Long Term Care Insurance – Planning for the Future

Testimony to the Michigan House of Representatives Health Policy Committee

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The Reality

Many Michigan residents are continuing to recover from the impact of the economic downturn, stabilizing their lives to secure a future that will provide access to home, food, clothing, transportation and some level of health care coverage. For those of the baby-boomer generation, they are facing a future retirement that, for many, includes less healthcare coverage, less savings, possibly a loss of the family home, caregiving responsibility of parents, continued financial support of adult children, and little time to come up with a "Plan B".

Boomers are smart people. Many have already experienced the stress and strain of caring for aging parents while still raising their own families. For many boomers, the reality of their modest childhood beginnings comes roaring back as they now make provisions for their aging parents care, often with limited cash resources. Yes, boomers are smart people. They may not fully understand what long-term care insurance is, how you get it, and what it covers. They just know that someday, they too will become old, frail and/or physically and mentally challenged and hope they will have access to affordable, quality, compassionate care that they are providing for their parents.

Boomers want to maintain independence and not become a burden to society or their families. The Michigan economic downturn resulted in many Michigan parents watching their children pursue opportunities outside of Michigan. They silently wonder who will help them navigate the most vulnerable next phase of their lives. What is their "Plan B"?

Preparing for "Plan B"

The goal of "Plan B" is to financially provide for a person's independent living choices and maintain access to needed high quality health care services. Helping Michigan residents prepare for their own "Plan B" will require access to unbiased information, education on their available options to care for themselves, along with an understanding of the impact of those options, and a network of quality providers to support their choices. While some may be of the belief that the "Goal" is to divest themselves of their assets to become eligible for Medicaid coverage, many simply do not understand that divesting of their assets may also divest them of their choices. Unintended consequences of these choices may result in the use of limited government resources that should be there for our most vulnerable Michigan residents.

Insurance Options

Medicare covers people over the age of 65 and some people under the age of 65 with disabilities. Medicare Part A helps to pay for inpatient care in hospitals, skilled nursing facility care, hospice and home health care. Medicare Part B helps to cover services from doctors and other health care providers. Medicare Part D helps to cover the cost of prescription drugs. Medicare Part C is offered by

Medicare-approved insurance companies and will include all the Part A, B, and D benefits plus some additional services. But Medicare does not pick up 100% of the cost of healthcare. There are copays and deductibles which must be paid out-of-pocket or through supplemental insurance coverage.

Medicare supplement insurance, also called "Medigap" or "MedSupp" is private insurance that will "wrap around" or cover most of coverage gaps of Medicare, such as hospital deductibles and physician charges above what Medicare approves. While Medicare will pay for some skilled nursing and in-home care, it is only for a short period to cover the rehabilitative or stabilization needs of a medical condition. Medicare or a Medicare supplemental insurance will not cover services for ongoing supportive assistance for people to remain in their homes independently.

Medicaid, similar to Medicare, provides for a broad base of health care coverage for low-income persons under the age of 65, and, for certain eligible persons who are low income and are in need of supportive home and community based services or nursing home care.

Long-term care (LTC) insurance is designed to provide a defined level of coverage for skilled nursing or therapy care, personal care or stand by assistance with activities of daily living (ADLs) for someone with a prolonged physical illness, a disability, or a cognitive impairment (such as Alzheimer's disease). Personal care, sometimes also referred to as custodial care, includes helping someone with bathing, eating, dressing, toileting, continence, and transferring.

Refer to Attachment 1 for a Benefit Coverage Comparison.

Who is buying LTC insurance?

Medicare does not pay for LTC services beyond the limited skilled nursing facility and home health benefits. Industry estimates indicate that state Medicaid programs will spend $1.6 trillion on LTC services over the next 20 years. Today, LTC expenses (i.e. nursing homes and in-home supportive services) account for about a third of total Medicaid expenditures and are projected to grow at a faster rate than Medicare and significantly faster than overall health care spending.[1]

According to a 2011 released study from America's Health Insurance Plans (AHIP), Who Buys Long-Term Care Insurance in 2010-2011?[2]", the following was revealed:

- Three in four individuals, age 50 and older, do not agree that it is the government's responsibility to pay for the long-term care needs of everyone.
- The vast majority of individuals, age 50 and older, believe that it is the federal government's responsibility to encourage people to buy long-term care insurance by allowing premiums to be fully tax-deductible or allowing employed individuals to use pretax dollars to pay for insurance.

