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Use of Managed Care in Long-Term Care Insurance Contracts

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Summary: Most long-term care policies being developed today require use of a "care manager" in order to receive either benefits or enhanced benefits. Is this benefit a "frill" or does it actually lead to reductions in expected claim costs? Panelists discuss:

- *The ways in which care coordination and reimbursement for claims can be coordinated with the risks inherent in LTC insurance.*
- *The tools and methodologies used by the typical care coordinator.*
- *The type of experience that has been achieved under various Medicaid programs that have implemented managed LTC programs.*

Ms. Dawn E. Helwig: Don Charsky, from Life Plans, is going to be our second speaker today. Don is the president of Life Plans, which is an LTC administrative company. He does underwriting and claims administration. My third speaker is Peggy Hauser with Long-Term Care Group, which is another LTC administrator. Peggy had spent 12 years with Milliman & Robertson prior to that.

Care management for LTC is something that has been around for a little while. However, it's probably just in the last couple of years, since the advent of the Health Insurance Portability and Accountability Act (HIPAA) that it's really taken off. The HIPAA legislation requires that a plan of care has to be provided to the insured, and that plan of care has to be prepared by a licensed healthcare practitioner. Because of that, we're seeing the advent, more and more in policies, where companies are incorporating a plan of care and a care coordinator, which

borders on many managed care elements. Some of the care coordination policies that we see are very loose. The care coordinator can be totally optional; the insured can use the coordinator if he or she wants, just as an added benefit to the policyholder. In other cases, we see that somewhat of a penalty approach is being used, where the insured is told that he or she can choose to use the care coordinator, or if he or she chooses not to, that his or her benefits under the policy will be reduced. Probably the furthest extreme is there are some plans of care, or policies, out there that are requiring that the care coordinator be used 100% of the time, or at least that the care coordinator be reviewing and approving the plan of care that is provided.

Because this care coordination is actually not a cheap benefit to add to the policy, there is an added expense associated with it. There has been a little bit of debate, or some discussion, as to whether that benefit is actually buying you anything, or if it's just an illusory benefit. I guess I would like to present the viewpoint today that if managed care is really done correctly, if it's true managed care rather than an illusory benefit, then there can be some significant savings involved. I'd like to begin with a definition of managed care, as a way to transition into LTC. Under managed care, we're talking about providing the right care at the right time in the right way by the right provider. As we think about LTC, if we're talking about providing the right type of care, an example of that could be a situation where an elderly person is diagnosed as being depressed. The question could be, "Could companion services solve that, or do they really need to go on medication?"

The "right time" is a critical aspect of LTC managed care. You really need to get the LTC manager involved as close to the time of the claim as possible, which usually means before the elimination period has run out, quite often before the patient goes into the hospital or starts on any kind of Medicare home health care or skilled nursing facility services. We want to provide the care in the right way, and this sometimes goes in the opposite direction that you might think. I think what "right way" implies is that it really needs to be medically correct services and of good quality. This might mean that you're not going to allow the home health aid to do a service that really should have been done by a skilled nurse. You want to be using the right providers, in the sense that you don't want to have to put a person into the nursing home if you feel home health care is appropriate, or you don't want to be sending a licensed practical nurse to do housekeeping services just because the licensed practical nurse was most convenient.

I alluded, a little bit ago, to one of the reasons why managed care has become more prevalent, and that's because of the HIPAA legislation. HIPAA has resulted in a little bit more standardization of LTC policies, which has, in turn, led to some competitive pressures for lower premiums. As a result, companies are trying to look

for other ways, including managed care, to get their premiums down. I have two other reasons why managed care has become more popular for LTC. One is what we call the "quicker and sicker syndrome," where, because of shifts from inpatient facilities to outpatient facilities, we see more serious conditions going into the skilled nursing facilities or coming home, and there is a greater need for home care or some kind of ongoing LTC. The second is fraud and abuse, which for many companies has been the final straw in going to a managed care approach. The Government Accounting Office has estimated that in Florida probably as much as 25% of home healthcare services are fraudulent. That number's a little bit old, and hopefully it's been coming down, especially as a result of some of the legislation in the last couple of years. But there definitely have been a lot of fraud problems in pocketed areas around the country, and a lot of companies are trying to go to managed care in an effort to control some of that fraud.

There are two basic approaches that companies can take to managed care. The first is what we call a case management approach; the second is a true care management approach. Remember, managed care can either be considered a responsibility of the payer or of the provider, or it can be a collaborative effort of both. Some of the limited results that have been coming in on managed care programs have shown that if you can do true care management on a collaborative effort, you're likely to get the greatest savings.

Case management is sometimes known as fiscal management because it is primarily done to manage dollars. A case manager will usually be the advocate of the insurance company in a care management plan. The case manager performs assessments of the individual's functional capacities, determines what services the individual needs, and prepares a plan of care for them (Insert A). I should point out that in analyzing the appropriate services and preparing the plan of care, to be effective it really needs to be done by someone who has some geriatric specialty—either a licensed practical nurse or someone who's very familiar with the over-65 claim situation. The insured's family doctor needs to be involved and to review the plan of care to make sure it's appropriate, but he or she is usually not the right person for deciding whether Mrs. Jones should get housekeeping services every day of the week. If you did nothing more than case management, you should see some savings. This is not trivial, but you may not see savings that are in excess of what you're having to spend to do that case management.

INSERT A
CASE (FISCAL) MANAGEMENT

Assess individual's needs
Determine functional level
Determine appropriate services
Develop care plan

In the second type of care management, sometimes called clinical management because it gives more emphasis on the actual care of the patient, the care manager is more of an advocate for the patient, getting involved with the patient early on and walking him or her through the possible avenues of care. The care manager has the same responsibilities as the case manager; that is, to assess the individual's functional capacity and prepare the plan of care. But in addition, the care manager also helps the insured with implementing that plan of care, helping find providers, negotiating discounts with those providers, and monitoring the outcomes to make sure that the right care had been given (Insert B).

