An Analysis of a Proposed Long-Term Care Insurance Benefit:

A Report to the Legislature

January 1997

Minnesota
Department of
Employee
Relations

Leadership and partnership in human resource management

Prepared in compliance with Chapter 384, Section 8 of the 1996 Laws of Minnesota.

Title: *Analysis of a Proposed Long-Term Care Insurance Benefit: A Report to the Legislature*
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Publisher: Minnesota Department of Employee Relations
Date of Publication: January, 1997
Place of Publication: St. Paul, Minnesota

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As required by Minnesota Statute 3.197: This report cost $6,150 to prepare, including staff time, printing and mailing expenses.

This report is printed with a minimum of 10% post-consumer materials, and can be made available, upon request, in alternative formats such as large print, Braille, or audio tape.

Executive Summary

Chapter 384, section 8 of the 1996 Laws of Minnesota directed the Department of Employee Relations (DOER) to consider offering long-term care insurance as an optional benefit to *retiring* state employees. The intent of this proposal is to encourage these employees to insure themselves against the devastating financial effects of chronic illnesses and disabilities, while reducing their reliance on state Medical Assistance programs for elderly long term-care.

In a time of diminishing public resources, exploration of this option is an important first step towards an overall state policy of encouraging the middle class (in this case, a segment of that group -- public sector employees) to take more responsibility for financing their own long-term care. DOER's analysis, however, concludes that a bolder approach is needed.

A successful employer-sponsored long-term care insurance program requires a critical mass of eligible participants. DOER finds that the proposal to cover only retiring state employees would have limited participation because the small eligible population of approximately 1,100 would not have the economic leverage to negotiate the purchase of an insurance product that large numbers of eligible participants would find either affordable or sufficiently comprehensive.

Although the proposal does not meet the criteria for the type of long-term care insurance program that would significantly address the state's long-term care financing issues, it has generated a great deal of discussion among knowledgeable staff in key state agencies, and provided DOER with an opportunity to study other strategies toward that end. As a result, DOER concludes that the taxpayers of Minnesota may have a financial interest in providing long-term care coverage to public employees and their families, *but only if it is purchased by a significant number of people*. However, DOER also finds that even if such a program attracts a significant number of participants, its impact on state long-term care expenditures will not be felt until well into the next century.

DOER recommends that a more in-depth feasibility study be done to determine the minimum size and content of the eligible pool, the interest and the attitudes of the eligible pool, the impact on the state's elderly long-term care expenditures, the impact on the private long-term care insurance market, and the administrative framework of any long-term care insurance program. DOER also recommends that it be assisted in this study by experts in the fields of long-term care benefit design, underwriting, and market research.

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I. Introduction

In 1996, the Minnesota legislature directed the Department of Employee Relations (DOER), with the assistance of the labor-management committee, to consider whether the State of Minnesota should offer an optional long-term care insurance benefit to retiring state employees. This benefit would provide coverage for nursing home and home care, with the full cost of coverage paid by its participants (Laws of Minnesota, 1996, Chapter 384, § 8; see Appendix A).

Although not explicitly stated, DOER understands that the intent of this legislation is threefold:

(1) To enable retiring state employees to take major responsibility for financing their own future long-term care.

(2) To provide a means for public sector employees to protect themselves from the devastating financial effects of long-term care, thereby securing their retirement.

(3) To reduce --albeit future -- reliance of this group on public programs for long-term care, thereby reducing or at least stabilizing public expenditures in this area.

To fulfill this directive, DOER undertook a study which included a review of other long-term care insurance programs both locally and nationally, a survey of insurance-eligible state employees' attitudes, a review of current long-term care insurance literature, and discussions with various experts. This study was conducted with the assistance of an informal interagency group comprised of representatives from the Departments of Human Services, Health, Commerce, Finance, and the Minnesota State Retirement System. From their variety of perspectives, this group provided valuable input.

This report provides background information on the current system of state employee benefits and long-term care financing, an assessment of the legislative directive, and finally, recommendations for further action. It does not recommend a particular plan for providing long-term care coverage. Rather, it provides a framework within which further study should be conducted.

II. Background

A. Employee Benefits From DOER

1. What Benefits are Currently Offered and Who Receives Them?

Currently, DOER offers a variety of employee benefits, including health, dental, basic life insurance, optional life, accidental death and dismemberment, short and long term disability insurance, workers' compensation, and pre-tax benefits. These benefits are provided to executive branch employees,[a] their dependents and retirees, as well as to other organizations authorized to participate in the program. This includes the legislative and judicial branches of state government, the University of Minnesota, and numerous other smaller organizations such as boards and commissions.

In 1996, DOER's program covered 146,822 people, including 39,852 state employees (employees on the state's central payroll system), 19,419 individuals in other groups participating in the program, and 75,561 of their dependents (spouses and children). In addition, the program covered 7,768 retirees age 65+ and their dependents. (See Appendix B for further information on DOER's program.)

2. How are Benefits Determined?

The commissioner of DOER has the authority to request bids from carriers, to negotiate with carriers, and to enter into contracts with carriers which, in the judgment of the commissioner, are best qualified to underwrite and service the benefit plans.[1] The commissioner also has the authority to make available certain optional coverages to be purchased at employees' expense.[2] Employee benefits are considered terms and conditions of employment under the Public Employment Labor Relations Act and can become mandatory subjects of collective bargaining.

B. Long-Term Care

1. What is Long-Term Care?

Long-term care is a broad array of services designed to help people of all ages with chronic physical and mental conditions maximize their ability to function independently and carry out the normal routines of daily living. These services can be provided formally -- by paid professionals, or informally -- usually by unpaid relatives and friends.

Long-term care differs substantially from what most people associate with medical care. Medical care relies primarily on intensive, high technology, hospital-based services to *cure* acute symptoms of a disease or injury. Long-term care, often also referred to as

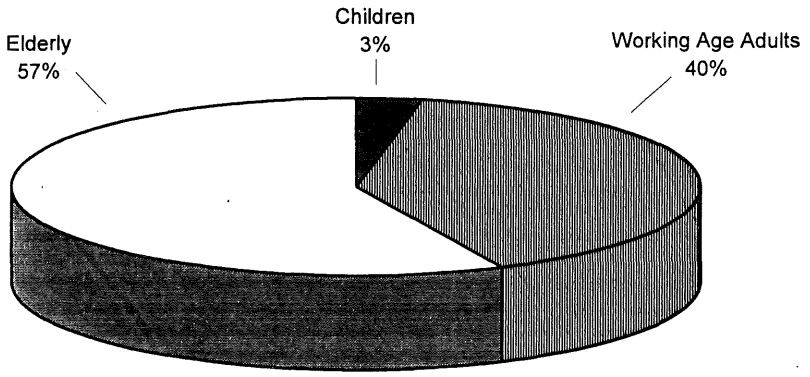
[a] Executive branch employees include employees of the executive departments, agencies, and semi-state agencies.

chronic care, seeks to enable people with functional limitations to regain or maintain the maximum level of independence and function possible. While long-term care may occasionally involve episodes of medical care, most of it is non-medical assistance from a wide range of formal and informal caregivers in a variety of settings. Since chronic conditions, by definition, cannot be totally cured, long-term care also emphasizes long-term assistance and care designed to help the person cope with his or her chronic condition.

2. Who Uses Long-Term Care?

While long-term care is usually associated with the elderly, it is in fact needed by people of all ages. Figure 1 shows that of the almost 13 million people who required some form of long-term care in 1993, 40 percent were working-age adults (18-64 years of age) and three percent were children (0-17 years of age). In other words, the elderly accounted for only about six out of ten (57%) long-term care users nationwide.[3]

Figure 1/ Users of Long-Term Care/ 1993



Source: U.S. General Accounting Office

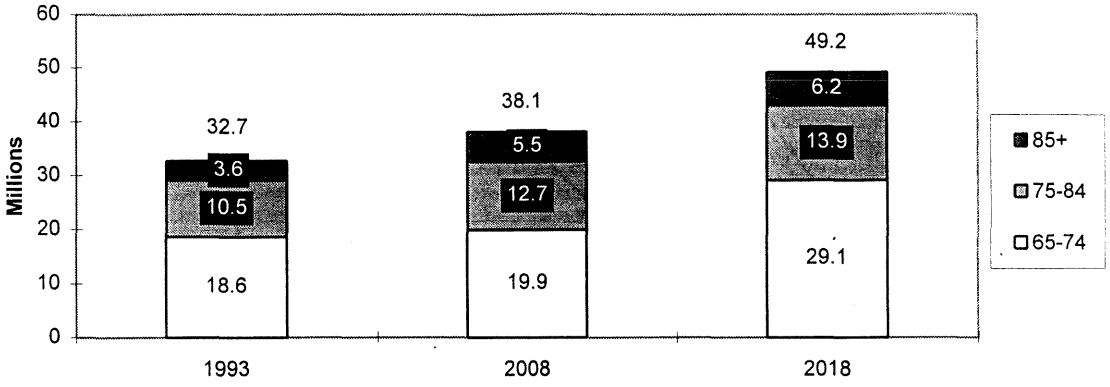
Although long-term care is used by people of all ages, this report focuses on long-term care insurance for the elderly because most of the non-elderly who currently receive long-term care have chronic conditions which likely would have precluded them from purchasing insurance prior to their needing long-term care.

3. Why is the Use of Long-Term Care Growing?

Today, almost half (43%) of all people who have reached age 65 will be admitted to a nursing home during the remainder of their life and 60 percent will need *either* nursing home or home health care. About 70 percent will stay in a nursing home less than one year, while about 9 percent will require five or more years of nursing home care.[4] Medical advances are permitting people to live longer, creating the greater likelihood that they will develop chronic conditions that will require long term care. Very shortly, this trend will be compounded by changing demographics, as the baby boom generation ages. As shown in Figure 2, the number of elderly is projected to grow

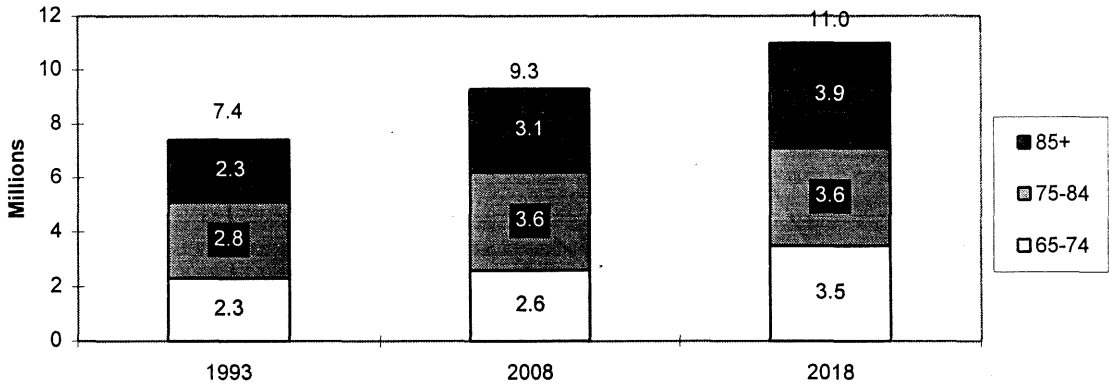
rather dramatically in the coming decades. Consequently, the number of long-term care users is also expected to grow, as shown in Figure 3.

