

BRANCHES



SECURE AGING: THE NEW SOCIETY

We are enjoying an era of medical breakthroughs. While it is true that each successive generation is expected to live longer than the preceding one, with cures for Alzheimer's disease and many cancers and the regeneration of organs and tissues all on the horizon, life expectancy could explode.

Post retirement years will represent over one third of the life of someone who reaches 105 years. By 2015, approximately 50 million people in the US will be over 60 – one in six. Scientists refer now to an upcoming demographic inversion. By 2010, technology breakthroughs could extend life by 20 years or more.

Consider the benefits of this new social order. Our seniors are valuable resources for our communities, supporting our cultural and recreational assets, contributing their talents as volunteers, and building our local economy. Innovative medical care, new health services and customized residential options can maintain vitality and generativity indefinitely for many.

But, we haven't resolved how to finance this future. Low and middle income families lack sufficient financing mechanisms for medical, rehabilitative and long term care services. Many believe, inaccurately,

that Medicare and Medicaid will cover most health services and medical care.

Not so. One stroke episode could cost a family \$8,000 out of pocket, after Medicare coverage! And the solvency of these funds is precarious. The current social insurance funds were established in an era when medical interventions were narrower, fewer people living less long were covered, and fewer rehabilitative services were available. We are not prepared to pay for the exploding population of seniors and new advances — artificial limbs and organs, transplants, and pharmaceuticals.

A new reimbursement solution — blending private and public sources of funds — could cover service needs of uncertain duration, intensity and complexity. Some viable remedies are worthy of advancement. The bundling of private and public funding options could prevent bankruptcy of families and governments.

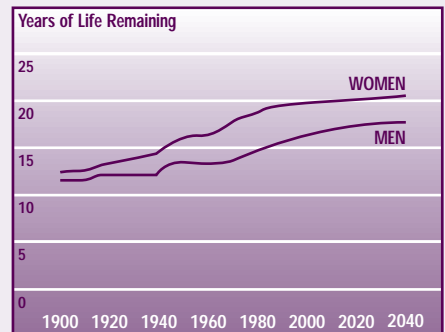
However, every year that we procrastinate as a society robs us of important insurance protections. The younger people are when they start saving, the less they pay, the greater the pool, and the more services we can cover.

"I am hopeful that science, technology and rehabilitative breakthroughs will equip me to walk through Schenley Park when I am 105. The question remains, will I be able to afford them?"

Karen Wolk Feinstein

INCREASING LIFE EXPECTANCY

Life expectancy at age 65 has increased throughout the 20th Century in the United States



Source: Economic Report of the President, February 1999.

THE CRISIS AHEAD: LONG TERM CARE EXPENDITURES

In 1997:

- a single year in a nursing home cost an average of \$46,000
- nursing home and home health care expenditures combined totaled \$115 billion

Projections:

- **2000** - total \$123 billion - \$86 billion on nursing home care \$37 billion on home-based care
- **2020** - predicted to total \$207 billion
- **2040** - expected to skyrocket to \$346 billion



EXPANDING THE CURRENT LONG TERM CARE INSURANCE MARKET

STEPS TO CREATE A PUBLIC/PRIVATE LTC INSURANCE SYSTEM FOR ALL:

Eric B. Schnurer, President of Public Works, a public policy analysis and consulting firm in West Chester, PA suggests the following:

- Require individuals to purchase LTC insurance or spend down assets before accessing public dollars.
- Require those who do not purchase insurance to pay their out-of-pocket costs. Penalize those who “game the system.”
- Support prevention and research to lower costs of health and long term care.
- Offer public education funded by the government on LTC costs, risks, options.
- Allow payroll deductions for long term care insurance.
- Offer an optional government LTC insurance benefit as a competitive spur to private plans.
- Create a tax policy that incentivizes and assists middle income families to purchase LTC.
- Subsidize the lowest income individuals with public funds.

One might imagine that every Baby Boomer from Maine to Malibu is rushing out to buy some kind of long term care insurance plan. One would be mistaken.

Today’s average long term care insurance consumer is a 69-year old married woman making less than \$35,000 a year but with assets of more than \$50,000. Some 80 percent of consumers buy dual coverage policies, entitling them to both nursing home and home health care, and the average duration of coverage is somewhere between three and five years. As for why they buy it, the stated reasons range from:

- avoiding dependence on others (25 percent)
- guaranteeing the affordability of and access to services (23 percent)
- protecting standards of living (15 percent).

According to recent industry information, there are two target markets for long-term care insurance: middle-to upper-income seniors who are healthy and not immediately eligible for Medicaid (an estimated 25 to 35 percent of all seniors); and younger, middle-income adults who are using long-term care insurance as part of their retirement planning (55 to 70 percent of Americans ages 40 or older).

To get there, however, certain obstacles must be overcome:

- 20 percent of Americans don’t believe insurers’ claims about coverage
- 57 percent say that the available plans are too costly
- 28 percent find the choices too difficult
- 31 percent are simply waiting for better policies
- Some say they don’t know enough about their probability of needing care, while others believe that with Medicare, Medicaid and private insurance, they’re already covered.