INSERT B
CARE (CLINICAL) MANAGEMENT

Same responsibilities as case management, plus:
Implement care plan
Monitor outcomes
Monitor experience
Contract with providers

I should comment that the case management that I discussed earlier is really where most insurance companies are right now; that is more the level of what's going on in the market at the moment. Care management is being performed, but right now it is usually more limited to situations where you have' a skilled nursing facility, a home healthcare agency that's contracting for a Medicare risk plan, or some situation where they're being fully capitated and they really have to do very serious care management.

How is care management performed? The insurance company quite often has the capacity to do the care management, although many insurance companies' care management has been more focused on under-65 types of plans, and that, as I said earlier, doesn't really translate that well to the over-65 market. You really need to have somebody who understands geriatric medicine. More and more, insurance companies are using outside coordinators or LTC organizations to do a lot of the care management for them. One of the reasons is because they don't have those capabilities internally. But another reason is, quite often the insurance companies don't want to have to be seen as the enforcer. It's a little bit more palatable to insured people to have someone from an outside care management agency sit down with them and present him or herself as their advocate and work with them to prepare a plan of care, as opposed to somebody who's a representative of the insurance company coming and saying, "This is how we want you to get your care."

The obvious question is, if the insurance company does not perform the care management feature, how do you make sure that there are some financial savings

involved? Most of the care management companies charge on some kind of basis that's related to claims, either a certain dollar amount per claim or a percentage of claims, or something that's tied into the functions that are being performed. Some people have a bit of concern that could be likened to the fox guarding the henhouse: If they're compensated based on the claims that they pay, how do you motivate them to keep the number of cases down or to keep the payments down? There are two ways that can be done. The first way is to, obviously, do a lot of checking on the care management agency, make sure that they're a quality company, and then perform regular internal audits of what they're doing to ensure that the care plans and assessment methods fit in with what your policy is allowing and what you want them to be doing. The second way is to get the LTC coordinators financially involved in the LTC plan that you're administering. In other words, you get them, if you can, to share in the risks that they're taking on by monitoring claims.

We're going to talk about how to do that, but before we do I want to just briefly review something fundamental—the general way that a claim cost is determined. For LTC, determination of a claim cost is a combination of the frequency of becoming disabled times the average length of the disablement times the cost per service being used times the percentage of people who are actually using each service times the number of services that they're using per month. Those last three elements are all going to vary depending on the type of care. You're going to have a different cost per service, percentage using, and number of services per month, depending on if it's a nursing home, skilled nursing at home, a therapist, home health aid, a homemaker, etc. Care management can affect each one of those elements.

We have the risk of the frequency of occurrence. Translating this to what a care manager can do for you, the care manager is the one who's doing the assessing of the claims, so he or she is going to directly affect what the frequency of those services, or the occurrences, is. The care manager can have the biggest impact on cognitive claims, which are the most difficult to assess and the ones that they can probably have the biggest impact on.

The second type of risk is the risk of the length of stay. While on the surface it may seem that you want to get that length of stay or the length of care being provided as short as possible, in reality, what you're really looking for is the right length of stay. If it gets too short and too much care is cut out, you could end up with people being sent into more serious conditions either in nursing homes or hospitalized situations or whatever. Their care could actually deteriorate if their length of stay and care is cut short.

A third element of risk is the charge per service rendered. Care managers, again, quite often have significant impact in this area. Even if it's not a PPO-type product, care managers quite often go out and negotiate with the nursing homes or the home healthcare agencies to get the fee levels reduced below the normal market levels.

Lastly, the fourth type of risk that we see with LTC is just the risk in terms of the intensity of services, the number of services the person gets, and the mix. Again, care managers can have a fair amount of impact here. They can take many of the services that are being performed by skilled nurses and move them down and have a home health aid perform them, basically putting the services in the right place.

Assuming that we've gotten the LTC organization to go along with accepting some financial participation, how do we define or determine that participation? There are four different types of reimbursement methods that we can use. The first is to provide a discounted fee-for-service, and again, this is something that many care managers are doing right now via internal negotiations. The second method is a per-diem method, where you would actually pay the care manager a certain amount per day of service. In this case, the care managers not only have the risk of the charge level and 'be motivated to do discounted services as often as possible, but they also take on the risk of a mix of services, because here they're trying to keep the total amount or the total cost per day as low as possible. They'll also be more motivated in this case to move some of those services that were nursing home to the home healthcare setting, or some that were skilled nursing down to a home health aid setting.

The third type of reimbursement method is a per case method, where you'd be paying a certain dollar amount per claim that the care manager takes on. Care managers are given the same two risks as in the first two items, but here you will add the risk of the length of stay. With this method, they will be motivated, again, to make sure that the mix of services, the average charge, and the length of stay are all within the bounds of the pricing.

The last method is a full capitation method, which again is currently just being used with Medicare-risk-type plans. Most care managers are not going to be very interested in doing a full capitation method, in which you're also going to transfer the risk of frequency to them. If the care managers are also performing the underwriting, it's not unreasonable to change by moving that risk to them. But if they're not doing the underwriting, there's an element of the whole class that's out of their control.

Let's just revisit briefly the four different types of risks that we talked about, as well as the four different reimbursement methods, and who is taking on each of the risks

at each of those different reimbursement methods (Table 1). Again, if you're not doing any kind of care management, the insurer will have the risk for all of these things. As you move down each level of reimbursement, the provider takes on one additional level of risk. If you go to either the per case method or the fully capitated method, setting the rates, whether per case rates or the capitation rates, is very complicated. Your claim costs are going to vary by age, sex, duration, and area, particularly if you have a care manager who's just dealing in one particular geographic area. You really shouldn't be using nationwide claim costs to determine capitation rates. Getting the right set of claim costs and the right expectations and setting the cap rate is also very complex. The cap rates should also vary based upon what the underlying degree of health management is in the medical plan that the people have. If they're coming from a medical plan that is very well managed, you're going to see more of this "quicker and sicker syndrome," where they're going to be coming out and needing more LTC services.