Figure 2/ Number of Elderly/ By Age/ Selected Periods



Source: Brookings-ICF Long-Term Care Financing Model.

Figure 3/ Long-Term Care Users/ Selected Periods



Source: Brookings-ICF Long-Term Care Financing Model.

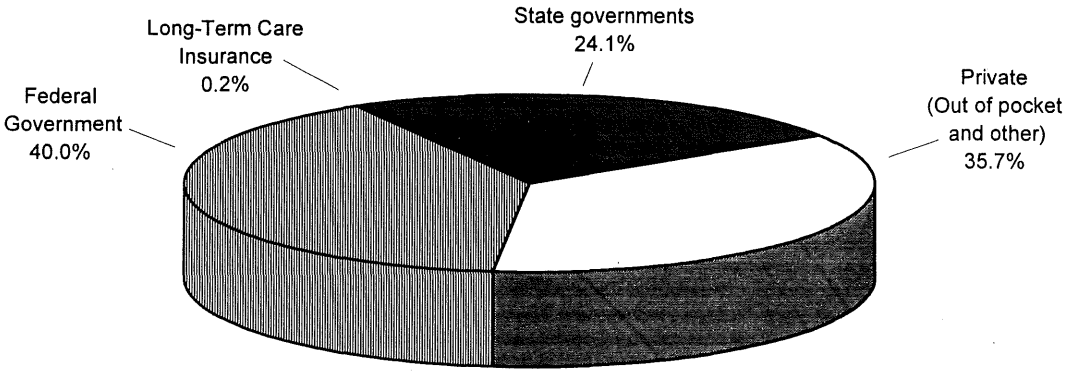
4. How Much Does Long-Term Care Cost?

In 1996, the average cost of a day of nursing home care in Minnesota was over $99, for an annual cost exceeding $36,000. Home care can be almost as expensive, with the actual cost reflecting the frequency and intensity of the services required. For example, a person needing six hours of personal care attendant services daily would cost, on average, about $71 per day for an annual cost of almost $26,000.[5] *It is estimated that less than 10 percent of elderly nursing home users can afford to pay for a year of nursing home care solely out of income.*[6] Extended long-term care often depletes a person's savings and assets, leading many to rely on Medicaid to pay for the costs of care.

5. Who Pays for Long-Term Care?

Currently, the funding for long-term care comes from a number of sources, but federal and state governments are the largest payers. The proportion of long-term care that is financed by insurance continues to grow, but it remains very small. As shown in Figure 4, insurance paid for less than one percent, or about $200 million, of all long-term care costs in 1993. Federal and state governments accounted for 40 percent and 24.1 percent respectively, while private sources -- primarily out-of-pocket by individuals and families -- accounted for almost 36 percent.[7]

Figure 4/ Payers of Long-Term Care/ 1993



Source: Office of the Assistant Secretary for Planning and Evaluation, HHS

C. Long-Term Care Insurance

1. What is Long-Term Care Insurance?

Long-term care insurance is designed to provide benefits for prescribed long-term care services ranging from skilled nursing facilities, to home care, to assisted living facilities. Most long-term care insurance policies sold in Minnesota provide a specific daily benefit, typically payable after a defined waiting period. Most also have a maximum total lifetime benefit (Minnesota's statutory minimum is $25,000), although a few offer unlimited lifetime benefits. Benefits are triggered either by a plan of care prepared by a physician, or the inability to perform certain activities of daily living ("ADLs"), or both.

2. How Much Does Long-Term Care Insurance Cost?

While comprehensive long-term care policies can be expensive, basic policies may seem relatively affordable. However, they are not always the best value -- particularly if purchased well before the person needs long-term care services. In Minnesota, the average annual premium for a 65-year old buying a *basic* long-term care policy ($60 daily benefit, $100,000 of lifetime benefits and a 90-day waiting period *without inflation protection* and *nonforfeiture benefit*) was $700 in 1996.[8] Nationally, the average annual premium for a 65-year old buying a basic long-term care policy with a somewhat richer benefit structure ($80/$40 a day nursing home/home health benefit and a 20-day waiting period) was $855 in 1994.[9]

Policies which have greater value are those that include inflation protection, which prevents inflation from eroding the value of the benefits over time, and nonforfeiture benefit, which guarantees some residual value to the policy holder if the policy lapses or is dropped (lapse rates are estimated to be 20-30 percent).[10] As shown in Figure 5, adding inflation protection and/or a nonforfeiture benefit to a basic policy increases the cost significantly, although age is still the factor that increases premiums the most.

Figure 5/ Average Annual Premiums/
Leading Long-Term Care Insurance Sellers in the U.S./ 1994*

Age	Base Plan	With Lifetime 5% Compounded Inflation Protection Only	With Nonforfeiture Benefit (NFB) Only	With NFB and Inflation Protection
50	$325	$659	$448	$924
65	$855	$1,538	$1,177	$2,187
79	$3,641	$5,095	$4,983	$7,077

* Based on coverage amount of $80/$40 a day nursing home/home health care, generally, with a 20-day waiting period and four years of coverage.
Source: Health Insurance Association of America

3. Why Do People Need Long-Term Care Insurance?

Long-term care is expensive. As a result, even the middle class has come to rely on public programs to pay for it. This has led to state and federal budget deficits which threaten to balloon as the number of people requiring long-term care grows. Lacking the political support to raise taxes to levels that would keep public programs solvent, governments may be forced to curtail programs. One way to prevent this is to encourage the middle class to purchase long-term care insurance. While American society typically uses private insurance to protect against loss from other catastrophic events such as acute illness, automobile accidents and damage to property, insurance against the potentially devastating costs of long-term care is relatively rare. Nationally, only about four to five percent of the elderly have some kind of private long-term care insurance.[11]

4. What Are Some Characteristics of the Long-Term Care Insurance Market?

The National Long-Term Care Insurance Market

By the end of 1993, the number of long-term care insurance policies that had been purchased nationally had grown to over 3.4 million across 118 insurers. This represents an average annual increase of over 27 percent since 1987. Other characteristics of the national long-term care insurance market include the following:[12]

- Most plans now offer both nursing home and home health care coverage, reflecting the substantial improvement in the quality of long-term care insurance policies over the past decade.
- Most companies sold long-term care insurance policies through the individual or group association markets, which represents almost 80 percent of all long-term care insurance policies sold. The remaining 20 percent is represented by employer-sponsored products (12%) or as part of life insurance policies (8%).

- 968 employers offered a long-term care plan to their employees, up from just two in 1987. These are employer-*sponsored* plans. Virtually no employer is actually contributing toward the cost of long-term care insurance for their employees.

Minnesota's Long-Term Care Insurance Market Vs. Other States'

There is little state-specific data regarding long-term care insurance. However, several surveys do reveal the following comparisons:[13]

- Minnesota, New York, Alaska and Nevada have the lowest market penetration rates in the nation for long-term care insurance policies sold elderly. For each of these four states, the market penetration rate was one percent, compared to a high of 26 percent and a national average of about five percent. (The market penetration rate is measured by dividing the number of policies sold in a state by the state elderly (age 65+) population.)

- Minnesota's neighboring states of North Dakota (26%), South Dakota (13%) and Iowa (13%) have the highest market penetration rates in the country.

5. Who Buys Long-Term Care Insurance?

Recent surveys of the national long-term care insurance market provided the following socio-demographic profile of the population actually buying long-term care insurance.[14]

- In 1994, almost 50 percent of all long-term care policies were purchased by individuals over age 70.

- The majority (62%) of long-term care insurance purchasers were persons with annual incomes of more than $25,000, and 59 percent had *liquid* assets valued at $50,000 or more.

6. What Kinds of Long-Term Care Insurance Do People Buy?

Recent surveys of the national long-term care insurance market show that the policies sold had the following characteristics:

- The proportion of policies covering home health care increased from about one-third in 1990 to two-thirds in 1994.

- Between 1990 and 1994, the average daily nursing home benefit increased 18 percent, from $72 to $85. The daily home health benefit doubled from $36 to $72.

- In 1994, the average annual premium for all long-term care insurance policies was about $1,500.

7. Why Should the State Be Concerned About Long-Term Care Insurance?

The majority of long-term care costs are publicly financed. In fiscal year 1995, Minnesota's Medical Assistance (MA) program paid for two-thirds (67%) of all nursing home days. In the same fiscal year, MA expenditures for *elderly* long-term care accounted for over one-third (35%) of the MA program's $2.6 billion annual budget.[15] Demographic trends, specifically the aging of the state's population, will put increasing pressure on MA funding for nursing home and home- and community-based long-term care. This spending is one of the most powerful drivers of government spending, and is partly responsible for the sizable structural deficits predicted in future state budgets.[16]

Given the large and growing amounts of long-term care costs that are publicly financed, the state has a clear interest in options that could reduce the reliance on public long-term care spending in Minnesota. While long-term care insurance as an option for financing long-term care costs has had minimal effect both locally and nationally, its impact could be more significant if greater numbers of people purchased coverage.

Minnesota has had only limited public discussion of the possible role of long-term care insurance in financing long-term care.[17] Private long-term insurance will certainly never be a feasible alternative for all segments of society. There will, for example, always be a "residual Medicaid population"[18] and, as mentioned previously, long-term care insurance may not be a realistic option for the non-elderly with existing disabilities and chronic conditions. But as an option for the working and retirement-age middle class, private long-term care insurance may well play a significant role in reducing future reliance on publicly funded long-term care programs.

8. What Roles Can States Play Concerning Long-Term Care Insurance?

There are at least three areas in which states do or can play a role with respect to long-term care insurance: as a regulator of the long-term care market, as a developer of a tax policy to encourage the purchase of long-term care coverage, and as an employer.

a. State as a Market Regulator

The state's role as a regulator is to provide information and consumer protection. In Minnesota, the Department of Commerce performs this function. States must balance consumer protection with consumer choice in the long-term care insurance market. Consumer choice is often defined as the availability of a number of policy and coverage options. Yet one of the principle concerns regulators have expressed is that long-term

care insurance often provides inadequate protection against the costs of long-term care; by the time an individual needs benefits, their policy has either lapsed or their policy's benefits have been so eroded by inflation that they no longer cover costs.

