ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672
6266 SENATE HEALTH, EDUCATION AND SOCIAL SERVICES

Section 4E(1) shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage or an insured person.

(2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

(3) The Commissioner may extend the limitation periods set forth in Sections 6C(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6C(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6C(2).

D. Prior hospitalization/institutionalization:

(1) No long-term care insurance policy may be delivered or issued for delivery in this state if such policy:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement; or

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(2) (a) A long-term care insurance policy containing any ~~limitations or conditions for eligibility other than those prohibited above in Paragraph (1)~~ post-confinement,

post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

(a)--A long-term care insurance policy containing a benefit advertised, marketed or offered as a home health care or home care benefit may not condition receipt of benefits on a prior institutionalization requirement.

(b) A long-term care insurance policy or rider which conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days for which benefits are paid.

Drafting Note: The amendment to the section is primarily intended to require immediate and clear disclosure where a long-term care insurance policy or rider conditions eligibility for non-institutional benefits on prior receipt of institutional care.

(2) No long-term care insurance policy or rider which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty days after discharge from the institution.

Drafting Note: The Dec. 1988 amendment to this section will eliminated the three-day prior hospitalization screen for new long-term care insurance policies. Some states may wish to consider a "dual-option" alternative to the total prohibition against the prior hospitalization screen, based on the state's particular demographic, geographic and market characteristics. If so, the following provision is such an alternative: "No long-term care insurance policy which conditions the eligibility of benefits on prior hospitalization may be delivered or issued for delivery in this State unless the insurer or other entity offering that policy also offers a long-term care insurance policy which does not condition eligibility of benefits on such a requirement."

Editors Note: Section 6D(2) is language from the original model act which did not prohibit prior institutionalization. The drafters intended that Section 6D(2) would be eliminated after adoption of the amendments to this section which prohibit prior institutionalization. States should examine their Section 6 carefully during the process of adoption or amendment of this Act.

E. The Commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

F. Right to return - free look:

Long-term care insurance applicants shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined Section 4(E)1 of this Act, the applicant is not satisfied for any reason.

G. (1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(a) The Commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(b) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(2) The outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contain governing contractual provisions;

(e) A description of the terms under which the policy or certificate may be returned and premium refunded; and

(f) A brief description of the relationship of cost of care and benefits.

H. A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(3) A statement that the group master policy determines governing contractual provisions.

Comment: The above provisions are deemed appropriate due to the particular nature of long-term care insurance, and are consistent with group insurance laws. Specific standards would be contained in regulations implementing this Act.

I. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(3) Any exclusions, reductions and limitations on benefits of long-term care; and

(4) If applicable to the policy type, the summary shall also include:

(a) A disclosure of the effects of exercising other rights under the policy;

(b) A disclosure of guarantees related to long-term care costs of insurance charges, and

(c) Current and projected maximum lifetime benefits.

J. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

(1) Any long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

(3) The amount of long-term care benefits existing or remaining.

K. Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this Act.

Section 8. Administrative Procedures

Regulations adopted pursuant to this Act shall be in accordance with the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

Section 9. Severability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 10. Effective Date

This Act shall be effective [insert date].

Legislative History (all references are to the Proceedings of the NAIC).

1987 Proc. I 11, 19, 655, 677-680, 700 (adopted).
1987 Proc. II 15, 23, 632-633, 727, 730-734 (amended and reprinted).
1988 Proc. I 9, 20-21, 629-630, 652, 661-665 (amended and reprinted).
1989 Proc. I 9, 24-25, 703, 754-755, 789-793 (amended).
1989 Proc. II (amended and reprinted).

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HIAA

Health Insurance Association of America

THE CONSUMER'S GUIDE TO

LONG-TERM CARE INSURANCE

Selecting the health insurance that's right for you can be very complicated. There can be confusing words, exclusions and differing costs for various coverages to understand.

Recently there has been yet another form of insurance introduced to the American people. It is long-term care insurance. While many people think that Medicare insurance will cover the cost of long-term care, such as care in nursing homes, it actually pays for such coverage only in certain cases. Even if you have purchased private supplemental insurance, sometimes called Medigap, it does not cover long-term care either. Because there has been limited insurance for this care in the past, people have had to pay for their own care with their own resources or become impoverished in the process and qualify for Medicaid.

This booklet will explain what long-term care is and how long-term care insurance works. It also provides a handy checklist you can use to compare policies before you buy.

You owe it to yourself to examine carefully all aspects relating to this coverage and its cost. Many of the different types of policies available will be suitable for you and will meet your needs. Some may be suitable for others, but may not be suitable for you. This booklet will tell you in plain language most of what you need to know.

What is long-term care?

Long-term care is the kind of assistance you could need if you ever have a chronic illness or disability that lasts a long time and you are unable to care for yourself. Long-term care does not refer only to nursing home care. It can be provided in your own home if you need help with activities such as bathing, walking or doing chores.

There is a range of services available in the community to meet long-term care needs besides the nursing home. These services include: visiting nurses, home health aides, friendly visiting, meals on wheels, chore services and respite care that is available for caregivers who need an occasional break from daily responsibilities.

Some or all of these services may be available in your community. You may want to check with the Area Agency on Aging, listed in the telephone book, for help in locating these types of long-term care services.

Long-term care refers to more than nursing home care.

What are the chances that you will need long-term care?

By 2000, more than 8 million Americans aged 65 or more probably will need some form of long-term care due to disability or chronic illness. Most people can be cared for at home. Family and friends are the sole caregivers for 70 percent of these elderly.

Those aged 85 or older are the most at risk for needing long-term care. In fact, statistics show that, at any given time, 22 percent of those age 85 and older are in a nursing home. One study showed that in 1985, 2.3 million people who were 65 years old and older spent at least part of a year in a nursing home. An additional 4 million elderly people received care in their homes.

At the same time, it is estimated that two out of five people aged 65 or more risk entering a nursing home. Half of them will need to stay about six months or less; and half will need to stay an average of 2.5 years. Only a small number stay longer than 5 years.

What are the costs associated with long-term care?

Long-term care can be very expensive. Recent figures indicate that a year in a nursing home costs an average of $25,000. Depending on where you live it could cost more than that.

Home-based care (help with dressing, bathing, household chores) provided by an aide just three times a week for a year can easily cost $440 each month, or $5,300 a year. If you require someone to assist you in administering oxygen or medication, for example, skilled nursing visits can cost even more with three visits per week for a year running as much as $8,200 per year.

Medicare pays for nursing home care in limited situations.

Who pays for it?

Neither Medicare nor private Medicare supplemental insurance (or the health insurance you may have through your employer) will pay for most long-term care expenses. Medicare supplemental insurance (Medigap) is private insurance that is designed to help cover some of the gaps in Medicare coverage—but not long-term care. Even the new Catastrophic Care Amendments to Medicare do not cover long-term care. Many people think that this new expansion of Medicare insurance will cover the cost of nursing home care or home health care, but it actually pays for such coverage only in extremely limited circumstances.

Medicare will help pay for long-term care under these conditions only:

- Skilled nursing care is covered for up to 150 days per calendar year. You must meet restrictive eligbility criteria and a physician must show that nursing home admission is necessary. Under the new law, in 1989 there is a $25.50 copayment per day for the first through the eighth day of a nursing home confinement. After the eighth day there is no copayment required.
- Part-time skilled home health care is covered but only for short-term unstable conditions. You must be homebound and certified by a doctor that care is necessary. Also, the home health agency must participate in Medicare. The new law allows more frequent use of the benefits under limited circumstances.

People can lose most of their assets after entering a nursing home.

Your care will not be covered if what you need is custodial care, or if you need prolonged home health care on a daily basis. (See Glossary for definition of intermediate care and custodial care.)

It is not surprising then that Medicare pays for less than 2 percent of the nation's annual nursing home bill. Medicare supplemental policies generally do not cover services in addition to Medicare, but rather are designed to pay the costs Medicare does not cover such as hospital deductibles or physician copayments. More than half of nursing home care expenses are paid out-of-pocket by individuals and their families.

Medicaid is a major payer of nursing home care, accounting for 42 percent of all payments to these facilities. Medicaid is a federal-state welfare program meant to provide help with medical expenses to the aged, blind and disabled poor. Many people who begin paying for nursing home care out of their own pockets are often impoverished soon after entering a nursing home. They then turn to Medicaid to pay part or all of their nursing homes expenses.

Recent changes to Medicaid allow your spouse to keep at least $786 per month and at least $12,000 in assets in 1989, if you should

become Medicaid-eligible for nursing home care. These amounts will increase annually.

It is difficult to know what kind of care you may need or what the costs will be. But knowing that you will be responsible for the majority of expenses, you need to know what kind of insurance coverage you should consider. The rest of this booklet describes features of private insurance policies and provides a convenient work sheet you may use in evaluating insurance policies.

What kind of insurance is available?

Private long-term care insurance can fill a growing need.

Long-term care insurance is a relatively new type of private insurance. More than 100 companies offer private long-term care insurance today and that number is rising as more insurance companies seek to fill this growing need.

Almost all policies now available are called indemnity policies, meaning they pay a set amount, usually a fixed dollar amount per day for nursing home or home health care. No policy, however, provides full coverage for all expenses. In addition, many policies do not increase the indemnity amount as the cost of care increases over time. Several newer policies do offer increased benefits over time to allow for increased costs.

Long-term care coverage also is offered as part of individual life insurance policies. Under this arrangement, a certain percentage of the policy's death benefit is paid for each month the policyholder requires long-term care.

Each policy is priced differently. In 1987, individual policy premiums ranged from about $250 a year in premiums to more than $2,500 depending on several factors.

Age

The younger you are when you buy a policy, the lower the premium. Most policies are sold on an entry-age level basis, so that the premium should

remain at that level and not increase with age, unless there is an increase for everyone that has the same kind of insurance.

Elimination or deductible periods

These are defined as the number of days you must be confined in a facility or the number of home care visits you must receive before policy benefits begin. For example, if the policy you select has an elimination period of 20 days for nursing home care or home health visits, your policy will begin paying you benefits on the 21st day. Usually the longer the elimination or deductible period, the lower the premium.

Indemnity value and duration of benefits

These vary from policy to policy, but in general the more money the policy will pay or the longer the benefit period, the more the policy costs. For example, a policy that pays $100 a day for up to five years of nursing home care will cost more than a policy that pays $50 a day for three years.

Policies can cover round-the-clock care and help with daily activities.

What kind of coverage is provided?

Long-term care policies usually pay for skilled, intermediate or custodial care in a nursing home. Generally, skilled care refers to round-the-clock treatment by a registered nurse under a doctor's supervision. Intermediate care refers to occasional nursing and rehabilitative care under the supervision of skilled medical personnel. Custodial care primarily meets personal care needs in activities of daily living such as help in bathing or eating that can be provided by someone without professional medical skills.

Most policies will pay for expenses in facilities that are licensed by the state to provide skilled and intermediate care and participate in Medicaid and Medicare, and meet the policy's definition of skilled, intermediate or custodial care.

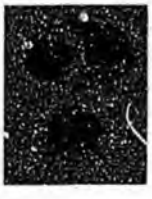
Many long-term care policies require hospitalization before covering any portion of a

nursing home stay. This is increasingly not the case, however. A few require that the policyholder receive skilled or intermediate care before they will pay for custodial care or allow that custodial care be covered only if it is provided in a skilled or intermediate nursing home.

Also, policies usually cover home health care services such as skilled or nonskilled nursing care and homemaker and home health aides, although many policies require a prior nursing home or hospital stay before they will cover home health care benefits. This, too, is changing. Newer policies do not base benefit eligibility for nursing home or home health care benefits on a prior hospitalization requirement.

Therefore, it is very important to make sure the coverage you seek is provided in the policy. Also, make sure you understand the conditions under which your policy will pay for nursing home or home health care.

Make sure the benefits you want are covered.



What kinds of limits are there?

All policies contain limitations and exclusions in addition to age, elimination or deductible periods, and the amount and duration of benefits. The purpose of these provisions is to help maintain reasonable premiums that would cover anticipated costs should that become necessary.

Other limitations for consideration are:

Preexisting conditions

An insurance company generally requires that a certain period of time passes before the policy pays for care related to a health problem you may have already had when you became eligible for coverage. Such health problems are called preexisting conditions. At this time, most companies use a six-month preexisting condition limitation period. (For these policies, if you need to use long-term care benefits within six months

(Continued on page 10)

Long-Term Care Policy Checklist

The following checklist will help you compare policies you may be considering.

Policy A Name: _____

Policy B Name: _____

	Policy A	Policy B
1. What services are covered? ■ Skilled care ■ Intermediate care ■ Custodial care ■ Home health care ■ Other care		
2. How much does the policy pay per day for: ■ Skilled care ■ Intermediate care ■ Custodial care ■ Home health care ■ Other care		
3. Does the policy offer a means for increasing benefits to account for expected future costs? If so, how? Is there an additional premium?		
4. Does the policy have a maximum lifetime benefit? If so, what is it? ■ Nursing home ■ Home health		

5. Does the policy have a maximum length of coverage per "spell of illness" of maximum benefit period? If so, what is it? ■ Nursing home ■ Home health		
6. How long do I have to wait before preexisting conditions are covered?		
7. Is Alzheimer's disease covered?		
8. How many days is the elimination or deductible period before benefits begin?		
9. Does this policy require: ■ Physician certification of need ■ A functional assessment ■ A prior hospital stay for: ▪ Nursing home care ▪ Home health care ■ A prior nursing home stay for home health care ■ Other		
10. Can the policy be cancelled?		
11. Will the policy cover you if you move to another area?		
12. What is the age range for enrollment?		
13. What does the policy cost? ■ per month ■ per year		

of the effective date of coverage due to a preexisting condition, you may be denied coverage.

Eligibility

For most individual policies, you will be unable to buy a policy after a certain age. Each company sets its own age limit, usually around age 79. Most policies are available only to those over the age of 50. These age limitations refer only to the ability to purchase long-term care insurance, not to the age you are when you use the benefits.

Renewability

Most policies sold on an individual basis are guaranteed renewable and cannot be cancelled. This renewability provision normally is found on the first page of the policy and tells under what conditions the policy can be cancelled and under what conditions premiums may be raised.

Exclusions

Policies may not pay for long-term care related to inorganic mental or nervous conditions, alcoholism, mental retardation, or certain other health conditions or situations. Alzheimer's disease and other related cognitive impairments, leading causes for nursing home admissions, generally are covered. Check policy provisions carefully to determine what exclusions apply.

Don't be afraid to ask an insurance agent if something is unclear.

What should you look for in a long-term care policy?

Be sure to read policies you are considering carefully and compare them. Ask for a summary of the policies' benefits or a disclosure form outlining the policies' features. Don't be afraid to ask your insurance agent about anything unclear. There is no single solution for everyone, but your financial plans should include consideration of your long-term care needs.

Glossary

The following definitions of commonly used long-term care terms are meant to provide a general definition of each term but may differ somewhat from those found in long-term care policies, in Medicare or by actual nursing homes.

■ **Conditionally renewable**—An insurance company agrees to continue to insure a policyholder as long as it continues to insure all people in the state holding the same kind of policy.

■ **Coinsurance**—A percentage of allowed expenses that an insured person is required to pay, e.g., 20 percent of "reasonable" charges under Medicare.