TABLE 1
WHO ASSUMES THE RISK?

Type of Reimbursement	TYPE OF RISK			
	Charge Level	Mix of Services	LOS	Freq. Rate
Discounted FFS	Provider	Insurer	Insurer	Insurer
Per Diem	Provider	Provider	Insurer	Insurer
Per Case	Provider	Provider	Provider	Insurer
Capitation	Provider	Provider	Provider	Provider

There are several keys that will help you make the managed care programs work besides just getting the managers financially involved. The first is policy language, and it is absolutely critical. If your policy language is not tight enough to give you the ability to do the care management when you need to and you leave open that hole that says they don't have to use the care manager, there are some pretty big fish that are going to get through that hole. That's where the fraud problems are going to come in. You need to have a very well-defined claim procedure on doing managed care. You need to make sure that you can get early notification of the claim, usually well before you're actually going to start paying. Even before the person starts on a series of Medicare reimbursed home health care that you're not even paying for, you still would like to know about that so you can start planning his or her care at that point. You also need to dispute some kind of grievance procedure in case there are disagreements between you and the insured on what the care plan should be. You need good assessment tools, such as face-to-face analyses, so that you can define what the functional or cognitive impairments are. Ideally, the care managers should have some good claim protocols, where they, for a particular diagnosis, have an ideal plan of care that they would like to see implemented. Such a scenario in LTC is really still in its infancy. There has not

been a lot of research done in that area yet. You need to have good data collection so that you can be checking for outcomes. We already mentioned the need for early involvement. You need to be able to do, on a fairly regular basis, some follow-ups and revisions to the plans of care.

I want to close by just giving you a rough idea of what some of the potential could be if you're doing true managed care. We know that there is a significant potential for utilization abuse if there is no managed care going on at all. We have seen, in some areas in Southern Florida, Dade, and Broward counties in particular, where companies have experienced actual to expected ratios of 200% or greater because of' fraud problems. If you do true managed care, there can be some significant savings potentials. I think Peggy is going to get into what kinds of savings the various states have had as they've gotten into Medicaid managed care plans. We have seen Medicare risk plans where it's really been the acute side, Medicare-type reimbursed skilled home care or skilled nursing care. We've seen savings as great as maybe 30–60% when managed care is introduced. In the case of LTC plans, you have that large group of people who are getting chronic care, which is a lot harder to do something about, and the savings are nowhere near as great.

The last issue I would like to touch on is the potential of well-managed versus unmanaged care (Table 2). These numbers should not be taken as the gospel for how much you can save, but I think that they do tie into what some of the states have achieved. Basically what happens when you introduce managed care with LTC is you'll see the frequency of your nursing home stays go down pretty dramatically, but the frequency of your home healthcare stays will go up. You're essentially moving many of the people from that nursing home to the home health setting. Likewise, you should be able to get some savings in the number of services that are being used per month and the cost per services on the home healthcare side. You're probably going to get a greater percentage of people who are eligible for home care services using those services, because the care manager is going to go in early on and recommend that the person start getting some services that he or she might not have thought of otherwise. The net impact if you have a comprehensive plan is that you might be able to get somewhere in the range of a 9–10% savings with managed care. Even though it looks like the savings on nursing home care are significantly greater than that, I would caution you that if you have a nursing-home-only plan, you obviously won't be able to get that level of savings because there is no home health care to move the people over to.

TABLE 2
EXAMPLES OF MANAGED CARE POTENTIALS

	NURSING HOME		HOME HEALTH CARE	
	Unmanaged	Well Managed	Unmanaged	Well Managed
Frequency	.0246	.0184	.0220	.0264
# Months Disabled	20.1	22.1	25.9	23.3
Cost/Service	$120	$120	$47	$45
% Using Services	100%	100%	66%	80%
# Services/Month	30.4	30.4	27.8	27.6
Annual Claim Costs	$1,804	$1,483	$491	$611

Net savings on comprehensive plan = 9%

I'd like to turn it over to Don now, and he's going to tell you a little bit about the various types of tools that care managers can use.

Mr. Donald M. Charsky: I'm going to spend quite a bit of time on the insurer perspective as it relates to managed LTC, and an awful lot of time on care management and case management. Our three presentations necessarily overlap a little. It's very difficult to get into the details on care management without spending a bit of time on definitions, because I believe what one has to appreciate and recognize is that care management, as it relates to LTC insurance, is still a work in progress. One of the first things I experienced when I started to talk about care management years ago was that we were all talking about different things, depending on where we came from. People who came from the medical side understood care management to mean one set of things. Now we have managed disability and managed workers' compensation. Depending on people's historical perspectives and business experience, they're going to think differently on what this all entails. I'm going to spend time defining what it is, in my opinion, that insurers are doing, and then what kind of experience we are seeing.

As Dawn mentioned, there's a clinical aspect and there's a fiscal aspect. It's kind of a five-step process as it relates to care management in LTC insurance. The steps are needs assessment, plan development, plan implementation, monitoring, and finally an ongoing evaluation as to the plan's effectiveness in meeting its needs. I will go into greater detail on each of those aspects in a little while. When we flip to the fiscal side, as it relates to LTC insurance, I always think about benefit eligibility and coordination, also termed nonduplication, for either a group with other insurance or nonduplication with Medicare. I also consider care norms—what is appropriate, what is reasonable, what is customary—for a given set of circumstances for an individual, depending on his or her needs, age, gender, etc. There is also provider contracting, something we're just starting to get to in LTC insurance. Finally, Dawn already touched on financial arrangements quite significantly, so I'm not going to spend any time on that.