- When Americans over age 50 were asked what the single most important action government could take in the area of long-term care, the most cited response was to offer more tax incentives for the purchase of private insurance policies.

The Landscape of LTC Products

With people making greater strides to plan for their future retirement, LTC products have continued to evolve to provide comprehensive policies that provide for the continuum of long-term care services. No longer are policies limited to nursing homes or institutional alternatives. New products have included increases in the average daily nursing home benefit and home care benefit. Unlimited lifetime maximum benefits (LMB) have been replaced with defined benefit periods (i.e. five years) and a defined maximum benefit. "Integrated benefits" or policies that allow for a total dollar amount to be used for different types of long-term care services are now offered by most companies. Current policies now also offer, for an additional cost, an "Inflation adjustment" which allows for the premium and benefit level to be increased to adjust for inflation in future years. While fewer companies than in the past, there are still a number of companies offering long-term care insurance products, including the following major carriers:

1. Genworth
2. Mutual of Omaha
3. John Hancock
4. MedAmerica
5. TransAmerica

LTC premiums depend on the amount of daily benefit a person would like and how long they want the benefit to be paid. A policy covering $150 a day for up to five (5) years, would cost more than a $100 a day benefit for three (3) or five (5) years. Per the AHIP Report, in 2010, the average annual premium paid by individual purchasers, was $2,283. The average age of an individual purchasing a policy was 59 and the policy generally covers about $150 per day for 4 to 5 years with a 90-day deductible.

A look to the future and the challenges

In a March 2013 report released by the Alzheimer's Association, the annual number of new cases of Alzheimer's and other dementias is projected to double by 2050.[3]

By 2030, the segment of the U. S. population age 65 and older is expected to grow dramatically, and the estimated 72 million older Americans will make up approximately 20 percent of the total population (up from 13 percent in 2010).[3] As the number of older Americans grows rapidly, so will the incidence of Alzheimer's disease:

- By 2025, the estimated number of people age 65 and older with Alzheimer's is expected to increase 40%, growing from 5.0 million to 7.1 million.
- By 2050, the estimated number of people age 65 and older with Alzheimer's may triple from the current 5.0 million to 13.8 million, barring a medical development to prevent, slow or stop the disease.

The impact Alzheimer's disease and other dementia will have on all payers will be significant. As stated in the March 2013 report, in 2008, the average payments per person for Medicare and Medicaid beneficiaries with Alzheimer's disease and other dementias were 19 times as great as those without the disease.

In addition to the healthcare costs of the disease, the impact on caregiver's will be significant. With a significant increase in long-distance caregivers, those who travel more than an hour or two to perform caregiving tasks, improvements in technology and care coordination resources will also be necessary to sustain the increased needs.

The full Alzheimer's report can be found at: http://www.alz.org/downloads/facts_figures_2013.pdf

Future Planning to Meet the Gaps

The Affordable Care Act (ACA) has provided the framework to allow the integration of medical, behavioral health and long term care services and supports to be fully integrated to support the needs of beneficiaries dually eligible for Medicare and Medicaid services. These needs are not exclusive to the dually eligible population. All beneficiaries, regardless of their income, will need access to long-term care products, services and support. To adequately prepare sustainable solutions, we must begin to build the community platform now.