Mandating higher standards -- for example, requiring inflation protection or liberal nonforfeiture provisions (see page 10) -- inevitably drives up the cost of policies. This, in turn, limits consumer choice and reduces the number of people who can afford policies. Minnesota has among the highest statutory long-term care insurance standards in the country in terms of mandating minimum benefits. This may be one reason why Minnesota's long-term care insurance market penetration rate is so low.[19]

b. State as Developer of Tax Policy

A recent industry survey found that nearly half of all *non*-purchasers of long-term care insurance would have been more interested in purchasing a policy if they could deduct its premiums from their income tax.[20] Given Minnesota's relatively small marginal tax rate relative to the federal rate, it is unlikely a policy change by the state alone would have much impact.

Tax policy in this area is mostly a federal issue. This concern has been somewhat addressed in the recently enacted Health Insurance Portability and Accountability Act of 1996 (more commonly know as "Kassebaum-Kennedy Bill"). This legislation not only makes long-term care insurance premiums deductible for taxpayers who itemize their deductions, but also provides that certain long-term care (out-of-pocket) expenses will also be deductible. While the long-term care insurance industry has long campaigned for such tax treatment, there remains some doubt whether these changes will have more than a minimal impact on the number of people buying coverage.[21]

c. State as an Employer

While long-term care insurance associations argue that the private market has the potential to greatly increase the number of persons purchasing coverage, many question whether that will ever be the case -- especially if the industry continues to focus primarily on the affluent elderly. This approach is unlikely to ever achieve the market penetration necessary to make a significant difference in long-term care financing.

In response to relatively low market penetration rates, several state governments have begun offering long-term care coverage to public employees, retirees, and their dependents. These states include Ohio, Maryland, Nevada, Illinois, Alaska and California. Two examples for which there is a fair amount of information are Alaska and California. They have both experienced a great deal of success and represent two different approaches for offering optional long-term care insurance.

Alaska

In 1987, Alaska began offering optional long-term care insurance to members of its public employees retirement system. These include state employees, non-classified school district employees, and municipal employees, retirees, and their spouses. Altogether, the eligible population is approximately 50,000.

Alaska's program was the first of its kind in the country. It is technically fully insured, but the employer does bear some risk. The cost of the coverage is borne entirely by the participants. Its policies contain a unique provision which pays a different daily benefit rate depending if the care is obtained in state ($125) rather than out of state ($75). Since its inception, enrollment rates have been high, beginning at 20 percent and increasing to a current rate of approximately 30 percent. The plan partly attributes its success to a culture that encourages self-reliance and retirement planning.[22] (See Appendix E for further information.)

California

In 1994, the California Public Employees Retirement System (CalPERS), the State Teachers Retirement System and a number of other public employee groups (more than 2000 in all) joined together to offer long-term care insurance to public sector employees, their spouses, parents, and parents-in-law and retirees. The total eligible population is three to four million, or roughly ten percent of the state's population.

A self-insured program with an extremely flexible benefits package, California's program addressed perhaps the principle barrier to greater market penetration -- affordability. Because the program is self-funded and not-for-profit, and has a large risk pool, CalPERS claims its premiums are about 30 percent lower than comparable private market rates. The program also seeks to educate a segment of the market -- the 30 to 50 year olds -- that generally does not give planning for long-term care much thought.

During the program's initial 18 month open enrollment period (January 1995 through June 1996), CalPERS long-term care insurance program received over 93,600 applications, resulting in over 72,000 policies in force by the end of 1996. Actual enrollment during the first 18 months exceeded program officials' initial projections by a factor of almost three.[23] (See Appendix F for further information.)

III. Assessment

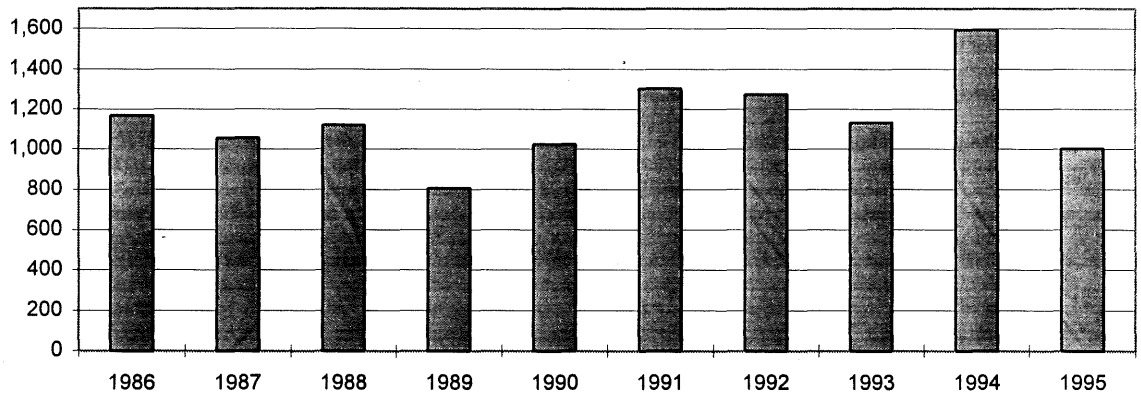
Why a Program For Retiring Employees Would Have Limited Success

The proposal for DOER to consider offering long-term care insurance to *retiring* state employees is an important first step towards encouraging the middle class to take major responsibility for financing their future long-term care needs. However, any program that limits enrollment to retiring state employees is likely to generate very low participation, and thus, have no measurable impact on the state's overall long-term care expenditures for the elderly.[24] Low participation would result because this small eligible population would not have the economic leverage to negotiate the purchase of a group product that significant numbers of retiring state employees would find either affordable or sufficiently comprehensive.

1. Eligible Group Too Small

The number of state employees who retire each year is quite small -- slightly less than two percent of the state's 59,000-person workforce. As shown in Figure 6, the number of Minnesota State Retirement System (MSRS) members who began receiving retirement benefits each year has fluctuated, but has averaged 1,150 over the last 10 years (1986-95). Early retirement legislation has had some effect. The last major incentive package expired in January of 1994. Accordingly, a spike in the number of retirees occurred in that year.

Figure 6/ Number of MSRS Members Who Began Receiving Benefits/ 1986-95



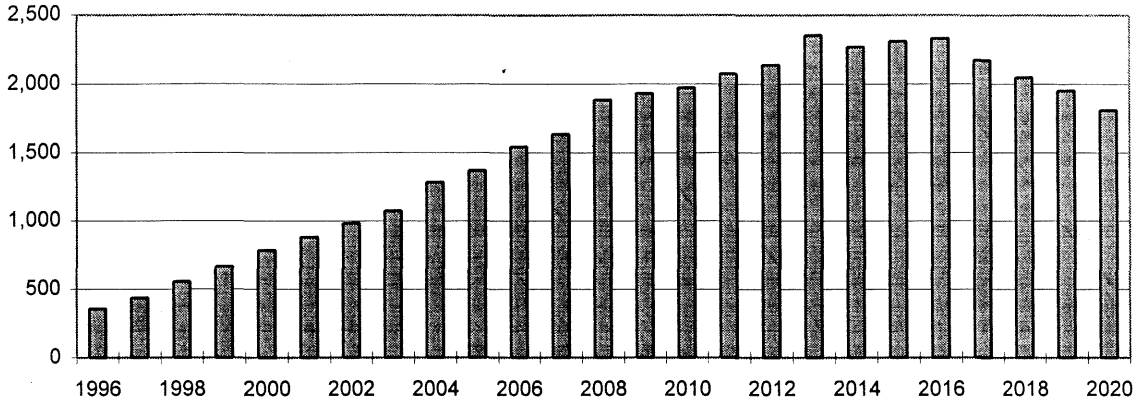
Source: Minnesota State Retirement System

Past experience may help predict how many employees will retire in the future. However, an accurate prediction is difficult to obtain because a number of factors can contribute to employee's decision to retire. One factor, of course, is eligibility. Typically, state employees do not choose to retire until they reach "rule of 90" status -- that is, when their age and years of service equal 90. Figure 7 shows how many of

MSRS's 1995 active members will reach rule of 90 status over the next 25 years. In 1996, the number of eligible employees will be just 359. This number is projected to grow slowly over time as the baby boom reaches retirement age, peaking at 2,356 in the year 2013.

Figure 7/ When Age Plus Service Equals 90/

1995 Active MSRS Members/ 1996-2020



Source: Minnesota State Retirement System, State Demographer

While eligibility is clearly an important factor in determining the number of employees who will retire, it alone cannot predict how many employees will actually retire. Each year many employees who become eligible to retire choose not to. In 1995, 14.4 percent of the executive branch workforce was eligible to retire but had not (see Appendix C).

It is unclear why so many retirement-eligible state employees are continuing to work. Some may be taking advantage of their peak earning years to save additional funds for retirement. Others may be waiting to take advantage of early retirement incentive legislation in which the state continues to pay a portion of their health insurance. (State employees who retire before age 65 typically must pay the full cost of their health insurance until they become eligible for Medicare.)

2. Few Insurers Willing to Underwrite Group

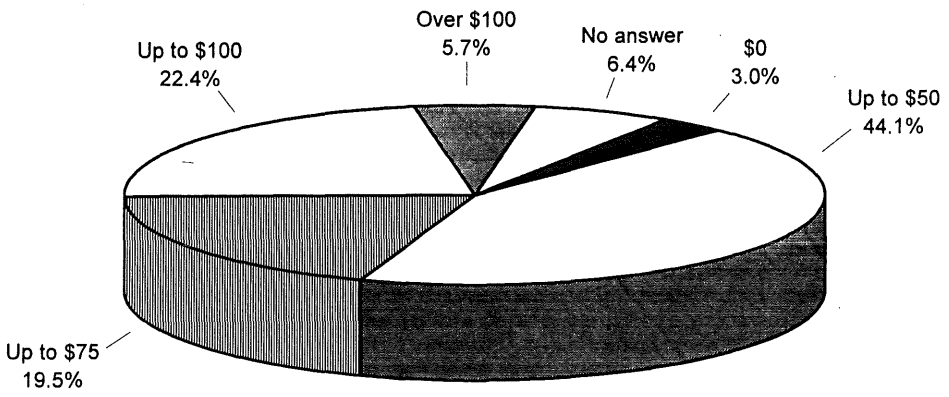
While it is difficult to estimate the number of future retirees, it is clear that the number will remain small. With a small eligible group averaging only about 1,150 over the past ten years, DOER's only viable option would be to attempt to negotiate a group rate below that charged for a fully insured long-term care insurance product on the individual private market. Unfortunately, DOER may have a difficult time finding many insurers willing to underwrite a policy for such a small group. A survey of nine major long-term care insurers doing business in Minnesota showed that the average minimum group size was 2,961. Of the nine insurers, only three would even consider insuring a group of less than 1,000.[25]

3. Eligibles Likely to View Rates as Too High

Assuming the group were able to find an insurer willing to underwrite a group policy for a small eligible population, retiring state employees might still find the rates too high. Group rates do tend to be somewhat lower than those charged in the individual private market, but are comparable. In 1994, the average monthly premium for a basic individual policy without nonforfeiture benefits or inflation protection offered by the leading national sellers was $71 at age 65. When nonforfeiture benefits and lifetime five percent compounded inflation protection were added, the amount climbed to $182 a month.[26]

As shown in Figure 8, a 1996 survey of all insurance-eligible state employees found that, of those employees ages 60 and over, 22.4 percent were willing to pay up to $100 a month for long-term care insurance, while only 5.7 percent were willing to pay over $100 a month. The largest proportion by far (44.1%) was willing to pay only up to $50 a month. These results may reflect a lack of knowledge about long-term care insurance, but they do reinforce the point that affordability is the largest barrier in the selling of long-term care coverage.

