

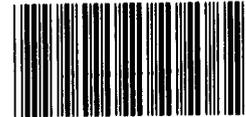
GAO

Report to the Chairman, Subcommittee
on Health and Long-Term Care,
Select Committee on Aging,
House of Representatives

September 1990

LONG-TERM CARE INSURANCE

Proposals to Link Private Insurance and Medicaid Need Close Scrutiny



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Human Resources Division

B-240641

September 10, 1990

The Honorable Edward R. Roybal
Chairman, Subcommittee on Health
and Long-Term Care
Select Committee on Aging
House of Representatives

Dear Mr. Chairman:

This report responds to your request for information on proposed state demonstration projects using private insurance in conjunction with public programs such as Medicaid to finance long-term care costs. These projects are an outgrowth of planning grants made to eight states (California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin) by the Robert Wood Johnson Foundation (RWJF). The purpose of the grants is to promote long-term care insurance for the elderly, thus helping them avoid impoverishment resulting from long-term care needs.

The states envision different types of projects. Most have proposed demonstrations that would allow persons who purchase a qualifying private long-term care insurance policy to become Medicaid-eligible after the policy pays for a period of long-term care costs. Participants would not have to "spend down" or deplete as much of their assets as is now required to meet program eligibility thresholds. Implementation of the projects, however, requires that the Medicaid program waive certain statutory requirements such as those relating to spend-down. The Department of Health and Human Services (HHS), which administers Medicaid at the federal level, has authority to do so for demonstration projects. However, the proposed RWJF demonstrations will operate for periods longer than allowed under Medicaid's current statutory authority. Consequently, legislation is needed to allow HHS to authorize these demonstrations. During the last congressional session, two bills were introduced, though not enacted, to give HHS such authority.

Your office expressed two main concerns about authorizing these projects:

- Would the projects result in increased costs to Medicaid? Because long-term care insurance can be relatively expensive, the persons choosing to participate in these projects may be those with higher incomes who ordinarily would not be expected to become eligible for Medicaid.

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- Could the states adequately safeguard consumer interests? Recent studies have questioned the restrictiveness of private long-term care policies and the adequacy of state consumer protection regulations.

With these concerns as a backdrop, your office asked for our views on the projects. Specifically, we were asked to consider whether the projects' designs reasonably assure (1) no additional Medicaid costs and (2) adequate consumer protection.

Our results are summarized below and discussed in more detail in appendix I.

Results in Brief

Several factors will determine how successful the RWJF projects are in developing long-term care insurance for the elderly that coordinates with Medicaid benefits while not increasing Medicaid costs. One is the extent to which the projects encourage purchase of such insurance by the persons most likely to become Medicaid-eligible if they needed services—those who would have to spend down their assets. If instead, higher income individuals predominate among the participants, they could add to Medicaid rolls and hence to overall Medicaid costs. Projects that mitigate the risks of increases in Medicaid costs are those that incorporate features to (1) make insurance more affordable to lower income persons and (2) limit the amount of assets that individuals can protect from Medicaid's spend-down requirements.

Consumer protection is another factor. The projects will involve the states in an activity that has its risks—promoting long-term care insurance products. These are relatively new products that are evolving rapidly—often more rapidly than states' regulatory and oversight mechanisms. For the RWJF projects to work as intended, there needs to be reasonable assurance that the long-term care insurance products being sold and endorsed by the states under their projects provide adequate coverage that will be available to purchasers when needed. Should subsequent problems arise with the products because of such factors as coverage restrictions or an insurer's financial difficulties, project participants may look to the states to provide the coverage that was expected of the insurer. Consequently, states should have adequate regulatory standards and oversight mechanisms to help ensure that such products give consumers reasonable protection.

Further, by virtue of their involvement in the promotion of private long-term care insurance, states also will have added responsibilities to

ensure that consumers understand any risks associated with the policies offered under these projects. The policies can lessen, but may not eliminate, an individual's risk of impoverishment as a result of catastrophic long-term care costs. For example, consumers who choose to participate in such projects by buying approved long-term care insurance would continue to be at risk for high out-of-pocket costs. These could stem from several sources, including payments for services not covered under their insurance policy or the difference between what the policies pay and billed charges. Thus, states need to ensure that the information and counseling consumers need to make informed decisions is made available.

Appendix II provides a brief description of each state's project.

Matters for Congressional Consideration

The proposed projects could reduce significantly the financial hardships that some elderly endure as a result of catastrophic long-term care costs. Additionally, the projects could provide a key source of information on the use of long-term care services by project participants. Such information could help insurers in developing long-term care products that best meet consumers' needs and are affordable. It also could assist state regulators in developing better standards and oversight mechanisms to increase consumers' protection, and educational campaigns to inform them of the appropriateness of long-term care insurance options.

Linking private insurance coverage with Medicaid, however, has its risks. The states participating in these projects currently account for nearly half of all Medicaid expenditures. Unlike other Medicaid demonstrations, these proposed projects could operate for 20 or more years. Thus, the proposed demonstrations would represent a fundamental change in the way Medicaid determines eligibility. Further, if the proposed demonstration projects are not structured correctly, the Medicaid program could experience cost increases, while consumers risk not achieving the benefits they expected.

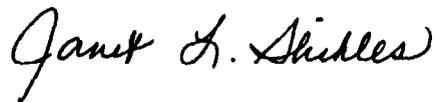
Accordingly, adequate safeguards to minimize these risks should be carefully designed and incorporated into the projects at the outset. If the Congress wishes to give HHS authority to approve demonstration projects such as those proposed by the RWJF grantee states, it should consider including the following in the legislation:

- Statutory requirements to minimize the financial risks to the Medicaid program and to consumers and

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- Requirements that the Secretary of Health and Human Services prepare interim reports to the authorizing committees on whether the statutory requirements are meeting their intended purposes.
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As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies of it to the Secretary of Health and Human Services, the Director of the Office of Management and Budget, and other interested parties. We also will make copies available to others on request. Please call me at (202) 275-5451 if you or your staff have any questions concerning the report. The major contributors to this report are listed in appendix III.