■ **Custodial care**—Care that is primarily for meeting personal needs such as help in bathing, dressing, eating or taking medicine. It can be provided by someone without professional medical skills or training but must be according to doctor's orders.

■ **Deductible or elimination period**—This amount is the initial sum that must be paid for services covered under an insurance plan before benefits are paid by the insurance company. It is usually expressed in terms of days in long-term care insurance policies (e.g., 20 days).

■ **Disclosure form**—A description of benefits, exclusions and provisions of a policy that facilitates understanding of the plan and comparison among plans.

■ **Exclusion**—Any condition or medical expense for which the policy will not pay.

■ **Guaranteed renewable**—An insurance company agrees to insure a policyholder for life as long as the premium is paid and for a fixed premium unless there is an across-the-board rate increase.

■ **Home health care**—Care received at home such as part-time skilled nursing care, speech therapy, physical or occupational therapy, part-time services of home health aides or help from homemakers or choreworkers.

■ **Individual insurance**—Insurance underwritten and sold on an individual basis.

■ **Intermediate care**—Occasional nursing and rehabilitative care that can be performed by, or under the supervision of, skilled medical personnel only. Care must be based on doctor's orders.

■ **Intermediate care facility**—A nursing home that is licensed by the state and one that may be certified by Medicaid to provide intermediate care. It may provide custodial care as well.

■ **Medicaid**—A joint federal-state program that provides payment for health care services to those with low incomes or with very high medical bills relative to income and assets. It provides benefits for long-term nursing home care once income and assets have been "spent down" to eligibility levels. It also provides some home health services.

■ **Medicare**—The federal program providing people aged 65 and older, some disabled persons and those with end-stage renal disease with hospital and medical insurance. Active employees covered under their employers' plans do not qualify. It provides only very limited benefits for nursing home and home health services under narrowly defined circumstances.

■ **Medigap**—Medicare supplemental insurance is private insurance that supplements or fills in many of the gaps in Medicare coverage, such as deductibles and coinsurance amounts. It does not, however, provide benefits for long-term care.

■ **Preexisting condition exclusion**—An exclusion of benefits for medical conditions that a policyholder had before applying for health or long-term care insurance.

■ **Skilled nursing care**—Daily nursing and rehabilitative care that can be performed only by, or under the supervision of, skilled medical personnel. Care must be based on doctor's orders.

■ **Skilled nursing facility**—A nursing home that is licensed by the state and one that may be certified by Medicare and/or Medicaid to provide skilled care. It also may provide intermediate and custodial care.

Questions we hear most often

What does long-term care insurance cover?

Generally, today's policies cover skilled, intermediate and custodial care in state-licensed nursing homes. They also cover home health services provided by state-licensed and/or Medicare certified home health agencies.

How much do policies pay?

Almost all policies pay a fixed amount per day, or an indemnity, that is independent of a particular nursing home or home health agency rate. Policyholders are usually offered a choice of indemnity amounts ranging from $40 to more than $100 per day. Generally, the higher the indemnity, the higher the premium. In most cases, the indemnity for home health care is 50 percent of the nursing home rate.

What about five years from now, when costs probably will rise?

The cost of nursing home care varies widely and depends on factors such as geographic location, and staffing and personnel requirements. The average cost of a year in a nursing home is $25,000 and rising steadily.

Most policies currently do not automatically adjust the benefit amount upward to account for higher costs expected in the future. Make sure you understand whether the policy you are examining offers protection against future, increasing costs. If the policy does offer protection, make sure you understand how the provision works. While these types of policies are more expensive, more companies are offering them.

Do these policies cover Alzheimer's disease?

Policies generally cover Alzheimer's disease specifically or "organic mental and nervous disorders," which generally include Alzheimer's disease and related disorders.

What are the real chances of entering a nursing home?

A Brandeis University study indicates that persons aged 65 or more face a 40 percent chance of entering a nursing home for any length of time. For those who do, 40 percent will stay three months or less.

What do policies cost?

Policy premiums are based on the age of the purchaser. The premium remains at one level for as long as you own the policy, although premiums can be increased if they are raised for all individuals who hold a policy just like yours. Premiums, in general, cannot be increased because of your age or if your health deteriorates. At age 50, a policy offering a $60 per day nursing home indemnity and a 20-day deductible period costs around $300 per year, at age 65, about $675 and at age 79 or 80, about $2,100 per year.

How does the preexisting condition limitation work?

Preexisting conditions are conditions that warranted medical attention prior to the policy's effective date. Benefits for preexisting conditions will be paid if you require long-term care after buying the policy, usually after a period of six months. What this means is that if you buy a policy and need services for a preexisting condition within six months of purchase, it will not pay. If everyone who already needed long-term care purchased a policy, premiums would not be affordable for healthy persons.

What else do I need to know?

Insurance policies are legal contracts; make sure you understand what you are buying. If you are not satisfied with an agent's answers, ask for a phone number or an address of someone you can contact in the company itself. Good agents want you to know what you are buying. Community consumer organizations such as the Better Business Bureau, which is listed in your telephone book, might also help answer your questions.

Who offers long-term care insurance?

You may obtain a list of all companies offering long-term care policies by writing to:

Health Insurance Association of America
P.O. Box 41455
Washington, DC 20018

Additional Reading

Additional publications about health care coverage and long-term care are available from other organizations.

American Association of Homes for the Aging
Suite 400
1129 20th Street, N.W.
Washington, DC 20036
Telephone: 202/296-5960

Brochures describing continuing care retirement communities.

American Association of Retired Persons Health Advocacy Services
1909 K Street, N.W.
Washington, DC 20049
Telephone: 202/872-4700

Booklets and pamphlets on long-term care choices for older Americans.

American Health Care Association
1202 L Street, N.W.
Washington, DC 20005
Telephone: 202/842-4444

Various pamphlets about long-term care facilities.

Council of Better Business Bureaus
Suite 800
4200 Wilson Boulevard
Arlington, VA 22203
Telephone: 703/276-0100

Written materials on home care and nursing homes.

National Consumers League
Suite 516
815 15th Street, N.W.
Washington, DC 20005
Telephone: 202/639-8140

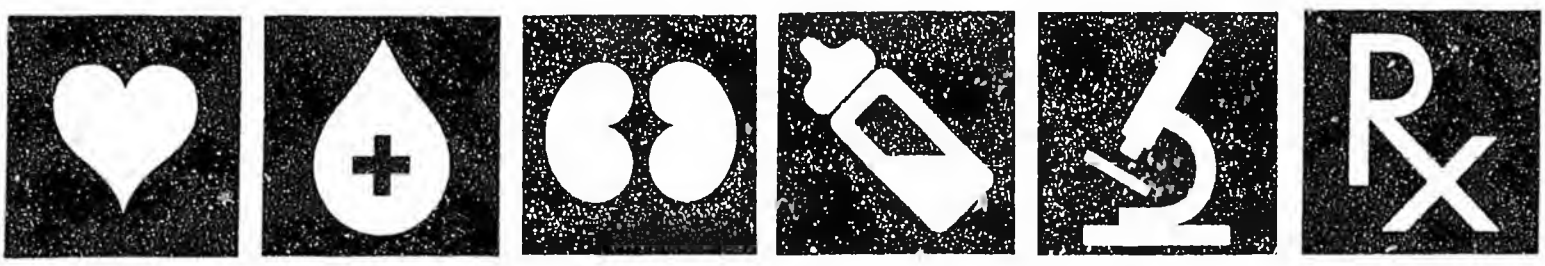
Consumer's guide to life care communities has health and ambulatory fact sheets on Medicare.

Health Insurance Association of America
1025 Connecticut Avenue, NW
Washington, DC 20036-3998
(202) 223-7780

What Legislators Need to Know About Long-Term Care Insurance

National Conference of State Legislatures

Foundation for State Legislatures



What Legislators Need to Know About Long-Term Care Insurance was written by David Landes, health care program manager, National Conference of State Legislatures (NCSL).

Persons who provided information and who also reviewed drafts were:

Gary Claxton, Ron Hagen, Gail Kirby, Bette Mullen, and Jane Tilly, American Association of Retired Persons; Carroll Wendland, Ph.D. and Glen Duncan, Beverly Foundation; Cynthia Fuller, Florida Department of Insurance/ Treasurer; Alice Clamp, John Mathews, Shirley Nagelschmidt, Susan Van Gelder, and Karen Williams, Health Insurance Association of America; Kim Bellard, Prudential Insurance Company of America; Linda Schofield, Traveler's Insurance Company; and Martha King, Bob Pierce, and Candace Romig, National Conference of State Legislatures.

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Introduction

Long-term care insurance is an emerging private financing mechanism for long-term care services – those services required due to a chronic illness or a condition lasting over a prolonged period of time. Currently, through the Medicaid program, government payment for long-term care is available only for the poor. Individuals not qualifying for Medicaid generally use their own assets until they are exhausted. State governments are searching for ways to reduce the burden of Medicaid expenses and to halt the financial drain on individuals. Long-term care insurance and other private financing mechanisms for long-term care represent a group of possible solutions to the problem.

State governments are also responsible for insurance regulation and consumer protection. Having begun to assess the need for regulation of long-term care insurance, states are finding that such regulation raises some difficult issues. Because long-term care insurance is relatively new, insurers consider it a financially risky venture. Some state attempts to protect consumers and regulate the insurance market raise the possibility that insurers may withdraw from the state rather than operate under conditions of increased financial risk. Each state must balance the need to protect consumers against the possibility of losing any potential benefits of long-term care insurance. States also may want to take action promoting the purchase of long-term care insurance.

This booklet discusses the potential importance to states of long-term care insurance, describes general policy characteristics, and summarizes state actions to both regulate and promote long-term care insurance. It is intended as a resource for both legislators and others involved in long-term care financing and public policy formulation.

Question One: What Are Long-Term Care and Long-Term Care Insurance?

Long-Term Care

> *Long-term care* refers to a broad spectrum of medical and support services provided to persons who have lost some or all capacity to function on their own due to chronic illness or condition and who are expected to need such services over a prolonged period of time.[1]

As used in this booklet, *long-term care* does not include short-term rehabilitative care, whether provided in nursing homes, other institutional settings such as extended care or rehabilitation units of acute care hospitals, or individuals' own homes. In contrast to acute care, long-term care typically requires less technical and intensive medical treatment. Nurses, nurses aides, rehabilitation and other specialists, and persons providing homemaker services play key roles. Physicians are less prominent than in acute care.

There are three different levels of long-term care:

- *Skilled nursing c* nursing and rehabilitative s es given by skilled health nel on a daily basis, under c a physician;
- *Intermediate ca* same as skilled nursing cept that procedures may rmed on an occasional basis; a
- *Custodial/personal care*- nce in activities of daily living tha be provided by persons without medical skills.[2]

Although there is general agreement on the existence of the three levels of care, insurers, government officials, and other groups all define the three levels differently.

All three levels of long-term care can be provided in nursing homes or in patients' own homes. The cost for each type of care, however, may vary by the setting. In 1984, approximately 20 percent of persons receiving long-term care resided in nursing homes, with the remainder living at home. Of those in their own homes, 75 percent were maintained solely through the efforts of unpaid caregivers such as family, friends, and volunteer community workers.[3]

The elderly (over age 65) population, the primary users of long-term care services, will increase in the future. By the year 2000, the number of elderly (over age 65) persons will have increased by 37 percent over the number in 1980.[4] As a percentage of total population, the elderly will increase from 11.3 percent in 1980 to 13.1 percent by 2000.[5] Increasing longevity will swell the over-85 age group, those elderly most likely to need long-term care. The number of persons over age 85 in the year 2000 will be 129 percent higher than the number of persons in the same age group in 1980.[6] It is estimated that on any given day in 1978 22 percent of those over 85 resided in nursing homes, compared with 7 percent of the age 75 to 84 population and only 2 percent of the age 65 to 74 population.[7]

The need for long-term care services will reflect the growth in the elderly population. The number of elderly persons with limitations of activity due to chronic conditions is projected to increase 38 percent between 1978 and 2003, assuming current mortality rates.[8] Should mortality rates

continue to decline, the increase could be as high as 64 percent.[9] Nursing home utilization is projected to rise by between 62 percent and 125 percent in the same time period, depending on whether mortality rates remain constant or decline.[10]

Long-Term Care Insurance

Long-term care insurance is insurance intended to cover long-term care services. The definition of long-term care used in this publication excludes short-term rehabilitative or acute care services. Consequently, the definition of long-term care insurance excludes insurance intended primarily to cover short-term care, such as Medicare supplemental insurance covering Medicare deductible and coinsurance payments. (See Question Four for a complete discussion of the Medicare nursing home benefit.) Existing long-term care insurance policies cover long-term care services exclusively, but long-term care insurance eventually may be sold as part of a more comprehensive health or life insurance package.

Policies now on the market have the following general characteristics:

- Coverage for nursing home care (almost always skilled nursing care, sometimes intermediate or custodial level care) and sometimes for home health care services. Benefits are paid up to a specified maximum number of days, home visits, or dollars, and often are contingent on a prior stay in a nursing home or hospital.
- Indemnity benefit payments. Policyholders receive a specified amount of money per day or per home visit, regardless of the actual expenses incurred. Policyholders then are responsible for paying providers of care, making up the difference between insurance receipts and charges incurred out of their own funds. Some policies escalate the amount of the indemnity payment each year the policy is in force, charging a higher premium for this option.
- Benefit or coverage limitations. Long-term care required for certain conditions, such as alcoholism or mental illness, may be excluded entirely from coverage. Care for other medical conditions diagnosed or treated before the policy is purchased ("pre-existing conditions"), such as heart disease or stroke, may be covered only after a waiting period of between three months and one year. Policyholders generally pay for a minimum number of nursing home days or home health visits before benefit payments can begin ("elimination periods").

Should current policies achieve satisfactory results, insurers can be expected to broaden their offerings to include policies with wider coverage and fewer exclusions and limitations.

Estimates of the number of insurers offering long-term care policies range as high as 35.[11] At least one policy is available in every state. Between 130,000[12] and 200,000[13] policies are estimated to be in effect.

Long-term care insurance helps consumers pay for long-term care by spreading the risks and the costs over large numbers of persons. There also exist two types of asset accumulation programs (not discussed further in this publication) that help consumers generate funds to pay for long-term care services by themselves:

- Asset accumulation programs targeted to health care. These include life insurance with pre-death long-term care benefits and "individual medical accounts" ("medical IRAs") that allow individuals to save their own money to pay for future health care expenditures. These are largely proposals at this time. Only one state, Colorado, has enacted legislation recognizing individual medical accounts,[14] and no insurers currently offer life insurance with long-term care benefits.
- Asset accumulation programs not targeted to health. These include life insurance cash value savings, pension accumulations, and reverse annuity/mortgage programs that allow individuals to convert their equity in real property or other assets into monthly income. These programs supply unrestricted income that individuals may use for any purpose, including health care. All are widely available except for reverse annuities/mortgages, which are available only in certain states and localities.

Accumulated assets also could be used to purchase long-term care insurance rather than long-term care services directly.

Question Two: Why Is Long-Term Care Insurance an Important Issue for State Legislators?

