

In response to concerns about the growth in spending for Medicare services, including skilled nursing facility and home health services, the BBA included provisions to slow Medicare spending growth. The BBA required prospective payment systems (PPS) to be implemented for Medicare services provided through home health care agencies and skilled nursing facilities, replacing retrospective, cost-based reimbursement systems that did not provide adequate incentives to control costs. The skilled nursing facility PPS began to be implemented in July 1998 and will be completely phased in this year.

For home health, rather than immediately introducing a PPS, an interim home health care payment system was implemented in October 1997, pending development of a case-mix adjusted prospective payment system. Between 1997 and 1998, Medicare home health spending fell by nearly 15 percent, while home health visits dropped sharply by 40 percent, and this decline continued in 1999.[6] The new home health PPS, implemented in October 2000, is expected to be a more appropriate payment tool than the interim payment system because it is designed to more closely align

[6]See *Medicare Home Health Care: Prospective Payment System Could Reverse Recent Declines in Spending* (GAO/HEHS-00-176, Sept. 8, 2000).

payments with patient needs.[7] PPS rates are based on a higher number of home health visits per user than those currently being provided. As a result, the PPS can support a large expansion of services. However, PPS incentives are intended to reward efficiency and control use of services. Because criteria for what constitutes appropriate home health care do not exist, it may be difficult for Medicare to ensure that patients receive all necessary services. How home health agencies respond to the PPS and its incentives could have major implications for the amount of future Medicare funding for home health care, the services provided, and whether Medicare remains a significant payer of long-term care.

Private Long-Term Care Insurance Is Small but Growing

Many baby boomers will have more financial resources in retirement than their parents and may therefore be better able to absorb some long-term care costs. However, long-term care will represent a catastrophic cost for a relatively small portion of families. Private insurance can provide protection for such catastrophes because it spreads the risk among larger numbers of persons. Private long-term care insurance has been viewed as a means of both reducing potential catastrophic financial losses for the elderly and relieving some of the financing burden now shouldered by public long-term care programs. Some observers also believe private long-term care insurance could give individuals a greater choice of services to satisfy their long-term care needs. However, less than 10 percent of elderly individuals and even fewer near-elderly individuals (those aged 55 to 64) have purchased long-term care insurance. The National Association of Insurance Commissioners' (NAIC) most recent data show that approximately 4.1 million persons were insured through long-term care policies in 1998, compared with 1.7 million persons in 1992.[8] In contrast, about two-thirds of the elderly—about 23 million individuals—have private Medicare supplemental (Medigap) insurance policies for non-Medicare-covered expenses such as copayments, deductibles, and prescription drugs.

Barriers to purchasing long-term care policies still exist, including misunderstandings among consumers about the roles of public programs, personal resources, and private insurance in financing long-term care. Private long-term care insurance is still a little known product, but insurance providers are seeking to build a larger market. Many baby

[7]See *Medicare: Refinements Should Continue to Improve Appropriateness of Provider Payments* (GAO/T-HEHS-00-160, July 19, 2000).

[8]The accuracy of these policy numbers is dependent upon the accuracy of the information filed by the insurers themselves with the NAIC.

boomers continue to believe they will never need such coverage. A recent survey of the elderly and near elderly found that only about 40 percent believed that they or their families would be responsible for paying for their long-term care. Some mistakenly believed that public programs, including Medicaid and Medicare, or their own health care insurance would provide comprehensive coverage for the services they need. This low perceived need for protection decreases demand for long-term care insurance. People also may be concerned about whether they can afford such insurance now or in the future when their premiums may increase and their retirement incomes may have decreased.

Some employers offer employees a voluntary group policy option for long-term care insurance, but this market remains small and includes predominantly large employers. Usually employers do not pay for any of the costs of these policies, but group policies have lower administrative costs than individually purchased policies, which can result in lower premiums. One study estimated that 6 to 9 percent of eligible employees took advantage of employer-provided group long-term care insurance where it was available.[9] Last year, the Congress passed legislation to offer unsubsidized, optional group long-term care insurance to federal employees and retirees beginning by fiscal year 2003. This initiative will likely establish the largest group offering of long-term care insurance and could significantly expand this market.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) extended tax deductibility of some premiums and tax exemptions for certain benefits to qualified long-term care insurance policies that must satisfy certain consumer protection standards and other requirements.[10] The consumer protection standards are deemed satisfied if a policy complies with NAIC's Long-Term Care Model Act and Regulation as of 1993. As of July 1998, the Health Insurance Association of America (HIAA) reported that all 50 states (which have primary responsibility for regulating insurance policies) required policies to adhere to at least three

[9]Steven Lutzky and others, *Preliminary Data From a Survey of Employers Offering Group Long-Term Care Insurance to Their Employees: Interim Report*(June 1999).