So what is the answer? According to industry analyst Marc Cohen, long-term care insurance can and should play an increasingly important role in paying for care. However, he stresses, it is not “a solo solution.”

“We still need a strong Medicaid program,” says Cohen, Vice President, Life-Plans, Inc. “But the way to ensure that is to relieve the pressure on the public expenditure side.”



“\$15,000 invested in long term care insurance between the ages of 35-40 can cover all your long term care needs for the rest of your life — inflation included.”

Jeffrey Merrill
Professor

ANNUAL PREMIUM COSTS FOR LTC INSURANCE

Because rates increase with age, insurance is decidedly more affordable at a younger age...

Purchase Age	Base Policy	With 5% Compounded Inflation Protection
40-50	\$247-364	\$589-802
65	980	1,829
79	3,907	5,592



Source: HIAA, Princeton Conference, Charles Kahn

LEADING THE WAY: PITTSBURGH AS A NATIONAL MODEL OF SUCCESSFUL AND SECURE AGING



Since its inception, the Foundation has directed a large portion of its endowment to putting the Pittsburgh area on the frontier of services to seniors. The intent is to create a community that realizes the assets presented by healthy and engaged seniors, and honors its obligations to provide good care. Refusing to recognize the effects of aging as irreversible, or acknowledge aging as a condition of dependency and frailty, our grant making has explored:

- **Research to prolong vitality and prevent disability:**
Falls prevention, nutrition, wound prevention and healing, treatments for depression, reducing the co-morbidity of hospitalization; new pharmaceuticals, vaccines, exercise and assistive and informational technology.
- **Discoveries that are marketable—taking research into development:**
Innovative housing, pharmaceuticals, assistive technologies, senior learning and engagement strategies, communications vehicles.
- **Financing that makes everything else possible:**
Expansion of public and private insurance options extending coverage for more people, for more services, for more options for home and community based care; private and public funding partnerships for services demonstrations, research and development.

We have used our standard grant format, Program Related Investments, internal staff-directed research, outside consultants, foundation and public funder partnerships, communication and public relations strategies to build the region's capacity and by seeding the Pittsburgh area's emerging strengths:

- medical discovery: tissue engineering, robotics and artificial organ and blood development
- information technology: home monitoring, telemedicine, consumer education, delivery system improvements, outcomes measurement
- senior engagement: regional Elderhostel demonstration
- residential options: Alzheimer's personal care, PACE models
- clinical trials: herbal medicines, vaccines, breast MRIs
- genetic counseling

A Guide for Families

The Medicare Rights Center in collaboration with the Henry J. Kaiser Family Foundation, recently published a guide designed to help individuals and their parents sort through basic issues about Medicare and health coverage. The 40 page booklet is a valuable tool, containing information about insurance options and long term care planning as well as talking points and tips on how to engage in conversations about aging. This publication is available through their website at www.kff.org or by calling 1-800-656-4533 and requesting publication 1522.

Selected Resources & Contacts

State:

Pennsylvania Department of Aging
(717) 783-3126

State Health Insurance Assistance Program
(800) 783-7067

Long Term Care Ombudsmen
(717) 783-7247

National:

Health Care Financing Administration
www.hcfa.gov
(202) 690-7063

Health Insurance Association of America
(202) 824-1600

Institute of Certified Financial Planners
(800) 782-7526

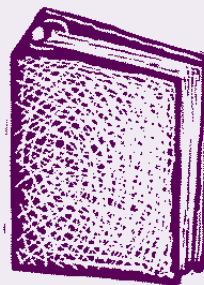
American Association of Retired Persons
(800) 424-3410

Center for Long Term Care Financing
(877) 557-3627
www.centerltc.com

Life-Plans, Inc., Marc Cohen
(781) 893-7600

Public Works
(610) 296-9443

PricewaterhouseCoopers
HealthCast 2010
Smaller World, Bigger Expectations
(800) 211-5131



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A FIRST STEP:

AWAKENING TO THE CRISIS

Most people underestimate the costs of medical and long term care. Only a medical crisis alerts families to the fact that the majority of the costs of aging are borne by the individual rather than the government. While many people believe that Medicare will cover the costs of acute and chronic care, the reality is far different. In fact, Medicare covers only a fraction of those costs, primarily some acute medical care and care required immediately after a hospitalization. And while Medicaid covers other long term costs, it does so predominantly for nursing home care and is available only to those seniors who are already very low income or have become so by “spending down” their assets, typically to only \$2,400.



Many essential services—particularly home-based following a stroke, a serious illness or surgery—exceed families’ resources. Many people do not anticipate the financial demands of medical crises. We can help individuals and governments share responsibility for planning a future in which seniors can remain independent, both physically and financially, for as long as possible. “Default” options for low and moderate income individuals include:

- Impoverishment to qualify for state-funded nursing home or community waiver programs;
- Dependency on children for care or financing;
- Doing without needed services and supports.