- Promote development of medical research and technologies designed to prevent, slow or stop the incidence of Alzheimer's disease.
- Modernize Medicare, Medicaid and commercial insurance plan coverage to recognize the future and changing needs of the aging population and rebalance benefits, premiums, and employee contributions between health care and LTC programs.
- Develop community-based initiatives to support and encourage the growth of locally-based supportive service networks, including caregiver supports.
- Develop education programs and incentives to encourage people to buy long-term care insurance by allowing premiums to be fully tax-deductible or allowing employed individuals to use pretax dollars to pay for insurance.
- Another means by which to encourage people to buy long-term care insurance is for Michigan to establish a LTC Partnership Program. These programs are currently available in most states, but not Michigan. Due to LTC Partnership Programs, individuals are able to provide some

Creating A Sustainable Long-Term Care Program

Michigan House of Representatives
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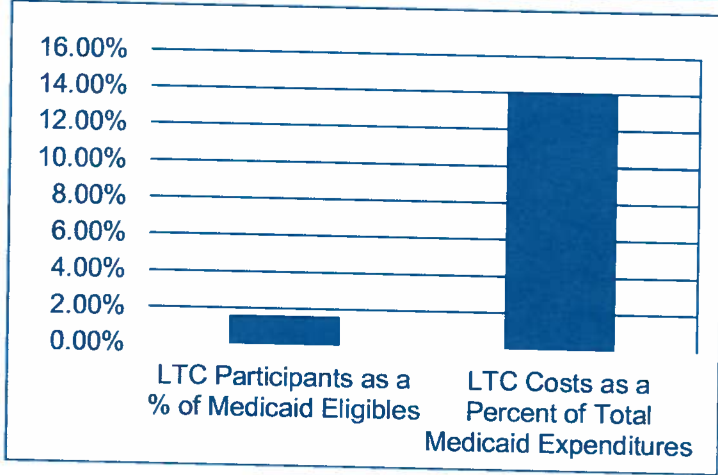
Michigan's Long-Term Care Opportunity

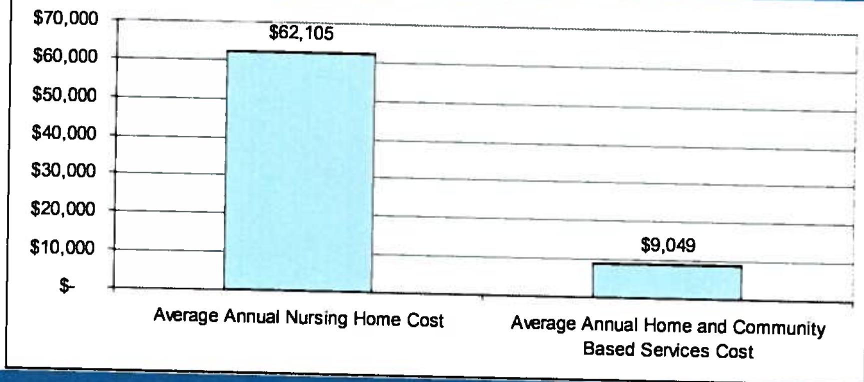
Michigan's LTC Beneficiaries Disproportionately Drive Medicaid Costs



Michigan's Dependence on Nursing Homes versus Home & Community Based Services (HCBS) is a Main Driver of LTC Cost Because Nursing Home Care is Nearly Seven Times the Cost of HCBS Care

State	Placement Rates	
	Nursing Home	HCBS
Indiana	77%	23%
Michigan	**72%**	**28%**
Hawaii	42%	58%
Arizona	29%	71%

LTC - Average Annual per Participant Cost in Michigan – Nursing Home and HCBS



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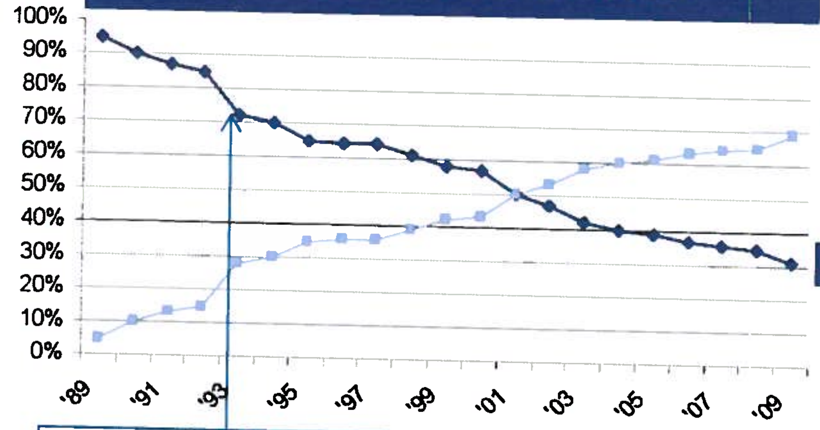
Learning from Other States' Experience



Arizona, the nation's longest running managed long-term care program has demonstrated year-over-year improvements in its mix of community-based and nursing facility care

TennChoices, Tennessee's managed long-term care program, reduced dependence on nursing facilities in the program's first year. The result was a rebalancing of the nursing facility/HCBS mix by six percentage points in favor of HCBS statewide in less than 12 months.