When we talk about needs assessment, we go back to the historical development of care management as it relates to chronically disabled individuals. In terms of LTC, if you talked to care managers ten years ago about what they did, they were primarily involved in financial/ budgeting issues. Once they were asked to help an individual and his or her family, how could they take the situation in terms of free services: informal help from family, whether or not they had insurance—and most people didn't have insurance back then—Medicare and Medicaid? How could case managers get the services all organized in such a way so that all those various providers and financing systems could meet the needs of the individual?

Now we've kind of flipped it around, at least from an insurance perspective, because we know these individuals have insurance. The financing has become less of a concern; now we're starting to concentrate on defining their needs. Functionally, we have activities of daily living (ADLs) and instrumental activities of daily living, which are measures of a person's ability to live independently. We have cognitive impairment, which really has three dimensions. There is the most obvious, the inability to remember. We also, in this area, get into issues of behavior, such as abusive types of behavior, and we get into safety. Lastly, we have this medically necessary category, which is sickness and injury.

In terms of service alternatives in the insured environment, we see both formal and informal. Informal is always considered to be family and friends. Then we go to home, community, and institutional, as the various sites where individuals can have their needs met.

When we get to the care plan, it all becomes a natural progression. We take that needs assessment, in which we've now evaluated individuals' needs in the context of what drove them to require LTC services, and we put together a formal recommendation of what will be provided, by whom, how frequently, and when. A care plan typically is done in a couple of steps. The needs assessment, and all these activities related to care management, can be done either over the phone or in person.

In care planning, there's typically a two-step exercise. The individual gets the needs assessment, goes out and looks in the community to see what is available, and then sits down with the family and goes over all the alternatives. When we think of care plans here, it is usually something that has been presented to the insured and his or her family. Power of attorney (POA) is often involved and they understand all the options, since they have explored what's out there, who can provide for these services, and how the needs will be met. This is a process by which, through iteration, they arrive at that plan that they believe to be optimal.

Let me go to implementation. Implementation begins with having a multiple array of service providers when you do a care plan. The insured's POA, or family, can determine who among that group they decide to choose. It can be based on what they know, on cost, on access, or on quality. There are a number of different criteria that the family looks at before they choose the service provider. Implementation is nothing other than taking that care plan, getting rid of the providers that aren't going to be used, contacting the providers that are going to be used, and making sure that the services will begin as appropriate.

Now we have' everything assessed, planned, and implemented; obviously there's a monitoring function, which is regular follow-up. This function gave rise to the need for LTC services. In some instances, there could be follow-up as frequently as daily and weekly, and in others, there may not be follow-up for a few months or it may be monthly, depending on how quickly the status of the individual is expected to change. Finally, we start over with reassessment, which is the fifth stage of care management. We now go out and say, "We've been through the whole process, it's been implemented, it's been in place, what needs to be changed? Have the individual's needs changed? Do we have to adjust the plan? What about providers, are they working as they promised? What about follow-up schedules?"

Dawn mentioned, as it relates to LTC, that there are a few different options in terms of policy design and how the services are provided. Is it a benefit, or is it a value-added service? If it is a benefit, are insurers offering it as a covered service, or are insurers offering it as a service that they will actually provide, either by themselves or through subcontracting with other organizations? Along with the Health Insurance Association of America , we talked to 16 of the top 20 LTC insurers in terms of 1996 sales about care management and what was going on at their companies (Table 3). We didn't differentiate between whether these services were provided, as Dawn mentioned earlier, by the insurance company themselves, including telephonically, or whether they were provided by someone through an outsourcing arrangement, either telephonically or in person. Every company did benefit eligibility assessments, or needs assessments, in terms of what an individual's status was. Ten out of 16 took it one step further and actually provided for care planning, either as an administrative expense, or covered it or provided it as a benefit. Nine companies worked on implementation of the plan. There were six companies that stayed involved on an ongoing basis to make sure that everything was working and monitored that everything was tried out. Four companies performed scheduled reassessment, and one of the 16 was actually involved in provider management. Provider management went beyond discounts, so it was management in a larger sense, including some of the things that Dawn talked about in terms of ongoing management of individual situations.

TABLE 3
SURVEY FINDINGS

Activity	#
Assessment	16
Care Planning	10
Implementation	9
Monitoring	6
Reassessment	4
Provider Management	1

Let's look at the number of insurers by number of activities (Table 4). Five of the insurers only performed needs assessments, the very top one. Two companies provided two of the activities, needs assessments and reassessments. Then you start to see the implementation of care planning, ongoing monitoring, etc.

TABLE 4
SURVEY FINDINGS

# of Activities	Insurers
1	5
2	2
3	3
4	3
5	3

Among these insurance companies, the survey findings were actually quite unanimous in terms of the opinions expressed. The big debate they had was, Is managed LTC a gatekeeper or is it something to benefit the consumer? How do you reconcile those two sometimes conflicting objectives as they relate to care and management? What about providing it internally versus externally? How do you evaluate those choices and which one is appropriate for you? It's not an easy thing to provide. There are a lot of information, data, and interaction between the insurer and the claimant and his or her family and providers and a tremendous intensity around data and information that we don't usually experience in other lines of coverage. Consumers like it. We're actually in the midst of doing a study right now, which the Department of Health and Human Services and the Robert O. Johnson Foundation have jointly funded. It is a study with eight insurance companies providing data on almost 1,000 claimants, an industry-wide study on individuals and how they use their insurance and what the impact is on families, friends, spouses, etc. That study will be out, I think, in another four or five months; there are only about 100 or 200 more people who have to be visited. Just as an anecdote: Of course, when people are receiving benefits, they're going to tell you their insurance is wonderful. Not a surprise. It's still good to ask that question. However, people are very much in love with companies that actually do care

management. When asked the question about care management and helping navigate a complex, fragmented system in terms of providers and provider quality, they responded that they love any help they can get from the companies. They're actually actively seeking more help, and help in different dimensions, things like provider and quality. Lastly, insurers were unanimous; they did believe that they were all benefiting fiscally from providing this service, either as a benefit or, again, as an administrative expense.