The Default Option: Family Caregiving

Traditionally, as people aged, they faced one of two basic options: stay in their own homes with care provided by family or move into a nursing home. But dramatic social shifts have occurred, including fewer seniors now living near family and an increasing number of women in the workforce.

There are an estimated seven to twenty-seven million family caregivers. They strain their own financial, physical and emotional health in the care of their relatives. In over twenty percent of families recently studied, a family member either had to quit work or make a significant change in family arrangements to provide long term care for a relative. Thirty-one percent of families used most or all of their savings to pay for that care that wasn’t covered. In 1996 alone, the combined price tag of replacing workers, absenteeism and workday interruptions totaled some \$11.4 billion. When the costs of caregivers’ own increased health care needs are factored in, the total cost to employers is estimated at over \$29 billion per year.

Paying for Long-Term Care in Pennsylvania

	MEDICARE INSURANCE	MEDICARE SUPPLEMENTAL INSURANCE (BASIC)	MEDICARE SUPPLEMENTAL INSURANCE (HIGHER PREMIUM)	PENNSYLVANIA MEDICAID INSURANCE	PRIVATE LONG TERM CARE INSURANCE *
HOSPITAL CARE	♥	♥	♥	♥	
HOME CARE	♥			♥	♥
HOME & COMMUNITY BASED CARE			♥	♥	♥
ASSISTED LIVING (MEALS, HOUSEKEEPING)			♥	♥	♥
ADULT DAY CARE				♥	♥
PRESCRIPTION DRUG COVERAGE		♥		♥	♥
IN HOME SKILLED NURSING				♥	♥
LONG TERM CARE FACILITY	♥		♥	♥	♥
ASSISTED LIVING/ PERSONAL CARE					♥

♥ Covered
 ♥ Limited coverage with mandated eligibility requirements or fees.

* Most state insurance regulations require that policies meet these standards of coverage.



STEP TWO: SOLUTIONS

Options that Exist but Need to Be Promoted:

■ *Private Long-Term Care Insurance*

This form of insurance is already being marketed to middle income families. It offers comprehensive and flexible coverage. To be effective, however, this approach requires a large pool of consumers purchasing reliable, affordable and wide-ranging insurance products. To achieve that goal, consumers must be educated about their value; confidence must be built up and incentives offered to encourage people to buy products when they are younger. As the pool of customers increases, the cost decreases making it affordable for moderate income individuals increases.

■ *LifeCare (Continuing Care Retirement Communities)*

For a prepaid amount, these insurance/delivery models provide seniors guaranteed residential, assisted living, and LTC services. LifeCare Without Walls is also a promising but less tried model that omits the residential benefits but makes LTC services more affordable for lower middle income consumers.

■ *Reverse Mortgages or Annuities*

In these financing mechanisms, seniors can, for instance, mortgage a home either to increase their income or to pay for long term care services. Upon their death, the house or a portion of the equity is transferred to the financing entity.

Demonstration Projects to be Monitored:

■ *Expanded Social HMOs*

This approach builds on existing voluntary care management models known as Social Health Maintenance Organizations (or "SHMOs") to serve middle income Medicare recipients. Long term care benefits are added to traditional HMO services with the goal of integrating acute and long term care. Barriers include: the need for federal waivers, the current widespread consumer distrust of managed care systems, HMOs' lack of experience in delivering long term care, and their bias towards the medical model of service delivery.

■ *Private Long-Term Care/Medicare Partnerships*

In the early 1990s, four states implemented these partnerships as part of a Robert Wood Johnson Foundation pilot program. They allow individuals to purchase private long-term care insurance and, after those benefits are exhausted, access Medicaid funding for further care needs. At the same time, private assets are protected from Medicaid "spend down" requirements in amounts based on the insurance purchased. However, further use of public/private partnerships has been blocked since 1993 by federal legislation, which

would have to be repealed before any new implementation of this model could occur.

■ *Cash and Counseling*

A recently launched Robert Wood Johnson Foundation pilot project allows eligible Medicaid recipients in four states to choose between receiving traditional agency-delivered services or an equivalent cash grant. Funds—within each state's guidelines—can be used to tailor services to individually determined needs for care. Participants not only gain greater flexibility in meeting caregiving needs by being able to arrange for their own caregivers, but will be able to utilize funds for modifications to their home environment.

Options Under Discussion:

■ *Retirement Benefit Options: Pensions and IRAs*

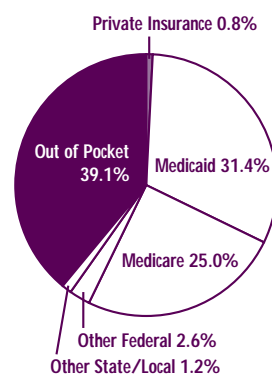
Existing pension plans could be expanded to include long term care coverage. Such an approach might take a number of forms, among them the creation of pension pay-out options to cover the costs of insurance premiums, and the establishment of long term care IRA accounts that can be accessed to pay either for direct coverage or insurance premiums.