Long-term care insurance has the potential to reduce state Medicaid expenditures by decreasing the number of persons who are forced to rely on Medicaid to pay their nursing home and home health care costs. A major study of private financing of long-term care, conducted by ICF Incorporated for the U.S. Department of Health and Human Services, estimated that long-term care insurance could reduce Medicaid nursing home expenditures by between $3 billion and $9 billion annually over a 35-year period (depending on the assumptions used to estimate how many persons would purchase long-term care insurance).[15] These dollar amounts represent reductions of between 8 and 23 percent in annual Medicaid nursing home expenditures.[16] Another study, done by The Brookings Institution using different assumptions, estimated a maximum average 5 percent reduction in Medicaid expenditures in the years 2016 to 2020.[17] Reductions might increase, however, in subsequent years.

Medicaid expenditures are one of the fastest growing components of state budgets. Between 1975 and 1981, state-only Medicaid costs increased from 5.6 percent of all state expenditures to 7.7 percent.[18] Long-term care expenditures are a significant component of Medicaid expenditures. Nursing home care is the second largest expense in the national Medicaid budget after hospital care, accounting for 37 percent of total state-funded Medicaid expenditures in 1985.[19] Between 1980 and 1985, total Medicaid nursing home expenditures increased from $9.8 billion to $14.7 billion, a 10 percent annual increase, growing faster than any other part of the Medicaid budget except hospital care.[20] The predicted increase in the over-65 population and the especially large increase in the over-85 population are expected to accelerate the rise in Medicaid expenditures.

The present, near-exclusive reliance on Medicaid and private financing for long-term care raises additional public policy concerns about access to care and family impoverishment. In 1985, payments out of personal funds accounted for 53 percent of all long-term care services purchased in nursing homes while Medicaid covered 42 percent.[21] Medicaid recipients may find it difficult to gain admission to Medicaid-certified nursing homes because their operators prefer patients who pay privately, generally at rates higher than those Medicaid pays. This is especially true for patients requiring intensive and technically difficult care and in states where bed supply has been strictly controlled by certificate of need programs. Medicaid recipients are excluded entirely from nursing homes that choose not to be Medicaid certified. Medicaid emphasizes institutional long-term care, and many state programs provide only limited home health care. Finally, the pressure on legislatures to reduce state budgets makes Medicaid recipients vulnerable to future benefit cuts.

Private-pay patients incur nursing home charges that average $67 per day, or nearly $25,000 annually.[22] Many exhaust their resources. One study, using computer simulations, estimated that between 40 and 72 percent of the persons entering nursing homes as private-pay patients would spend down to Medicaid eligibility levels within six months of admission.[23] Between 55 percent and 82 percent would do so within one year of admission.[24] For elderly couples with one spouse in a nursing home, the depletion of assets for long-term care also impairs the remaining spouse's ability to live independently. This problem of spousal impoverishment has been of special concern to state legislators, and states have begun searching for ways to limit the amount of assets that must be spent before becoming eligible for Medicaid.

Question Three: What Types of Long-Term Care Insurance Policies Are Available?

Long-term care insurance is a relatively new phenomenon, and policy offerings will be refined continually over the next few years. While policies on the market differ in a number of ways, they share some general features.

Benefits

Nursing Home Care

Coverage for nursing home care is the principal component of almost all long-term care insurance policies. Generally, a specified dollar amount per day is paid for a maximum number of days (most frequently three or five years) in a state-licensed nursing home. Some policies impose lifetime maximum limits on total days of care paid for or total reimbursement dollar amounts or both. Almost all policies cover skilled nursing care. Some also cover intermediate or custodial level care. Benefit payments often differ by type of facility or level of care.

Most policies include provisions designed to reduce induced demand – the tendency of policyholders to use more services because insurance pays some or all of the costs. These provisions may require, for example, that covered nursing home care be preceded by a minimum length of stay in a hospital (usually three days), or that care be certified by a physician as "medically necessary." Elimination or deductible periods before benefit payments begin serve a similar purpose. Policyholders are discouraged from unnecessary nursing home use, since they must pay the initial charges themselves until benefit payments begin. Elimination periods also screen out nursing home stays intended more for short-term rehabilitation or posthospital recovery.

Adverse selection – the tendency of high-risk or already-ill persons to seek insurance – is reduced by applicant screening, which all insurers writing individual policies have the right to do. Many policies exclude coverage for alcoholism, mental retardation, or mental illness not of organic origin. For insurers, these exclusions represent high-risk coverages since they are difficult to define in an insurance policy and use of services is difficult to manage effectively. Other pre-existing conditions (conditions diagnosed or treated prior to purchase of the insurance), such as a recent stroke or diagnosed Alzheimer's disease – the existence of which could encourage already-sick individuals to seek insurance, generally are covered only after a waiting period, typically six months.

Home Health Care

Some policies cover home health care. Home health coverage is not universal because insurers are less able to protect themselves against adverse selection and induced demand. There is no general agreement on the services included in home health care and the need for such care is more difficult to judge objectively. Policies covering home health care differ in the scope of covered services. Some cover only those services provided by licensed health care personnel: rehabilitation services such as physical, speech, and occupational therapy; and nursing services

such as injections, wound dressing, and intravenous fluid administration. Policies with broader coverage also may include personal care services intended to assist with activities of daily living: bathing, routine physical exercise, walking, eating, and monitoring of medication use.

All policies limit the number of home health visits or days of home health care covered. Most policies include provisions to guard against adverse selection and induced demand similar to those applied to nursing home benefits. Use of home health benefits may be contingent on a prior nursing home stay, for example.

Payment Mechanisms and Premiums

Individuals who have purchased long-term care insurance have done so at about the same time they perceived the need—in middle to late life. Policies typically have a minimum age of 55 or 60.[25] If clients would purchase at a younger age, insurers could reduce annual premiums since they would have a longer payment period to build up funds to pay benefits. However, since even elderly individuals often do not see the need to purchase long-term care insurance (see Question Four), purchase by younger individuals does not appear likely without employer-sponsorship or changes in public attitudes.

Long-term care insurance premiums vary depending on the policyholder's age. "Level premium" policies have premiums that are determined by the policyholder's age at the time of purchase and remain the same as long as the policy remains in effect. "Graduated premium" policies increase the annual premium as the policyholder ages. Premiums for these policies are lower for younger individuals than those of the level premium policies but are higher for older persons. In addition to age, scope of covered services, the length of elimination periods before benefits can begin, the length of time benefits will be paid, and the amount of the daily benefit payment all influence the premium amount. Insurers often reserve the right to increase premiums for whole classes of policyholders based on changes in benefit utilization. A comparison of nine relatively comprehensive policies published in March 1986 showed that monthly premiums ranged from $28 to $37 at age 55 to from $106 to $148 at age 75.[26]

Most long-term care policies are sold on an individual, rather than a group, basis. Experts generally agree that premiums would decrease with a shift to group long-term care insurance. Group insurance covers larger numbers of persons allowing insurers to spread the risks more broadly and offering greater protection from adverse selection. Most group insurance, however, is employer based, and numerous obstacles exist to offering long-term care insurance as a component of employers' benefit packages.[27] Younger employees generally are not interested in long-term care insurance, preferring more immediately useful benefits such as longer vacations. Court decisions and existing legislation may restrict an employer's ability to alter benefits of current retirees, limiting the freedom to reallocate funds to new benefits for active workers. Tax laws do not provide favorable tax treatment for the expenses of pre-funding retiree health benefits such as long-term care insurance. Finally, accounting standards soon may require companies to show unfunded retiree health benefits as balance sheet liabilities. Long-term care insurance benefits for retirees ultimately could cost much more than expected given the difficulty of accurately estimating future expenses of providing such care. Despite these obstacles, some employers are considering long-term care insurance benefits for employees.

Combining Long-Term Care Insurance with Other Forms of Insurance

While existing long-term care insurance policies cover long-term care exclusively, there is no reason why long-term care insurance could not be part of a broader life or health insurance policy. An experimental program offering both acute care and long-term care services on a capitated basis is being tested in four locations (Long Beach, California; Portland, Oregon; Minneapolis, Minnesota; and Brooklyn, New York), with technical assistance paid for by the U.S. Department of Health and Human Services. Labeled "social" health maintenance organizations (S/HMOs), these are traditional medical HMOs that also provide long-term care (nursing home, home health) and social services (homemaker and case management services) to Medicare beneficiaries for limited amounts of time. S/HMOs combine insurance and service provision in a single entity. Since S/HMOs must provide all necessary services for a set monthly fee, they have a strong incentive to provide services in the most cost-effective manner. This could mean substituting less expensive nursing home care for hospital care, and home care for nursing home care, wherever possible. The S/HMO structure also should help control induced demand. Since the S/HMO controls access to care, it should be able to manage and coordinate service use and reduce inappropriate utilization. Since these experimental programs only began operation in 1985, it is too early to judge their success. Should they succeed, however, capitated systems will offer another mechanism for combining long-term care financing and services with acute care and Medicare supplemental benefits in a managed care environment.

Life care communities, in which persons are guaranteed a lifetime residence and long-term care services in return for an initial payment and continuing monthly fees, are a form of long-term care insurance. Some life care communities provide nursing home and home health services using their own employees; others contract with outside entities for the provision of services. In 1984, between 55,000 and 100,000 persons nationwide were believed to reside in life care communities.[28]

Long-term care insurance also could be incorporated into a life insurance policy. Policyholders generally would begin paying premiums at a younger age than current long-term care insurance purchasers. Policy benefits would be similar to those available under existing life insurance policies, except that a long-term care insurance coverage option would be available at the time the policyholder chose to begin benefit payments. A number of insurers are developing such policies. A first step in this area is the Office of Personnel Management's recent proposal that certain older federal employees be allowed to convert a portion of their life insurance to long-term care insurance.

Question Four: What Are the Barriers to the Expansion of Long-Term Care Insurance?

Barriers to the expansion of long-term care insurance exist both among potential purchasers and among insurers. Elderly consumers often do not see a need for long-term care insurance or believe they already are covered in the event they need to use long-term care services. At the same time, many insurers view long-term care insurance as risky and potentially unprofitable, given the nature of the product and the absence of historical experience on which to calculate premiums. Governmental actions (discussed in Question Five) also have influenced the availability of long-term care insurance.

Consumer Disinterest Toward Long-Term Care Insurance

Among the over-55 population, the rate of purchase of long-term care insurance is low. Of a potential market of approximately 50 million persons over age 55 in 1985, only 0.3 to 0.4 percent had such coverage. If long-term care insurance is to become a viable financing mechanism for long-term care, the reasons for this low rate of purchase must be understood.

Market research data do much to explain consumers' low level of interest. The findings of two surveys are especially relevant: the Long-Term Care Insurance Survey, a 1982 six-state survey of 1,403 elderly persons done by the National Center for Health Services Research; and the American Association of Retired Persons (AARP) Survey of 1,009 AARP members nationwide, done by the Gallup Organization in 1984.[29]

The research data indicate that many of the beliefs and expectations of the elderly that discourage purchase of long-term care insurance are incorrect. A common misconception concerns the probability of needing long-term care services in later life. Long-Term Care Insurance Survey results indicate that older persons may underestimate the likelihood of needing nursing home care. While 24 percent of the respondents believed that the average person in their age group was "very likely" to require long-term care in the future, only 15 percent believed it "very likely" that they themselves would ever need long-term care.[30] By contrast, some researchers estimate the likelihood the average person age 65-69 will ever use at least one day of nursing home care to range from 31 percent for men to 52 percent for women.[31]

Survey results also show that the elderly are not thoroughly familiar with existing insurance benefits, believing that Medicare will pay for most long-term care services. Among respondents to the AARP Survey who believed they would need long-term care, 79 percent believed Medicare would pay all or part of their nursing home charges.[32] In fact, Medicare coverage criteria are very stringent: no more than 100 days of skilled nursing care in a Medicare-certified skilled nursing facility following a three-day minimum hospital stay, and then only when a physician certifies that the patient requires skilled nursing care. Consequently, the average covered nursing home length of stay for Medicare patients in 1980 was less than 30 days, compared with an average length of stay for all patients of 456 days.[33] Medicare pays in full only the first 20 days of nursing home care; the beneficiary must pay the first $65 (in 1987) in charges for each of the remaining 80 days. As a result, Medicare's role in long-term care delivery is insignificant. Medicare accounted for only 2 percent of total payments to nursing homes in 1985.[34] Only about 30 percent of

all licensed nursing homes in the United States were certified to accept Medicare patients in that year.[35]

Additional data confirm the relative lack of knowledge about insurance coverage. Only 33 percent of the Long-Term Care Survey respondents were considered to have "solid" knowledge of their Medicare benefits, based on answers to a set of six Medicare-related questions.[36] AARP Survey respondents overestimated their insurance coverage for long-term care; 35 percent believed their insurance policies covered long-term care, when in fact they did not.[37]

Underlying attitudes toward long-term care also may play a role in consumers' reactions to long-term care insurance. A more psychologically oriented study found that individuals viewed contingency planning for long-term care as "an overwhelming, solutionless problem."[38] Study participants felt they were unable to plan for the future because they had little control over future events and because they had little credible information about the costs of long-term care and ways to meet those costs.

Some have argued that the availability of Medicaid may discourage the purchase of long-term care insurance since older persons willing to "go on welfare" will not buy the insurance. There are contradictory findings on attitudes toward welfare. The AARP Survey showed that 62 percent of the respondents considered it acceptable for someone (not necessarily themselves) to accept Medicaid benefits when all other assets had been exhausted.[39] This attitude was more common among younger respondents. Only 19 percent of the elderly in the Long-Term Care Insurance Survey, however, indicated that the availability of Medicaid would prevent them from purchasing long-term care insurance.[40]

A 1984 study of 1,000 members of the "prime life" generation, those age 50 to 64, showed disparate attitudes about responsibility for payment of nursing care after age 65. While 35 percent of the respondents believed individuals had that responsibility, 31 percent believed the responsibility rested with government. Twenty percent indicated that responsibility should be shared.[41]

Another consumer-related deterrent to the growth of long-term care insurance has been the relatively high cost of premiums compared with the average income of the elderly population. Many of the elderly have relatively low incomes, leaving little after costs of food and shelter have been met. What discretionary funds are available for health care usually go for Medigap insurance and noncovered items such as pharmaceuticals and eyeglasses. Thus, some elders may not have enough income to pay long-term care insurance premiums.

Insurer Disinterest in Long-Term Care Insurance

Until recently, there was relatively little interest in long-term care insurance among insurance companies and few policies were available. Insurers generally regarded long-term care by its very nature to be an uninsurable risk, for a number of reasons:

- Individuals' future use of long-term care services is difficult to predict because the factors that influence such use are difficult to measure and quantify. Medical and physical conditions alone do not determine use of long-term care services. Of two persons with the same level of physical or medical disability, only one actually may seek formal long-term care services. Personal preference, availability of family and other social support networks, financial status, and other variables all influence a person's decision to seek long-term care services. Insurers cannot measure these factors accurately and thus find it difficult to calculate the risk of individuals' using long-term care and to determine appropriate premiums.
- Long-term care itself is difficult to define for insurance purposes. Should routine help with bathing

and dressing at home be considered long-term care services? What about nursing home care provided during a three-month recovery from a broken hip? Lack of a clear definition of long-term care makes it difficult to calculate risks to the insurer accurately.