In summary, there has been a rapid movement in this industry toward comprehensive products that provide for a continuum of service options at a location that is appropriate and desirable by the individual. Hand-in-hand with that is this development of care management services, and the coverage of them as either benefits or provided as value-added services. We don't expect to see the trend, in terms of its development and evolution, slow down at all.

Ms. Peggy L. Hauser: Well, Dawn has talked quite a bit about what managed LTC is, and the different ways that insurers can control the risk financially. Don has talked about how that's done administratively. I'm going to switch gears a little bit and talk about what the Medicaid LTC program has tried and accomplished. I think almost everybody in this room is working in the LTC insurance industry, but I think because Medicaid is such a big provider, or financer, I should say, of LTC services, it's important to keep abreast of what they're doing and see what they've been able to accomplish; it might help us with the work that we're doing.

First, I want to give you a little bit of background about the Medicaid LTC program. Then I want to talk about what has happened in several states that have actively tried to reduce their expenditures by doing what I would call care management. Finally, I want to talk about two states that have moved to actually capitating providers for providing LTC services and what some of their experiences have been.

Let's talk about the Medicaid LTC program. Medicaid was originally started to help low-income families meet their acute care needs. But, over time, it's expanded, and has become the dominant source of financing for LTC services. Due to the cost of LTC services, it is not only covering care for the low-income people, it has' also expanded to providing a lot of financing for people who were initially middle-income families. The Medicaid LTC program could be looked upon as an insurance program that has a person's lifetime savings as his or her deductible, and his or her annual income as the copayment. The Medicaid program was actually paying about 58% of all of the LTC services that were provided in the U.S. Roughly 68% of all nursing facility residents in 1997 relied on Medicaid to provide some of their financing. The Medicaid program is spending a lot of dollars on LTC services, and their funding is only going to go up in the future. They're expecting that it might

double during the next 20 years because of the aging of the population and also because the prices for LTC services have been going up at a higher rate than inflation.

Historically, the Medicaid LTC program has been very biased toward institutional care. Prior to the early 1980s, home healthcare services were not a covered Medicaid benefit. In fact, even though home- and community-based services had been implemented as recently as 1995, 85% of all of the LTC expenditures were on nursing facility care. In the early 1980s, states were able to apply for what are called home- and community-based service waivers. If states obtain those waivers, they can start providing home care to their residents, which they have done, hoping they can substitute less-costly home care services for the more costly nursing facility care. But in order to obtain one of these waivers, states are required to do several things. First, they can only target people who would otherwise need to be institutionalized. In putting together a waiver filing, they have to prove or assert to the Health Care Financing Administration (HCFA) that doing this waiver program will not increase their overall costs. Finally, they receive an approved number of waiver slots, so that they have only so many slots of people who can use these home- and community-based care services. I mentioned that the earliest states could have started doing these waivers in the early 1980s, and it started pretty slowly. In recent years, states are starting to spend more and more on home- and community-based care services.

So what is the impact of home- and community-based care services? As I said, they were doing this in hopes they would reduce their costs, but some of the initial research indicated that it, in fact, increased the total LTC costs. This is pretty consistent with what all LTC insurance actuaries would have done if they'd priced a nursing-home-only policy and then expanded it to a nursing home and community care policy. Even though the Medicaid agencies required that it had to be for a person who would have been institutionalized, there is such a stigma attached to going into the nursing home that people, even if they could have been eligible for Medicaid benefits, were not going into the institution. Therefore the woodwork effect occurred, and they did end up with more users, and, in some cases, were not able to save money.

But more recently, a study showed, in at least three states, that home- and community-based services have been cost-effective. The study was done by the Lewin Group and the American Association of Retired Persons (AARP) Public Policy Institute. They studied results from three states, Washington, Oregon, and Colorado. They compared the actual utilization of nursing facility and home- and community-based services in those states. They found that, in those states, the nursing facility growth was slower than in other states. Both the number of people

who were going into nursing homes and the Medicaid program's spending (their expenditures on nursing facilities) was also growing more slowly than in other states. On the other hand, home- and community-based services grew faster than they were projected to grow, just based on the increase in the elderly population in these states. They picked these three states because they had a program in which they were actively trying to divert people from nursing facilities to home- and community-based services. The results then indicated that although fewer people were going into nursing homes and more people were going into home- and community-based care services, overall, the states were having a slower growth in LTC users when you combined those two together.

Let's look at some of the data from this program (Table 5). In Oregon, 39% fewer people were served in a nursing facility compared to what their studies had projected. On the other hand, each of these states experienced an increase above what the demographics would have projected should have been served in home- and community-based services, and they went up in the ballpark of 15%. Colorado had a 31% increase in patients or residents being served by home- and community-based care services. The bottom row shows what the states' overall projected savings were. This is the actual dollars that they spent, versus what the demographics of the state would have indicated they should have spent. The states saved between 13% and 23%, which I think is consistent with Dawn's last points. It was very consistent with the numbers used here, if you compare what she assumed as far as the decrease in nursing facility utilization and the increase in home- and community-based care.

TABLE 5
HCBS EXPANSION DATA

Statistic	OR	WA	CO
Lives Served—Actual Versus Projected			
Reduction in NF	39%	18%	21%
Increase in HCBS	15	18	31
HCBS Percentage	75	58	44
Overall $ Savings	23	13	17

Another interesting statistic from this study indicated the proportion of people who they ultimately ended up serving in each setting. I've only shown what the home- and community-based care percentages were. But you can see that there's a huge discrepancy between what Oregon, which had 75% of all of its LTC recipients being served in the community, which is considerably higher than either of the other two states were able to achieve, and what all three were able to achieve. That shift of care allowed them to decrease their costs by 23%.