■ *Voluntary Public Long Term Care Insurance*

Under this model, seniors would be offered the chance to buy long-term care insurance administered by Medicare at the same time they enter the Medicare program. Such insurance would protect middle-income seniors, and could be less expensive than currently available private policies because of lower administrative and marketing costs and the absence of a profit requirements. This method also might include a level of asset protection for Medicaid purposes. However, federal legislative changes are required to implement this approach.



Elderly Long-Term Care Expenditures by Source of Payment: 1995



Source:
U.S. House of Representatives
Committee on Ways and Means (1998)
[1998 Green Book](#)
Washington, DC

Total = \$90.9 Billion

POLICY OPTIONS:

As of March 2000, Congress appears to be moving towards a bipartisan effort to provide tax relief for those struggling with long term care. The proposed federal legislation would allow for both a tax credit of \$3000 annually to family members providing long-term care for dependents and a tax deduction for premium payments for long term care insurance policies. While not creating a total solution, by supporting those currently providing care while simultaneously encouraging individuals to protect against future dependency on family or the government, Congress is taking positive action on this issue.

How Pennsylvania Can Multiply the Effects: Tobacco Funding

While the total solution of financing for long term care is beyond the capacity of state governments, there is an important role to be played. Pennsylvania has good reason to supplement national coverage: our aging demographics lead the nation and our ratio of working persons to seniors are among the lowest. These trends are putting pressure on what is already a fragile, overburdened public financing system.

In Pennsylvania, LTC accounts for over 2/3 of the Medicaid budget. State budget leaders understandably seek solutions to contain long term care costs. The Balanced Budget Act of 1997 (BBA) made the situation even more tenuous. Health providers' margins—already decreasing due to managed care—continue to erode.

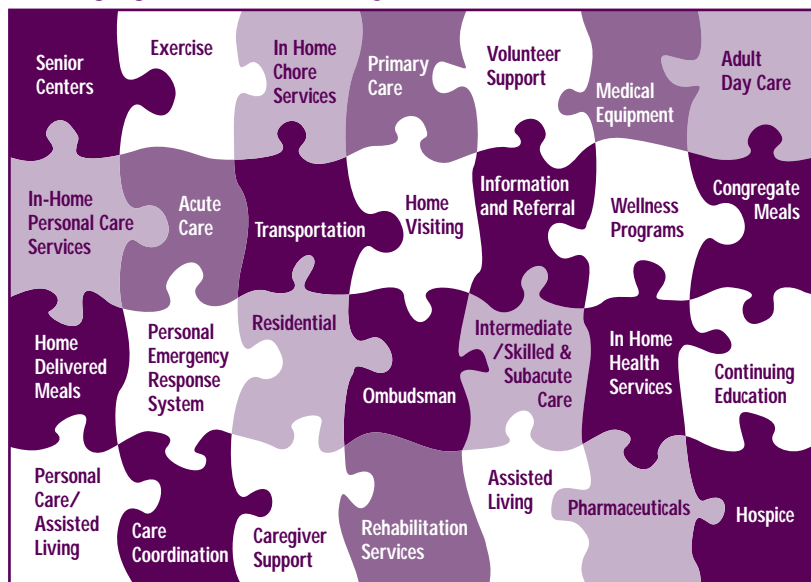
A new lever has emerged for Pennsylvania: the national tobacco settlement money. Governor Tom Ridge recently proposed using 15% of the tobacco settlement money

in Pennsylvania to fund home and community based long term care. This proposal is valuable, but it only applies to those who are nursing home and Medicaid eligible. It bypasses private solutions that could serve a much broader constituency.

Now is the time—when millions of people are just beginning to think about their retirement years—to educate the public on the importance of taking personal responsibility for their own long term care. Financial incentives could be developed to encourage individuals to invest their own funds, perhaps using the tobacco funds to provide some form of tax incentive, such as tax credits or deductions for the purchase of private long-term care insurance or for employers offering such insurance as a benefit. *Such incentives exist in 19 other states.* Any one of these models, most of which operate at relatively low cost to the state, could be adapted as well to encourage using annuities and similar directed retirement savings for long term care. The Pennsylvania General Assembly has several related legislative proposals under consideration, but little action has been taken to date.

If the younger generation could be motivated to purchase private coverage, governments could preserve the bulk of public long term care dollars to care for the very poor and foster access to an appropriate array of services for all elderly. The 15% set aside by the Governor has opened the door for Pennsylvania to create an innovative and workable solution.

The Aging Services Delivery Puzzle



- Universally Covered
- Covered with Copays and Deductibles
- Low Income Coverage
- Not Covered

“The world is graying. Many nations will be looking down the barrel of an exploding cannon.”

PricewaterhouseCoopers
HealthCast 2010



LONG-TERM CARE INITIATIVES: FEDERAL AND STATE ACTIVITIES AND OPTIONS

Prepared for

THE JEWISH HEALTHCARE FOUNDATION

Prepared by

MARC A. COHEN, PH.D.
VICE PRESIDENT
LIFE-PLANS, INC.