[10]A qualified long-term care insurance plan is defined as a contract that covers only long-term care services; does not pay for services covered under Medicare; is guaranteed to be renewable; does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed; applies all refunds of premiums and all policyholder dividends or similar amounts as a reduction in future premiums or to increase future benefits; and meets certain consumer protection standards. Also, payments received from a qualified plan are considered medical expenses and are excluded from gross income for determining income taxes. Per diem policies that pay on the basis of disability rather than reimbursing for services used are subject to a cap of $180 per day per person in 1998. Out-of-pocket expenses for long-term care are allowed as itemized deductions along with other medical expenses if they exceed 7.5 percent of adjusted gross income.

of these NAIC long-term care insurance standards. These three standards require policies to (1) not make prior hospitalization a condition for coverage, (2) have an outline of the coverage the policy provides, and (3) be guaranteed to be renewable and noncancelable except for nonpayment of premiums. In addition, all but one state adheres to the NAIC definition of long-term care insurance (policies that provide coverage for at least 12 months for necessary services provided in settings other than acute-care hospital units), and all but two states adhere to the preexisting conditions standard. Overall, HIAA identified 14 NAIC provisions specified for long-term care policies to be tax-qualified under HIPAA that had been adopted by at least 35 states as of July 1998.

Affordability of Long-Term Care Insurance Concerns Many Elderly Individuals

Many elderly and near-elderly individuals question the affordability and the value of long-term care insurance relative to the premiums charged. Long-term care insurance costs vary depending on the policyholder's age at the time of purchase, optional benefits and terms selected, and the insurer. Premiums for a 65-year-old are typically about $1,000 per year and can be much higher for more generous coverage or for older buyers. The affordability of long-term care insurance determines to a great extent its market and is a key factor in individuals' decisions to purchase and retain a long-term care insurance policy. Although assessing whether individuals can afford a policy is subjective, some studies estimate that long-term care insurance is affordable for only 10 to 20 percent of the elderly. Affordability is even more of an issue for married couples, who must each purchase individual coverage. While some insurers offer discounts to married couples when both purchase long-term care coverage, elderly couples are still likely to pay at least several thousand dollars annually for long-term care coverage. Those who consider and decide against purchasing long-term care insurance say they are skeptical about whether private policies will give adequate coverage. Those who do find long-term care insurance affordable when purchased may later decide it is not if their financial circumstances change or the premiums increase. An industry group estimates that 55 to 65 percent of all long-term care insurance policies sold as of June 1998 remain in force.

Insurers state that it is prudent to buy long-term care insurance earlier rather than later in life because premiums are based largely on an individual's age when the policy is purchased. A policy purchased when a person is in his or her 40s or 50s has much lower premiums than a policy purchased later; however, the younger person pays the premiums over a longer period. If a person waits until age 79 to buy, the premiums are typically about 2-1/2 times higher than if the same policy had been

purchased when he or she was 65, and about 6 to 10 times higher than if the policy had been purchased at age 50.

Unfamiliarity with the concept and uncertainty of the value of long-term care insurance may deter some people from purchasing a policy. A relatively low premium at age 45 may nonetheless seem high for a risk that may not be realized for 40 years. Concerns about the cost of premiums relative to the value of policies may be a factor deterring purchases, especially when premiums for a similar policy for the same individual can vary widely. For example, a 65-year-old in Wisconsin can pay $857 to $2,061 per year for a long-term care insurance policy depending on the carrier, even if the terms are similar.[11]

Consumer Protection Vital, Especially If Private Insurance Plays a Larger Role in Financing Long-Term Care

Consumers deserve complete and accurate information about any insurance product that they purchase, and sales of long-term care policies are not likely to increase significantly unless consumers are given adequate and understandable information to assess them. If long-term care insurance is to help address the baby boom generation's future long-term care needs, individuals must understand what they are buying and what future changes, if any, they may face in their policy's coverage or premiums. While NAIC's model standards have helped address prior deficiencies in the terms of long-term care policies,[12] it is uncertain whether these have been sufficient to assure consumers that long-term care products are reliable and the terms of the products are easily understood and will be fulfilled. Recently, NAIC further amended its models in response to concerns about dramatic premium increases that some long-term care policyholders experienced.