- Adverse selection is more difficult to control in the case of long-term care because of the difficulty of predicting who will use long-term care services. The lower cost of insurance compared with the actual cost of health care, however, can be maintained only if adverse selection is controlled and a relatively small proportion of policyholders actually use benefits. Insurers' failure to limit adverse selection may result in financial losses since long-term care is relatively expensive and also may force premiums up to unaffordable levels.
- Induced demand increases the use of long-term care services. This problem would be most severe for noninstitutional services, where judging appropriateness of services is most difficult. As with adverse selection, uncontrolled induced demand would result in greater than expected utilization of services and possible financial losses for insurers.
- Establishing policy coverages and corresponding premiums in the present for benefits that may be paid far in the future can be risky without reliable historical data. An individual purchasing a policy at age 55 may not collect benefits until age 75 or 80. Future changes in circumstances, such as use of more nursing home care and less home health care, can have a large negative impact on insurers in the future.

Indeed, one of the greatest barriers to insurer participation has been the lack of reliable data on which to base product development and premium-setting decisions. Two types of data in particular are lacking: data on the need for, and use of, long-term care services in the population as a whole, especially in an insured environment; and studies of attitudes and desires of the elderly population.

The first type of data – information on the use of nursing home and home health services by various population groups over time – is needed for pricing long-term care insurance products. Insurers also need more information on the factors that cause persons in need to seek long-term care services so they can calculate the risks of service use accurately and price the premiums accordingly. Such data are not readily available now.

The potential value of the second type of data is illustrated by the AARP Survey. In that survey, 77 percent of the respondents said they would prefer a long-term care plan covering home health care to one covering nursing home care.[42] Yet, home health care benefits are not universal. Such studies are indispensable if products acceptable to the buying public are to be brought to the market.

Reducing Barriers to Long-Term Care Insurance

A number of steps must be taken if the barriers among consumers and insurers are to be reduced. Education and information programs will be needed to increase consumers' awareness and understanding of current long-term care financing mechanisms and the potential role of long-term care insurance. Among insurers, recent events already have stimulated interest in the long-term care insurance concept. Insurance companies have recognized the older population as a potentially profitable new market due to its increasing numbers and affluence (see Question Seven). Insurers are beginning to recognize that while long-term care may be a difficult risk to insure, there may be ways to counteract adverse selection, induced demand, and other uncertainties that threaten the financial viability of long-term care insurance. Finally, insurance companies and government will need to begin collecting the necessary market research and utilization data. The end result should be policies constructed and priced to better meet the expressed needs of consumers.

Question Five: What Have States Done to Regulate the Sale and Content of Long-Term Care Insurance Policies?

To date, few states have enacted laws regarding the sale or content of long-term care insurance policies specifically. Several others have seen some legislative activity but no significant enactments. Still others have initiated studies in the legislative or executive branches to make recommendations regarding long-term care insurance. States with studies in progress or completed are Alaska,[43] Arizona,[44] California, Connecticut, Florida, Georgia,[45] Hawaii,[46] Massachusetts,[47] North Carolina, Texas, and Virginia (citations are given for completed studies only).

The states have primary responsibility for overseeing most activities in the insurance market. The McCarran-Ferguson Act of 1944 affirms the primacy of the states in regulating the insurance industry and limits federal government activity. Generally, state regulation is performed by agencies of the executive branch using statutorily delegated authority to promulgate necessary rules and regulations.

Consumer protection has been the driving force behind state actions to regulate long-term care insurance. State regulation has focused on two areas: the manner in which policies are sold to consumers and the financial attributes of policies and insurers ("performance-based" aspects of the insurance policies); and the specific provisions contained in the policies being sold ("product-based" aspects).

The National Association of Insurance Commissioners (NAIC) recently published a Long-Term Care Insurance Model Act intended to serve as a basis for state regulation of long-term care insurance. The model act relies on both performance-based and product-based regulation.[48]

The following discussion of state regulatory actions is not intended to be a complete listing. Rather, it describes sample enactments and proposals representing approaches to long-term care insurance regulation. Provisions of the model act also are discussed.

Regulating Performance-Based Aspects of Long-Term Care Insurance

Insurance regulators in all states are empowered to promulgate regulations protecting purchasers of insurance. As a result, numerous performance-based requirements intended to protect all purchasers, including those who buy long-term care insurance, already exist. These generally cover:

- Authorization of insurance companies to sell insurance in a state;
- Licensure of insurance salesmen;
- Approval of specific policy wording and format for understandability;
- Disclosure of policy benefits and limitations;
- Specification of conditions under which buyers may return previously purchased insurance (termed "free look" provisions);
- Review of advertising and marketing materials;

- Required notification of rate changes;
- Imposition of financial solvency and reserve requirements to assure that insurance companies can meet future obligations to policyholders.

In addition to these generic consumer protections, some states have enacted or proposed specific measures applicable to long-term care insurance. A common action, derived from existing insurance regulation, is the establishment of minimum loss ratios for policies. A loss ratio is the proportion of premium income from a particular type of policy projected to be ultimately paid back to policyholders in the form of benefits. The lower the loss ratio, the more premium income the insurance company retains for operating expenses and profit. Establishment of a minimum loss ratio attempts to assure that premiums will be fairly and reasonably related to the cost of benefits by making certain that a minimum portion of every premium dollar received will be paid out in benefits. Connecticut and Minnesota have established minimum loss ratios for long-term care insurance by statute: 55 percent and 60 percent, respectively, for individual policies, and 60 percent and 65 percent, respectively, for group policies. Maine and Washington have elected to give authority to insurance regulators to set minimum loss ratios by regulation.[49] The model act allows regulators to prescribe minimum loss ratios as long as they are specifically for long-term care insurance.

Minimum loss ratios have been opposed by the insurance industry because the proposed ratios generally are higher than the industry believes is warranted, given the level of risk and uncertainty in pricing involved. Because long-term care insurance is relatively new, insurers argue, there is no experience on which to base judgments about appropriate loss ratios. Also, imposition of unreasonable loss ratio requirements during the next 10 to 20 years of long-term care insurance "start up" could prevent insurers from building up the reserves necessary to pay future claims. Low loss ratios will occur because the majority of today's purchasers will not begin to claim benefits until 10 or 20 years from now, and insurers will be collecting premiums in anticipation of future benefit payments but paying relatively little in benefits. Insurers claim that the result would be long-term financial losses and that they might have to withdraw from the market rather than run the risk of selling potentially unprofitable policies.

Limiting insurers' ability to cancel policies has been another common legislative action. Minnesota and Washington prohibit cancellation of policies except in the case of nonpayment. South Dakota has considered, but not passed, similar legislation. The model act prohibits cancellation of policies for reasons of age or health status.[50] Advocates of noncancellation provisions argue that it is unfair to allow policyholders to pay premiums for years only to have the policies cancelled in later life when benefits are most likely to be paid.

In another type of consumer protection action, Washington prohibits sale of long-term care insurance policies to persons already receiving Medicaid assistance. This action was taken in an effort to stop the unethical practice of knowingly selling insurance policies to persons who do not need them.

Regulating Product-Based Aspects of Long-Term Care Insurance

As with performance-based regulation, the goal of product-based regulation has been consumer protection. Product-based regulation has caused more controversy, however, than performance-based regulation because its potential impact on market development and on the financial condition of insurers is greater.

Product-based regulation has focused on requiring minimum benefits for long-term care insurance policies and prohibiting inclusion of certain provisions. Examples of minimum benefit provisions either approved, or considered but not approved, include:

- Minimum daily payments for nursing home or home care.

  In Minnesota, the statutorily prescribed minimums are $40 to $60 per day for nursing home care and $20 to $25 per day for home care.[51] Other unsuccessful state proposals would have tied the minimum payments to other indicators. New Jersey would have required that the daily home care benefit equal 75 percent of the daily nursing home benefit.[52] Kansas would have mandated that the daily nursing home benefit be no less than 75 percent of actual charges.[53]

- Coverage of specific services.

  Kentucky requires that skilled, intermediate, and custodial care all be covered by at least one policy offered by each insurer. A number of states have proposed that specific services be covered, such as respite care ("short-term" long-term care intended to give family members a break from attending elderly relatives at home) and home care. Maryland indirectly addresses long-term care coverage by requiring health insurers to offer optional coverage for Alzheimer's disease, the later stages of which require long-term care, and any other care required by the elderly and mandated by the insurance commissioner.[54]

- Minimum numbers of nursing home days or home care visits

  Kansas and New Jersey considered, but did not pass, such provisions. Kansas proposed a two-year minimum for nursing home benefits; New Jersey, a three-year minimum.

Some states have enacted, or have considered but not enacted, prohibitions on certain policy provisions. These include:

- Prohibiting deductible or copayment amounts above specified levels.

  Minnesota limits copayments to 20 percent of actual charges. Kentucky requires insurers to offer at least one policy with copayments no more than 25 percent of actual charges.

- Prohibiting exclusion from coverage of pre-existing conditions for longer than specified maximum times.

  Generally, medical conditions that were diagnosed or treated within a specified time immediately prior to commencement of the policy are excluded from coverage for a specified time period immediately following commencement of the policy. Washington law specifies that only medical conditions that were diagnosed or treated within one year prior to policy commencement can be excluded, and then only during the first six months following commencement. The model act uses standards of "two years before commencement-two years after commencement" for policyholders under age 65 and "six months before commencement-six months after commencement" for older policyholders. An unsuccessful South Dakota proposal would have limited the definition of pre-existing conditions to only those for which treatment was received within six months prior to the effective date of the policy. This proposal would have prohibited exclusion of coverage for conditions present but not treated in the six-month period.

- Prohibiting the requirement of a prior stay in a hospital as a condition of nursing home benefit payments.

  Kentucky has enacted this prohibition and also proscribes requiring prior care at the skilled nursing level as a condition of

payment of benefits for intermediate level nursing home care.[55] Kansas and New Jersey considered, but did not enact, such a provision.[56]

The practices targeted by these prohibitions are those used by insurance companies to protect themselves from adverse selection and induced demand. The public, however, sometimes sees them as ways of unfairly preventing policyholders from claiming benefits to which they are entitled.

States that have acted to regulate the content of long-term care insurance policies have taken a variety of approaches in allocating responsibility between the legislative and executive branches of government. Kentucky, Minnesota, and Washington have enacted relatively extensive and specific statutes, leaving less discretion to regulators.[57] On the other hand, Maine statutes delegate all regulatory authority to regulators.[58] Some states, such as Arkansas and Wisconsin, have enacted no statutes, but insurance regulators have used existing authority to promulgate long-term care insurance regulations.

Regulation of policy content has been controversial. Proponents argue that the state is obligated to protect consumers from the sale of insurance policies that do not provide meaningful benefits. The elderly, the primary target of long-term care insurance marketing, are particularly vulnerable to deceptive and misleading sales practices. They are not always well informed about the long-term care delivery and financing system or its associated costs. The highly publicized fraud and abuse associated with Medigap policies are cited as a reminder of what can happen when states fail to safeguard the interests of the elderly population. For all these reasons, proponents claim, it is necessary to set minimum benefit levels and prohibit certain provisions, thus preventing the sale of inadequate policies that do not provide the coverage for which consumers believe they have paid.

Opponents of product-based regulation claim that state prescription of policy content limits the flexibility of insurers to adapt their offerings to changing market conditions. Persons desiring relatively low benefit levels or only one kind of coverage, such as nursing home or home health care, will be forced to pay higher premiums for coverage they do not want. Low-income persons may have to do without insurance entirely because they cannot afford the higher premiums insurers must charge for the state-mandated minimum benefits. A second argument is that development of long-term care insurance currently entails excessive financial risk and that imposition of minimum benefit levels and other regulatory requirements will discourage insurance companies fearful of future financial losses. The end result will not be consumer protection but nonavailability, or limited availability, of long-term care insurance.

The States' Experience with Long-Term Care Insurance Regulation

The experience of states that have attempted to regulate long-term care insurance indicates that insurers are highly sensitive to some statutory or regulatory requirements that pose potential financial risks. In general, the insurance industry has supported performance-based regulation. The Industry Advisory Committee on Long-Term Care of the National Association of Insurance Commissioners supported a position of "regulatory flexibility," but with consumer protection safeguards.

Most problems have arisen when states have acted to regulate policy content. An extreme example occurred in Wisconsin. The insurance commissioner, motivated by complaints from policyholders failing to receive benefits to which they believed they were entitled, decided that existing regulations did not protect consumers

sufficiently. He concluded that the most effective way to reduce the number of complaints was to require all policies to provide a minimum level of benefits and to prohibit certain policy provisions limiting benefits. Consequently, the commissioner issued a relatively stringent set of regulations that, among other things, prohibited use of a prior hospital stay as a precondition for payment of nursing home benefits and required insurers to pay for all days of care certified only as "necessary," rather than as "medically necessary." To the insurers, this meant paying benefits for long-term care services that might be necessary for nonmedical reasons, such as social isolation, in addition to those services required due to illness or accident. These requirements increased the likelihood of induced demand since the need for long-term care due to nonmedical factors is difficult to judge objectively or to predict with any reliability. The result was that all but one insurer discontinued sales of long-term care policies in the state, and this insurer did not market this policy actively. The state now has promulgated a revised set of regulations.

Whether Wisconsin and other states are better off with more stringent regulations and fewer insurers or more liberal regulations and more insurers, is a question for each to decide individually. Wisconsin policymakers apparently concluded at the time that it was preferable to have a small number of "good" policies available rather than a large number of policies that did not meet policyholders' expectations. In other states, the opposite may be the case. What the Wisconsin experience demonstrates is that states face difficult tradeoffs in considering proposals to regulate long-term care insurance.

States must balance consumer protection against insurers' avoidance of markets where they perceive inordinate financial risk. State studies of long-term care insurance have emphasized finding a middle ground where consumers are adequately protected and insurers still are willing to offer a variety of coverage. The Arizona and Georgia study commissions recommended no restrictions on long-term care insurers beyond already-existing consumer protections. Although the Massachusetts study called for minimum benefits, they were similar to those already offered in many existing policies. The authors also suggested requiring some policy features but avoided conditions they considered especially onerous to insurers, attempting to leave them free to experiment with new policy features. The National Association of Insurance Commissioners has published a model act intended to balance the interests of consumers and insurers.[59] The model act approach has the advantage of assuring uniformity of both performance-based and product-based requirements from state to state.

Federal Support of State Efforts

Despite lack of direct involvement with insurance, the federal government is interested in long-term care insurance. There have been numerous suggestions for extension of Medicare coverage to long-term care, and long-term care insurance is a potential private sector substitute. Also, budgetary reductions in Medicaid could result from widespread acceptance of long-term care insurance. The federal government has supported a number of research efforts and feasibility studies on long-term care insurance. The recently passed Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA, Section 9601) established the Task Force on Long-Term Health Care Policies to develop recommendations regarding consumer protection, consumer education, and promotion of long-term care insurance. The task force's report will be completed by August 1987.

Question Six: What Have States Done to Encourage the Sale of Long-Term Care Insurance?

States have taken little concrete action to encourage purchase of long-term care insurance. State actions that have been taken have been of two types: requiring insurers to offer long-term care insurance, and encouraging market development through incentives and consumer education. State actions involving requirements have mandated that all insurers offering health insurance also offer coverage for some long-term care services, either as a standard benefit or as an option. Kentucky requires all insurers – individual and group insurers, HMOs, and Blue Cross plans – issuing health policies to make available at least one long-term care policy.[60] Unsuccessful bills in Kansas, Massachusetts, and New Jersey have contained similar requirements. While this kind of requirement may increase the number of insurers offering long-term care coverage, policies offered might not be appealing to consumers. Critics argue that most insurers, fearing financial losses in long-term care insurance, will design unattractive policies with limited benefits and high premiums. Others may withdraw from the state. The upshot would be only a small increase in the number of policies sold and public dissatisfaction with long-term care insurance.