Sincerely yours,



Janet L. Shikles
Director, Health Financing
and Policy Issues

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Abbreviations

HHS	Department of Health and Human Services
HMO	health maintenance organization
NAIC	National Association of Insurance Commissioners
RWJF	Robert Wood Johnson Foundation

Long-Term Care Insurance: Proposals to Link Private Insurance and Medicaid Need Close Scrutiny

Background

Long-term care refers to a wide range of medical and support services provided to persons who have lost some or all capacity to function on their own due to a chronic illness or condition and are expected to require such services over a prolonged period of time. For most people, the costs of long-term care can be catastrophic. Nursing home care, for example, currently costs in excess of \$25,000 per year. For this reason, financing long-term care services has become a major problem for the elderly and their families and for federal and state governments.

Long-Term Care Financing Split Between Public and Private

Because of the limited coverage of such care under other public programs and private health insurance, Medicaid is the largest payer for long-term care services. In 1988, an estimated \$42 billion was spent on nursing home care nationally. Such expenditures have been divided almost evenly between public programs and private sources, with Medicaid accounting for the vast majority of the public funds.

Medicaid has become the long-term care payment source for many middle-income elderly persons. In most states, they can become eligible for Medicaid through the spend-down process.¹ That is, they become eligible once their income, less expenses incurred for medical services, has been reduced to Medicaid's income eligibility threshold (which varies considerably by state). In addition to meeting income limits, Medicaid applicants must deplete all but about \$2,000 of their assets, excluding the home.² Once a person has spent down to Medicaid eligibility levels, Medicaid will help pay nursing home bills. However, the Medicaid recipient is required to contribute much of his or her income toward the cost of care.

Many insurers, providers, and policy analysts believe that the growing population of elderly and their current financial status signal a strong market for future growth of private sector financing mechanisms. The market for long-term care insurance, while still relatively small, is

¹The process applies in the 36 states and District of Columbia that have a "medically needy option" as a part of their Medicaid program. This option extends coverage to individuals who are ineligible for cash assistance on the basis of income but whose income and resources are insufficient to meet their medical needs. A medically needy person establishes eligibility through a spend-down process that occurs once the person's income, after deducting medical or remedial service expenses, has been reduced to the state-set income eligibility threshold. In the remaining states, Medicaid eligibility is established on the basis of applicants' income and assets.

²A Medicaid spousal impoverishment provision that became effective September 30, 1989, provides a partial exemption of spend-down requirements to spouses of Medicaid nursing home residents. Such spouses now are entitled to keep \$815 in monthly income and the greater of \$12,000 in assets or one-half of the couple's assets up to a maximum of \$60,000 (excluding their home).

expanding. As of December 1989, more than 1.5 million long-term care insurance policies were in force, an increase of 36 percent over 1988.³

Private long-term care insurance policies typically offer nursing care indemnity benefits. That is, they pay a set amount each day for a specified period of time that a policyholder stays in a covered facility. A policy may or may not cover all types of long-term care, and different policies may define long-term care services or facilities differently. There is considerable variation among private long-term care policies in terms of coverage, the amounts payable per day of service, duration of coverage, and other conditions affecting the value of policies.

For his or her policy, a long-term care policyholder normally pays a fixed annual premium, which is set at the time the policy is first issued. Older individuals who obtain long-term care coverage pay significantly higher premiums than younger individuals because the likelihood of needing long-term care services increases with age. Persons aged 85 or older are most at risk of needing long-term care, and the average age of persons obtaining individual policies in 1988 was 70.

Both the government and consumers can benefit potentially from an expanded long-term care insurance market. The government can benefit if middle-income elderly no longer rely on Medicaid for assistance in paying for extended long-term care services, and consumers can benefit if spending-down to meet Medicaid eligibility levels is delayed or avoided. However, many long-term care insurance policies have been found to be deficient in such matters as coverage, eligibility for benefits, and inflation protection. Further, recent studies have shown that policies tend to be too expensive for most elderly to purchase.

**Robert Wood Johnson
Foundation Projects**

To address the concerns about costs of long-term care and inadequate policies, as well as how to proceed with new national financing strategies, the Robert Wood Johnson Foundation established its Program to Promote Long-Term Care Insurance for the Elderly. In response to the need for programmatic and empirical experience, the Foundation gave planning grants to eight states (California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin). The grants

³Survey data from a Health Insurance Association of America publication dated March 1990.

finance investigation of the potential role of a public/private insurance partnership in long-term care financing.⁴

A major purpose of the RWJF program is to help the elderly avoid the impoverishment required to establish Medicaid eligibility and reduce the reliance of middle-income elderly on Medicaid. In addition, the projects focus on consumer education and improving the value of long-term care insurance products. Each state project plans to

- work with insurers to develop policies that better meet the long-term care needs of the elderly and are more affordable;
- establish stronger regulatory controls over long-term care insurance; and
- establish consumer education programs to better inform the elderly about the limitations of public financing and the availability of private long-term care insurance.

Appendix II provides a brief description of each state project.

Two basic approaches to promoting the purchase of long-term care insurance have evolved from the eight states: (1) offering purchasers protection of assets and/or income protection from Medicaid's spend-down requirements based on the benefits they receive from the insurance policies they buy and (2) subsidizing premiums or coinsurance and deductibles for long-term care insurance policies that meet state requirements. Implementing the income and/or asset protection provisions of the projects would require waivers of current Medicaid spend-down requirements. All but one of the states have proposed or are considering such provisions. Waiving such requirements is the basis of concern among federal and state officials that high-income individuals will become eligible for Medicaid, thereby increasing costs to the program. The concern is heightened because the eight participating states account for about 44 percent of Medicaid's total expenditures.

While HHS has broad authority to waive Medicaid requirements for demonstration projects, the proposed RWJF demonstrations will operate for periods longer than allowed under current statutory authority.⁵ During the past congressional session, legislation was introduced in the House

⁴The timetable for completion of the planning phase varies by state; however, all planning should be completed by the fall of 1990.