How did these states do it? They first made sure that every applicant for nursing facility benefits was screened to make sure that care could not be provided in the community. These are all things that are fairly representative of what LTC insurers are doing and what Don talked about. They found they were able to keep the people in the community who had fairly serious impairments, and they also sought to keep their costs low by first exhausting all other resources. They used two methods. First, the states tried, as much as possible, to maximize Medicare benefits, which I think is consistent with what Don said, making sure LTC insurers are coordinating with Medicare. The Medicaid programs actively sought to maximize those Medicare benefits so that, to the extent possible, the dollars were being spent by the federal government rather than being spent jointly by the federal and state governments, which is how the Medicaid program works. Second, the state actively encouraged use of informal care, where the patients had informal support systems that could provide some care. They sought to maximize that care as much as possible. That might be a little bit more difficult thing for us to do in an insurance policy, but they found it to be successful. Probably the last goal, which is also a little bit more difficult for insurers to do than it is for a Medicaid state agency, is that they also kept the provider payments relatively low. They're in control of that, and the state has a lot of clout and can do that. I don't think that the LTC insurance industry can get anywhere close to the same savings that the state Medicaid agencies have been successful at getting.

Now I want to switch gears a little bit and talk about two states in particular and what they have done to move toward actually capitating Medicaid LTC services. I'll give you some background on not just the Medicaid LTC program, but the Medicaid program for elderly people in general. When elderly people seek LTC services, they encounter a fairly fragmented delivery system. I am talking about people who are duly eligible for Medicaid and Medicare. As I alluded to before, a lot of cost-shifting goes on between the Medicaid program and the Medicare program. The Medicaid programs in many states actively seek to maximize the acute care, maximizing the Medicare dollars. The result can be that you end up spending more money in total on the two programs than you could have if you had integrated the two programs. Secondly, not only is the financing not coordinated, but the delivery system really isn't either. A person might end up staying too long in a hospital because there isn't a nursing facility bed available for them; Medicare ends up spending too much money on the hospital bed in a situation where a nursing facility stay that might be Medicaid-eligible might have worked. The whole system, then, ends up spending too much money. States are now trying to integrate both the Medicare and Medicaid benefits so that there is a more coordinated financing and delivery system.

One of the hurdles that states have to overcome in integrating the Medicare and Medicaid benefit is HCFA approval. Right now, HCFA has stated that in no circumstances can we require or mandate that a person who is eligible for Medicare benefits must get that care from a managed care organization. For everybody who is Medicare-eligible, it must be a voluntary choice whether to stay fee-for-service or go into a managed care program. This creates a problem for these dual-eligible people where a state Medicaid agency might like to force all of their eligible to be in managed care, but those with Medicare benefits have to have a choice. You still have some fragmentation. I want to talk about how two states, in particular, have gone about capitating Medicaid LTC services and how they got over the hurdle of making sure that Medicare benefits remain voluntary and that nobody's mandating that the Medicare benefits be in managed care.

The first state I want to talk about is Minnesota. While I was an actuary at Milliman & Robertson, we developed capitation rates for the state of Minnesota. What is a little bit unique about Minnesota is that they already mandate that all of their elderly have their Medicaid acute care services provided by a managed care organization. They introduced a new program, the Minnesota senior health options (MSHO) program, which combines the prepaid medical assistance program (PMAP), which all of the elderly Medicaid-eligible already had to be in, covering just the Medicaid acute care services, with Medicare dollars and some Medicaid LTC services. The health plan will get one capitation rate and will have to provide all of those services out of that cap rate. Keeping this voluntary and pacifying HCFA means giving each eligible person the choice, when they become Medicaid-eligible, to either take just a PMAP plan, or to go with MSHO, which will combine PMAP, Medicare, and Medicaid LTC services.

Since this is a voluntary program, it presented some very interesting rate-setting issues because they wanted to have multiple health plans in each geographic area eligible to work with the enrollees and to have each of these enrollees be voluntary. Not really knowing what kind of population would enroll in the health plans created some rate-setting problems. Because of that, Minnesota's capitation rate for LTC covers' all home- and community-based care services, but as far as nursing facility services go, they've decided to prepay the first 180 days of any nursing facility confinement. I'll go through a rate calculation later to show what that's like. In effect, that prepayment of nursing facility services was very similar to what we're doing when we're pricing LTC insurance policies. The person is paying a premium. Once the person goes into a nursing facility, typically we waive premiums and we stop getting a premium. The same thing happens in this Minnesota capitation rate that I'll go through later.

The other state that I want to talk about is Arizona. In Arizona, if you are Medicaid–eligible and need nursing facility service or you need LTC services, you are mandatorily placed in an Arizona LTC Services plan. In all cases, their Medicare services are covered fee-for-service; they can mandate this because they're not doing anything with Medicare services—they are always going to be fee-for-service. Arizona hasn't gone to completely integrating all of the types of care for these eligible people, but they are capitating the LTC services. What's different about Arizona, though, is that they are going to have only one program contracted per county. Everybody who needs the services is going to go into that one contractor, and you don't have the gaming or risk selection issues that Minnesota has because you have' the whole population that needs services and they're all going to one health plan. Arizona calculated the blended rate for their LTC cap, blending the nursing facility and the home- and community-based care costs.

Here's an example of how the rates would have been calculated for the two different states (Table 6). The second column shows what you might expect the monthly costs to be. For a nursing facility, I'm using a 30-days-per-month, $100-per-day, home- and community-based care services model. I think those figures were fairly consistent with what one county in Minnesota had for their average expenditures on home- and community-based care services. As far as LTC costs for people who are in the community but not yet receiving services, their costs are zero.