Other states have focused on encouraging long-term care insurance. New York has sought to promote policy availability by giving the superintendent of insurance power to "modify or suspend" certain statutory or regulatory requirements for experimental long-term care insurance policies.[61] Other states have taken more specific actions. These include:

- Preferential Tax Treatment for Long-Term Care Insurance Premiums

  Tax incentives to encourage particular actions are a common strategy in many situations. In 1986, Colorado enacted an income tax deduction for long-term care insurance premium payments for policies meeting specified minimum benefit criteria.[62] An unsuccessful Hawaii proposal would have allowed a tax credit equal to twice the amount of long-term care insurance premiums.[63] Tax incentives were rejected by Arizona's study commission, however, which argued they might hinder development of other incentive programs that would accomplish the same objective without reducing state tax revenues. No action has been taken at the federal level to give preferential treatment to premium expenses on federal income taxes.

- Premium Tax Reductions for Companies Selling Long-Term Care Insurance Policies

  Reductions in premium taxes for long-term care insurance policies could encourage purchasers if part of the savings were passed on in the form of lower premiums. Lower taxes on long-term care insurance premium income also would encourage insurers to sell more long-term care policies since the premium income would be taxed at a lower rate. Colorado has been the only state to take this step, enacting a one percentage point tax reduction on long-term care insurance premium income.

- Consumer Education About Long-Term Care Insurance

  Consumer education programs on long-term care insurance are a frequently mentioned market development strategy. Such programs encourage wise buying and address consumer misconceptions about long-term care and its costs. Long-term care insurance studies in Arizona and Georgia have emphasized the importance of consumer education. The Washington state Insurance Commissioner's Office has established a separate senior citizens' program unit to oversee the state-sponsored Senior Health Insurance Benefit Advisors (SHIBA) program. Working through trained elderly volunteers, the SHIBA program conducts public meetings and media campaigns to educate elderly consumers about a range of insurance-related topics, including long-term care insurance. Topics covered include Medicare and Medicaid eligibility and program benefits, as well as comparison of available long-term care insurance policies. SHIBA also publishes a number of consumer guides for the elderly.

  Additional materials from which states might draw in formulating consumer education programs are also available. A report prepared for the Massachusetts insurance commissioner contains a draft "Guide to Long-Term Care Insurance" describing Medicare and Medicaid benefits, materials to aid prospective purchasers in evaluating the adequacy of benefits, and a proposed disclosure statement to be given to purchasers explaining policies in uniform language.[64] The report done for the National Association of Insurance Commissioners by an advisory committee of insurance industry representatives also contains a model consumer education booklet.[65] The booklet discusses topics similar to those covered by the Washington program. It also has a list of "Questions to Ask [About Long-Term Care Insurance]" and a glossary of long-term care terms. The American Association of Retired Persons also has prepared a consumer's guide to long-term care entitled "Making Wise Decisions For Long-Term Care."[66]

- Removing Barriers to Long-Term Care Insurance Availability

  State laws written prior to the advent of long-term care insurance sometimes create unintentional barriers. Failure to define long-term care insurance as a separate category of insurance may cause it to be considered a form of disability, Medigap, or other supplemental insurance. The result may be the application of inappropriate regulatory criteria and discouragement of interested insurers. Minnesota prohibited sale to Medicare beneficiaries of all health or accident insurance except Medigap policies in an attempt to eliminate the sale of duplicative insurance policies to the same person. This prohibition made the sale of long-term care policies effectively illegal, however, an obstacle that was removed recently.

  In some states, statutory definitions of group insurance may not include the insurance offered by HMOs and Blue Cross plans, making it impossible for them to offer long-term care insurance on a group basis. The public, however, may best be served by a wider selection of policies.

  Legislators may want to review state statutes and reconsider those that restrict development of long-term care insurance. An unsuccessful

South Carolina proposal would have required the Department of Insurance to conduct a review of state regulations to be sure none discouraged long-term care insurance. The Arizona study commission conducted such a review and concluded that no additional laws or statutory revisions were necessary to encourage long-term care insurance. Review of the NAIC model act also may be useful in this regard.[67]

- State Catastrophic Coverage for Long-Term Care Insurance Purchasers

  While not yet introduced as legislation, a proposal from the Massachusetts Special Commission on Elderly Health Care is noteworthy.[68] Under the proposal, the state would agree to assume financial responsibility for persons who purchase Medigap and long-term care insurance with specified minimum benefits, but who exhaust their benefits while receiving long-term care. No asset "spend-down" or other financial requirements would be imposed. Consumers would be encouraged to purchase long-term care insurance since they would be guaranteed future state protection without having to spend down their own funds when their insurance benefits ended. The state would benefit from substitution of private insurance coverage for Medicaid and postponement of Medicaid responsibility for payment. Whether this program is to be implemented through Medicaid or through some other program will depend on interpretation of existing Medicaid program regulations. The advantages and disadvantages of such a plan in terms of access, quality of care, and cost to both consumers and the state are yet to be explored fully. A successful program of this nature, however, might hasten the spread of long-term care insurance by creating a large customer base and stimulating market entry by more insurers.

- State Participation as a Long-Term Care Insurer

  States could act as insurers when private insurance is not widely available. An unsuccessful California proposal would have created a Long-Term Care Association within state government to issue a long-term care insurance policy offering benefits specified in the statute.[69] The policy was intended specifically to supplement policies already available to consumers. It would have covered intermediate, personal, and home care, but not skilled nursing care, which generally is covered by policies now on the market.

- Long-Term Care Insurance Benefits for State Employees

  An additional proposal is for states to purchase long-term care insurance for their own employees and retirees. As pointed out in Question Three, however, legal and practical obstacles must be overcome if employers, including the states, are to offer long-term care insurance.

Question Seven: What Is the Future of Long-Term Care Insurance?

Long-term care insurance has a definite role to play in financing long-term care. The demand for long-term care services will increase in the coming years, and government and personal funds alone may be inadequate to pay the costs. A range of new funding mechanisms will be necessary, and long-term care insurance is important among these. Although it has achieved wide visibility only recently, there is growing interest on the part of insurers, consumers, and government. All three groups have incentives to promote its use, but all three groups must take action if long-term care insurance is to play a significant, meaningful part in the nation's long-term care financing scheme.

Insurers

Insurers see a new market for insurance in the growing over-55 age group. Between 30 and 40 companies currently offer long-term care insurance policies. Many more are developing policies for introduction in the next few years. Over 20 Blue Cross plans also are considering offering long-term care coverages. All this activity clearly indicates that insurer interest in long-term care insurance will continue to grow.

But the increased interest among insurers is accompanied by widespread uncertainty about the ultimate financial viability of long-term care insurance. Long-term care is difficult to insure by its very nature. There is little agreement on exactly what constitutes long-term care or on the definitions of the three levels of care. The probability that persons will use long-term care services is not easily calculated, and adverse selection and induced demand are difficult to control. In addition to the inherent difficulties in insuring long-term care, there exist little historical data on which to calculate risks and price premiums. All these factors increase insurers' financial risks.

Insurers temper their interest with words of caution:

> Long-term care insurance is in an embryonic state of development and as yet, it is not known which policy designs might work best. Established carriers are entering this market but products are in an evolutionary stage. The challenge of insurers is to establish benefit levels and premium charges in products which minimize insurance induced demand for services and adverse selection, which avoid stimulating increased provider charges, and which provide meaningful benefits to consumers.[70]

Consumers

Existing long-term care financing alternatives do not always meet the needs of consumers well, so they have been motivated to seek other ways of financing long-term care. Individuals needing such care now must become Medicaid recipients immediately, or they must deplete most or all of their own assets on long-term care expenditures. Medicaid, however, provides little financial support for those desiring home health care, and consumer choice in selection of a nursing home is restricted. Those who must spend down their own funds suffer the loss of self-esteem accompanying the loss of self-sufficiency. Noninstitutionalized spouses may become impoverished paying the expenses of spouses receiving long-term care.

The lack of interest in long-term care insurance up to now may mean that the financial and other burdens of long-term care are not evident to consumers. Potential purchasers may be underestimating the risks of needing long-term care and may not be completely knowledgeable about the limitations of Medicare and Medigap insurance policies. Effective consumer education programs gradually might diffuse these misconceptions and help potential policyholders better assess the risk of needing long-term care and the role private insurance might play. Consumers need specific information regarding available long-term care financing options, planning for future needs, and the costs of long-term care. Long-term care insurance cannot reach its full potential without educated and aware consumers.

Affordability is also an obstacle to consumer acceptance. While the cost of long-term care insurance always will be too costly for many of the elderly, studies indicate that a larger proportion of the future elderly population will be able to afford long-term care insurance as it is presently sold. One study predicts that the proportion of elderly households with annual real incomes greater than $20,000 will increase from 21 percent in 1980 to 31 percent in 1995.[71]

One solution to the affordability problem is purchase of long-term care insurance at an earlier age, when premiums are lower. A second possible solution may be group insurance, which offers lower premiums because risk is spread over a larger number of persons and adverse selection is reduced. Life insurance and similar capital accumulation vehicles incorporating long-term care insurance options, should they appear on the market, also might be less expensive than currently available exclusively long-term care policies because the premium payments would be spread over a longer time period of time. Barriers to consumer acceptance must be overcome, however, for these more inclusive options to be effective.

The need for consumer protection in long-term care insurance is a recurring theme. Consumer groups, legislators, and government leaders alike have emphasized the importance of insuring that policyholders receive benefits commensurate with premiums paid, and that consumers fully understand the policies they purchase. The question here is what measures are needed to insure that consumers are protected adequately. AARP, speaking on behalf of its members, has taken the following position:

> [States] should encourage the development of a range of private, long-term care insurance products by eliminating legal and regulatory barriers that impede this development. At the same time, states should protect consumers' interests by such actions as prohibiting fraudulent advertising, developing a buyer's guide, and providing public education about long-term care insurance.[72]

State Government

To governments, long-term care insurance offers the possibility of reduced Medicaid expenditures. This option is especially attractive in a time of declining federal financial support and resistance to tax increases. Long-term care insurance alone will not solve the problem of increasing Medicaid budgets, however. Researchers estimate that, at most, a 23 percent maximum decrease in total annual Medicaid expenditures can be expected because of long-term care insurance. Others estimate the impact to be as low as 5 percent annually, on average. Thus, a need always will exist for public funding of long-term care. Long-term care insurance is only one of a number of private and public financing mechanisms that must be developed to create a more accessible, flexible, and efficient long-term care financing system.

At the same time that government seeks to promote the purchase of long-term care insurance, it also must act to assure fair and principled marketing of these policies. Government actions to protect consumers

may focus on the manner in which policies are sold (such as disclosure provisions and "free looks") or their contents. Because the content-related requirements may influence the financial viability of policies, insurers have objected to many of these measures. In some cases, insurers have left states rather than sell policies, leaving little insurance available. State legislatures will have to reconcile the requirements of consumer protection and insurer encouragement, finding a solution that meets each state's unique needs.

The preamble to Georgia Senate Resolution 314 of 1983, creating the Senate Private Long-Term Care Insurance Study Committee, sums up the states' perspective on long-term care insurance:

> . . . . it is projected that one-tenth of the population of Georgia will be age 65 or over by the end of 1985; and
>
> . . . . it is a public policy goal of this state that every senior citizen should have access to quality care; and
>
> . . . . Medicare covers only a maximum of 100 days of care in a skilled nursing facility, provides no coverage for intermediate facility care, and only limited coverage of home health services; and
>
> . . . . most Medigap policies only pay for the deductibles and coinsurance required by Medicare for skilled nursing facility care between the twenty-first and one hundredth day; and
>
> . . . . coverage for comprehensive long-term care services and home health services is offered on a limited basis by only a few companies; and
>
> . . . . long-term expenses may have devastating financial consequences for senior citizens, often forcing them to liquidate assets and exhaust savings until they become eligible for benefits under the Georgia Medical Assistance program; and
>
> . . . . the lack of availability of private insurance for long-term care has resulted in tax supported programs having to bear more than their share of the costs of nursing home services; and
>
> . . . . the health care marketplace is in a state of uncertainty and transition regarding Medicare and coverage for comprehensive long-term care.

States must be concerned about the needs of the growing elderly population and seek ways to meet the financial demands of long-term care. The states' own resources may not be enough, and long-term care insurance should be investigated as one possible alternative.

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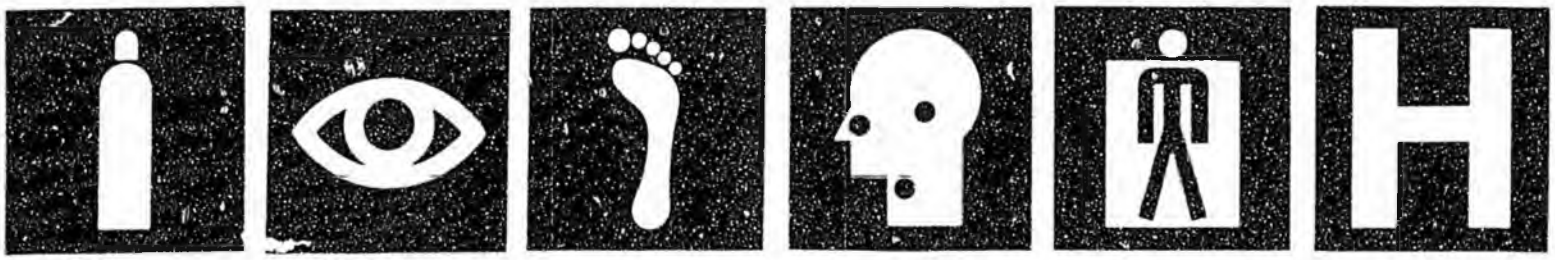
National Conference of State Legislatures

Earl S. Mackey, Executive Director

Denver Office
1050 Seventeenth Street, Suite 2100
Denver, Colorado 80265
303/623-7800

Washington Office
444 North Capitol Street, N.W., Suite 500
Washington, D.C. 20001
202/624-5400



SB 319

SENATE COMMITTEE REPORT

FIRST COMMITTEE OF REFERRAL

Date of 5-DAY NOTICE 2/1/90
IN ACCORDANCE WITH UNIFORM RULE 23

FURTHER
SA
FIN

**FISCAL NOTE(S) MUST BE ATTACHED
IN ACCORDANCE WITH AS 24.08.035

DATE TURNED INTO OFFICE 2/14/90

5/4/89

Mr. President:

HESS Committee considered SB 319

issuance of general obligation bonds in the amount of $41,400,000 for the purpose of paying the cost of hospital construction, reconstruction, renovatio and expansion of hospitals at Kodiak, Seward, and Ketchikan; efd

and recommended:

[ ] replace with CS SB 319 [] same title
(X) new title

[ ] attached amendment(s) and

[ ] _____ letter of intent adopted

[ ] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] further referral to _____

FISCAL NOTE(S) attached [ ] zero (X) fiscal impact
(X) appropriation no FN attached [ ] Gov. FN introduced w/ bill

MEMBERS SIGNING DO PASS

Hoyt Jones

OTHER RECOMMENDATIONS

Gail Adams - No Rec
J. Duncan No Rec
T. Kelly - No Rec - Needs balance

Paul Fritz (Do Pass)
Chair signature and recommendation

[ ] Committee backup attached

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: SB 319
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: $41,400,000 General Obligation Bonds for Kodiak, Seward, & Ketchikan Hospitals
Sponsor: Zharoff
Requestor: Senate HESS

Agency Affected: State Bond Committee
BRU:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
OPERATING						
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LANDS & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	1293.8	5691.7	5691.7	5691.7	5691.7	5691.7
TOTAL OPERATING	1293.8	5691.7	5691.7	5691.7	5691.7	5691.7
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	1293.8	5691.7	5691.7	5691.7	5691.7	5691.7
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	1293.8	5691.7	5691.7	5691.7	5691.7	5691.7

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: attach a separate page for analysis. Fiscal year 1990 cost is zero

Debt service on $41,400,000 bonds with a maximum maturity of 10 years at an average interest rate of 6.25%. Fiscal year 1991 is one semi-annual interest payment.