Massachusetts Senior Care Options (SCO), a managed care program for Medicare-Medicaid Enrollees, demonstrated success in maintaining individuals in community-based settings. An externally conducted study found that SCO participants were admitted to nursing homes at a rate of 8.7% compared to 12% for the control group in unmanaged fee-for-service.

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Achieve Success Through Managed Long-Term Care

- Each of the programs listed on the prior page, as well as, others in Florida, Hawaii, New Mexico and Texas have achieved increased reliance on community-based care rather than more costly and restrictive institutional care.

- These programs have been developed through a managed care model specifically designed to support individuals who wish to move back home, or to other community settings, from institutions – commonly known as repatriation – and to identify individuals who are at risk for future placement and provide them supports to avoid institutional placement.

- Through comprehensive care coordination, managed care can achieve appropriate repatriation and significantly divert institutional placement.

- Leveraging the success Michigan has had through it's managed care program, there is significant opportunity to rebalance the long-term care system to achieve a more sustainable Medicaid program.

If Michigan could achieve a one percentage point rebalancing in its Nursing Home/ Community-based care mix in favor of Community-based care, we estimate it could reduce annual costs by more than $20 million.

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Essential Elements of Managed LTC

Through our more than 20 years of experience supporting the needs of individuals eligible for long-term care services (currently serving 11 states), we have developed Essential Elements on which to build a long-term care model. Several of these Essential Elements are:

Element	Features/Policies Key to Successful Managed LTC Program
Population	• Broad inclusion of populations is key to most effective program • Individuals who are not yet eligible for long-term care should be included
Enrollment	• Mandatory enrollment is essential • Auto assignment should ensure equal enrollment and mix among MCOs • Weighted auto-assignment to high quality MCOs should be considered after 12 months program experience
Eligibility	• Eligibility requirements should not create barriers to HCBS waiver participation • Nursing home eligibility should be at least equal to HCBS waiver eligibility if not more stringent • Tiered waiver eligibility may be considered to provide waiver "light" benefits to encourage community placement
Lock-In	• Sufficient lock in – optimally 12 months – is necessary to achieve quality improvement
Benefit Design	• Comprehensive benefits are ideal

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Creating Sustainability for Michigan's Long-Term Care Beneficiaries

The Case for Change

While Michigan has long been a thought leader in deploying managed care for the majority of its Medicaid beneficiaries, individuals who are eligible for long-term care have remained in an unmanaged model. These individuals account for a disproportionately high share of the costs to the Medicaid program and maintaining them in an unmanaged program creates pressures on the Medicaid program that could largely be avoided by transitioning these complex beneficiaries to a managed approach.

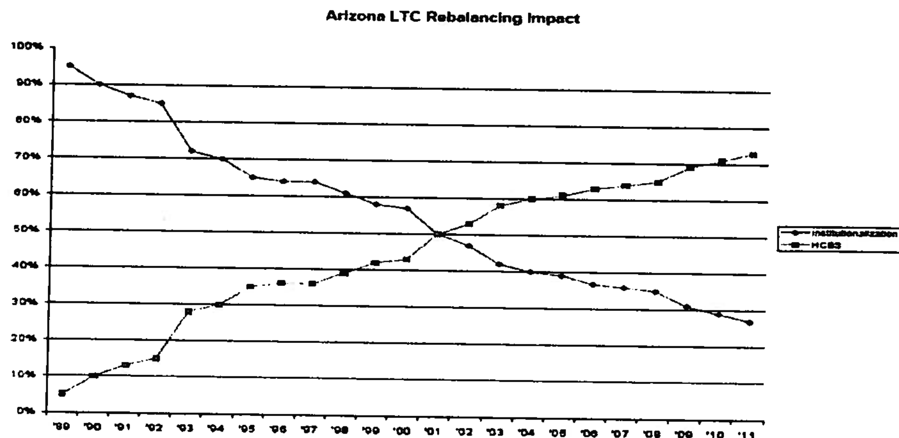
The costs associated with individuals in need of long-term supports and services continue to be driven by the costs associated with nursing home care. Based upon data from the Kaiser Family Foundation, eighty-two percent of long-term services and supports are attributable to nursing home care[1]. This is particularly troublesome for Michigan because the cost of caring for individuals in nursing homes is nearly seven times more than caring for them in the community.[2] Comparing the number of individuals in nursing homes to those served by Michigan's home and community based waivers more than seventy percent are served in nursing homes.[3]