SPRING 2000

Over the last five years, a number of important trends in the financing and delivery of long-term care have occurred. Perhaps the most important is that the responsibility for long-term care financing has been shifting away from the Federal government to states, individuals and their families. While the mid-1990s witnessed a tremendous increase in federal dollars allocated to home and community-based care through the Medicare home health benefit, recent changes in program reimbursement have severely curtailed such payments. Thus, a growing share of community-based as well as institutional long-term care expenses are paid by sources other than the federal government.

Second, providers are responding to market competition, shifts in consumer preferences, and changes in reimbursement and financing policy by adding new services to the continuum of care. An important example of this is the tremendous growth in the assisted living industry. Assisted living facilities typically offer a combination of housing, health care, personal assistance and supportive services in a homelike environment that strives to maximize the individual functioning and autonomy of the frail elderly and other dependent populations. Today, there are more than 28,000 assisted living residences in the U.S. housing more than one million people.

Regarding nursing home care, over the last 15 years, there has been a fairly dramatic decline in use of this traditional long-term care service. The reasons are varied but include the imposition of restrictions on supply through Certificate of Need (CON) programs, an expanding home and community-based care network, the growth in assisted living facilities, and a decline in age-specific rates of disability. At the same time that there has been a decline among chronically disabled users of nursing home care, there has been a fairly dramatic increase in use by patients with sub-acute and rehabilitation needs. These short-stay patients are able to receive care that would normally only be available in more costly hospital settings. The implication is that Medicare has been playing a more significant role in financing nursing home care, although not for a typical "long-term care" population.

These macro trends have served to dramatically shift the terms of debate about long-term care policy at the national level and have led both states and individuals to explore new ways to finance the growing long-term care bill. They have also forced providers and payers to experiment with new models of service delivery that attempt to integrate acute and long-term care or introduce elements of managed care into the provision of services.

FEDERAL POLICY

Long-term care financing reform is not a high priority item either for Congress or for the Administration. Much of the public policy debate over the past few years has been focused on how the Federal government can control expenditures and ensure the solvency of major entitlement programs like Social Security and Medicare. Also, the increasing acceptance of the need to offer some level of prescription drug coverage to the Medicare program has served to diminish interest in significantly expanding expenditures or coverage for long-term care services. Almost all current policy proposals dealing with long-term care are designed to achieve the following purposes:

1. To encourage the provision of long-term care services by informal (unpaid) caregivers. This strategy is designed to help to minimize dependence on formal service providers that are reimbursable under Federal and state programs and to strengthen family caregiving.

2. To encourage individuals to assume greater personal responsibility for planning and paying for their future long-term care expenses by purchasing private long-term care insurance. This strategy is aimed at reducing future dependence on public programs and increasing the available pool of private pay dollars to support the development of the long-term care service delivery system.

3. To encourage state experimentation with new models of service delivery as well as financing through the expansion of Medicaid waivers for home and community-based services (HCBS waivers).

THE ADMINISTRATION

In January, President Clinton proposed a \$28 billion 10-year initiative that included a \$3,000 tax credit targeted to people with long-term care needs or their caregivers.

This proposal follows on the heels of a similar more modest plan — a \$1,000 tax credit — rejected by the Republican-led Congress. The plan also called for funding for services that support family caregivers of older people and proposed allocating additional funds to improve equity in Medicaid eligibility for people in home and community-based settings. Finally, to signal employers about the desirability of having long-term care insurance as an employer-sponsored benefit, the government would offer such insurance to Federal employees.

The Department of Health and Human Services, through the Health Care Financing Administration has also stepped up its granting of waivers for home and community-based care services (HCBS) under the Medicaid program. Medicaid spending on HCBS is now growing faster than spending on nursing home care – an annual rate of 25% compared to 4% for nursing home care. Most states — 36 of 50 — indicate that they expect to expand their programs and few expect serious Federal impediments to doing so.

THE CONGRESS

On August 5th, 1999, the Senate and the House of Representatives approved the Taxpayer Refund and Relief Act of 1999 (H.R. 2488) which among other things, proposed changing the tax status of premiums paid on long-term care (LTC) insurance contracts. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the tax advantages associated with the purchase of accident and health insurance were extended to LTC insurance. This meant that individuals purchasing LTC insurance could deduct LTC premiums when medical expenses (including LTC premiums and expenses) exceeded 7.5% of their adjusted gross income. Moreover, HIPAA stipulated that benefits received under LTC contracts would be excluded from income and that employer contributions for the purchase of LTC insurance also would be excluded from income.

Under the new legislation, which was subsequently vetoed by President Clinton, individuals would be able to take an “above the line deduction” of LTC insurance premiums. Individuals purchasing LTC insurance would be able to deduct the full amount of their premium payment from adjusted gross income, whether or not they itemize deductions or have medical expenses above the 7.5% threshold. As with HIPAA, the purpose of the proposed legislation was to use the tax code to encourage individuals to acquire private insurance to cover the potentially catastrophic costs of long-term care.