Figure 8/ Maximum Amount Employees (Age 60+) Willing to Pay



Source: July, 1996 mail survey of 45,137 insurance-eligible employees. The margin of error is ± 2%. See Appendix D for more information.

4. Administration and Marketing Costs Too High

The unit costs for administering and marketing a long-term care insurance program for retiring state employees only are likely to be quite high. Marketing costs for group long-term care insurance products do tend to be lower than for individual products because marketing is done all at once rather than individually. However, group long-term care insurance policies do not enjoy the marketing advantages associated with group acute care policies. This is because enrollment for long-term care policies is generally much lower than for acute care policies. So, for example, the sponsor must send marketing materials to a large number of people who will never purchase it.[27] These inefficiencies will make the cost of coverage for such a small group relatively expensive.

5. Likely Result: Low Enrollment

Nationally, enrollment in employer-sponsored group long-term care insurance plans has typically been less than ten percent of a company's work force, even when policies can be purchased to include coverage for spouses, parents, and parents-in-law.[28] However, if local long-term care insurance programs are any guide, DOER may find participation in a plan for retiring employees to be much lower than ten percent.

Research into the local market was unable to uncover any long-term care insurance plans comparable to that proposed for DOER. However, some examples are worth noting. Dakota County, for instance, began offering an optional employee-paid group long-term care insurance product to its 1,350 employees, retirees, and their dependents in 1995, and has had a participation rate of just 0.4 percent. Another example is the City of Minneapolis. It also began offering a similar product to its 56,672 employees and retirees in 1995, with a participation rate of just one percent. Finally, there is the Minnesota Education Association (MEA), which began offering long-term care insurance to its 49,000 actives and retirees in 1993. Participation in that program has been somewhat higher, at four percent.

IV. Findings

What Are Some Characteristics of Successful Programs?

If the state's goal is to move forward in search of a successful strategy for addressing its long-term care financing challenges, it should look to other programs for guidance. Successful long-term care insurance programs have taken many forms, but they appear to have the following in common:

- Affordable pricing
- Appropriate and comprehensive coverage
- Sound underwriting
- A trusted sponsor
- An educational approach to marketing
- A program advocate
- Participant input
- Simplicity
- A "call to action"

1. Affordable Pricing

A successful long-term care insurance plan requires that premiums be affordably priced. Many people believe that long-term care insurance costs too much. A 1994 survey by LifePlans, Inc. showed that 57 percent of people said that expense was the most important reason for their *not* buying long-term care insurance.[29] Coverage must therefore be priced in a way that entices younger employees to participate, while still keeping coverage for older members affordable. Premiums will, of course, vary with age. Some programs, such as Alaska's, use five year increments (see Appendix E), while others, such as California's, use yearly increments (see Appendix F).

Affordable long-term care insurance pricing can be obtained when the potential risk pool is large enough to take advantage of economies of scale and market leverage. If the risk pool is large enough, as with CalPERS, the plan may choose to self-insure. This will eliminate the costs normally associated with fully insured products, such as the carrier's profit margins and sales commissions. These savings can in turn be passed on to participants in the form of lower premiums. CalPERS estimates that this approach has resulted in its premiums being 30 percent below the individual private market.

2. Appropriate and Comprehensive Coverage

In addition to being affordable, long-term care insurance coverage must be right for the purchaser. This has not always been the case. The first generation of long-term care products tended to focus on institutionalization, covering only nursing home care following hospital confinement. Options such as inflation protection and nonforfeiture benefits were often not included in many policies.[30] As a result, some policies -- though affordable -- were not the best value. A good long-term care insurance plan should allow participants to choose coverage that best fits their circumstances.

3. Sound Underwriting

Underwriting is one of the primary keys to the long-range success of a long-term care insurance program. Long-term care insurance is a relatively new product, available only since the mid-1980s as an employee benefit. As a result, there is little information, such as claims experience, to guide an underwriter. In many cases, it will be a long time before underwriters know if their actuarial assumptions are correct.[31] It is therefore important for the underwriter to do their best to price the product correctly from the start so that premiums remain stable over time.

4. Trusted Sponsor

In order to be successful, the sponsor of the long-term care insurance program should be an entity that participants feel they can count on to still be around when they start drawing long term care benefits. A 1994 CalPERS market survey showed that 69 percent of retirees and 54 percent of active employees said that CalPERS was the best organization to sponsor long-term care insurance. (In addition, six percent of retirees said "employer", four percent said "insurance company", and 20 percent said "don't know". For active employees, 14 percent said employer, four percent insurance company, and 26 percent said don't know.) For each organization, this sponsor may be different, but it should be determined before the program is set up.

5. Educational Approach to Marketing

A strict "sales" approach to long-term care insurance seems to have limited success. Long-term care and long-term care insurance are complicated and much misunderstood subjects. The public does not agree on the necessity of long-term care insurance the way they do with many other coverages, such as life, health, or casualty insurance. Therefore, a long-term care insurance program should first approach the potential buyer with the intent to educate. Once a person understands the problem of long-term care financing, the product is more likely to sell itself.

The level of participation in a long-term care insurance program will depend heavily on the quality and intensity of its marketing efforts. As previously mentioned, the public is generally not well-informed about long-term care -- either about the probability that they will need such care or the adequacy of existing insurance to pay for it. Unless people understand these facts, they are not likely to want long-term care coverage. In turn, low participation tends to create adverse selection (by attracting people who are at higher risk to use the product) and drives up costs, thus making the program even less attractive.[32] A successful long-term care insurance program must therefore be willing to put a great deal of resources into marketing efforts geared heavily toward education.

6. Program Advocate

As part of an effective communications plan, a long-term care insurance program needs visible and respected members of both labor and management who are willing to champion long-term care insurance. Before education can occur, a climate must be created that encourages people to take the first step and attend educational seminars. People need to feel long-term care insurance is something the organization truly

believes is valuable for many people -- that it's not just another optional benefit that the organization is offering as a favor.

7. Participant Input

The needs and preferences of participants may vary from one organization to another. An "off the shelf" product that works for one employer may not work for another. It is therefore important that the organization get employee input through surveys and focus groups before any long-term care insurance program is formulated.

8. Simplicity

A successful long-term care insurance plan should provide flexibility and choice, while being simple for participants to understand and use. Many plans offer a bewildering number of choices which tend to cause inertia rather than action. A 1994 CalPERS market survey showed that 71 percent of retirees and 68 percent of active employees thought that it was "too confusing to know what policy is right." The sponsor should oversee the participant research and plan design. If the sponsor is trusted and the participants feel that they have been listened to -- and that the sponsor has narrowed the plan choices with their interests in mind -- then they will be more likely to enroll.

9. A "Call to Action"

To encourage people to enroll, a successful long-term care insurance program should have a deadline. A sense of urgency should be created without making people feel that it is a "hard-sell" approach. The amount of time for open enrollment should be limited since some programs' experience has shown that many people will wait until right before the end to enroll no matter how long the period is open.

V. Recommendations

What Should the State Do Next?

Although it appears that an optional long-term care insurance program that includes only retiring state employees would generate limited participation, this proposal has stimulated much discussion among staff from several state agencies concerning the middle class's responsibility for financing their future long-term care needs. While there is no consensus on a single strategy, there is general agreement that the state *may* be able to lower future long-term care expenditures for elderly persons by covering significant numbers of public employees and their families, and that the state should therefore continue to examine options for providing this benefit. Furthermore, there is a general agreement that any plan must be large enough to take advantage of economies of scale that will result in effective, affordable coverage.

The legislative mandate of 1996 Minn. Laws 384, § 8 (Appendix A) requested that DOER consider a program for retiring state employees only. However, the interest this directive has generated has encouraged DOER, in coordination with other key state agencies, to use this legislation as an opportunity to study other strategies for addressing the state's long-term care financing challenges. This study has included a review of other long-term care insurance programs both locally and nationally, a survey of insurance-eligible state employees' attitudes, a review of current long-term care literature, and discussions with various experts.

As a result of this work, DOER recommends that the legislature authorize a more in-depth feasibility study that includes assistance from experts in the field of long-term care benefit design, actuarial science, and market research. The following section examines what issues should be considered in a future study.

VI. Considerations

What Issues Need Further Study?

If the state's goal is to have a successful strategy for addressing its long-term care financing challenges, it should undertake a feasibility study that addresses the following issues:

- Size and the content of the eligible pool
- Interest and attitudes of the eligible pool
- Impact on the state's long-term care expenditures
- Impact on the long-term care market
- Risk assumption
- Administration
- Start-up costs

1. Size and Content of Eligible Pool

If a long-term care insurance program just for retiring state employees is not feasible, then what is? What is the minimal size needed for DOER to deliver an affordable, effective long-term care insurance product? What is the optimum size? Who should be included?

Successful long-term care insurance programs have merged different groups together to create large groups of eligible members. The largest, California Public Retirement System (CalPERS), has 1.7 million eligible employees from over 2,000 different public sector groups, including members of California's Public Employees' Retirement System (PERS), the State Teachers' Retirement System (STRS), and most California public employee retirement systems. When spouses, parents, and parents-in-law are included, the total number swells to about 4 million eligible members. (See page 14 and Appendix F for further information.)

Alaska's plan also covers more than just state employees. It covers 31,000 members of Alaska's Public Employees Retirement System (PERS), the Teachers' Retirement System (TRS), the Judicial Retirement System (JRS), and Elected Public Officers' Retirement System (EPORS). With spouses included, the total is approximately 50,000 eligible persons. (See page 14 and Appendix E for further information.)

Who might be included in Minnesota's plan? Figure 9 shows 1997 estimates of the number of retirees, employees, and dependents from various groups who might be considered for inclusion in a long-term care insurance plan.