TABLE 6
SAMPLE LTC CAP RATES

Rate Category	Expected Monthly Cost	Capitation Rates	
		MN	AZ
Nursing Facility	$3,000	$0	$2,100**
HCBS	750	850*	2,100
Other Community	0	100	0

*$850=$750 + .01 x 100 days x $100/day
**$2,100=$3,000 (60%) + 750 (40%)

For Minnesota, I'd like to go through their capitation rate. I've indicated at the bottom of the table how I've calculated the $850. First let's talk about how I calculated the $100 for the other community people. They're planning to prepay the first 180 days of care. We looked at their data and found that, on average, the length of stay was about 100 days for that care. Similar to Dawn's calculation of a claim cost for LTC, we calculated their LTC services cost. We found that the frequency was about 1% per month, and given that a person would have a confinement, their average length of stay would be 100 days (I'm assuming a $100 average monthly charge). I want to point out here that the 1% varied—we

calculated separate rates by age, gender, and area, and those frequency rates varied dramatically by those components. But, 1% is about what it came out to in total, overall. What happens each month, then, is the state will pay to the health plan this $100 payment, and that payment is intended to be adequate to cover whatever confinements occur during that month for their full length of stay.

I have a feeling that, in talking to this group of actuaries, that probably sinks in a lot quicker than it did when we talked to the actuaries at the state working with the health plans. Because you're used to thinking about frequencies and continuances, whereas health plan actuaries are a lot more used to thinking, "I have $100 and I'm expecting to spend that whole $100 in a month." If I have a claim, it's going to be a $10,000 claim, which is a pretty boring concept for them. But you can see then that if we're expecting 1% admissions and the health plan is able to cut that in half, there's a lot of savings. For every nursing facility admission that they can divert, there's a lot of savings. The state at this time chose to use the fee-for-service data and didn't build in any discounts. But over time, if there are savings, that could change. On the other hand, a lot of savings can accrue to the state, because for every nursing facility admission that is diverted, the health plan might save in that first 180-day period, but the state then saves for every admission that never gets to the 181st day where they would then have to start picking up the claim. They paid the $100 both to people in the community and to people who were receiving home- and community-based services. In addition, those people that are getting home- and community-based care services get their average payment of $750. That was how Minnesota ended up pricing out their cap rates.

Arizona is a little bit different, and they could do quite a different rate because of the characteristics of their program, a mandatory program, with only one program contractor per county. What Arizona does every year is estimate what proportion of people they believe will be served in the community versus in a facility. They then just take the weighted average of those costs. The assumption is that 40% can be served in the community. The program started in the very late 1980s, and at that time they were using an assumption of 10% being served in the community and 90% being served in the nursing facility. The cap rates probably were higher at that point than they are now. As time has gone on, the health plans have been successful at keeping people out of the nursing home and diverting them to home- and community-based care; the proportion being served in the community currently may be even more than 40%. I want to point out that regardless of where your patients are being served, they are receiving $2,100 per month, so the states can save a lot of money if their costs are only $750 per month for anybody they can keep in the community, but they will' lose money for people who are in the nursing facility. Such a rate structure wouldn't have worked for Minnesota, though, because you wouldn't have many health plans that would be willing to take $2,100 if they

were the only health plan in that particular area that got all the nursing facility people. Even if for some reason all the home- and community-based service people decided to stay in the other plan and didn't volunteer to get the Medicaid LTC services, there was so much opportunity for selection that they couldn't go through and do a totally blended rate; they had to go the prepayment route.

That should give you just an idea of what is going on in the Medicaid LTC program. Hopefully, there's something interesting that you can take home when you're pricing your LTC insurance policies. Now I think we can open it up for questions.

From the Floor: I am wondering if in the claim dollars savings that you estimated, did you try to differentiate any savings from the different levels of disability?

Ms. Hauser: Which program are you talking about? Are you talking about the Colorado, the Washington and the Oregon?

From the Floor: Yes, the one where you estimated actual overall dollar savings.

Ms. Hauser: In other words, was the new population less ADL-dependent? I think they may have looked at that.

Now, it might not reflect whether, in general, there are fewer people using a nursing home. I think that was one caveat that they noted, that there may just be less need for nursing facility utilization, and that was not reflected in the numbers. I'm actually pretty sure that they did reflect the disability status of the different people.

From the Floor: My question is related to the last: Are these overall cost savings net or gross of managed care costs?

Ms. Helwig: I think they're before the administrative costs, so they have not tried to add the expenses of doing the claims management back into their figures.

From the Floor: Do you know roughly how much that costs?

Ms. Helwig: I don't know that they were able to analyze that. It was so mixed in with their Medicaid program administrative costs that I don't know that they were able to split that out. I don't remember seeing it in there.

From the Floor: Do you see any trends in the future towards LTC policies having an informal caregiving benefit, within a managed care context?

Ms. Helwig: You're asking if it would actually pay for that informal care being done? I guess I've seen one or two policies that have done that. I think I've seen more recently ones that are moving towards caregiver training of some sort, in which they're maybe not actually paying for the informal care, but they're paying for the training of someone to be able to do that. The actual cost of paying someone to do the informal care raises some big pricing questions as far as what the effect of that is going to be.

From the Floor: Are there any problems with tax-qualifying definitions and paying the informal caregivers?

Ms. Hauser: I think that you can have a disability policy in which the benefit is triggered just by the fact that you're impaired. It doesn't have to be an expense reimbursement policy. I think you could have it be qualified. Does anybody else have an opinion on that?

From the Floor: I heard there's a differentiation if something's a medical expense or not, with informal care or not. But not if it's still not a qualified LTC service or not, particularly if there are two different issues going on there. But I think that it would be OK under tax policy.

From the Floor: I am interested in the cost of these care management expenses, in particular an individual policy where you're subject to loss-ratio requirements. I was wondering what everyone's experience has been with filing the different components of the expenses, and where you put them in your filings.