More than $1.6 billion of Michigan's Medicaid budget is spent on nursing homes and home and community based waiver services. These services account for fourteen percent of the total Medicaid budget while individuals receiving these services represent less than two percent of the total Medicaid beneficiaries.[4] This disproportionate liability creates a threat to the sustainability of the entire Medicaid program. This is particularly true as the State faces the pressures of the introduction of Baby Boomers into the Medicaid rolls as well as an ever growing disabled population.

Leveraging the Experience of Other Managed Long-Term Care Programs

Several states have developed comprehensive care management approaches for the challenges facing Michigan. While each state's program is unique, they have all demonstrated that significant improvements can be made through the reduced reliance on costly institutional care.

Arizona's Long Term Care System (ALTCS) is the longest standing managed long-term care program and has demonstrated for more than 20 years the ability of managed care to substantially shift reliance on costly services. Through appropriately repatriating individuals from nursing homes to community-based care as well as identifying individuals who are at risk of future nursing home placement, Arizona has demonstrated year-over-year rebalancing improvements.[5]



[1] www.statehealthfacts.org
[2] Ibid
[3] Ibid
[4] Ibid
[5] Arizona Health Care Cost Containment Commission

Massachusetts developed an integrated model for Medicare-Medicaid Enrollees through a demonstration more than nine years ago known as Senior Care Options (SCO). While different in structure from Arizona's ALTCS program, SCO has demonstrated the value of managing some of the state's most complex populations. An externally conducted study found that through the comprehensive management of services and encouraging community based care, only 8.7% of SCO members were placed in nursing homes compared to 12% in a control group in unmanaged fee-for-service.[6] Moreover, individuals ultimately placed in nursing homes in the SCO program had significantly higher levels of frailty indicating that SCO was able to maintain more complex individuals longer in the community than an unmanaged model.[7]

Tennessee implemented TennCHOICES as part of the TennCARE program to meet the needs of individuals in need of long-term supports and services. At the time of implementation, Tennessee had a significant dependence upon institutional care – more than ninety percent. Through thoughtful program design and development of a comprehensive approach in collaboration with its health plans and other interested stakeholders, Tennessee developed a program that had substantial impact beginning in the first year following implementation. In the Middle Tennessee Region, the use of community-based care increased by fifty percent in nine months. Although the state developed a phased implementation approach and the East and West Regions implemented several months later, the state shifted its nursing facility/community-based care mix by six percentage points in favor of community-based services statewide in less than twelve months.[8]

The Opportunity for Michigan

Michigan has the opportunity to substantially improve the sustainability of its Medicaid program by developing a model that is based upon the foundation of changing the way individuals who are eligible for long-term care are managed. Based upon the experience of states operating programs today, Michigan can appropriately reduce the reliance upon costly services while increasing access and availability of community-based services. By rebalancing institutional care with community-based care by just one percentage point in favor of community-based care, we believe the state can save more than $20 million making a compelling argument to strive to achieve similar rebalancing results of states like Arizona.

The proposed model and savings achieved would be applicable in either a stand-alone managed long-term care program or if the state successfully negotiates a Memorandum of Understanding with CMS to participate in the Financial Alignment Demonstration. In either case, the majority of Medicaid liability for individuals who are dually eligible are attributable to long-term services and supports. For individuals who are not dually eligible, the State would have the ability to capture acute care savings – similar to the experience of the existing managed care model – as well as savings achieved through the reduced reliance on institutional care.