Figure 9/ 1997 Estimate of Potential Eligible Groups

Potential Eligible Groups	Actives/ Retirees	Other Eligibles*	Total	Cumulative
Retiring MSRS members	1,150	757	1,907	1,907
Retired MSRS members	18,000	11,880	29,880	31,787
State Group in SEGIP**	40,000	89,600	129,600	161,387
Other Groups in SEGIP***	19,000	42,560	61,560	222,947
School District employees	91,000	203,840	294,840	517,787
County Employees	37,000	82,880	119,880	637,667
Municipal/Township employees	33,000	73,920	106,920	744,587
Special District employees	12,000	26,880	38,880	783,467
Total	**251,150**	**532,317**	**783,467**	
*"Other Eligibles" includes spouses for retired and retiring MSRS members, and spouses, parents, and parents-in-law for all other groups.				
**"State Group" includes employees on the state's central payroll system. The majority are from executive branch state agencies.				
***"Other Groups" includes the University of Minnesota, independent billing units (IBU's), individuals off the payroll (due to layoff, medical leave, maternity leave), individuals continuing their coverage under COBRA, early retirees, disabled former employees, and former legislators and judges who are participating in the State Employees Group Insurance Program.				
Sources: Minnesota State Retirement System, State Demographer, DOER, U.S. Census				

Most successful programs have expanded their eligible population by offering coverage to some dependents or family members. Alaska, for example, offers coverage to spouses only, while CalPERS offers coverage to spouses, parents, and parents-in-law. Other programs have also included grandparents and grandparents-in-law. The reasoning is that people have an interest in seeing not only that their parents' assets are protected, but that their parents have the means to purchase their own long-term care services and not rely solely on their children for assistance.

One option that would expand the eligible population might be to cover retiring *and* retired MSRS members and their spouses. This would result in an eligible group of over 31,000. However, many in this group will be elderly. Since there is a relatively short period of time for their reserves to build, the cost of coverage may be quite expensive.[33] Consequently, their participation would probably still be at an unacceptably low level.

People over age 65 are not the only people who will buy long-term care insurance. Young and middle-aged people will also buy it if it is marketed to them correctly. A 1994 Health Insurance Association of America survey showed that the average age of buyers in an employer-sponsored plan was 42.2 years.[34] A 1994 CalPERS survey showed that the average age for all buyers in their program was 50. The average age for retirees was 67, and the average age for actives was 46. When the Ohio State Teachers' Retirement System (OSTRS) began offering long-term care insurance to their active members, they found that 44 percent of the purchasers were under age 50,

and 86 percent were under age 60. Thus, people will indeed buy long-term care insurance before age 65.[35]

Another option, therefore, would be to cover retiring and retired MSRS members, active state employees in State Employee Group Insurance Program (SEGIP), "other groups" participating in SEGIP, and their spouses, parents, and parents-in-law. This would raise the number of eligible people to nearly 223,000. This would be quadruple the approximately 50,000 eligible people in Alaska's plan, but would still be far short of the four million people eligible under CalPERS.

Given its relatively small population, Minnesota could never expect to achieve the scale of the CalPERS program, but there are ways in which it could increase its eligible population. One option would be to include some of Minnesota's other public sector employee groups, such as those in the school districts, counties, municipalities/ townships, and "special districts". This would bring the eligible group to about 783,000 -- more than tripling it.

Still another option would be to include members of the Buyers Health Care Action Group (BHCAG), to which the state is an associate member. Not counting the state, its number of employees and dependents total 375,840. This would raise the eligible population to over 1.1 million. However, mixing public and private groups may not be feasible and may require much study.

A final option for expanding the eligible population would be to include groups currently covered under or enrolled in publicly-funded health programs. For example, including Qualified Medicare Beneficiaries (QMBs -- Medicare beneficiaries who also qualify for Medical Assistance) would add approximately 50,000 to this group. A possible scenario would be for the state to purchase long-term care insurance for those QMBs who meet program underwriting standards. The economic rationale for this would be that in the long run, it may be less expensive for the state to insure this group rather than pay directly for its long-term care. Obviously, fairly sophisticated economic modeling would be necessary to determine if this is feasible and cost-effective. If it is, then perhaps other groups -- such as segments of the MinnesotaCare population -- could also be included in some kind of subsidization plan.

2. Interest and Attitudes of Eligible Pool

How strong is the demand for long-term care insurance for state employees and others? How much will educational efforts raise the level of interest? Are the results of surveys done elsewhere valid in Minnesota, or are attitudes different here?

A future feasibility study should include some measure of the target population's interest in and attitudes toward long-term care insurance. One approach might be a random mail survey of a representative sample of the target population. Focus groups could be convened beforehand to obtain information for constructing survey questions.

DOER did send a mail survey to 45,137 of its insurance-eligible population in July, 1996. 6.5 percent of the population responded. While the survey showed strong interest in long-term care insurance (see Appendix D), the reliability of the results is probably open to question. The survey was not random, but self-administered. As a result, a great deal of self-selection occurred -- people who were most interested in long-term care insurance were more likely to respond -- so a representative sample was not obtained. Nevertheless, the survey did serve as a valuable educational tool and collected over 700 names of people interested in participating in long-term care insurance focus groups.

3. Impact on State's Long-Term Care Expenditures

What impact might a long-term care insurance program have on state Medical Assistance expenditures for long-term care? How many people would need to enroll to have any effect? Would such savings justify the costs to set up and administer a program?

A future feasibility study should include some assessment of a long-term care insurance program's impact on the state's public program expenditures for long-term care. Some benefits consultants have done estimates based on unrealistically high participation rates. A future study should therefore determine what the state can reasonably expect for participation, and in turn, what effect this might have on public long-term care expenditures.

4. Impact on the Private Sector Long-Term Care Insurance Market

What impact might a long-term care insurance program for public sector employees have on other Minnesotans? Would it act as a catalyst for the private market by raising public interest in and awareness of long-term care insurance?

For many years now, the state's activities in the acute care market have been watched carefully not only by those in the insurance and health care industry, but the general public as well. The state's activities in the long-term care market are likely to have a similar effect. Since any program is likely to be quite large and will involve public employees -- which are always of interest to tax payers -- the media is sure to follow it closely. One impact of this might be to raise the general population's knowledge level concerning long-term care insurance. This, in turn, may increase the number of individual policies purchased. Similarly, the state's activities may spur other private sector employers to offer group long-term care insurance programs.

5. Risk Assumption

If the state were to offer long-term care coverage, who would assume the risk? Should the program be fully insured, self-insured, or some combination of both (i.e. self-insured with heavy reinsurance)? How large must a potential pool be to self-insure? Would the legal and regulatory environment in Minnesota permit it? If not, what legislative changes would be needed? If the state were to self-insure, who would manage the trust? What would the state's liability be?

A major question for a future feasibility study concerns risk assumption. Until recently, most employer-sponsored long-term care insurance plans saw no choice but to transfer risk to an insurance company. However, the success of large, self-insured programs such as CalPERS may have begun to change that. As has been the case with acute care coverage, more employers may begin to explore self-insuring to eliminate profit and commission costs associated with insured products purchased from private long-term care insurance carriers.

6. Sponsorship

If the state were to begin a long-term care insurance program, who would sponsor it?

The choice of who sponsors any long-term care insurance program is very important. A program's success will have a fair amount to do with how much participants trust the sponsor. It must be a sponsor that participants believe will still be around when they begin drawing benefits.

While DOER may seem to be the obvious choice for such a program in Minnesota, it is worth mentioning that California, Alaska, and Ohio's plans are administered through their retirement systems. Minnesota's system is somewhat fragmented compared to other state employee benefit systems. DOER administers insurance coverages, MSRS administers pensions, a private vendor administers deferred compensation, and the credit union provides financial services, such as loans. In other states, some or all of these functions are handled by the same entity. This has the advantages of providing a coordinated approach while having financial clout.

7. Start-Up Costs

How much would it cost the state to set up a long-term care insurance program? Where would the funding come from? Would the potential savings on Medical Assistance offset the start-up costs?

Once a state long-term care insurance program were up and running, the costs to administer it on an on-going basis would be borne by its participants through a portion of the premiums they pay. However, some expenditure will be necessary to set up the program. These costs will, of course, depend on the size and type of program the state chooses, but the program must be willing to make sizable investments in marketing if it wishes to attract a significant number of participants. One possible source for these start-up costs might be in the form of a loan to establish the trust fund.

VII. Conclusion

Perhaps because it lacks the immediacy of acute care issues such as Medicare, long-term care has not received the same amount of attention from policy makers. While almost everyone agrees that the long-term care financing system is strained, the problem has been kept on the backburner -- at least until recently. It is becoming clear that as the baby boom ages and federal and state budgets become increasingly strained by public expenditures for elderly long-term care, states must begin to address this crucial issue. By asking the state of Minnesota to consider offering long-term care insurance as an optional benefit for retiring state employees, the Minnesota legislature has taken an important first step. However, it is not enough. A program limited to retiring state employees will almost certainly generate nominal participation and have virtually no impact on state expenditures for long-term care.

As this report recommends, action must be taken on a larger scale. Significant numbers of public employees, retirees and their families must be persuaded to purchase long-term care coverage if the state hopes to have an impact on public expenditures for elderly long-term care. Education is crucial. Any program adopted by the state must be willing to invest sufficient resources into educating potential purchasers about their likely need for long-term care and its potentially devastating financial effects. But education will not be enough. Affordability remains the greatest barrier to large numbers of the middle class purchasing long-term care insurance. With the recent changes in the tax treatment of long-term care insurance premiums, the private insurance industry will probably step up its argument that the individual market has the potential to greatly increase the number of persons covered by long-term care insurance. However, as long as the cost of individual policies remains high and they are marketed primarily to the affluent elderly, the market penetration of long-term care insurance and its ability to finance long-term care will be severely limited. Even with liberal assumptions about the elderly's willingness to spend a substantial portion of their income -- and even some of their assets -- to purchase policies, only a very small minority is likely to have coverage within the next 25 years, and impact on the level of public expenditures will be minimal. [36]

The successful approach taken by several states to increase the level of long-term care insurance coverage by offering it as an optional benefit to a large segment of their public sector employees represents both an interesting and challenging example for Minnesota. While it is too early to accurately measure the impact of these programs, it appears that they could reduce middle class reliance on public long-term care programs. Such large public employee group programs should not be expected to be short-term panaceas for financing public long-term care programs. Still, obtaining wide-spread coverage among public sector programs may well spur development in the private sector group market, and could become at least part of the solution to the financing of long-term care in the next century.

VIII. Notes

[1] Minn. Stat. § 43A.23

[2] Minn. Stat. § 43A.26

[3] United States General Accounting Office, Long-Term Care Diverse, Growing Population Includes Millions of Americans of All Ages, Washington, D.C., November 1994, pp. 4-5.

[4] Kemper, P. and Murtaugh, C., "Lifetime Use of Nursing Home Care", in New England Journal of Medicine, Vol 324, February 28, 1991, pp. 566-600.