Ms. Helwig: I guess I'll speak to that first. We've handled it in a variety of ways, quite often depending on how the company wants to do it. I generally just make sure that I'm pretty obvious in where I've put it in the actuarial memorandum. If I am adding it into the claim costs for purposes of loss-ratio demonstration, I talk about the care management as being a claim cost. I'll say that I've increased the claim costs by 5% or 2.5% for the care management feature. If I am considering it an expense and I don't put it into the loss ratio, I show it in the expense section of the memorandum so that it's not being added in. My experience has been that the majority of states do not mind, or don't have any objection to, it being in the loss ratio. There are a couple of exceptions to that: Florida, and I think Maine, don't allow you to do so. New York is questionable; we're trying to find that answer out right now. There are some that are going to object to it, but it pretty much flies everywhere else. I also think that where you put it is going to depend on how the contract language reads. If it's actually in the benefits section of the policy and described as being a benefit to the insured that they're provided with the services of

a care manager, I think there's a lot of justification for considering it part of the loss ratio.

From the Floor: Does the management of care practice differ significantly in rural areas, as opposed to urban areas?

Ms. Helwig: Actually, I would say probably it does not differ as much, in a LTC policy, as it does in a medical policy or some of the other things where we've run across a lot of these issues of "managed care just doesn't work in the rural areas." A lot of what you're doing with managed care and LTC is really just determining if there's a need there and trying to find the right services and the right level of services. Now, if there's only one nurse in the county and there aren't any people who provide home health aid services, you're going to have a little bit of a problem moving the care down to a lower level. But in most rural areas, that's not the case. There's usually a pretty good supply of people to do almost any of those kinds of services. You might not be able to get the Meals on Wheels and some of those kinds of things, but a lot of policies aren't covering those anyway.

Mr. Charsky: I think it depends on the nature of the covered services that one is dealing with. Availability of service provision is all over the board when you move outside of major metropolitan areas. It is the case that a lot of carriers, when they're recommending providers, like to have choice so that the consumer can be involved in that process. You will lose choice when you move into the rural areas. As Dawn said, you might find one, whereas you would hope to find three or four so people could choose among various options. The biggest thing I think you give up when you move into rural is choice.

Ms. Helwig: Actually, one of the things a lot of companies have started to do is to try to make managed care work a little bit better in the rural areas, or to make home health care more attractive to the rural areas. They've modified the definition of home healthcare agency, where previously home healthcare agency used to have to be an agency certified with the state. Some companies are going away from that a little bit, and saying it can be someone who is certified to provide those types of services. Then if you go into a rural area, and there isn't any licensed home healthcare agency for miles around, you can still hire a nurse from the local hospital to come do the care. There's really probably not any impact on the cost of having to do that; it's just providing greater access to some services.

From the Floor: Did you mention any movement of agencies becoming preferred providers at higher levels of reimbursement?

Ms. Helwig: At higher levels of reimbursement?

From the Floor: Or preferred providers where the individual didn't have a disability?

Ms. Helwig: I've seen a lot more of that in the state of Florida, for example, where companies have started putting some preferred provider home healthcare agency together in an attempt to control some of the fraud problems that they've seen. Actually, I have developed one policy with Nationwide with a company that is trying to do that. Nationwide is thinking they're probably going to be able to get about a 10% discount off the regular billed charges from the agencies by doing it. But it's a slow process, in putting together all those preferred provider groups, because they don't really exist right now. There are some areas of the company, a few nationwide networks of nursing homes and a few kind of localized networks of home healthcare agencies, but there's not a lot of cohesiveness there.

Ms. Hauser: I think that's kind of hard to do at this point, where companies can't really promise a lot of volume to these agencies, not as far as giving discounts.

Ms. Helwig: Yes, we don't have the Medicaid negotiation powers yet.

Ms. Hauser: Right.

Mr. Chrasky: It's true that when carriers are spreading their entire business over the entire nation, they certainly don't have the opportunity to deal with providers in the way regional or local healthcare providers or financing systems and plans would. It's a big challenge.

From the Floor: What is the biggest opportunity in care management to these claims? Is it with cognitives or strokes or arthritis? Have you seen any experience with that?

Mr. Charsky: Well, when I looked at some of the state Medicaid data, it was interesting how successful they were at getting diverted, even individuals who have a lot of need. In the state of Connecticut, what we found is we were able to divert people that probably wouldn't go into nursing homes anyway away from nursing homes, because their level of need was so low. I think we're starting to see alternative service provision and providers for people who are severely disabled, as well as for people who are not as severely disabled. The easiest people to divert heretofore were the people who had the lowest level of need, so it was a very, very low level of ADL loss. What we found when we tried to divert people who had high level need is that typically we relied on informal caregiving, and that broke down in a relatively short period of time.

Ms. Hauser: The company that I just joined is studying that, but I don't know what the results are yet. I think that they have had success with making sure that they're in there right away before they get into the nursing home. This is probably the easiest place to reach success, because if they're in the nursing home for six months or a year, chances are there's no place left to go back to. I've heard the biggest piece of success is making sure that you're early in diverting the nursing home claim. But I'm not sure about success or opportunities by type of condition yet.

From the Floor: How does the assisted community living facilities (ACLF) factor in?

Ms. Helwig: I kind of assume that's part of what we're talking about here. I think that they are a very important part of that. They can be a very good avenue to divert people from the nursing home chain, and while I didn't mention it, I think I was automatically assuming that would be part of this benefit structure as well. You kind of start to draw a fine line. Where do you get to the point where you're starting to really add something extra, versus just providing an opportunity for diverting care from the nursing home into a lower level? You start getting into things like the residential facilities in Kansas and that kind of stuff, but I don't know, it gets a little more questionable.

Ms. Hauser: I think in the numbers that I was referring to, the ACLF is included in the home- and community-based service numbers.