⁵Under its demonstration authority, HHS can grant waivers of Medicaid requirements for up to 2 years; however, a state may request an extension of the initial waiver.

of Representatives (H.R. 2499) and passed in the Senate (S. 1998) to allow the Secretary of HHS to authorize extended demonstration projects such as those proposed by the RWJF grantee states. The bills authorized HHS to grant 5- or 10-year waivers, which HHS may renew for an additional 5 years at a state's request. HHS could grant the waivers for up to 10 state Medicaid programs after determining that the states' projects would be (1) cost-effective and efficient and (2) not inconsistent with the purposes of the Medicaid program. Both bills contain language that assures policyholders participating in the projects of continued Medicaid eligibility should the demonstrations or waivers be terminated. In addition, the Senate bill would require the state seeking a waiver to assure HHS that it will not approve a long-term care insurance policy unless it meets standards at least as stringent as those recommended by the National Association of Insurance Commissioners (NAIC).⁶

Scope and Methodology

We examined documents on the demonstration projects provided by the RWJF project director and interviewed officials of HHS and various public interest groups such as the American Association of Retired Persons. In New York and Connecticut, where projects have advanced beyond the initial planning phase, we interviewed project officials. Additionally, we analyzed data from selected studies, reports, and books concerning the elderly and long-term-care-related issues.

We obtained additional information on the remaining six projects through telephone interviews with project officials. To gather information on the states' legislation and regulations regarding long-term care insurance, we contacted officials in the states' departments of insurance. Our work was performed between January and March 1990 in accordance with generally accepted government auditing standards.

Cost of Projects to Medicaid Uncertain

The ultimate effect of the RWJF projects on Medicaid costs is uncertain and will depend on several factors. Among the determinants are the income and assets of the persons who participate and the insurance coverage they buy, which can be known only after the projects are underway. Another factor is the participants' subsequent use of long-term care services, for which it will take 20 or more years to develop sufficient data. Further, while each of the proposed demonstration

⁶The NAIC is an organization comprising the heads of the insurance regulatory agencies in each state, the District of Columbia, and U.S. territories. It provides a forum for state insurance officials to discuss common problems, standardize the annual reporting of financial information by insurance companies, and develop model legislative acts and regulations for adoption by the states.

projects is intended to either reduce or not increase Medicaid costs, the projects' cost estimates do not always include all relevant factors that may increase costs.

Costs Can Increase If Projects Attract High- Income Persons

The RWJF projects' success in not increasing Medicaid costs will depend in part on the extent to which they encourage the purchase of long-term care insurance by persons who are most likely to become Medicaid-eligible if they need services—those who would have to spend down their assets. If instead, higher income individuals predominate among the participants, they could add to Medicaid rolls and hence to overall Medicaid costs.

A recent study found that 58 percent of all nursing home residents remained non-Medicaid patients during their stays and only 7 percent spent down during their stays to become Medicaid-eligible.⁷ The remaining 35 percent were Medicaid-eligible when they entered. Successfully targeting the 7 percent of the population who spend down is the key to attaining the projects' cost containment goals.

Yet this population may be unable to participate in the projects, because they are likely to have relatively low incomes and assets and hence be unable to afford long-term care policies. A recent study examining the cost of policies from nine companies found that policies offering a basic range of services averaged \$1,346 annually for a 67-year-old (based on January 1990 prices). Policy prices escalate with a person's age, and by age 77 premiums averaged \$3,208. Reportedly, less than 20 percent of persons between the ages of 65 and 79, the target market for most long-term care insurers, could afford such policies.⁸

Because of their income and assets, individuals who could afford such insurance coverage are the least likely to become eligible for Medicaid, except in instances of long lengths of stay. Nearly two-thirds of nursing home stays, however, have been for 6 months or less and only about 16 percent of persons stayed for longer than 2 years. Further, individuals with higher incomes are also the least costly to Medicaid when they do become eligible for benefits. This is because the Medicaid program requires persons to use their income after deductions to offset their

⁷Korbin Liu, Pamela Doty, and Kenneth Manton, "Medicaid Spenddown in Nursing Homes," *The Gerontologist*, Vol. 30, No. 1, Feb. 1990, pp. 7-15.

⁸Families USA Foundation, in collaboration with James P. Firman and Susan Polniaszek of United Seniors Health Cooperative, *The Unaffordability of Nursing Home Insurance*, Jan. 1990.

costs of care. For example, single individuals are required to offset Medicaid costs with all income, less a personal allowance that varies by state with the minimum set at \$30 per month. Some states allow an individual to retain additional funds to maintain his or her home if a physician certifies that the individual is likely to return home within 6 months.

Risk of Medicaid Cost
Increases Varies by Project

Many factors can affect the likelihood that spend-down waivers will increase Medicaid expenditures. But how the projects are structured—that is, how much income and assets individuals can protect from spend-down—is of greatest significance. This determines the likelihood that people who would not otherwise qualify for Medicaid benefits could establish their eligibility for the program. Essentially, the more money that a person can protect from Medicaid’s spend-down requirements, the more likely that the projects will appeal to wealthier persons and the greater the risk of Medicaid cost increases.

New York’s proposed project poses relatively more risk of Medicaid cost increases than the other projects we reviewed because it would not (1) limit the amount of assets or income that persons can protect from spend-down requirements nor (2) target lower income persons. Specifically, New York proposes to allow persons who purchase long-term care coverage to become Medicaid-eligible after their policy pays at least 3 years of nursing home coverage or 6 years of community-based services, such as home health care. Eligibility would occur without regard to the person’s assets or income. That is, no income or assets would be applied to the cost of care once an individual becomes eligible.⁹ This can result in persons with relatively high income and assets becoming eligible for Medicaid—a significant risk because the state estimates that 73 percent of its project participants will be higher income persons (i.e., incomes 500 percent or greater above the poverty level).

The state expects the project to reduce overall Medicaid costs because it estimates that the savings resulting from the insurance coverage of moderate-income persons will more than offset the Medicaid benefits for higher income persons. New York’s data indicate that, without insurance, moderate-income persons would have spent down to Medicaid eligibility well in advance of the expiration of the proposed 3-year insurance coverage. Thus, the insurer rather than Medicaid would pay

⁹Project officials told us they were considering requiring copayments that would be based on a sliding scale depending on income.