A recent noteworthy development is increased support for a tax credit for family caregivers. Within the last few weeks, two powerful lobbying organizations (that have often been at odds on Federal long-term care policy) have joined forces to support above the line tax deductibility for long-term care insurance and tax credits for caregivers. The Health Insurance Association of America (HIAA) and the American Association of Retired Persons (AARP) have held a series of joint press conferences in support of these initiatives.

CANDIDATES GORE AND BUSH

To date, the primary focus of both the Republican and Democratic presidential nominees has been on shoring up Social Security and adding prescription drug coverage to Medicare. For his part, candidate Bush has promised to create a “lock box” that would protect the Social Security trust funds from being spent on other Congressional programs. He has also advocated dedicating 62% of the non-Social Security surplus to the trust fund and creating personal retirement accounts to encourage workers to save for retirement. Regarding long-term care, Mr. Bush has expressed his support for tax incentives for the purchase of private long-term care insurance policies. The campaign has not yet issued a detailed summary of his views on the issue.

Vice President Gore supports a non-refundable tax credit for care recipients or their caregivers and would create a national network of family caregiving support centers. He also would allow states to offer home and community-based care services more frequently without requiring a federal waiver. Finally, he supports providing an option for federal employees to purchase long-term care insurance at group rates. He has not taken an explicit position on changing the tax status of long-term care insurance contracts. He has signed the Long-term Care Campaign’s Leadership Pledge.

THE STATES

Across the country, states have been particularly active in seeking ways to control expenditures on long-term care and enhance the efficiency with which long-term care services are delivered. In broad terms, states have adopted two primary strategies: (1) Encourage a shift to greater private financing of services and less reliance on Medicaid funded services. This typically means encouraging the purchase of private long-term care insurance; (2) Find new service delivery models that enable individuals to receive care in less costly non-institutional settings.

(1) Encouraging the Purchase of Long-term Care Insurance

Approximately half of the states have enacted legislation or changed regulations to stimulate expansion of the market for private long-term care insurance. In their role as regulators of long-term care insurance well over 75% of states require insurers to offer policies that cover both institutional care as well as home and community-based services.

1.A. Individual Tax Incentives

Over the past few years, a growing number of states – 19 as of late 1999 — have put in place a series of tax incentives to encourage the purchase of private long-term care insurance. These deductions or credits have the effect of reducing the net price of long-term care insurance premiums to buyers. For the most part, because state income tax rates

are relatively low and because most states place limits on the size of the allowable tax credit, the financial impact of such incentives is small. Their main effect is to send a message to individuals that in general, the state endorses the product and its purchase.

1.B. State-sponsored Group Plans

A second means of encouraging the purchase of insurance or the provision of insurance is through example. A number of states like Maine, Oregon, and Maryland are offering small tax incentives to employers who contribute to the costs of a group long-term care insurance plan for their employees. Other states – 21 in all – have enacted laws making private long-term care insurance benefits an option for state or other public employees. (As mentioned, the Federal government is examining how to do this for its employees and retirees.) As is true for the employer group market as a whole, participation rates in these programs are typically below 10% of eligible employees.

1.C. Partnership Programs

Four states – New York, Connecticut, Indiana, California — have received special waivers to implement Partnership Programs. These programs link the purchase of long-term care insurance to liberalized Medicaid eligibility criteria, that is, higher asset protection levels. In essence, these states allow individuals to maintain either all of their assets or a level of assets equal to the amount of insurance benefits paid out and obtain Medicaid funding of services once their insurance benefits run out. The program is designed to encourage middle class elders, who in the absence of their insurance would quickly qualify for Medicaid, to purchase policies. Over the past two years, there has been significant growth in the sale of Partnership policies and more than 70,000 people have them.

While other states have expressed interest in these programs, the Omnibus Budget Reconciliation Act of 1993 made expansion of these programs virtually impossible. The law required states to recover, from the estates of individuals, Medicaid financed long-term care expenses including insurance protected assets from Partnership programs. Thus, states wishing to replicate the Partnership model cannot yet do so.

1.D. Consumer Education

A growing number of states — 18 in all — are allocating resources to the area of public education about long-term care risk, exposure, and the availability of insurance for long-term care. These attempts at “social marketing” are designed to educate consumers and make them more receptive to the product. The California Public Employees Union (CALPERS) has invested significant resources into public education about long-term care and insurance. Because there remains a significant misunderstanding about public program coverages, these states’ efforts will be supplemented with a major federal initiative in this area; nearly \$10 million has been allocated to a federal program of consumer education about the limitations of Medicare vis-à-vis long-term care coverage.

Most policymakers and industry analysts agree that among individuals age 65 and over, the product is most appropriate for middle and upper middle-income elders. At younger ages, however, the insurance can be positioned as part of a retirement planning package and is far more affordable to greater numbers of individuals. This is particularly true when the insurance is offered as part of a group plan. The implication is that any public education strategy should account for the different market segments.