Prepared By: Milt Barker MB
Division: Treasury
Phone: 465-2350
Date: February 7, 1990

Approved by Commissioner:
Agency: Department of Revenue
Date: 2/7/90

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: CS SB 319 (HESS)
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: $60,450,000 State General Obligation Bonds for Hospitals
Sponsor: Senate HESS
Requestor: Senate State Affairs

Agency Affected: State Bond Committee
BRU:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
OPERATING						
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LANDS & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	1888.9	8309.8	8309.8	8309.8	8309.8	8309.8
TOTAL OPERATING	1888.9	8309.8	8309.8	8309.8	8309.8	8309.8
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	1888.9	8309.8	8309.8	8309.8	8309.8	8309.8
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	1888.9	8309.8	8309.8	8309.8	8309.8	8309.8

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: attach a separate page for analysis. Fiscal year 1990 cost is zero.

Debt service on $60,450,000 bonds with a maximum maturity of 10 years at an average interest rate of 6.25%. Fiscal year 1991 is one semi-annual interest payment.

Prepared By: Milt Barker MB
Division: Treasury
Phone: 465-2350
Date: February 20, 1990

Approved by Commissioner:
Agency: Department of Revenue
Date: 2/20/90

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Tama

6-1309Aa
Bradley

A M E N D M E N T

OFFERED IN THE SENATE BY SEN. DUNCAN

TO: SB 319

Page 1, line 7:

Delete "$41,400,000"

Insert "$56,400,000"

Page 1, line 10, after "at":

Insert "Juneau"

Page 1, line 14, after "hospitals at":

Insert "Juneau,"

Page 1, line 16:

Delete "$41,400,000"

Insert "$56,400,000"

Page 2, after line 14, insert a new bill section to read:

"* Sec. 7. The amount of $15,000,000 is appropriated from the "1990 Hospital Construction and Renovation Fund" to the Department of Administration for payment as a grant under AS 37.05.315 to the City and Borough of Juneau to be used for the construction, reconstruction, and renovation of the Bartlett Memorial Hospital."

Renumber the following bill sections accordingly.

Page 2, line 16:

Delete "$144,900"

Insert "$197,400"

Page 2, line 28:

Delete "$41,400,000"

Insert "$56,400,000"

Page 3, line 1:

Delete "$41,400,000"

Insert "$56,400,000"

Page 3, line 4, after "renovation in":

Insert "Juneau,"

Ketchikan General Hospital
3100 TONGASS AVE.
KETCHIKAN, ALASKA 99901

January 26, 1990

Senator Lloyd Jones
P.O. Box V
Juneau, AK 99811

JAN 2[illegible] 1990

Dear Senator Jones:

I am writing to update you on the current status of the Ketchikan General Hospital Remodeling and Expansion project.

Certificate of Need - The Certificate of Need was filed on October 4, 1989. The State Department of Health and Social Services met with the hospital on November 18, 1989 and made a request on December 4, 1989 for additional information.

The Certificate of Need request was for $18,890,000 for the total project. The State Department of Health requested the total project be broken down, if possible, to increase funding potential from the state. After study by the architects, the Certificate of Need was amended on January 25, 1990 to include full funding for the project costing $18,890,000 plus a Phasing Plan that increases the cost by $1,483,457 and increases construction time to 56 months and seriously disrupts the hospital operations. The Phasing Plan is as follows:

Phase I Cost: $5,505,570 (plus $100,000 hospital equipment, plus contingency of 5%, plus $150,000 project clerk of the works for a total of $6,018,348)

This phase is the infill between the nursing home and hospital for expansion of emergency and outpatient facilities and corrects critical and long standing code deficiencies in the laboratory.

Phase II Cost: $8,523,167

This phase consists of constructing a new south addition, new service entrance, new boiler plant, new electrical switch gear, new emergency power facilities, and essentially providing new mechanical/electrical infrastructure for the entire hospital complex.

Phase III Cost $5,228,720

Phase III consists of constructing alteration work on the space vacated and will be the most disruptive to the operations of the daily business of the hospital. The major departments affected will be X-Ray, Food Service and Materials

KGH

Ketchikan Gen. Hospital

The construction plan for the hospital was developed to correct the fire life safety violations, building code violations and space deficiencies that were identified by the state's own assessment in 1982. It is now eight years later and two plans later and our problems have been intensified by increased volumes and new services. I believe the deficiencies have reached a critical level for the hospital to continue to provide high quality services in the future. Ketchikan General Hospital has patiently waited while other hospitals identified in the 1982 reports have been funded by the State of Alaska.

In summary, our request is for the full project or enough to cover Phase I and Phase II. If that is not avilable, any help would be appreciated.

If you need additional information, please call me at 225-5171 ex. 326 or ex. 389.

Sincerely,

Edward Mahn
Administrator

cc: Jack Pearson, City Manager

EMpa

Ketchikan General Hospital
3100 TONGASS AVE.
KETCHIKAN, ALASKA 99901

31 1989

March 29, 1989

Senator Lloyd Jones
Sttae of Alaska
P.O. Box V
Juneau, Alaska 99811

Dear Lloyd:

Attached is a copy of the cost estimates from the presentation last night to the City Council for the addition and improvements to Ketchikan General Hospital.

1. The City of Ketchikan has the money for the parking structure: $1.6 million from the "Jobs Bill", $140,000 left over from the State grant of $500,000 for the design and construction of Ketchikan General Hospital, and the remainder from the sales tax.

2. You'll note that the Hospital portion is $16,143,407 estimated out to start up of October, 1991.

3. We may move the decompression chamber off site.

4. The moveable furniture and equipment will be the responsibility of our Corporation.

The project was thoroughly reviewed by our Project Advisory Committee (50% City & 50% Hospital) twice and by a City Council work session last night. A decision has been scheduled for April 6, 1989, for acceptance of the design and cost estimates.

We are 50% complete on the Certificate of Need and after Council's decision we should be able to finish quickly in presenting the CON to the Department of Health & Social Services.

Thank you for your assistance. Any further questions you may have on funding costs should be addressed to Acting City Manager, Jack Pearson, or Mayor Ted Ferry.

Thank you for all your help.

Sincerely,

Sister Barbara

Sister Barbara Haase
Administrator

KGH ek

3. PROJECT COST

A. SUMMARY SHEET

The following Cost Estimate Summary is based on Mills, John & Rigdon Schematic drawings, dated January 12, 1989, and the Alaskost "Schematic Estimate for Ketchikan General Hospital, Additions and Alteratilons," dated March 10, 1989. In accordance with the Project Schedule, the Costs have been adjusted for an October 1990 Bid Date.

(1.)	**Parking Structure:** (Now Bidding)			
	(a.)	Estimated Construction Cost	$ 1,882,200	
	(b.)	Design Fees	206,000	
	(c.)	Construction contingency (5%)	94,110	
		Subtotal		$ 2,182,310
(2.)	**Hospital Additions and Alterations:**			
	(a.)	Estimated Construction Cost	$13,614,600	
	(b.)	Design Fees	1,868,417	
	(c.)	Construction Contingency (5%)	660,390	
		Subtotal		16,143,407
(3.)	**Other Costs:**			
	(a.)	Relocation of Decompression Chamber Facility		70,000
		TOTAL		$18,395,717

(4.) **Costs Not Included:**

(a.) Development of Alternate Ambulance Routes at West Side

(b.) Loose Furniture and Furnishings and Movable Equipment

(c.) Owners Administration

(d.) Construction Project Representative

(e.) Special Inspection & Testing During Construction

Alaska State Legislature

SENATOR PAUL FISCHER, Chairman
SENATOR JIM DUNCAN, Vice Chairman
SENATOR AL ADAMS
SENATOR LLOYD JONES
SENATOR TIM KELLY

P.O. BOX V
ROOM 508
STATE CAPITOL
(907) 465-3762

Senate Committee on Health, Education and Social Services

Proposal to add improvements and construction to SB 319 for Central Peninsula Hospital.

1.	Incineration Unit Construction	$ 375,000
2.	Construction for CT Scan Site	$ 320,000
3.	Boiler Conversion Improvements	$ 150,000
4.	Air Conditioning Improvements	$ 205,000
	TOTAL	$ 1,050,000

Mike:

I added this in HESS.

B. Smith.

MEMORANDUM

Renovation

February 12, 1990

To : **Senator Paul Fischer**

From : **Michael J. Lockwood, Administrator**
Central Peninsula General Hospital

Subj : **Funding for Projects**

You have requested additional documentation for capital costs.

Boiler Conversion - Cost: $150,000

This will convert the present heat exchanger from hot water to steam, $75,000. The deletion of all unused piping and would open the existing space for other use, $75,000.

Air Conditioning - Cost: $205,000

Air conditioning would be installed to increase patient comfort in all patient areas during the summer months when temperatures reach 80 - 90 degrees. It would also be installed in areas that contain sensitive computer equipment.

LUTHERAN HOSPITALS AND HOMES SOCIETY

BUDGET REQUEST-CAPITAL EXPENDITURES (OTHER THAN

FACILITY NAME: CPGH

RESPONSIBLE PERSON: _____ ASSIGNED PRO.

Brief description: Converting Present Heat exchang. Hot water to steam.

Goals and/or Objectives being met: Deletion of all old Boilers thus getting more effeciency from our New Steam Boilers and elimin. Preventive Maint. & Repair on 3 old Hot water Boilers. When Temp Drops to -20° and below the Hot water Boiler cannot handle the load.

Justification and effect of expenditure on facility: Reducing fuel Consumption + PM & Repair Costs,

FINANCIAL INFORMATION:

Identify expenses related to project: $75,000 Parts & Labor

Purchase Cost	_____
Annual Maintenance Cost	_____
Personnel Utilized	_____
Other (Describe)_____	_____
_____	_____
_____	_____
TOTAL	_____

Cost Recovery, if applicable (_____)

Describe Cost Savings/avoidance, if applicable 15 Less fuel Consump Preventive Maint., upkeep & Repair, Stocking of critical Spare Par.

Description of leasing or other financing arrangements available to pa for this expenditure, if known Not Available

KENAI PENINSULA BOROUGH

CAPITAL IMPROVEMENT PROGRAM

Project Request

1989-92

1. Title: Construction Of Site For CT Scan

2. Location: 250 Hospital Place Soldotna

3. Dept/Service Area/Community: Central Peninsula Hospital Service Area

4. Prepared By: Michael J. Lockwood, Administrator Randall Nichols, Director of Financ

5. Project Type

Real Property / Construction	x
Major Equipment / Vehicles	

6. Project Ranking

Dept./Service Area/Comm.	1
Assembly	

7. Narrative Description:

Funds for this project would provide building of the enclosure for our computed axial tomography system that would provide in excess of 600 Scans per year to the patients of Central Peninsula General Hospital. The program is in a 1,000 sq.ft. building and the electrical to support the CT Scan and also the air conditioning and mechanical systems. The project is currently in designed development and would be funded by local funds and matching legislative approved funds.

8. Economic Benefits / Jobs Created:

The economic benefits of this program would be to employ two CT Scanning operators and one radiologist to read Scans. The major impact would be the reduction of the need of transporting patients for advance imaging studies in the city of Anchorage. Currently it costs $2,300 per Medivac for people that need these kinds of studies, which would have a major impact on the healthcare expenses of the local community. It would also reduce the requirement for routine testing of local residents to make the round trip to Anchorage. This job would also create a multitude of construction jobs during the project.

KENAI PENINSULA BOROUGH

CAPITAL IMPROVEMENT PROGRAM

Project Request

1989-92

1. Title: Construction of Incineration Unit

2. Location: 250 Hospital Place Soldotna

3. Dept/Service Area/Community: Central Peninsula Hospital Service Area

4. Prepared By: Mike Lockwood, Administrator Randall Nichols, Director of Finance

5. Project Type

Real Property / Construction	X
Major Equipment / Vehicles	

6. Project Ranking

Dept./Service Area/Comm.	2
Assembly	

7. Narrative Description:

This would be a gas fired incinerator that would provide incineration of infectious waste, produced at Central Peninsula General Hospital and by the local healthcare providers. It would be the hospital's intent that the incinerator be installed at the solid waste disposal site in Soldotna so that others besides the hospital could use the incineration area.

8. Economic Benefits / Jobs Created:

Jobs created by the project would be one full time employee for Central Peninsula General Hospital. The economic benefit of the project would be the savings of transfer cost to the city of Anchorage for incineration of our infectious waste. Also, with the new regulations that are coming out, it would have a significant impact on regulation compliance necessary in burning waste, since we would be burning our own. This would also have a significant health impact to the Central Peninsula area since we would be able to burn infectious waste of other healthcare providers.