In August 2000, NAIC amended its Long-Term Care Insurance Model Act and Regulation to strengthen consumer disclosure and encourage insurers to set initial rates at levels unlikely to require further increases. In part, this was intended to address problems such as those highlighted by a recently settled class action lawsuit involving long-term care policyholders in North Dakota who had dramatic premium increases—some by more

[11]Annual premiums for individual basic long-term care insurance policies marketed in Wisconsin as of October 1999, with a $100 per-day nursing home benefit, $50 per-day home health benefit, lifetime benefits, a 90- or 100-day elimination period, and no optional benefits.

[12]In 1993, we reported on a number of problems in the long-term care insurance market, including those related to disclosure standards, inflation protection options, clear and uniform definitions of services, eligibility criteria, grievance procedures, nonforfeiture of benefits, options for upgrading coverage, and sales commission structures that potentially created incentives for marketing abuses. See *Health Care Reform: Supplemental and Long-Term Care Insurance* (GAO/T-HRD-94-58, Nov. 9, 1993).

than 700 percent—even though they believed that their premiums would not increase as long as they held their policies. In states that adopt the new NAIC model amendments, insurers will have to provide written information to prospective purchasers explaining

- that a policy's premium may increase in the future,
- why premium increases may occur,
- what options a policyholder has in the event of an increase, and
- the 10-year rate history for their policies.

In states that adopt the model, consumers will also have to specifically acknowledge that they understand their policy's premiums may increase, and insurers must explain any contingent benefit available to policyholders who let their policies lapse because of a substantial rate increase. Additionally, NAIC adopted amendments to better ensure that long-term care insurers price their policy premiums to be sufficient over the lifetime of the policy, so as to minimize the need for future premium increases. As a further consumer protection, these amendments require insurers to reimburse policyholders when any rate increase is found to be unnecessary and allow state insurance commissioners to ban an insurer from the long-term care market if the insurer has a pattern of offering initial policy purchasers inadequate premium rates. For the new NAIC model provisions to become effective, states must choose to adopt them as part of their statutes or regulations. An NAIC official reported that some states have begun considering legislation or regulations reflecting the revised NAIC models but that states will vary in whether and how quickly they adopt particular portions.

Concluding Observations

The aging of the baby boomers will greatly increase the nation's elderly population in the next 3 decades and thus increase the population who need long-term care services. The need for these services will become more critical after 2030, when this population reaches age 85 and older, which is the age group with the greatest need for long-term care. Recent legislation authorizing a new federal employees' long-term care insurance offering and proposals that would establish new tax subsidies for the purchase of private long-term care insurance aim to increase the role private insurance plays in financing long-term care. Increased confidence in long-term care insurance and the availability of affordable, reliable products are also crucial components of private insurance if it is expected to play a larger role in financing future generations' long-term care needs.

Chairman Grassley and Ranking Member Baucus, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Committee have at this time.

GAO Contacts and Staff Acknowledgments

For more information regarding this testimony, please contact Kathryn G. Allen at (202) 512-7118 or John Dicken at (202) 512-7043. Opal Winebrenner and Carolyn Yocom also made key contributions to this statement.

Related GAO Products

Long-Term Care Insurance: Better Information Critical to Prospective Purchasers (GAO/HEHS-00-196, Sept. 13, 2000).

Medicare Home Health Care: Prospective Payment System Could Reverse Recent Declines in Spending (GAO/HEHS-00-176, Sept. 8, 2000).

Medicare and Medicaid: Implementing State Demonstrations for Dual Eligibles Has Proven Challenging (GAO/HEHS-00-94, Aug. 18, 2000).

Medicare: Refinements Should Continue to Improve Appropriateness of Provider Payments (GAO/T-HEHS-00-160, July 19, 2000).

Low-Income Medicare Beneficiaries: Further Outreach and Administration Could Increase Enrollment (GAO/HEHS-99-61, Apr. 9, 1999).

Long-Term Care: Baby Boom Generation Presents Financing Challenges (GAO/T-HEHS-98-107, Mar. 9, 1998).

Health Care Reform: Supplemental and Long-Term Care Insurance (GAO/T-HRD-94-58, Nov. 9, 1993).

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