(2) Experimentation with New Models of Service Delivery

There is a broad consensus that when properly structured, financial incentives can lead to a more efficient and effective allocation of long-term care resources. Fragmentation in both the financing and delivery of long-term care has been seen to encourage wasteful and inappropriate patterns of service utilization. States have been at the forefront of testing new models of care to improve the match between client needs and service system response.

2.A. Capitated and Integrated Long-term Care Models

A growing priority among state policymakers is the expansion of capitated or managed long-term care programs and the integration of acute and long-term care. By the end of 1998, 20 states had one or more publicly funded programs with capitated long-term care services and another five were in the planning phases of such programs. For the most part, these programs have been developed through two federally sanctioned demonstration programs – the Program for All-Inclusive Care for the Elderly (PACE) and the Social Health Maintenance Organization (S/HMO).

The PACE Program

Currently operating in 11 states, the PACE program represents an innovative public approach to providing long-term care services to frail elders. The distinguishing features of the PACE approach are integrated funding and provider financial risk through capitated Medicare and Medicaid reimbursement, integrated service delivery through adult day care, case management through multidisciplinary teams, and nursing home-eligible clients choosing to receive long-term care services in the community. The program focus is to provide an alternative to institutional care by maintaining individual residence in the home and community setting for as long as is medically and economically feasible. Typically, enrollment in these programs is small – less than 500 people. Preliminary evaluations suggest cost savings but there is some question about whether such savings are a result of the program intervention or due to the specific profile of individuals who are participating in the program.

The S/HMO

The Social HMO is a demonstration that is being conducted at four sites in four states and serves more than 20,000 enrollees. The basic model adds community care services and short-term nursing home care to a Medicare HMOs' basic service basket. The program focuses

on providing a broad cross-section of the Medicare eligible population with acute care and limited community-based long-term care coverage. The purpose of the program is to administratively combine acute, long-term care and behavioral/social health services into an integrated health service delivery system. Medicare, Medicaid and private premiums on a prepaid capitated funding basis reimburse the HMO. A case manager acts to help ensure that enrollees are placed in the least restrictive, most cost-effective care environment.

A growing number of organizations are in the process of becoming S/HMOs. Because the initial sites have (for the most part) demonstrated financial feasibility, and there are a growing number of HMOs taking Medicare risk contracts, the Health Care Financing Administration, which supervises these demonstrations, will likely provide a mechanism for their expansion.

The Arizona Long-Term Care System

In 1989, the state of Arizona began capitating Medicaid-funded long-term care services to needy elders and the physically disabled. The program covers all traditional Medicaid acute care services as well as nursing home care and home and community-based services. The federal government, the state, and the counties fund the program. In each county, the state contracts with a single organization to assume responsibility for providing services and these "contractors" must arrange for both acute and long-term care services. They are paid a capitation amount per enrollee that varies according to county.

Evaluations of the program suggest that it has yielded significant cost savings compared to traditional Medicaid programs but there remain questions about the quality of services. Although Arizona is the only state to have a program of this kind, as other states contemplate a greater role in the management of their own long-term care population, many are looking to the Arizona experience for guidance. Delaware may become the second state to implement a similar program. The state is now in the final stages of program development.

Other Initiatives in Capitated Long-Term Care

The state of Wisconsin is planning a capitated payment system for long-term care. The plan would pool and capitate all state resources with Medicaid and attempt to reallocate resources away from the nursing home to home and community-based services. The program would target services to the most disabled and individuals would also have access to information and referral sources. Statewide implementation began in 1999.

Florida is another state facing a significant challenge in the long-term care financing arena. Recently, the state received a Medicaid waiver for a program that would integrate acute (Medicare) and long-term care services (Medicaid) through a managed care delivery system. While the funding streams would be kept distinct, service delivery would be integrated. The program is based on voluntary enrollment of individuals age 65 and over who are dually eligible for Medicare and Medicaid

services and are assessed to be at risk for nursing home placement. The pilot project will take place in nine counties. Contracted providers will be at financial risk for the full range of Medicaid services.

Texas has also recently begun implementation of a program — The STAR+ Integrated care project — that is designed to serve the elderly population needing long-term care. Beginning its implementation in the Houston area, this program enrolls individuals in managed care plans (HMOs) that are responsible for meeting both the acute and long-term care needs of individuals. To induce individuals to voluntarily enroll in the program, Medicaid beneficiaries receive additional benefits such as prescription drug and eyeglass coverage, services that are often provided by HMOs in the state at no extra charge.

Another noteworthy effort is found in Minnesota. The Minnesota Senior Health Options (MSHO) demonstration project integrates acute and long-term care for individuals who are dually eligible for Medicaid and Medicare services. Integration of the funding streams was seen as a way to control costs by reducing the incentives and associated activities around shifting costs between Medicare and Medicaid. While the Health Care Financing Administration did not approve a waiver for total integration of these funding streams, it has agreed to pay providers directly for care directed by the MSHO. Current projections are that upwards of 4,000 individuals will enroll in the plan which will provide all Medicare services provided under standard risk contracts, six months of nursing home care and all services currently authorized under the home and community-based care waivers.