Project Elements	Prior Years	1989-90	1990-91	1991-92	1992-93	1993-94	TOTAL
1. Planning / Designing	-0-	40,000	-0-	-0-	-0-	-0-	40,000
2. Land Acquisition	Existing Site	-0-	-0-	-0-	-0-	-0-	-0-
3. Construction	-0-	-0-	280,000	-0-	-0-	-0-	280,000
4. Equipment	-0-	-0-	-0-	-0-	-0-	-0-	-0-
5. TOTAL COSTS	-0-	40,000	280,000	-0-	-0-	-0-	320,000

Revenue Sources	Prior Years	1989-90	1990-91	1991-92	1992-93	1993-94	TOTAL
6. State Aid	-0-	-0-	160,000	-0-	-0-	-0-	160,000
7. Federal Aid	-0-	-0-	-0-	-0-	-0-	-0-	-0-
8. Local Sources	-0-	40,000	120,000	-0-	-0-	-0-	160,000
9. Bond Issue	-0-	-0-	-0-	-0-	-0-	-0-	-0-
10. User Fees	-0-	-0-	-0-	-0-	-0-	-0-	-0-
11. TOTAL REVENUE	-0-	40,000	280,000	-0-	-0-	-0-	320,000

Project Elements	Prior Years	1989-90	1990-91	1991-92	1992-93	1993-94	TOTAL
1. Planning / Designing	-0-	-0-	20,000	-0-	-0-	-0-	20,000
2. Land Acquisition	-0-	-0-	-0-	-0-	-0-	-0-	-0-
3. Construction	-0-	-0-	80,000	-0-	-0-	-0-	80,000
4. Equipment	-0-	-0-	275,000	-0-	-0-	-0-	275,000
5. TOTAL COSTS	-0-	-0-	375,000	-0-	-0-	-0-	375,000

Revenue Sources	Prior Years	1989-90	1990-91	1991-92	1992-93	1993-94	TOTAL
6. State Aid	-0-	-0-	375,000	-0-	-0-	-0-	375,000
7. Federal Aid	-0-	-0-	-0-	-0-	-0-	-0-	-0-
8. Local Sources	-0-	-0-	-0-	-0-	-0-	-0-	-0-
9. Bond Issue	-0-	-0-	-0-	-0-	-0-	-0-	-0-
10. User Fees	-0-	-0-	-0-	-0-	-0-	-0-	-0-
11. TOTAL REVENUE	-0-	-0-	375,000	-0-	-0-	-0-	375,000

BARTLETT MEMORIAL HOSPITAL

3260 HOSPITAL DRIVE • JUNEAU, ALASKA 99801 • TELEPHONE (907) 586-2611

Rava

February 8, 1990

File SB 319

Senator Jim Duncan
Room 119 Capital Building
P.O. Box V
Juneau, AK 99811

Dear Senator Duncan:

Roxanne Stewart of your staff asked for some information relating to the recent expansion/remodel project at Bartlett Memorial Hospital. The amounts and corresponding sources of funds are as follows:

$ 9,000,000	CBJ General Obligation Bond
1,100,000	State of Alaska Grant
2,500,000	BMH Funds (approximate)
$ 12,600,000	Total

The hospital funds that were used for the project were for equipment, furnishings, and some $ 750,000 that was used for the building itself.

A major portion of the project as planned, including relocation and improvements to the Critical Care and Obstetric units, was not undertaken due largely to the high costs associated with asbestos abatement/removal. The reasons for needing to do this portion of the project still exist. It would bring CCU up to code and improve the efficiency and level of care on all areas of the third floor which is where the patients rooms are located. Our information is that the needed work on the third floor will cost a total of $ 3,500,000.

I hope this information is what you need. As always, we are available to answer questions or provide information that you need. Please let us know how we can help.

Sincerely,

Garth M. Hamblin
Controller

RECEIVED FEB 12 1990

CITY OF UNALASKA
P.O. BOX 89
UNALASKA, ALASKA 99685
(907) 581-1251

DATE: JANUARY 16, 1990

MEMO TO: MEMBERS OF THE ALASKA STATE LEGISLATURE

FROM: HERV HENSLEY, CITY MANGER CITY OF UNALASKA

SUBJECT: JUSTIFICATION FOR A NEW HEALTH CLINIC IN UNALASKA

I would like to introduce you to our proposal to develop a comprehensive health care center in Unalaska. The current health care system in Unalaska is undergoing severe stress in proportion to the rapidly expanding fishing industry and support services. Rapid change, accompanying the importance of the community as a seafood processing center, in combination with the fact that Unalaska is the primary population center for the Western Aleutians has created an intense demand for medical services. The highly industrial nature of the work force also causes an unusually high number of injuries, and trauma, in the clinic's patient population. The clinic's physical facility is inadequate and outdated to the point that the provision of healthcare services is often compromised.

The present facility encompasses 3,500 square feet. Incorporated in that space are three exam rooms, two offices which are shared by three medical practitioners, a closet sized room used for a pharmacy, a very small room used as a lab, a small emergency patient area, a business office and a waiting room that is frequently so crowded that patients must often wait outside on the clinic yard, or steps.

The residents of Unalaska are dependent upon the services the clinic can provide. Given the inadequate physical facility there is a real question as to the ability of the health care professional to ensure an adequate and safe level of care. There are no other health care services available in Unalaska. In addition to the permanent resident population who utilize the services of the clinic, the fact that Unalaska is centrally located within the major fishing grounds of the Northern Pacific and Bering Sea means the clinic serves a population that now exceeds 15,000.

The patient load is projected to continue to expand in proportion to the level of fishing, processing and shipping activity in the area. In addition to the large number of patients seen on an annual basis, there were 200 medevacs from the clinic during 1989. It is anticipated that number could grow to 300 during 1990. All medevacs are transported by air, and weather frequently precludes any flights in or out of the community, sometimes for days. Our present small village clinic simply cannot support the numbers of people to be medevaced, and keep them alive while waiting for transportation. Several patients lost last year could be attributed to the facility's capacity of sustaining them.
Presently three major processing plants are either being built, or expanded. One new processing plant is completing a facility that will employ up to 400 new workers. This, along with the 60% growth in population over the last two years, and expected future growth, demand that we provide sufficient medical services.

As with other projects we have asked for, it is not our intention to request the full amount of this project to be funded by the State. However, given the major infrastructure needs of Unalaska, we cannot build the needed clinic on our own. It is our desire to create a project that is supported financially by the City, private industry and the State.

As you can see this is a basic community need, not fluff. For this reason and the fact that Unalaska is working toward accomplishing the stated goal of bringing fishing on shore, and providing jobs and revenue from a renewable resource, I kindly ask that you support funding this project.

FEB 12 1990

STEVE COWPER
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

February 8, 1990

The Honorable Paul A. Fischer
Chairman
Senate HESS Committee
P.O. Box V
Juneau, AK 99811

Dear Senator Fischer:

I am responding to the request of your committee for the administration's position on authorizing approximately $100 million in State general obligation bonds for medical facilities.

The administration is not in favor of authorizing additional State general obligation bonds at this time. Although State revenues appear to be fairly stable for the next five years, the projected rapid fall thereafter makes it unwise to push the burdens of paying for such facilities into the future. Borrowing money to pay for facilities increases that burden, of course.

The State's hard-earned recognition of the volatility and uncertainty of revenue estimates, in the face of the fixed obligations of debt service--obligations that approach death and taxes in terms of certainty--also gives us pause.

The State will be better served if it reserves the use of its finite amount of debt capacity for times of true fiscal duress, or until its tax structure is diversified to provide a degree of certainty that would allow us to better gauge the burdens we would be passing on to the future.

At the same time, the administration recognizes that there are needs for additional capital facilities that must be met. However, I believe that alternatives to general obligation bonding may be able to satisfy these needs.

In the case of medical facilities, the pursuit of State, federal or municipal grants, local general obligation bonding, directly or through the Alaska Municipal Bond Bank, and revenue bonding, directly or through the Bond Bank or Alaska Medical Facilities Authority are among the alternatives that should be explored.

Thank you for the opportunity to comment on this proposal.

Sincerely,

Steve Cowper
Governor

Alaska State Legislature

SENATOR PAUL FISCHER, Chairman
SENATOR JIM DUNCAN, Vice Chairman
SENATOR AL ADAMS
SENATOR LLOYD JONES
SENATOR TIM KELLY

P.O. BOX V
ROOM 508
STATE CAPITOL
(907) 465-3762

Senate Committee on Health, Education and Social Services

Proposal to add improvements and construction to SB 319 for Central Peninsula Hospital.

1.	Incineration Unit Construction	$ 375,000
2.	Construction for CT Scan Site	$ 320,000
3.	Boiler Conversion Improvements	$ 150,000
4.	Air Conditioning Improvements	$ 205,000
	TOTAL	$ 1,050,000

Project Elements	Prior Years	1989-90	1990-91	1991-92	1992-93	1993-94	TOTAL
1. Planning / Designing	-0-	40,000	-0-	-0-	-0-	-0-	40,000
2. Land Acquisition	Existing Site	-0-	-0-	-0-	-0-	-0-	-0-
3. Construction	-0-	-0-	280,000	-0-	-0-	-0-	280,000
4. Equipment	-0-	-0-	-0-	-0-	-0-	-0-	-0-
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8. Local Sources	-0-	40,000	120,000	-0-	-0-	-0-	160,000
9. Bond Issue	-0-	-0-	-0-	-0-	-0-	-0-	-0-
10. User Fees	-0-	-0-	-0-	-0-	-0-	-0-	-0-
11. TOTAL REVENUE	-0-	40,000	280,000	-0-	-0-	-0-	320,000

KENAI PENINSULA BOROUGH

CAPITAL IMPROVEMENT PROGRAM

Project Request

1989-92

1. Title: Construction Of Site For CT Scan

2. Location: 250 Hospital Place Soldotna

3. Dept/Service Area/Community: Central Peninsula Hospital Service Area

4. Prepared By: Michael J. Lockwood, Administrator Randall Nichols, Director of Financ

5. Project Type

Real Property / Construction	X
Major Equipment / Vehicles	

6. Project Ranking

Dept./Service Area/Comm.	1
Assembly	

7. Narrative Description:

Funds for this project would provide building of the enclosure for our computed axial tomography system that would provide in excess of 600 Scans per year to the patients of Central Peninsula General Hospital. The program is in a 1,000 sq.ft. building and the electrical to support the CT Scan and also the air conditioning and mechanical systems. The project is currently in designed development and would be funded by local funds and matching legislative approved funds.

8. Economic Benefits / Jobs Created:

The economic benefits of this program would be to employ two CT Scanning operators and one radiologist to read Scans. The major impact would be the reduction of the need of transporting patients for advance imaging studies in the city of Anchorage. Currently it costs $2,300 per Medivac for people that need these kinds of studies, which would have a major impact on the healthcare expenses of the local community. It would also reduce the requirement for routine testing of local residents to make the round trip to Anchorage. This job would also create a multitude of construction jobs during the project.

KENAI PENINSULA BOROUGH

CAPITAL IMPROVEMENT PROGRAM

Project Request

1989-92

1. Title: Construction of Incineration Unit

2. Location: 250 Hospital Place Soldotna

3. Dept/Service Area/Community: Central Peninsula Hospital Service Area

4. Prepared By: Mike Lockwood, Administrator Randall Nichols, Director of Finance

5. Project Type

Real Property / Construction	X
Major Equipment / Vehicles	

6. Project Ranking

Dept./Service Area/Comm.	2
Assembly	

7. Narrative Description:

This would be a gas fired incinerator that would provide incineration of infectious waste, produced at Central Peninsula General Hospital and by the local healthcare providers. It would be the hospital's intent that the incinerator be installed at the solid waste disposal site in Soldotna so that others besides the hospital could use the incineration area.

8. Economic Benefits / Jobs Created:

Jobs created by the project would be one full time employee for Central Peninsula General Hospital. The economic benefit of the project would be the savings of transfer cost to the city of Anchorage for incineration of our infectious waste. Also, with the new regulations that are coming out, it would have a significant impact on regulation compliance necessary in burning waste, since we would be burning our own. This would also have a significant health impact to the Central Peninsula area since we would be able to burn infectious waste of other healthcare providers.

Project Elements	Prior Years	1989-90	1990-91	1991-92	1992-93	1993-94	TOTAL
1. Planning / Designing	-0-	-0-	20,000	-0-	-0-	-0-	20,000
2. Land Acquisition	-0-	-0-	-0-	-0-	-0-	-0-	-0-
3. Construction	-0-	-0-	80,000	-0-	-0-	-0-	80,000
4. Equipment	-0-	-0-	275,000	-0-	-0-	-0-	275,000
5. TOTAL COSTS	-0-	-0-	375,000	-0-	-0-	-0-	375,000

Revenue Sources	Prior Years	1989-90	1990-91	1991-92	1992-93	1993-94	TOTAL
6. State Aid	-0-	-0-	375,000	-0-	-0-	-0-	375,000
7. Federal Aid	-0-	-0-	-0-	-0-	-0-	-0-	-0-
8. Local Sources	-0-	-0-	-0-	-0-	-0-	-0-	-0-
9. Bond Issue	-0-	-0-	-0-	-0-	-0-	-0-	-0-
10. User Fees	-0-	-0-	-0-	-0-	-0-	-0-	-0-
11. TOTAL REVENUE	-0-	-0-	375,000	-0-	-0-	-0-	375,000

MEMORANDUM

Renovation

February 12, 1990

To : Senator Paul Fischer

From : Michael J. Lockwood, Administrator
Central Peninsula General Hospital

Subj : Funding for Projects

You have requested additional documentation for capital costs.

Boiler Conversion - Cost: $150,000

This will convert the present heat exchanger from hot water to steam, $75,000. The deletion of all unused piping and would open the existing space for other use, $75,000.

Air Conditioning - Cost: $205,000

Air conditioning would be installed to increase patient comfort in all patient areas during the summer months when temperatures reach 80 - 90 degrees. It would also be installed in areas that contain sensitive computer equipment.

LUTHERAN HOSPITALS AND HOMES SOCIETY

BUDGET REQUEST-CAPITAL EXPENDITURES (OTHER THAN EQUIPMENT)

FACILITY NAME: CPGH FACILITY NO. _____

RESPONSIBLE PERSON: _____ ASSIGNED PROJECT CODE _____

Brief description: Converting Present Heat exchangers from Hot water to Steam.

Goals and/or Objectives being met: Deletion of all old Boilers thus getting more effeciency from our New Steam Boilers and elimin. Preventive Maint. & Repair on 3 old Hot water Boilers. When Temp Drops to -20° and below the Hot water Boiler cannot handle the load.

Justification and effect of expenditure on facility: Reducing fuel Consumption + PM & Repair Costs.

FINANCIAL INFORMATION:

Identify expenses related to project: $75,000 Parts & Labor

Purchase Cost	_____
Annual Maintenance Cost	_____
Personnel Utilized	_____
Other (Describe) _____	_____
_____	_____
_____	_____
TOTAL	_____

Cost Recovery, if applicable (_____)

Describe Cost Savings/avoidance, if applicable 1/3 Less fuel Consump Preventive Maint., upkeep & Repair, Stocking of Critical Spare Parts

Description of leasing or other financing arrangements available to pa for this expenditure, if known Not Available

MEMORANDUM State of Alaska

TO: FILE

DATE: February 23, 1982

FILE NO:

TELEPHONE NO:

FROM: Dave W. Williams DW
Chief
Health Resources Development

SUBJECT: Health Facility Inventory
Panel meeting of 2/22/82

The meeting began at 2:30 PM, February 22, 1982. In attendance were:

Mark Hawkins, member of the Alaska Hospital Association
Peggy Wilson, Health Planner, South Central Health Planning and Development, Inc.
Margaret Bixby, member of the Alaska Medical Facilities Authority and South East Alaska Health Systems Agency
Howard Gabriel, Director, South East Health Systems Agency
Dr. Rabeau, member of Medical Care Advisory Board

Available as resource persons were:

Dave W. Williams, Coordinator, Health Resources Development DHSS, State of Alaska
Ron Goldberg, Architect, Health Resources Development, DHSS, State of Alaska
Cintra Price, Chief, Health Planning Section, DHSS, State of Alaska

Gordon Jackson of the Statewide Health Coordinating Council, was scheduled to attend, but was unexpectedly called out of town. Brenda Bruce of his staff attended in his place as an observer. A member of Northern Alaska Health Resources Association was also expected to attend, but due to short notice and inclement weather was unable to arrive in Juneau.

Dave W. Williams began the meeting with opening remarks and a brief overview of the purpose of the meeting and purpose of the inventory and condition survey. The members of the review panel were requested to rank the surveyed facilities according to a desired order for addressing the correction of deficiencies noted for each facility. To be considered in the ranking were factors other than physical condition such as occupancy rates population trends, etc., as the panel deem appropriate.