**Appendix I
Long-Term Care Insurance: Proposals
to Link Private Insurance and Medicaid
Need Close Scrutiny**

for a considerable portion, if not all of those individuals' long-term care expenses. The state's estimate of cost savings, however, is highly sensitive to underlying assumptions about who will buy a policy, how many purchasers would have spent down to Medicaid without insurance, how long it would have taken them to spend down, and how much they would have contributed toward the cost of their care once they became Medicaid-eligible.

Most of the other projects would minimize the risks of Medicaid cost increases by limiting the amount of assets participants can protect and requiring that they spend down their incomes to Medicaid eligibility thresholds. For example, a project developed by Connecticut and being considered by several other states, proposes to treat long-term care insurance payments, "dollar-for-dollar," as if they were made by the policyholder by drawing down his or her assets.

To illustrate, a person with \$125,000 in assets subject to spend-down who received \$50,000 in insurance payments would be allowed to protect that amount from spend-down. To become eligible for Medicaid, the person would then have to spend down the balance of his or her assets, or \$75,000, in the same way as other persons applying for Medicaid. Under current Medicaid requirements, the individual's entire \$125,000 in assets would be subject to spend-down requirements. To the extent that the project works as intended, individuals would become eligible for Medicaid at about the same time they would have had they not purchased insurance and Medicaid would not incur additional costs.¹⁰ The only difference would be that the individual could retain \$50,000 of assets that otherwise he or she would have spent to meet Medicaid's eligibility thresholds.

Also, most projects are attempting to make long-term care insurance more affordable to lower or moderate-income persons. To accomplish this, the projects have proposed a number of strategies, which include: offering policies that cover only 1 or 2 years of care; offering competitively bid group policies to selected groups such as state employees; and

¹⁰ Actually, the individual would become eligible somewhat sooner if one assumes that the premiums paid for the private insurance coverage otherwise would have been saved.

subsidizing premiums and copayments.¹¹ For each project, however, participation is voluntary and will depend on the market appeal of the benefit packages offered and the purchaser's insurability,¹² as well as the price of the policies. Consequently, the income and asset levels of prospective participants remain uncertain. It would appear that other safeguards to avoid future increases in Medicaid costs, such as limiting the amount of assets that individuals can protect, are warranted.

Cost Estimates Sometimes Exclude Relevant Factors

Whether the projects meet their cost goals also will depend on whether the states have considered all factors that could increase Medicaid costs when making their cost estimates. Because the projects are in varying stages of development, we did not attempt to analyze all of the states' cost estimates. However, for two states whose projects were completed or near completion we did look at their estimates to see if any factors that could increase costs were not considered. Not all factors were considered. For example, at least one state did not take into account the losses it would incur by not seeking recoveries of Medicaid costs from project participants' estates, as they would with other Medicaid recipients. Further, participants' out-of-pocket expenses (such as copayments and deductibles) may well decrease assets and influence the timing of Medicaid eligibility. This potential effect was not evident in either of the states' cost estimates. Thus, if legislation permitting HHS to grant Medicaid waivers for the projects is enacted, a thorough analysis of the projects' cost estimates appears warranted.

States Should Be Required to Adopt Existing Regulatory Standards

Unanticipated costs to the Medicaid program and consumers can arise if states operating these projects fail to adopt adequate regulations and oversight of long-term care insurers. Long-term care insurance is a relatively new product that is evolving rapidly—often more rapidly than states' regulatory and oversight mechanisms. For the RWJF projects to work as intended, there needs to be reasonable assurance that the long-term care insurance products being sold and endorsed by the states under their projects provide adequate coverage that will be available to purchasers when needed. Further, states will need to collect and evaluate substantially more data than is now routinely collected through

¹¹These latter subsidy features are incorporated in several projects but will be funded entirely by the states.

¹²Long-term care policies are medically underwritten—that is, insurers require applicants to complete a medical history and will insure only those who do not have conditions likely to result in a high demand for long-term care services.

their oversight programs to (1) adequately monitor insurers' compliance with regulatory standards and (2) assess whether these demonstration projects are successful.

**Compliance With Minimum
Regulatory Standards
Should Be Required**

Over the past several years, concerns have arisen within the Congress and consumer advocacy groups about the quality of the long-term care insurance products being sold. As little as 2 years ago, studies by us and others demonstrated that most policies being sold contained provisions that were restrictive. For example, many policies excluded coverage for persons with Alzheimer's disease—a major cause of long-term nursing home stays. Further, we reported in April 1989 that most states had not adopted the minimum regulatory standards recommended by the NAIC that aimed to limit such restrictions.¹³ Since our report, more states have adopted NAIC's standards, but many have not.

Because the RWJF projects will involve states in promoting private long-term care insurance products, states that seek the necessary Medicaid waivers will assume an even greater regulatory responsibility than other states. For the projects we reviewed, the state will issue a seal of approval to the policies of insurers electing to participate if the policies meet the state's requirements. States also will undertake advertising campaigns to encourage the purchase of these products. Accordingly, we believe a state should be required to demonstrate, prior to being granted a waiver, that its laws and regulations meet at least NAIC's minimum standards and that it has the capability to enforce the requirements. Further, because NAIC's standards continue to evolve as the market evolves, a state should be required to maintain its standards to at least NAIC's minimum levels.

Each of the RWJF projects recognizes the need for strong regulation of long-term care insurance products offered under the projects. Additionally, most of the participating states have enacted or are considering legislation and/or regulations that meet or exceed NAIC's models, RWJF project officials told us.

**Adequate Data Collection
Should Be Required**

To effectively regulate long-term care insurers requires that states collect and analyze sufficient data to monitor insurers' performance and practices. In conducting our 1989 review of the states' regulation of

¹³Long-Term Care Insurance: State Regulatory Requirements Provide Inconsistent Consumer Protection (GAO/HRD-89-67, Apr. 24, 1989).

long-term care insurers, we found that much of the data collected by state regulators was not compiled in a way that allowed them or others to readily isolate long-term care policy data from insurers' other policy lines. This would include policyholder or other complaints and financial data such as loss ratios and reserves.