The Essential Elements

Through our more than 20 years working with numerous states to support the needs of individuals who qualify for long-term supports and services, we have had the opportunity to develop a foundation of "Essential Elements" that make an effective program. Our experience has shown that these Elements create a highly effective platform from which any state can develop a successful long-term care program. While these are not all encompassing, they certainly represent a foundation from which to develop a state-specific model.

Population

Including broad populations ensures meaningful impact for states. Limiting populations will limit the overall success and will ultimately reduce market acceptance for systemic changes. In addition to including individuals who have already met the nursing home eligibility levels, individuals should be included who have not yet met the nursing home level of care – individuals who are aged, blind, and disabled (ABD). This allows for managing

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[6] *MassHealth Senior Care Options Program Evaluation: Pre-SCO Enrollment Period CY2004 and Post-SCO Enrollment Period CY2005 Nursing Home Entry Rate and Frailty Comparisons*, JEN Associates, Inc., June 6, 2008
[7] Ibid
[8] *Improving Access to HCBS through Implementation of an Integrated Medicaid Managed Long-Term Care Program*, TennCare

individuals before they are in need of long-term care, thereby increasing the state's ability to effectively rebalance long-term care through early identification and alignment of less costly community-based services.

Enrollment

Enrollment into the program must be mandatory to ensure program success and market adoption. Programs without facilitated enrollment models have demonstrated very low participation and have had limited overall impact on program quality and budget predictability. Auto-enrollment algorithms should create a mechanism to balance enrollment among participating health plans to avoid negative impacts on program viability. In addition, states may consider adopting quality based auto-enrollment algorithms after the first 12 months of program experience to reward health plans with demonstrated high quality results.

Eligibility

Creating eligibility standards that encourage use of community-based services is fundamental to program success. At a minimum, eligibility standards for home and community-based waiver services should equal to those established for nursing home placement. Ideally, however, states should consider the creation of a tiered eligibility process that makes nursing home placement more difficult than accessing waiver services. In addition, to further support early identification of individuals at risk of future nursing home placement and align more cost-effective services and supports, states can consider developing waiver "light" eligibility that allows for a limited cost-effective benefit set – such as home delivered meals and homemaker services – to be available for individuals at an even lower eligibility level.

Lock-In

Establishing long-term relationships between individuals served in long-term care programs and care managers is fundamental to improved chronic condition management, care plan compliance, identification of opportunities for repatriation, and overall improvement of quality. To this end, beneficiaries should be locked into their health plan for 12 months or until the next open enrollment period.

Benefit Design

States should include the broadest benefit design possible to avoid ongoing fragmentation and encourage the holistic management of individuals served in the programs. Carving out any benefits maintains fragmentation and can ultimately lead to cost shifting and program inefficiencies. Carving out benefits such as pharmacy and behavioral health can lead to increased program costs and decreased quality.

Program Responsiveness

The structure of the contractual relationship with health plans can dramatically affect the overall performance of the program. Key contractual elements will enable optimal program effectiveness. First, health plans should be allowed to identify individuals who, based upon their needs, would be eligible for waiver services. Not allowing health plans the ability to make this determination will affect the ability to align cost-effective supports and services and may increase the risk of nursing home placement.

Second, the contract should include sufficient incentives to encourage repatriation and nursing home avoidance. Payment terms and quality monitoring should be structured in such a way as to place real and inherent incentives on health plans to decrease and avoid the need for nursing home placements.

Finally, the contract should encourage appropriate utilization and care plan development. Certain flexibilities should exist for health plans to appropriately align care management resources as well as coordinate the most effective, comprehensive array of services for each individual. Onerous contractual requirements that do not support underlying program goals can be detrimental to program success.

Consumer Direction

Consumer direction is an important program element – particularly for certain populations served in long-term care programs – and can be a highly effective component of a comprehensive care plan. In order to ensure the comprehensive nature of an effective long-term care program, consumer direction should be managed similarly to other benefits. Namely, the health plan's care manager should be responsible for assessing the ability of an individual to manage their own care and then include consumer direction as part of the overall care plan. Additionally, the state should maintain the relationship with a fiscal intermediary to maintain payroll and other employment functions.