[5] Department of Human Services, Rates Section; Home and Community-Based Services Section.

[6] Wiener, J., Illston, L., Hanley, R., Sharing The Burden: Strategies For Public and Private Long-Term Insurance, Washington, D.C, The Brookings Institution, 1994, p. 50.

[7] United States General Accounting Office, Long-Term Care Current Issues and Future Directions, Washington, D.C, April 1995, pp. 5-6.

[8] Minnesota Department of Commerce, Long-Term Care Insurance: Guide to Comparing Insurance Rates, Spring, 1996.

[9] Health Insurance Association of America, Long-Term Care Insurance in 1994, Washington, D.C., March 1995, p. 17.

[10] Wiener, Illston, and Hanley, p. 11.

[11] Ibid., p. 13.

[12] Health Insurance Association of America, Long-Term Care Insurance in 1994, p. 1.

[13] Ibid., p 14.

[14] Health Insurance Association of America, Who Buys Long-Term Care Insurance? 1994-1995 Profiles and Innovations in a Dynamic Market, Washington, D.C., 1995, pp. 15-17.

[15] Minnesota Department of Human Services, Reports and Forecasts Division, November 1995 Forecasts.

[16] See Minnesota Planning, Within Our Means, St. Paul, Minn., Minnesota Planning, January 1995; and Brandl, J., and Weber, V., An Agenda for Reform Competition, Community, and Concentration, November 1995.

[17] The 1993 Legislature directed the Interagency Long-Term Care Planning Committee (INTERCOM) to conduct a study of the feasibility of implementing a long-term insurance partnership in Minnesota (defined as an option to provide easier access to Medicaid (MA) for purchasers of state-approved private long-term care insurance policies; the policy holders would be allowed to keep more of their financial assets than usual and still receive nursing home benefits under MA.) The report resulting from that study concluded that such a partnership, similar to what four other states had adopted in a Robert Wood Johnson Foundation-sponsored pilot project, would likely *increase* Medicaid expenditures over what they would be without the partnership. On the basis of that report, INTERCOM recommended the state delay applying for or implementing such a long-term care insurance partnership pilot program. See Nyman, J. The Feasibility of Implementing a Long-Term Care Insurance Partnership in Minnesota. St. Paul, Minn, Interagency Long-Term Care Planning Committee (INTERCOM). April 1994.

[18] Minnesota Health Care Commission, A Strategic Plan for Integrating Acute and Long-Term Care in Minnesota, Minneapolis, Minn., Minnesota Department of Health. February 1996. p 23.

[19] Newman, D., "Long-Term Care Insurance: Putting a Premium on Peace of Mind in Retirement," in Footnote, Minnesota Society of Certified Public Accountants, July 1995, p. 2.

[20] Health Insurance Institute of America, Who Buys Long-Term Care Insurance?, p. 4.

[21] Commerce Clearinghouse, Pulse, Vol. 4, No. 14. April 14, 1996, p 6.

[22] Telephone interviews with Alaska benefits supervisor Lisa Tourtellot (February 1, 1996 and October 4, 1996), and with Deloitte and Touche official Pat Pehacek (February 2, 1996 and October 9, 1996,).

[23] Telephone interviews with CalPERS Office of Long-Term Care official Dan Schroepfer (May 17, 1996), and United HealthCare Corporation official Joelyn Malone (September 5, 1996 and January 9, 1997).

[24] Wiener, Illston, Hanley, pp. 58-59.

[25] Deloite and Touche, Inc., Everything Your Company Needs to Know About Sponsoring a Long-Term Care Benefit, p. 10.

[26] Health Insurance Association of America, 1994 Long Term Care Market Survey.

[27] Wiener, Illston, and Hanley, p. 62.

[28] *A Little Homework Can Boost Long-Term Care Plan Participation Rates*, in Employee Benefit Plan Review, October 1995, p. 20.

[29] Health Insurance Association of America, Who Buys Long-Term Care Insurance?, p. 31.

[30] Research Institute of America, Inc., Compensation and Benefit Advice, 1996, p. 2.

[31] Health Insurance Association of America, Statement to U.S. Senate Subcommittee on Health, 1987, p. 4.

[32] Gajda, A., Long-Term Care: The Newest Employee Benefit, 1988, p. 380.

[33] Wiener, Illston, and Hanley, p. 14.

[34] Health Insurance Association of America, Long-Term Care Insurance in 1994, p. 10.

[35] Atchley, R., Dorman, M., *Gaining Marketing Insights From the Ohio Long-Term Care Insurance Survey*, Journal of the American Society of CLU & ChFC, September 1994, p. 69.

[36] Commerce Clearinghouse, Pulse, p. 6.

IX. APPENDICES

Appendix A/

1996 Legislation

1996 Legislation

1996 Minn. Laws 384 § 8

Sec. 8. LONG-TERM CARE COVERAGE
The Commissioner of employee relations, with the assistance of the labor-management committee, shall consider an optional long-term care insurance benefit that may be offered to retiring home state employees. The benefit would provide nursing home and/or home care benefits. Premiums for the benefit would be paid for by retiring employees who choose to elect this coverage. The commissioner shall report to the legislature by January 15, 1997.

Appendix B/

Background on DOER's Insurance Program

Background on DOER's Insurance Program

Introduction

In 1996, the State Employee Group Insurance Program (SEGIP) covered 146,822 people, including 39,852 state employees (employees on the state's central payroll system), 19,419 individuals in other groups participating in the program, and 75,561 of their dependents. In addition, the program covered 7,768 retirees age 65+ and their dependents.

The program collected premiums totaling approximately $268 million for all types of coverage in 1996. Total premiums paid by the state as an employer for all types of coverage was approximately $153.6 million in 1996.

Total Enrollment in SEGIP

Figures 1 and 2 show 1996 total enrollment of employees and dependents in SEGIP separated into three groups:

- *State Group* consists of those employees on the state's central payroll system. The majority of these employees are from the executive branch, but the total includes a relatively small number of non-executive branch individuals.

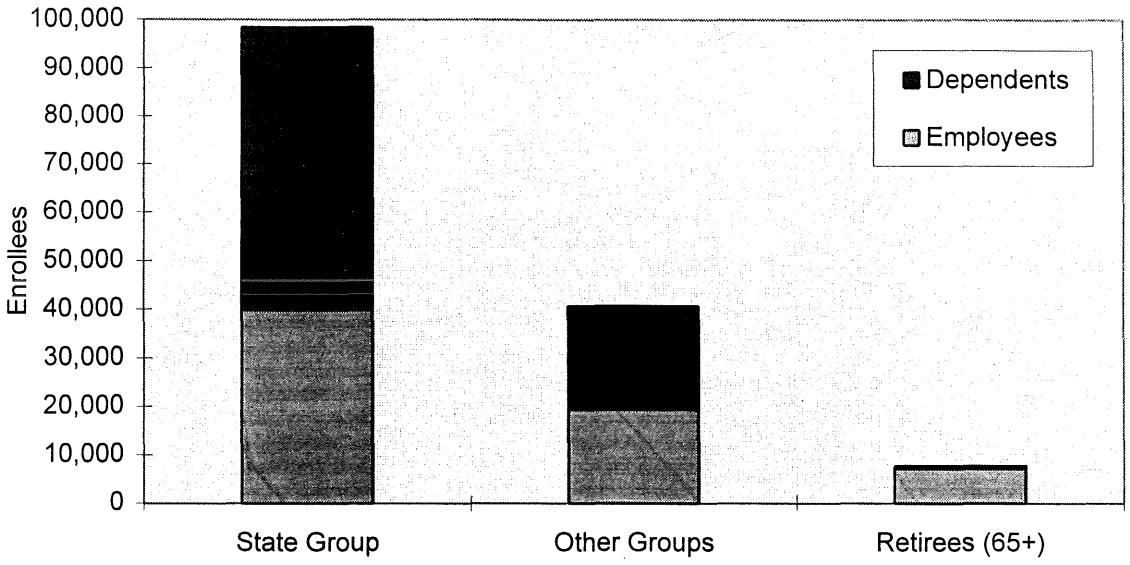
- *Other Groups* includes the University of Minnesota, independent billing units (IBU's), individuals off the payroll (due to layoff, medical leave, maternity leave), individuals continuing their coverage under COBRA, early retirees, disabled former employees, and former legislators and judges.

- *Retirees 65+* includes both retirees and their dependents age 65 or older.

Figure 1/ Total Enrollment/ Employees & Dependents/ 1996

Group	Employees	Dependents	Total
State Group	39,852	53,771	98,442
Other Groups	19,419	21,193	40,612
Retirees (65+)	7,171	597	7,768
Totals	**66,442**	**75,561**	**146,822**

Figure 2/ Total Enrollment/ Employees & Dependents/ 1996



Total Premiums Collected by SEGIP

Figures 3 and 4 show total premiums collected by SEGIP in 1996, separated by source. Figures 5 and 6 show total premiums separated by type of coverage.

- *Premiums paid by the state as an employer* includes the employer contribution toward the cost of employee and dependent coverage for employees on the central payroll, employees off the payroll (for example: due to layoff, or medical leave due to work related injury), and IBU employees.

- *Premiums paid by state employees* includes the employee payments toward the cost of employee and dependent coverage for employees on the central payroll, employees off the payroll (due to layoff, medical leave, or maternity leave), IBU employees, and employees continuing coverage under COBRA.

- *Premiums paid by the University of Minnesota* includes both the combined employer and employee contributions toward the cost of coverage.

- *Premiums paid by direct payers* includes those premiums paid directly to insurance carriers by former legislators and judges, disabled former employees, and early retirees.

- *Premiums paid by retirees 65+* includes the premiums paid for retirees and the their dependents age 65 or older.