Further, because these projects are demonstrations to test the feasibility of a private/public partnership, it is important that data be available to evaluate them. This will require states to collect and evaluate substantially more data from insurers than they now do under their regulatory programs. Much of the information needed to assess the adequacy and role of private long-term care insurance in a public-private partnership is unavailable, except to the insurers. Such information would include demographics of policyholders, the numbers of persons denied coverage or benefits, and the numbers of and reasons for policy cancellations.

In our opinion, these kinds of data are essential, for both the private sector in developing the long-term care insurance market and the public sector in instituting appropriate regulatory controls. The uncertainty that insurers and regulators face in the absence of data is one reason many state regulators allow long-term care insurers to write policies that contain many restrictions and limitations. The projects are in a unique position to help resolve this problem of insufficient data. Thus, we believe that waiver approval should be made contingent on states and insurers agreeing to collect sufficient data and to share all research and tracking data on program participants with HHS. In this way, HHS too can monitor the projects and the data can become a matter of public record.

States Should Provide Adequate Consumer Education

By virtue of their involvement in the promotion of private long-term care insurance, states will have added responsibilities to ensure that consumers understand any risks associated with the policies offered under these projects. The policies can lessen, but may not eliminate, an individual's risk of impoverishment as a result of catastrophic long-term care costs. Thus, we believe that states need to make available information and counseling services to help consumers make informed decisions.

Consumers Need to Be Made Aware of Risks

While effective state regulation will lessen consumer risks, it cannot protect a consumer from making a poor decision in the purchase of long-term care insurance. Studies have shown that consumers frequently are unaware of the risks they face and therefore are poorly positioned to

make appropriate decisions regarding long-term care financing. They may not understand or be aware of coverage limitations of Medicare and privately purchased Medicare supplemental policies, the eligibility requirements of Medicaid, and the proper role and limitations of private long-term care insurance.

Being able to afford a policy is not necessarily a basis for purchasing one. The wisdom of such a purchase depends on the consumer's personal circumstances and on the state's Medicaid requirements. For example, a person with no dependents may have little to gain by purchasing long-term care insurance, as would a person without substantial assets that are at risk of spend-down. Though states can save Medicaid costs by encouraging persons to buy more asset protection coverage than they have assets to protect, this is not a responsible policy option from the consumer's perspective.

Additionally, individuals electing to participate need to understand that the added protection afforded by the projects will continue only as long as they maintain their long-term care policies in force. If the insurer elects to increase long-term care policy premiums in the future, it can do so on a class basis. A policyholder who is unable to continue paying these increased premiums may lose coverage, along with his or her entire prior investment in premiums.

Risks of High Out-Of-Pocket Expenses Lessened but Remain

Consumers who choose to participate in these projects by buying approved long-term care insurance could continue to be at risk for high out-of-pocket costs. Consumers need to understand this. Such costs could come from several sources, including payments for services not covered under their insurance policy or the difference between the indemnity payments and billed charges.

Conclusions

The proposed projects could significantly reduce the financial hardships that some elderly endure as a result of catastrophic long-term care costs. Additionally, the projects could provide a key source of information on the use of long-term care services experienced by project participants. Such information could help insurers in furthering the development of long-term care products that best meet consumers' needs and are affordable. It also could help state regulators develop (1) better standards and oversight mechanisms to increase consumers' protection and (2) educational campaigns to inform consumers of the appropriate role of long-term care insurance options.

On the other hand, risks are involved if the projects are given authority to link private insurance coverage with Medicaid. The Medicaid program could experience cost increases, while consumers risk not receiving the benefits they expected. Any problems that arise can have significant impacts, because the states that potentially will seek Medicaid waivers account for nearly 44 percent of all Medicaid expenditures nationwide. Further, while the RWJF projects are considered demonstrations, their commitments to project participants may require that they operate for 20 or more years. Such a long operating time frame is more characteristic of programs than of demonstrations. Consequently, authorizing the demonstrations would represent a significant policy decision.

Accordingly, adequate safeguards to minimize these risks should be carefully designed and incorporated at the outset. Specifically, we believe the projects should be required to

- limit the amount of assets that individuals can protect from Medicaid's spend-down requirements. This would lessen the risks of subsidizing persons who have other resources and thereby increase Medicaid costs;
- adopt and continue to maintain regulatory standards at least equivalent to those in NAIC's model act and regulations. This would lessen the risk that consumers will buy policies that are unduly restrictive;
- develop effective consumer education and counseling programs. This would help assure that consumers are aware of the risks and buy coverage commensurate with their needs; and
- collect and make available to HHS sufficient data to monitor and evaluate the projects on an ongoing basis.

Matters for Congressional Consideration

If the Congress wishes to give HHS authority to approve demonstration projects such as those proposed by the RWJF grantee states, it should consider including in the legislation

- requirements to minimize the financial risks to the Medicaid program and to consumers and
- requirements that the Secretary of Health and Human Services prepare interim reports to the authorizing committees on whether the statutory requirements are meeting their intended purposes.

State Project Summaries

The following program descriptions and demonstration designs were taken from summaries prepared by project directors in each of the eight states selected to receive a long-term care insurance planning grant from the Robert Wood Johnson Foundation. As the summaries were dated October 1989, they may not reflect the current status of program development. This is particularly true for Oregon because its grant was the last to be awarded.

California

Program Description

A public-private partnership will be created to finance and provide long-term care services. Individual Californians will be offered the choice of purchasing affordable insurance or enrolling in health maintenance organizations that pay for or provide appropriate home, community, and institutional long-term care services. The state will subsidize the premiums and enrollment fees of low- and moderate-income older Californians who choose to buy approved long-term care insurance or enroll in HMOs, using a sliding scale according to ability to pay. Subsidies up to 50 percent or more of the annual premiums are planned. Financially well-off individuals will not be eligible for subsidies.