Assessments

Assessments are a vital program element that determines the needs and aligns services for individuals served by the program. Long-term care programs typically have a broad spectrum of individuals served and can include people who are typically well managed such as people living in the nursing home. This spectrum of needs requires flexibility in assessment expectations. Health plans are best suited to determine appropriate assessment timing based on the needs of the members served and can be supported through reasonable minimum requirements, but over-prescription will lead to inefficient and, likely, ineffective use of resources.

Care Tools

Proprietary care tools developed by health plans provide the ability for state programs to benefit from proven and tested tools. Allowing health plans to use these tools can speed implementation and can minimize administrative inefficiencies and cost. Proprietary care tools can be used to link clinical, behavioral, long-term care, functional, and social assessments to highly specialized and comprehensive plans of care.

Cost Effectiveness

Establishing a long-term care program that systemically reduces costs requires the ability for the health plan to individually assess needs and align services and supports up to a certain, predetermined cost. In order to do this effectively, the program should be structured in such a way as to measure individual cost effectiveness rather than program cost effectiveness. Through individual cost effectiveness mechanisms, the state will not reinforce the use of community-based services for individuals who are so complex and costly as to be better served in a nursing home.

Staffing Ratios

Membership in individual health plans will vary as well as underlying clinical delivery models. As such, over prescription of staffing ratios can limit innovation and actually increase administrative and/or health care costs. Allowing health plans to determine staffing ratios ensures an ability to leverage proven care management approaches as well as encourage efficiencies. Through effective rate design health plans are encouraged to appropriately staff to limit any unnecessarily adverse risk.

Redetermination

Medicaid eligibility redeterminations can result in inadvertent in gaps in service. Gaps in service can ultimately lead to increased cost to the program. Maintaining Medicaid eligibility is vital to consistent application of care plans and avoidance of unnecessary costly services. To achieve this goal, health plans should be allowed to help facilitate eligibility redetermination to ensure continuity of care.

Quality

In addition to creating budget predictability and reducing overall costs, long-term care programs should improve the quality of care provided. As compared to a highly fragmented fee-for-service program, managed long-term care should create a system for ongoing quality improvement. In order to appropriately measure the impact of the program, the quality program should be specifically structured to address the needs of the population served.

Program goals such as nursing home avoidance and person-centered care planning are much more effective at measuring program success than other traditional Medicaid quality measures.

Rate Methodology

Rate setting for long-term care programs should be based on reasonable savings assumptions and effective incentives to drive to a more sustainable program. Blending rates for individuals at the nursing home level of care based on percentages served in nursing homes and community-based services will effectively support transitions from nursing homes and discourage inappropriate utilization of nursing homes. Reasonable savings assumptions and goals of shifting nursing home dependence to community-based services should be considered when developing the rates.

If individuals who are dually eligible for Medicare and Medicaid are included in the program, unique rates cells should be established for them that reflect the Medicaid responsibility as compared to Medicare. Likewise, if special populations – such as developmentally disabled – are included, rates should be cost based to reflect the differences in services needed as compared to a more traditional long-term care population.

Incentives

Creating incentives through rate design is vital to program success and health plan engagement. Applying unrealistic savings assumptions will ultimately undermine the viability of the program. Rates should be balanced between up and down side risk clearly enabling experienced health plans with strong clinical management programs to benefit while striving to achieve appropriate savings for the state.

Should the state consider implementing quality incentives, the incentives should be based on the population-specific quality program as noted above and additive to performance. Quality incentives for the initial year of the program should be based on administrative metrics to ensure a strong program foundation with phase-in of member quality criteria in subsequent years.

Risk Adjustments

Risk adjustments can further enhance the program and ensure population-based risk. Long-term care programs, however, take rather significant amount of time to establish stability. To this end, risk adjustment should be considered and applied only after a minimum of three years of program experience.

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Business Segment	Employees
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Total	566

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Business Segment	Individuals
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UnitedHealthcare MEDICARE & RETIREMENT	94,677
Total	666,611