Figure 3/ Total Premiums by Source/ 1996

Source of Premiums	Premiums
State as an Employer	$153,588,759
University of Minnesota	$76,203,871
State Employees	$31,780,712
Retirees (65+)	$4,392,378
Direct Payers	$2,804,362
Total Premiums	**$268,770,082**

Figure 4/ Total Premiums by Source/ 1996

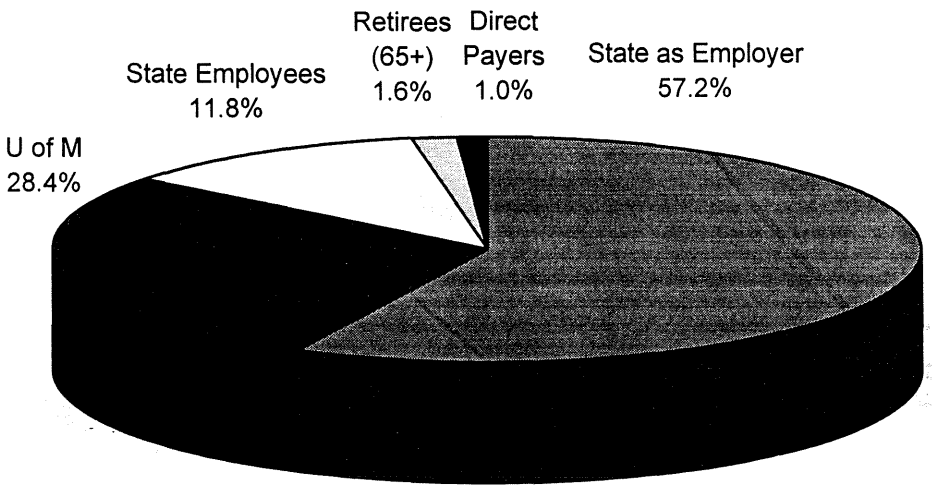
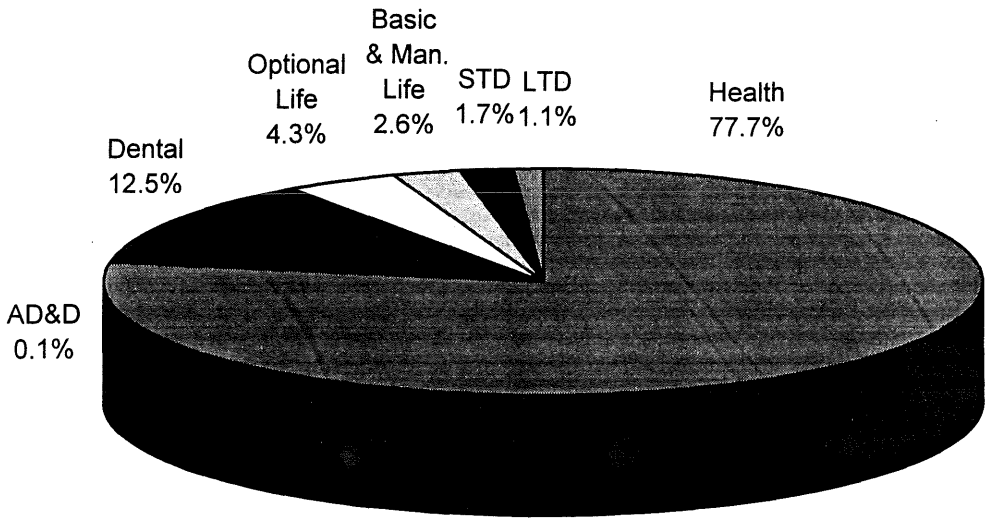


Figure 5/ Total Premiums by Type of Coverage/ 1996

Coverage	Premiums
Health	$208,816,687
Dental	$33,512,145
Optional Life	$11,539,305
Basic & Manager's Life	$6,914,939
Short-Term Disability (STD)	$4,695,379
*Long-Term Disability (LTD)**	$3,082,202
Accidental Death and Dismemberment (AD&D)	$209,425
Total	**$268,770,082**

*Includes Income Protection Program (IPP)

Figure 6/ Total Premiums by Type of Coverage/ 1996



Appendix C/

Executive Branch Workforce, Retirement Eligibility by Bargaining Unit

Executive Branch Workforce
Retirement Eligibility by Bargaining Unit

Bargaining Unit No.	Bargaining Unit Name	Total # Employees In 4/18/95	# Eligible To Retire In 6/30/95	Newly Eligible To Retire from 7/1/95 to 6/30/97	Newly Eligible To Retire from 7/1/97 to 6/30/99
201	Law Enforcement	693	144	47	48
202	Craft-Maintenance-Labor	2519	497	189	185
203	Service	2220	344	131	117
204	Health Care Non-Professional	3008	313	116	130
205	Health Care Professional	851	153	58	71
206	Office-Clerical	6577	884	303	320
207	Technical	2828	418	166	147
208	Correction Counselor	1574	93	62	91
209	State University Academic	2873	668	243	227
210	Community College Academic	2120	395	178	188
211	State University Administration	425	38	21	22
212	Professional Engineering	778	220	47	39
213	Health Treat Prof	65	17	7	4
214	General Prof	8164	814	381	475
215	Professional Resid. Instructor	226	35	16	26
216	Supervisory	2666	469	222	230
217	Confidential	851	121	43	57
218	Excl-Work Time	2359	233	147	139
219	Severed	166	10	11	12
220	Managerial	1500	291	130	181
221	Excl-All Other	584	52	26	30
	Total	**43047**	**6209**	**2542**	**2739**

Based on employees active as of April, 1995.
Projected age and service of employees as of 6-30-95, 6-30-97, and 6-30-99.
Number of employees who will meet the age and service requirement for retirement, with full benefits, by bargaining unit.

Appendix D/

Results From Survey of Insurance-Eligible State Employees

Results From Survey of Insurance-Eligible State Employees

Facts about the survey

- Results derived from a survey mailed to 45,137 insurance-eligible state employees as an insert to an employee benefit newsletter, Your Health Your Choice during July, 1996.
- Surveys were returned by 2,952 employees, representing a response rate of 6.5%.
- Roughly 25% of the respondents (over 700 people) expressed interest in being in a focus group in the future.
- The margin of error was ± 2%.

Findings

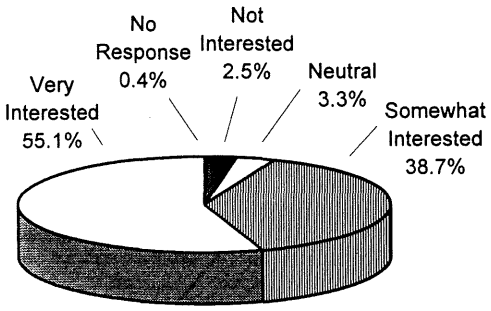
- Most respondents (93.8%) were either very interested or somewhat interested in purchasing LTC coverage for themselves.
- A somewhat smaller portion of respondents (76.4%) was also very interested or somewhat interested in purchasing LTC coverage for family members.
- Age and income were important factors in determining employees' interest in LTC coverage. That is, older, better-compensated employees were more interested than younger, lower-compensated employees.
- The majority (62.0%) of respondents would be willing to pay up to $50 per person per month for LTC coverage.

Concerns

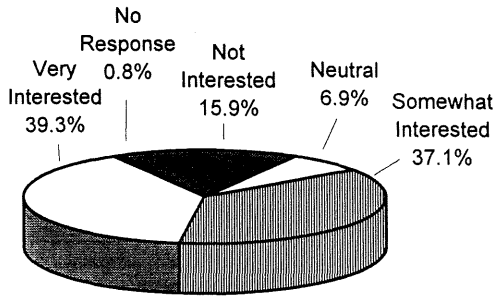
- Results have limited value. It was not a random sample, so a great deal of self-selection occurred -- people most interested in product responded. As a result, the sample was not representative of the population. This is evidenced by the median age and income of sample being higher than that for the whole population.
- Unclear if results from 45,137 employees can be generalized to entire target population of approximately 146,822 spouses/dependents, parents. Not sure if the group surveyed (insurance-eligible employees) would play key role in making decisions to purchase coverage for their spouses, parents, etc.

Question by Question Results from DOER's Long-Term Care Survey

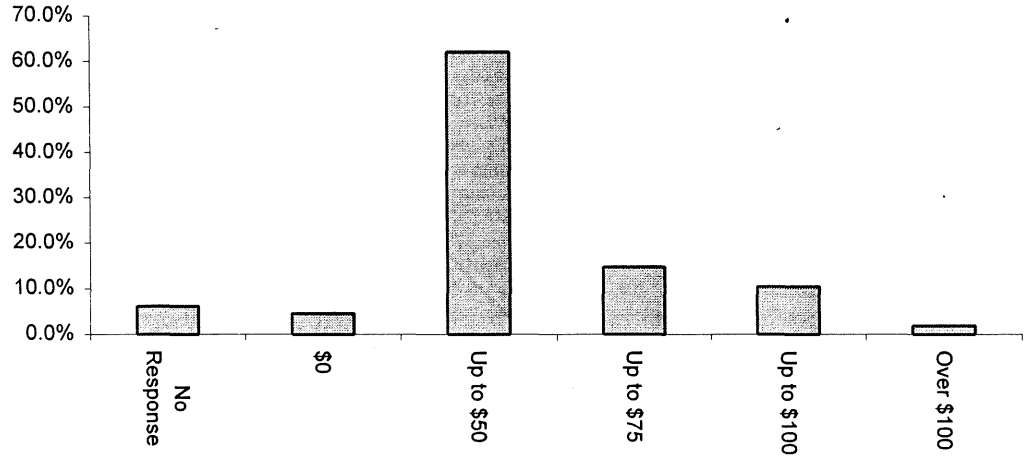
1. "If the State Of Minnesota offered group long term care insurance (as described on the previous page) as an optional benefit, what would be your interest in purchasing it for yourself?"



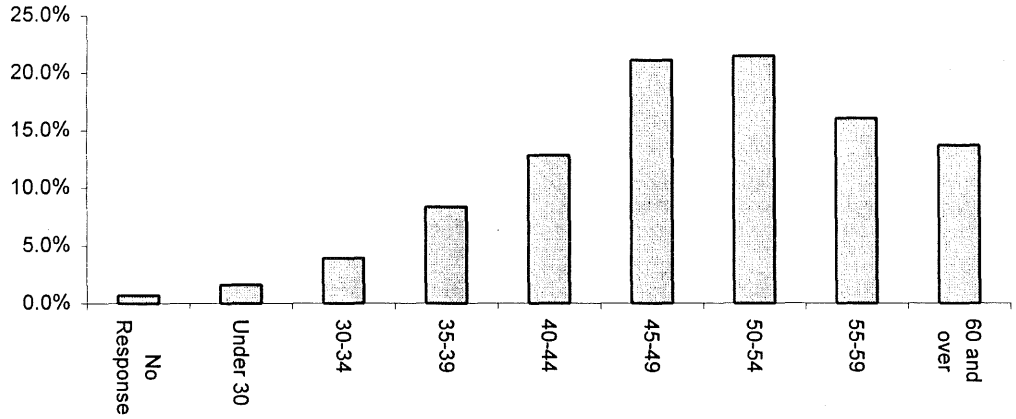
2. "What would be your interest in purchasing long term care coverage for other family members (spouse or parents)?"