Public Role in Partnership

A state agency will be assigned to oversee the program. The state agency will

- set standards for the review and approval of service plans of health maintenance organizations and insurance companies who choose to participate in the program and agree to offer an approved range of long-term care services;
- specify the scope of in-home, community, and institutional services that each long-term care service plan must cover in order to be approved to participate in the program;
- set uniform standards to be used by each participating service plan to determine when enrolled individuals qualify to receive covered services;
- establish appropriate loss-ratios;
- monitor the quality of long-term care service provided;
- offer a state long-term care service plan; and
- subsidize the costs of premiums and enrollment fees of individuals who purchase private insurance or join HMOs that offer long-term care services meeting state requirements.

Private Role in Partnership

To participate in the program and qualify to have their long-term care products eligible for subsidization, insurance companies and HMOs must

- develop service plans that cover and pay for the range of home-, community-, and institutional-based long-term care services required by the program;
- arrange with not-for-profit and for-profit providers to coordinate and deliver appropriate long-term care services that allow the individual to remain independent and in the community as long as possible;
- adopt quality assurance standards established by the program and monitor the quality of care delivered by case managers and providers;
- use the uniform eligibility criteria set by the program when marketing their long-term care coverage and enrolling consumers;
- use a uniform, disabled-based assessment measure set by the program to determine when policyholders and enrollees qualify to begin receiving long-term care services.
- guarantee enrollees and policyholders that their long-term care coverage will be renewed for life, except for failure to pay premiums and enrollment fees; and
- meet the state standards for the amount of benefits to be paid out for each dollar of premium paid in.

Demonstration Design

Details of the demonstration—size, duration, and so on, still are being developed.

Connecticut

Program Description

The Connecticut Partnership for Long-Term Care is a joint, private-public program that encourages individuals to plan for their long-term care needs by purchasing insurance protection in an amount commensurate with the amount of assets they wish to protect. Thus, an individual with \$25,000 in assets might buy \$25,000 in insurance protection; one with \$150,000 in assets might buy \$150,000. An individual who exhausts insurance benefits can apply for Medicaid, and each dollar that the insurance has paid out in accordance with state policy will be subtracted from the individual's remaining assets. The assets will not be recognized or considered in determining eligibility for Medicaid. That is, the insurance payments for long-term care services will be considered as

equivalent to the spending of assets for the purpose of establishing Medicaid eligibility.

Once on Medicaid, individuals will receive life-long coverage of health and long-term care needs and can keep control of assets up to the amount that insurance paid. Income still must be applied toward long-term care expenses. (In case an individual needs Medicaid assistance prior to exhausting insurance benefits, he or she can disregard assets equal to what the insurance has already paid out. One additional dollar in income can be retained for each additional dollar the insurance policy paid for approved expenses.) This resource protection could be available to the elderly and nonelderly alike.

Demonstration Design

The Connecticut Partnership for Long-Term Care is a 6-year, statewide, demonstration and evaluation project. It was launched in August 1989 with a 3-year RWJF grant of nearly \$1.8 million. The state's commitment to the partnership involves

- developing precertification requirements so that qualifying insurance policies incorporate comprehensive benefits (such as provision of case management in all home care benefits and built-in inflation protection or guaranteed offering of periodic inflation upgrades) and implement minimum standards (set minimum nursing home and home care per diems, notify potential purchasers of the state's toll-free assistance line, give them information prepared by the state on long-term care and the Connecticut Partnership for Long-Term Care, and so on);
- providing the promised asset protection; and
- undertaking, via the state's Department of Aging, a complete public education and consumer counseling strategy.

Indiana

Program Description

Indiana's Long-Term Care Insurance Program is designed to

- assure fiscal neutrality and ease of administration for the state;
- foster insurance industry flexibility and innovation in long-term care product design; and

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- maximize the opportunity for consumer choice among a wide array of long-term care insurance products, including service indemnity benefits and prepaid health as well as life insurance products.

At the same time, the program provides a basic level of consumer protection through a set of minimum standards that exceed those established by NAIC and must be met before products can qualify for participation in the Indiana program.

To serve the broadest possible range of income groups in the simplest and most equitable manner, the Indiana program provides asset protection equal to the amount of insurance payments for Medicaid-eligible long-term care services. Consumers can purchase a qualifying policy with the amount of insurance coverage (and asset protection) they believe they need and can afford.

After insurers over 65 have depleted their insurance benefits and become eligible for Medicaid, they will contribute income toward the cost of care in the same manner as other Medicaid-eligible individuals. For services covered in insurance policies but not covered by the Indiana Medicaid program (such as certain home care services), consumers may apply to the state for participation in other public programs that do provide these services.

To qualify for the Long-Term Care Insurance Program, insurance policies must provide coverage for at least 12 months. This 12-month minimum has merit in that (1) premiums are affordable to a larger number of people for this level of coverage, (2) the length of stay in nursing homes is less than 1 year for a majority of people (63-73 percent, depending on the source), and (3) a majority of the spend-down group (86 percent, according to Indiana statistics) spend down within 1 year.

Demonstration Design

Indiana plans to implement the Long-Term Care Insurance Program statewide for the population aged 65 and over for the period authorized by the terms of the federal Medicaid waiver. The state intends to make a permanent commitment to program entrants but may cease to accept new clients if circumstances warrant at the end of the waiver period.

With the program, Indiana expects to demonstrate that insurance is a viable method of financing a greater portion of long-term care expenses than has been the case to date. The state seeks to show it can simultaneously enhance the quality and affordability of long-term care insurance

coverage available to its citizens, reduce financial hardships for the elderly, and offset future public expenditures for long-term care.

Specifically, Indiana will attempt to

- compare the demographic characteristics and economic status of persons purchasing and not purchasing insurance;
- evaluate the types, features, and amount of coverage purchased and used;
- evaluate the extent to which insurance coverage is used to finance Medicaid-eligible and other publicly funded services;
- monitor the effects of underwriting, access to coverage, and access to benefits; and
- evaluate the long-term care expenditure patterns for insured and uninsured persons (such as client asset and income spend-down patterns, changes in the share of the costs born by insurers and public expenditure patterns, and effects of induced demand).