2.B. Cash and Counseling

The Cash and Counseling Demonstration provides a cash option to Medicaid enrollees who need personal assistance services. This project, which is being done in collaboration with the Robert Wood Johnson Foundation, will test the effects of “cashing out” Medicaid-funded personal assistance services for the disabled. The demonstration will include elderly as well as younger disabled consumers. Three states — Arkansas, New Jersey and Florida — have already received the necessary waivers to implement the program and Arkansas has already enrolled 1,000 people. In these states, control group members will receive “traditional” benefits — i.e., case managed home and community-based services, where payments for services are made to vendors — while treatment group members receive a monthly cash payment in an amount roughly equal to the cash value of the services they would have received under the traditional program.

It is hypothesized that cash payments will foster greater client autonomy and that, as a result, consumer satisfaction will be greater. Consumers are expected to purchase a somewhat different mix of disability-related services and/or assistive technologies when they make the decisions and payments themselves than when case managers contract with vendors on their behalf. It is also hypothesized that states will save Medicaid monies (mostly in administrative expenses) from cashing out benefits.

Encouraging Insurance Purchase

The initiatives designed to encourage long-term care insurance purchase do not require federal involvement. Additional expenditures are required, however, either in the form of tax expenditures or direct dollars spent on education or development of state insurance programs. Thus, they will need political support at the executive and legislative levels. Obtaining such support can be challenging. Arguments in opposition to such a strategy are likely to rest on the following (often overstated) claims: (1) the insurance is only a relevant option for the wealthy so there is no need to encourage its purchase; (2) few believe that expansion in the market will save Medicaid dollars; (3) the incentives may actually go to individuals who would have purchased a policy anyway; (4) the incentives are so small so as to be ineffective; (5) policies are not adequate; (6) if the market is not growing on its own, then the government need not expend additional resources to make it happen. Most of these claims can be refuted with the help of a growing body of empirical evidence. Nevertheless, these are the issues most likely to arise in the policy debate. Any strategy designed to encourage the purchase of private long-term care insurance must address them.

New Models of Long-Term Care Financing and Service Delivery

The biggest challenge to implementing new statewide programs in this area has traditionally been obtaining a waiver from the Health Care Financing Administration. To the extent that such initiatives can be shown (theoretically) to be at least budget neutral, there is a much greater likelihood of approval. At the state level, there are a number of additional challenges. First, providers may be reluctant to participate in such programs because they are being asked to take risk and some would no longer be assured of being able to participate in publicly funded programs. Also, the nursing home industry, which is already under pressure from low Medicaid reimbursement rates, may resist programs that capitate payments or emphasize home and community-based care. A hurdle that has been very difficult to overcome has been the actual establishment of capitated rates based on accurate risk adjusters. Consumer opposition to managed care should also not be underestimated. Finally, although there has been greater flexibility from HCFA regarding demonstrations and experimentation at the state level, obtaining a waiver to enable combining Medicare and Medicaid funds in a single capitated payment system has been very difficult. In short, any new initiatives in service delivery will require a great deal of planning and coordinating with multiple providers and payers to succeed.

Additional Options to Consider

While many of the initiatives discussed above are worthy of replication, there are additional strategies that may also be worth pursuing. For example, to encourage individuals to risk pool, the state may want to set up a voluntary insurance pool that is reinsured by commercial carriers. This would allow the state to realize economies of scale vis-à-vis marketing and also take advantage of the expertise garnered by the commercial insurance industry in underwriting and benefits management. Reinsurance would provide the state with financial back-up and minimize the financial risk to tax payers. State tax-favored savings mechanisms could also provide additional support for such a program as well as for private insurance in general.

Second, in addition to more general public education programs through the state Department of Insurance, there may be additional regulatory actions that can be

taken to enhance the affordability of products. This could involve new models for commission structures, alternative methods for guaranteeing that benefits keep pace with inflation, and encouraging long-term care preferred provider organizations. The goal is to expand the market by enhancing the affordability of products.

Third, models that tie private insurance to specific delivery systems may be easier to implement than those relying on government funding. An example of such a program that was tried in Pennsylvania in the late 1980s was called "Life Care at Home." This program allowed individuals to purchase private insurance and access to a specific service delivery system that had a very heavy case management component. While its initial sponsors did not market the program as successfully as they had desired, there may be greater receptivity to such a program today.

Finally, investments in caregiver support programs are dollars well spent. Today, relatives and friends, often at great emotional and material cost, provide 80% of all long-term care informally. To enhance the resiliency of these networks, support hotlines, tax credits, training programs, banked caregiver credit programs, and new linkages with the aging network ought to be considered. There exist a number of organizations such as the National Alliance for Caregiving that could act as a valuable resource to states interested in pursuing a strategy designed to actively support informal caregivers.

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LONG-TERM CARE INITIATIVES

Spring 2000