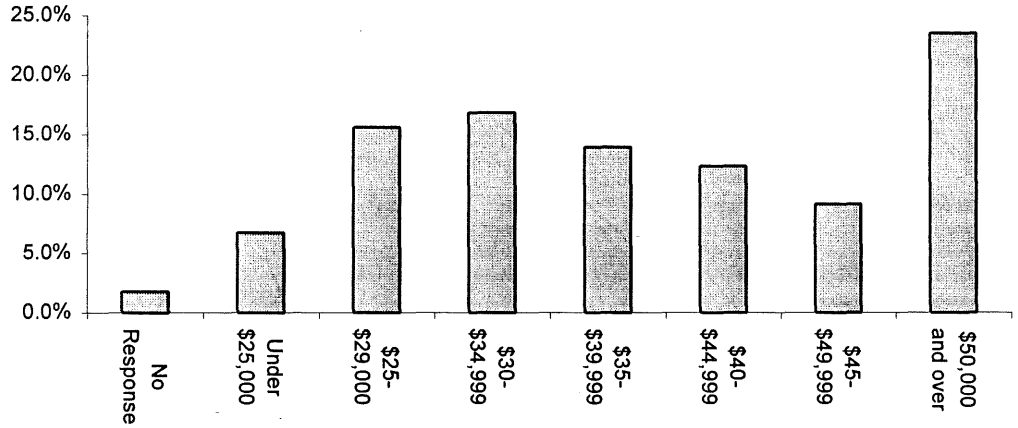
3. "What is the maximum monthly amount you would be willing to pay per person (in today's dollars) for group long term care insurance (individual policy) through the state?"



4. *"What is your age?"*



5. *"What is your annual income?"*



Appendix E/

Information on Alaska's Long-Term Care Insurance Program

LONG TERM CARE PLAN HIGHLIGHTS

- Requires a deductible period of 90 days of covered long term care before benefits begin.
- Pays for covered expenses after the deductible period, up to a lifetime maximum benefit of $200,000.
- Pays a maximum daily benefit for a nursing care facility of $125 within Alaska and $75 outside Alaska after the deductible period.
- Pays a maximum daily benefit for a home convalescent care facility of $75 within Alaska and $40 outside Alaska, after the deductible period, up to a lifetime maximum of $50,000.

PREMIUMS	
ENROLL AGE	PREMIUM
under 50	$16.10
50-54	$21.45
55-59	$26.80
60-64	$48.25
65-69	$80.45
70-74	$128.70
75-79	$193.05
80-84	$294.95
85/over	$412.90

COVERED LONG TERM CARE EXPENSES

Benefits are available for covered expenses for conditions that require long term care.

Covered expenses are those expenses incurred for medically necessary care received in connection with a Covered Program of Care when:

- initial certification by the facility or individual responsible for the supervision of nursing or other services and the attending physician confirm the need for services as prescribed and specified as appropriate in the Covered Program of Care; and
- recertification requests confirm the ongoing need for services as prescribed and specified in the Covered Program of Care.

Long-term care benefits are available for medically necessary services and supplies which, as determined by the long term

Appendix F/

Information on California's Long-Term Care Insurance Program

PERS LONG-TERM CARE PROGRAM

WHAT?
An innovative long-term care program, more comprehensive and affordable than anything available today. The nation's first self-funded long-term care plan offered on a not-for-profit basis.

BY WHOM?
Offered by PERS (California Public Employees' Retirement System). Endorsed by STRS (California State Teachers' Retirement System).

WHO CAN APPLY?
Active and retired members of PERS, STRS and California Counties (excluding San Francisco and San Luis Obispo), their spouses, parents and parents-in-law. The program is also available to active and retired members of some of the state's other public retirement systems.

YOU'RE NOT COVERED
Medicare, MediGap and health insurance plans do not cover long-term care for chronic, disabling conditions. (They mostly pay for hospital and doctor care.) They only pay for a few weeks or months of the skilled care you might need after a hospital stay -- not the extended care you would need as a result of a chronic illness or just from old age. Half of all long term care is paid out-of-pocket by individuals needing care. Medi-Cal only pays once you have exhausted your own resources paying for care.

WHAT'S THE RISK?
Chances are, many of us will need some type of long-term care. Six out of ten Americans over age 65 will need some form of long-term care. That care can be expensive. One year in a nursing home costs over $40,000 and care at home can cost $20,000 or more annually. The average nursing home stay costs over $100,000. And long-term care can be needed by anyone at any age.

THE PERS ADVANTAGE
What's so special about the PERS Long Term Care Plan?
- On average, rates are 30% less than comparable plans offered by insurance carriers.
- Comprehensive, flexible coverage. You choose the care and providers you prefer.
- Expert Care Advisors help you locate and select appropriate services, if you want.
- Offered by PERS on a not-for-profit basis. PERS has a 64 year history of financial stability and commitment to meeting its members' retirement needs.

JOIN THE MORE THAN 40,000 MEMBERS AND THEIR FAMILIES who, in just the first 6 months of this new offering, have already applied for this important financial protection against the high cost of long-term care. Enrollment ends June 30, 1996.

ENROLLING
Call **1-800-338-2244** for an enrollment kit today. The kit includes detailed information about the program, plan options and rates, and applications for you and your spouse.

THE PERS LONG-TERM CARE PROGRAM PLANS AT A GLANCE

You choose the type and amount of coverage that best meets your needs. These plan choices were designed based on extensive research to understand members' needs and preferences. We listened to what thousands of public employees, retirees and schoolteachers had to say about long-term care.

	COMPREHENSIVE PLAN	NURSING HOME/ ASSISTED LIVING FACILITY PLAN	PARTNERSHIP PLAN*
COVERAGE TYPE	Home, community, nursing home and assisted living facility	Care in a nursing home or assisted living facility	Home, community, nursing home and an assisted living facility.
COVERAGE AMOUNT	$131,400 or Lifetime	$131,400 or Lifetime	$36,500 or $73,000
INFLATION PROTECTION	Built-in automatic 5% annual increases with level premiums OR optional periodic increases (when you increase your coverage, your premiums will go up)	Same as Comprehensive	Built-in automatic 5% annual increases with level premiums.
BENEFIT	$120/day Nursing Home $60/day Assisted Living $1,800/month Home Care	$120/day Nursing Home $60/day Assisted Living	$100/day Nursing Home $50/day Assisted Living $1,500/month Home Care
DEDUCTIBLE	90 days once per lifetime	90 days once per lifetime	30 days once per lifetime
PORTABLE	Coverage continues if you change jobs or move out of state	Coverage continues if you change jobs or move out of state	Coverage continues if you change jobs or move out of state. Medi-Cal "spend-down" protection only applies in California.
RATES	Based on your age when you enroll. Designed to remain level over your lifetime. Do not increase simply because of age or illness.		
GUARANTEED RENEWABLE	Your coverage can never be cancelled as long as you continue paying your premiums when they are due.		

*** Partnership Plan Only: California residents only may apply. Provides Medi-Cal "Spend-down" Protection.**

Your Age at Application	PERS Comprehensive Plan				PERS Nursing Home/Assisted Living Facility Plan				PERS Partnership Plan (only available to California residents)	
	LIFETIME		$131,400		LIFETIME		$131,400		$36,500	$73,000
	Without inflation protection	With inflation protection	Without inflation protection	With inflation protection	Without inflation protection	With inflation protection	Without inflation protection	With inflation protection	Automatically includes inflation protection	
30	$14	$30	$12	$25	$11	$22	$10	$18	$20	$26
31	14	31	12	26	12	23	11	19	21	27
32	14	32	13	27	12	23	11	19	21	28
33	15	34	13	28	12	24	11	20	22	28
34	15	35	13	29	12	25	11	21	23	29
35	16	37	14	30	13	26	11	21	23	30
36	16	38	14	31	13	27	11	22	24	31
37	17	40	14	32	13	28	12	23	24	32
38	18	42	15	34	14	29	12	24	25	33
39	18	44	15	35	14	30	12	25	26	34
40	19	46	16	37	14	32	13	26	27	35
41	20	48	17	39	15	33	13	27	27	37
42	21	51	18	41	16	35	13	28	28	38
43	23	53	18	42	16	36	14	29	29	40
44	24	56	19	44	17	38	14	30	30	41
45	25	58	20	47	18	40	15	32	31	43
46	26	61	21	49	18	41	15	33	32	44
47	27	64	22	51	19	43	16	34	33	46
48	29	67	23	53	20	45	17	36	34	48
49	30	70	24	56	21	47	17	37	36	49
50	32	74	25	59	22	49	18	39	37	51
51	34	77	27	62	23	52	19	41	38	54
52	36	82	28	65	24	54	20	43	40	56
53	38	86	30	68	25	57	21	45	41	58
54	41	91	32	72	27	60	22	47	43	61
55	43	96	34	76	29	63	23	50	45	64
56	47	102	36	80	30	67	25	52	47	67
57	51	108	39	85	32	70	26	55	49	70
58	55	115	42	90	35	74	28	58	51	74
59	59	122	45	95	37	78	30	61	53	77
60	64	130	49	100	40	82	32	65	56	81
61	70	138	52	106	43	87	34	68	58	85
62	76	147	56	112	46	92	37	72	61	90
63	82	156	61	119	49	97	39	76	64	95
64	89	166	66	126	53	102	42	81	67	99
65	97	177	72	134	57	109	46	86	71	106
66	106	189	78	143	62	115	50	91	75	112
67	116	202	85	152	67	122	54	97	79	118
68	127	216	92	162	73	129	58	103	83	125
69	139	232	101	172	79	137	63	109	88	133
70	152	248	110	184	85	146	68	116	93	141
71	167	266	120	196	93	155	74	123	99	150
72	183	285	131	210	100	165	80	131	105	159
73	201	307	143	224	109	175	87	139	111	170
74	220	329	156	240	119	186	95	149	119	181
75	242	354	171	257	129	198	103	158	126	193
76	265	380	187	275	140	211	112	169	134	206
77	289	408	203	294	151	224	121	180	143	220
78	316	437	222	314	164	238	132	191	152	234
79	344	467	241	335	177	253	142	203	161	250
80	374	499	261	357	191	267	154	215	171	266
81	403	529	282	379	205	282	165	228	181	282
82	433	560	304	403	219	298	177	240	192	299
83	465	592	328	426	235	313	190	253	203	316
84	497	623	351	450	250	329	203	266	213	334
85	529	655	376	474	266	344	216	279	224	351
86	562	686	400	497	281	359	229	292	235	368
87	594	715	423	520	296	373	242	304	245	385
88	625	742	447	540	311	386	254	315	255	400
89	654	768	468	560	325	398	265	325	263	415
90	683	792	489	577	338	409	276	334	272	428
91	710	814	509	594	351	420	287	342	279	439
92	738	835	529	609	363	429	297	350	287	451
93	764	856	548	624	375	439	307	358	294	462
94	790	876	566	639	388	448	317	366	301	473
95	816	895	585	653	400	457	327	373	307	483
96	842	913	603	666	411	466	336	381	314	493
97	867	931	621	680	423	475	346	388	320	503
98	892	948	639	692	435	483	356	395	327	512
99	916	965	657	704	447	492	365	402	333	522
100	940	980	674	715	459	500	375	408	339	530