Insurers have agreed in principle to provide the state with data needed to administer the Long-Term Care Insurance Program and to evaluate its effectiveness. For example, insurers will track the characteristics of persons denied coverage due to underwriting. After the first 2 years of operating the program, Indiana in conjunction with insurers will evaluate the need for additional public-private approaches to serving persons with limited access to coverage due to economic or health status factors. The results of this evaluation will be compared with the results of the Governor's Health Policy Commission study of the uninsured. If additional approaches are recommended, they will be implemented during the third year of the program.

Massachusetts

Program Description

The commonwealth of Massachusetts has designed a public/private partnership for financing long-term care. This partnership would establish an agreement between the state and private insurance carriers to make long-term care insurance available to the citizens of the commonwealth. Insurers will develop quality long-term care insurance policies that offer lifetime benefits for nursing home and home health care. High-income elders will be able to purchase these policies at full price; low- and middle-income elders will pay a reduced premium for the same

lifetime benefit package. The state will share the risk with the insurers for low- and middle-income elders, not by paying premiums but by paying for care for these individuals if their private benefits are exhausted.

As a result, a large number of people currently uninsured will have access to long-term care insurance and avoid the risk of catastrophic nursing home and home health care costs.

Demonstration Design

To test the feasibility of this partnership, the state proposes a 5-year demonstration in which the partnership would enroll 7,500 Massachusetts elders between the ages of 65 and 69 over a 3-year period. They will include three target groups, composed of

- elders from the general state population,
- elders enrolled in a health maintenance organization (HMO), and
- state retirees.

The state also is interested in working with one or more employer groups to offer long-term care insurance to working age populations. The intent is to assist one or more employers in Massachusetts to enroll up to 2,500 workers in private insurance plans in the fourth and fifth years of the demonstration period. No public subsidies are planned for the working age group.

The commonwealth will request proposals from insurers who are interested in insuring both elders and working age employees in Massachusetts. The partnership to be established will guarantee policyholders that the program will continue for their lifetimes. The demonstration project is expected to serve as the first phase of statewide implementation of a long-term care insurance plan.

In years 1 and 2 of the state's partnership with private insurance carriers, coverage will be offered to 5,000 Massachusetts elders, half from the general population and half from among HMO enrollees. In year 3, enrollment will be offered to a group of 2,500 state retirees.

In years 4 and 5, the state will work with one or more private employers to offer long-term care insurance plans to workers. Year 5 also will be used either to plan statewide implementation or to integrate the current demonstration into ongoing state functions.

New Jersey

Program Description

New Jersey Senior Care is designed to be a public/private partnership based on a group insurance program, underwritten and offered by a carrier chosen through competitive bidding. The two chief goals of the pilot are to

- create a working model that encourages the spread of long-term care insurance programs offered to New Jersey residents by employers, unions, and other membership groups in the state; and
- demonstrate an insurance program that is affordable to people at a wider range of income levels than is currently available.

Participants' Roles

As a public/private partnership, the program involves three participants, as follows:

1. Carrier: In addition to risk-taking, the carrier will provide in-kind contributions to a targeted education program, training of case managers, on-going consumer service, claims management, and provision of data and statistical analysis.

2. State/sponsor: The state is responsible for the design and management of the overall program, funding of a subsidy program for those who qualify, and coordination of the insurance program with existing Medicaid programs for long-term care. The state also is responsible for reaching agreement and coordinating with the sponsoring organization whose members will be offered the pilot program. In this case, the state is working with the New Jersey Education Association.

3. Insured: Individuals will be responsible for the costs of their own premiums and some copayment and deductible costs.

Covered Services

The insurance program includes skilled and custodial care, both institutional and community-based, with strong emphasis on home care, adult day care, and respite care for families. This is a modified indemnity plan, providing 70 percent of usual and prevailing rates, up to \$100/day for nursing homes, \$50/day for home care, and \$25/day for adult day or respite care. (There are also monthly limits on each service, allowing for services to be aggregated by the case manager.)

Proposed Model Plans

Two models have been developed:

1. Basic plan: Individuals will be offered coverage in line with their level of personal resources (income and assets). Participants will be assigned to one of six resource groups, corresponding to years to spend-down. The insurance will have deductibles and copayment (120 days; 70/30 coinsurance) to lower premiums for everyone. Resource groups 1-3 will have sliding scale subsidies for the deductibles and copays. Resource groups 4-6 will be responsible for their own cost sharing.

2. Asset protection plan: This is an enhanced version of the basic plan, which will be implemented if the state obtains a Medicaid waiver. In this plan, the individuals in resource groups 1-4 will be entitled to waiver of Medicaid asset spend-down rules and income limits. If these individuals have purchased the required amount of insurance for their resource group, they will be entitled to a credit of the number of years of coverage they purchased. Individuals in resource groups 5 and 6 will not be entitled to the waiver of spend-down rules but would be expected to purchase concomitantly greater coverage.

Demonstration Design

A group insurance program will be offered to a defined population (New Jersey teachers and retired teachers). A pilot group of 10,000 active and retired individuals is expected, with an extensive education program preceding the enrollment period.

The demonstration is planned to begin in 1990, with enrollment effective in 1991. The first year will be devoted to designing and managing the request for proposal process for selecting the carrier, creating the case management network, and creating and implementing the education program. By collecting information and data through April 1996, the demonstration will create a 5-year data base.

A management information system will be an integral part of the demonstration, enabling the capture of data on the pilot population. Additional goals in the demonstration include

- creation of a certification process for case management agencies,
- establishment of a preferred provider organization arrangement for insurers under long-term care insurance, and
- creation of an outreach program to employers to encourage further use of the long-term care insurance model.

New York

Program Description

New York State will reinsure purchasers of state-approved, private, long-term care insurance policies who have exhausted all the benefits of such policies. The reinsured individual will be eligible for all long-term care services provided under New York's Medicaid program for as long as needed. Those who are reinsured by Medicaid will not be required to meet the income/asset regulations otherwise applicable to Medicaid applicants.

The New York State model contains the following features:

Services

Institutional long-term care: The program provides for 3 years in a residential health care facility qualified as a provider in the Medicare program pursuant to title XVIII of the Social Security Act.