The financial capacity of facilities requesting State funds;

(i.e. which facilities require grants and which facilites may secure financing through other means);

The preparedness of facilities to proceed with deficiency corrections (i.e. those which are ready to proceed should not be held up by those facilities which may not be prepared for a time).

Certificate of Need considerations:

1. The relationship to the proposed project to the Health Systems Plan and annual implementation plan of the HSAs;

2. The relationship of the project to the State Health Plan;

3. The relationship of the proposed project to the long-range plan to the facility in question;

4. The need of the population served for the facility;

5. The availability of less costly or more effective alternative methods of meeting the needs of the area to be served by the facility;

6. The immediate and long-term financial feasibility of the proposed facility;

7. The relationship of the facility to other existing health care facilities in the area;

8. The availabiltiy of resources including health man power management personnel and any additional funds needed for capital construction or those funds needed for operating costs;

9. The probable impact of the construction project on the cost of providing health services to the citizens to be served.

cc: Commissioner Beirne
Mark Hawkins, Administrator, Sitka Community Hospital
Margret Bixby, Alaska Medical Faciilities Authroity
Howard Gabriel, Director, SEAHSA
Peggy Wilson, Health Planner, SCHPD
Phoebe A. Lindsey, Director, DSHPD
Cintra Price, Health Planner III, DSHPD
Ron Goldberg, Architect, Health Resources Development

To perform this task, it was decided that the facilities should first be objectively ranked using only the information contained in the inventory and condition survey. Several methodologies assigning value systems to the components listed in the "Comparative Evaluation of Facilities" were used to arrive at preliminary rankings of the subject facilities.

FACILITY	EQUAL WT.	SIMPLE WT.	COMPLEX WT.	FINAL RANKING
Bartlett Memorial Hospital	11.5	9	11	11
Central Peninsula Hospital	11.5	10	9	10
Cordova Community Hospital	1	1	2	1
Faith Hospital	4	4.5	4	5
Ketchikan/Island View Manor	5.5	11	5	9
Kodiak	5.5	4.5	5	4
Norton Sound Regional Hospital	14	14	14	14
Petersburg General Hospital	2	2	1	2
Seward General Hospital	3	3	3	3
South Peninsula Hospital	9	8	8	8
St. Ann's Nursing Home	11.5	13	12.5	13
Valdez	11.5	12	10	12
Wesleyan	7.5	6	6	6
Wrangell	7.5	7	7	7

The rankings were averaged to arrive at a preliminary score for each facility. The panel discussed the preliminary score and agreed upon the final ranking shown in the right hand column above.

The panel discussed adjusting the final ranking by giving consideration to other factors such as utilization, population trends, etc.

At this point (4:30 PM) Dr. Rabeau expressed his need to leave in order to attend another meeting. The panel did not object to his leaving, but dersired to continue the meeting rather than to meet again the next day.

The remaining panel members discussed the relationship of other factors such as population tends, occupancy levels, health plans and concluded that such considerations were beyond the capability of the panel. It was suggested that such factors should be addressed by the Department of Health and Social Services, the Statewide Health Coordinating Council and the Legislature. The panel recommended that persons making decisions regarding State funding for the subject facilities should include the following factors in their decisions:

Nursing care offered through Pioneer Homes;

Recommendations of the Alaska Hospital Association;

The extent to which State assistance may be needed at Federal facilities (i.e. light of Federal cut-backs);

FIVE-YEAR CONSTRUCTION PLAN FOR STATE HEALTH PLAN LEVEL III

HOSPITALS AND NURSING HOMES

FACILITY	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987
Bartlett Memorial Hospital Juneau	long-range plan is complete	———	$2,000,000 for design	const. cost to be determined during design phase	———
Central Peninsula General Hospital Soldotna	Addition & remodel design is complete and construction to begin in 1982	construction is to be completed in FY 84 with borough funds	———	———	———
Cordova Community Hospital & LTCF Cordova	$1,000,000 for design of new facility	$13,000,000 for construction of new facility	———	———	———
Faith Hospital Glennallen	Addition & remodel $1,200,000 for construction of new facility	———	———	———	———
Ketchikan General Hospital and Island View Manor Ketchikan	new addition & remodeling has been completed	$50,000 for long-range planning	$1,000,000 for design	construction costs to be determined during design phase	———
Kodiak General Hospital & LTCF Kodiak	———	$1,000,000 for design	$10,000,000 for construction	———	———
Norton Sound Hospital & LTCF Nome	———	———	$50,000 for long range planning	design costs to be determined in planning phase	construction costs to be determined in planning
Petersburg General Hospital & LTCF Petersburg	$10,000,000 for construction design to be comp. w/state grant fund	———	———	———	———
Seward General Hospital Seward	———	$40,000 for long range planning	$1,500,000 for design	$15,000,000 for construction	———
Weselyan Nursing Home Seward	———	$40,000 for long range planning (cooperative program)			
Sitka Community Hospital Sitka	A new facility is under construction	———	———	———	———
South Pen. General Hospital & LTCF Homer	$4,000,000 for construction	———	———	———	———
St. Ann's Nursing Home Juneau	———	$40,000 for planning	$500,000 for design	Construction costs to be determined in design phase	
Valley Hospital & LTCF Palmer	Addition & remodel design is complete to be under construction in 1982	———	———	———	———
Valdez Community Hospital Valdez	———	———	$50,000 for long-range planning	design costs to be determined in planning phase	const. costs to be determined in design phase
Wrangell General Hospital & LTCF Wrangell	$1,000,000 for design	$8,000,000 for construction	———		
OTHER	———	———	———	unknown	unknown
TOTAL	$17,200,000	$22,170,000	$15,100,000	$15,000,000 plus	$15,000,000 plus

• LTCF = Long-Term Care Facility

APPROXIMATE COSTS SHOWN ARE ESTIMATED 1982 VALUES WITHOUT PROJECTIONS FOR FUTURE INFLATION AND DO NOT INCLUDE OTHER PROJECT COSTS SUCH AS FEES, EQUIPMENT, SITE ACQUISITION, ETC. THE ESTIMATED COSTS SHOWN ARE PROVIDED AS A GUIDELINE IN DETERMINING THE DIMENSIONS OF A GIVEN COMMUNITY'S NEED. NO ESTIMATES HAVE BEEN MADE OR INDEED CAN BE MADE FROM THIS INVENTORY AS TO THE LEVEL OF STATE ASSISTANCE APPROPRIATE TO ANY ONE COMMUNITY.

February, 1990

BACKGROUND

HOSPITAL/NURSING HOME CONSTRUCTION

(SB 319/HB 442 - GO Hospital Construction)

The 1981 Legislature authorized and funded a study by the Department of Health & Social Services of the plant condition and functional adequacy of 15 rural hospitals and nursing homes.

The result of that study was contained in a report by the Department to the Legislature in March, 1982.

Anchorage and Fairbanks hospitals were not included. Valley Hospital, Palmer and Sitka Community Hospital did not participate as they were currently under construction or reconstruction in 1982.

Overview of Surveyed Facilities

A study team evaluated the adequacy of the physical facilities at each hospital or long term care unit, a number of serious problems and deficiencies were discovered. Such inadequacies tended to fall into common classifications, the most important of which can be grouped as follows:

- Building, fire and life safety code deficiencies and violations;

- Lack of adequate mechanical ventilation to critical areas of the building, and mechanical and electrical inadequacies occasioned by the acquisition and use of high demand diagnostic and therapeutic equipment in laboratory and treatment programs;

- Facility inflexibility in response to changing attitudes, medical technologies and resultant changes in patterns of use; and

- Space shortages occasioned by new patterns of use, increasing complexity in information processing and records storage requirements, and growth in service area populations.

Generally, the deficiencies observed in the health care facilities surveyed are due to the advances and changing techniques in the medical field, coupled with more stringent building, fire and life safety codes which have been adopted over the last few years.

1982 Prioritization of Surveyed Hospitals and Nursing Homes

In conducting the inventory and evaluation study of the fifteen hospitals and long term care facilities in 1982, architectural consultants identified six facilities which were in greater need of immediate attention than others, due to their more severe physical and functional deficiencies. To arrive at a ranking of all surveyed facilities based upon relative need for construction to correct noted deficiencies, the Department assembled a committee to review the report.

(MORE)

Chuk - Local Match or Funding

This committee consisted of one member of:

The Alaska Medical Facility Authority;
The Alaska State Hospital Association;
Southeast Alaska Health Systems Agency, Inc.;
South Central Health Planning and Development, Inc.;
The Medical Care Advisory Committee, and
The Statewide Health Coordinating Council.

Ch Alaska 4.5M A.P.I

1982 Report

The ranking provided by this committee was based only upon the relative severity of all physical and functional deficiencies found at each facility and did not consider other factors such as facility utilization or population trends: The committee ranking was as follows:

* 1. Cordova Community Hospital and Long Term Care Facility
* 2. Petersburg General Hospital and Long Term Care Facility
3. Seward General Hospital
4. Kodiak Island Hospital and Long Term Care Facility
5. Wesleyan Nursing Home
* 6. Wrangell General Hospital
* 7. South Peninsula General Hospital and Long Term Care Facility
8. Ketchikan General Hospital and Island View Manor
* 9. Central Peninsula General Hospital
*10. Bartlett Memorial Hospital
11. Valdez Community Hospital
12. St. Ann's Nursing Home
*13. Norton Sound Regional Hospital

* completed

In 1987, the Health Association of Alaska, representing hospitals and nursing homes, recommended that Kodiak, Ketchikan and Seward be ranked as the top priority facilities needing construction grants.

SB 319 - By Senator Zharof
HB 342 - By Representatives Davidson, Cato, C. Davis and Taylor

Authorizes issuance of general obligation bonds in the amount of $41,400,000.00. This proposition to be placed on the 1990 general election ballot.

Kodiak Island Borough	$14,500,000.00
City of Seward	9,500,000.00
City of Seward	1,200,000.00
City of Ketchikan	16,200,000.00

# # #

For More Information Contact:

Harlan Knudson
Health Association of Alaska
586-1790

By: Mayor Selby
Introduced: 10/05/89
Adopted: 10/05/89

KODIAK ISLAND BOROUGH
RESOLUTION NO. 89-69-R

A RESOLUTION ADOPTING A CAPITAL IMPROVEMENT PROGRAM FOR FISCAL YEARS 1991 THROUGH 1995 AND ESTABLISHING CAPITAL PROJECT PRIORITIES

WHEREAS, a Five-Year Capital Improvement Program has been prepared by the Borough for fiscal years 1991 through 1995; and

WHEREAS, the Borough's Planning and Zoning Commission has recommended approval of the prioritized FY 91 capital improvement priorities at its meeting in accordance with Borough Code Section 2.24.030 (e); and

WHEREAS, the Borough Assembly held a public hearing on the Five-Year Capital Improvement Program including the priorities during its meeting on October 5, 1989;

NOW, THEREFORE, BE IT RESOLVED that the document entitled "Kodiak Island Borough Capital Improvement Program" for the years from July 1, 1991 through June 30, 1995 is hereby adopted by reference; and

BE IT FURTHER RESOLVED that the Borough's capital project priorities for FY 1991 are as follows:

1.	Hospital Construction	$14,000,000
2.	Mill Bay Road Reconstruction (Transfer to City)	5,000,000
3.	Airport Sewage Treatment Plant	800,000
4.	Left Turn Lanes at Airport & Base	800,000
5.	Resurfacing Rezanof Drive	4,500,000
6.	Borough Developmental Disabilities & Student Housing/Upgrade	600,000
7.	Cape Chiniak Road Erosion/Relocation	350,000
8.	Service District #1 Water & Sewer Projects	3,000,000
9.	Airport Development	500,000
10.	Selief Lane Drainage	60,000
11.	Bayside Fire Station Expansion	275,000
12.	KIB Solid Waste Disposal Site	1,500,000
13.	Womens Bay Water & Sewer System Design	1,100,000
14.	Monashka Bay Water & Sewer System Design	1,100,000
15.	Public Water System Filtration Plant A & E	600,000
16.	Sharatin/Perenosa Construction	2,500,000
17.	Road Designs Three Sisters, Sawmill Ext./Peninsula	30,000
18.	Bells Flats Road	1,250,000
19.	State Airport Expansion/Upgrade	5,000,000
20.	Karluk Access Road Design	25,000
21.	Gear Storage Facility Development	2,500,000
22.	Kalsin Hill Road Relocation	3,900,000
23.	DOT Maintenance Facility	4,500,000
24.	Spruce Cape Road Upgrade/Walkway	1,800,000
25.	East Elementary Roof	350,000

BE IT FURTHER RESOLVED that Borough administration is hereby instructed to advise the governor, legislature and appropriate state agencies of the Capital Improvement Program and priorities adopted by the Borough Assembly.

PASSED AND APPROVED THIS 5th DAY OF OCTOBER, 1989.

KODIAK ISLAND BOROUGH

Borough Mayor

Presiding Officer

ATTEST:

Borough Clerk

NEW FACILITY STATUS REPORT

KODIAK ISLAND HOSPITAL

MARCH, 1988

TABLE 3.2

State of Alaska
Debt Service on State-Supported Debt
($ Millions)

Fiscal Year	(1) State GOB's	(2) UA	(3) ASHA	(4) Lease-Purchase Obligations (Lease)	(5) School Debt (Muni)	Total Debt Service
79	$60.0	$1.7	$10.1	$0	$22.3	$94.1
80	75.1	1.8	10.1	0	24.1	111.1
81	97.6	2.2	10.0	0	38.4	148.2
82	97.5	2.3	10.0	0	38.3	148.1
83	143.6	2.3	9.9	0	36.2	192.0
84	166.3	2.0	9.9	0	90.6	268.0
85	169.5	2.0	9.9	.8	93.2	275.4
86	163.2	1.8	9.9	.5	106.3	281.7
87	154.9	1.8	6.5	4.7	115.8	283.7
88	147.9	1.5	6.5	.7	109.5	266.1
89	135.5	2.2	6.5	5.2	109.5	258.8
90	120.3	2.2	6.5	5.5	107.8	242.3
91	95.5	2.2	6.5	5.5	(120.2)	229.9
92	68.2	2.1	6.5	5.5	116.1	198.4
93	59.7	2.1	5.9	5.5	106.0	179.2
94	33.9	1.9	3.1	5.5	93.4	137.8
95	23.1	2.0	1.5	5.5	84.3	116.4
96	21.5	1.9	0	5.5	71.1	100.0
97	16.7	1.9	0	5.5	48.7	72.8
98	14.4	1.9	0	5.5	45.7	67.5
99	9.0	1.9	0	5.5	43.2	59.6
00	2.6	1.9	0	4.7	34.8	44.0
01	0	1.8	0	4.7	21.2	27.7
02	0	1.2	0	4.7	9.1	15.0
03	0	1.0	0	4.7	5.4	11.1
04	0	1.1	0	4.7	5.4	11.2
05	0	1.0	0	4.7	5.3	11.0

(1) State of Alaska general obligation bonds
(2) University of Alaska bonds
(3) Alaska State Housing Authority lease revenue bonds
(4) Debt issued to finance Seward Student Service Center, Spring Creek Correctional Center, and Palmer Courthouse
(5) State Reimbursement of municipal general obligation debt issued to finance school construction for debt issued through December 31, 1989