Home and community-based services: Nursing, personal, and respite care services are covered. They can be provided by a home care services, long-term home health care services, or certified home health care agency; a long-term home health care program; or a personal care provider licensed or regulated by any state or local agency. Qualification for reinsurance through the use of home- and community-based services will require usage and coverage of such services for periods longer than 3 years.

Eligibility

Eligibility for services will be determined by objective assessment. Eligibility for indemnity benefits will be premised on receipt of covered services.

Administration

For institutional long-term care, the minimum payments will be set at established average Medicaid rates. Inflation protection will be required, and insurer benefits may be either service or indemnity.

For home- and community-based services, per diem rates will be based on a fixed percentage of the institutional long-term care rate being paid when the services are utilized.

Underwriting will be permitted, and policies must be guaranteed renewable. The insurable event criteria will be approximately equivalent among insurers and consistent with New York State definitions. Assessment criteria and instruments must be comparable among insurers and

the state. The Superintendent of Insurance will establish minimum loss ratios, and pooling of loss ratios across product lines will not be permitted.

Insurers will maintain separate premium and loss data for policies. Private and public insurers will coordinate their data collection so that information on reinsurance eligibles will be known and tracked.

Demonstration Design

The demonstration is anticipated to continue for 6 to 10 years. Enrollment of 12,000 consumers is New York State's goal. There will be no age limit for purchasers and no limit on the number of purchasers above 12,000. The demonstration evaluation will focus on 60-80-year-olds.

Through negotiation of mechanisms and structures with the private sector, the state will make sure that data collection is coordinated and service delivery monitored. This will be done in such a way that insured individuals will clearly understand their transition to public reimbursement for long-term care services when private benefits are exhausted. Case management will be required.

The state will market the demonstration program through an identifying logo associated with qualifying insurance products. Carriers may market products by using the logo; carriers will be asked to contribute to the marketing and education effort.

Wisconsin

Program Description

Wisconsin's long-term care protection program consists of a variety of state incentives for long-term care insurance market participation. The incentives are designed to encourage (1) insurers to develop comprehensive policies and (2) consumers to consider purchasing these policies to protect themselves against long-term-care-related impoverishment.

The state will offer the following incentives:

1. **Consumer protection and education:** A variety of means, such as campaigns and public speaking, will be employed to inform the public about the costs and risks of long-term care, the pros and cons of buying long-

term care insurance, and the special features of the long-term care protection program as they are implemented.

2. Availability to state employees and retirees: The Wisconsin Department of Employee Trust Funds will make long-term care protection insurance available to state employees and retirees, their spouses, and their parents.

3. Increased monitoring and data coordination: The long-term care protection program will establish an individual-specific, long-term care data base through centralization of various state data bases. The data will be shared with insurance firms as a basis for their product pricing efforts and ongoing monitoring.

4. Private case management enhancement: Social service agencies in Wisconsin counties manage care for many public program clients. The long-term care protection program will work with interested county agencies to enhance their insurance/private pay case management capacity.

5. Reinsurance for sellers: The state proposes to establish a long-term care reinsurance pool for firms selling long-term care policies. Insurers offering such insurance would voluntarily participate, paying premiums to the pool against the risk that their long-term care insurance fund would experience unanticipated losses in the future. The reinsurance contracts may require that insurers maintain higher loss ratios than would be required by law.

6. Expanded medical assistance eligibility: The long-term care protection program will offer expanded Medicaid eligibility limits to insurance purchasers, under a federal waiver. Individuals will purchase qualifying long-term care protection insurance policies or other financing vehicles, and use the benefits as appropriate. If they exhaust their policy benefits before their long-term care needs end, they can apply for Medicaid under that program's medically needy guidelines. In analyzing such applicants' financial eligibility, the state will not count certain nonhousing assets toward Medicaid spend-down. The spend-down will be offset by the amount of money the insurer had paid on behalf of the beneficiary for services that otherwise would have been covered by Medicaid. This offset will count services covered under regular Medicaid.

Target Groups

To accomplish these goals, the long-term protection program would target two groups for state action:

1. Persons who could afford to buy long-term care insurance but could not self-finance a significant long-term care need and risk becoming Medicaid-eligible after a year or two of disability. An estimated 90,000 persons, aged 65 and older with annual incomes of \$10,000-30,000 and per-person assets of \$10,000-90,000, are now in the first target group.

2. Persons not quite able to afford long-term insurance for whom state subsidies of the premiums would be cost-effective because the insurance would prevent or delay Medicaid eligibility and lead to Medicaid savings commensurate with long-term protection subsidy dollars. The state's initial analysis of Wisconsin and national income and asset data shows approximately 15,000 residents of the state in this target group, those over age 64 with annual incomes of \$5,000-15,000 and nonhousing assets of \$15,000-25,000 per person.

Oregon

Program Description

As Oregon's project was one of the last to begin, this information should be considered tentative. The following elements in a potential partnership model for Oregon have been under consideration by state officials:

- Medicaid as stop-loss, with enhanced protection of assets at spend-down;
- Medicaid subsidy of policies, if that would be a cost-effective alternative to early spend-down;
- A comprehensive home- and community-based and nursing facility service package similar, if not identical, in scope to the state's Medicaid service package under its 1915(d) waiver;
- State screening and case management for the entire package utilizing objective functional impairment criteria similar to those currently used by the state to define the "insurable condition." These criteria include, for example, needing assistance in at least three of six activities of daily living (behavior, continence, eating, mobility, bathing, and dressing); and
- The state to take risk with respect to case management and home- and community-based service costs.

Demonstration Design

Oregon officials contemplate a target population consisting of either state employees, their parents and in-laws, and retirees; or public employees generally, their parents and in-laws, and retirees. The duration of interest, should there be a demonstration project, is at least 6 years; the scope would be statewide. There is no clear indication as to whether and under what conditions a single carrier would be best. Long-term contractual arrangements binding the partners probably will be a more politically feasible mechanism than the public trust fund originally considered.

Information sought from such a demonstration would include: marketability of long-term care insurance to younger age groups; utilization of both family and paid services in the insured environment compared with the public pay environment; costs in the insured environment compared with the public pay environment; and consumer acceptance of restrictions imposed by a single, statewide, public sector, case management system.

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