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The Role of Actuaries in Non-Traditional Long-Term Care Insurance

by James M. Robinson

Editor's Note: the following article is reprinted with permission. It last ran in the October 2001 issue of *Actuarial Digest*.

When actuaries consider long-term care insurance (LTCI), they are usually thinking of private level-premium individual policies or group certificates issued by legal reserve insurance companies. While this form of coverage is fraught with interesting and unresolved issues, it is the center of much attention within the actuarial community. Witness the new LTCI Section of the Society of Actuaries, the new SOA-sponsored LTCI conference and Actuarial Standard of Practice No. 18.

Rather than add to the discussion of this "traditional" form of LTCI, I would like to devote this article to a related area of LTCI which receives less attention in actuarial circles. To this end, I use the term "insurance" in its general form and refer to any compensated transfer of long-term care (LTCI) risk between two parties. Many current government programs and health care provider arrangements clearly fall within this broad definition. In this article, I refer to such risk transfer programs as "non-traditional LTCI."

Examples of High-Profile Non-Traditional LTCI Insurance • The Program for All-Inclusive Care of the Elderly (PACE)

The Program for All-Inclusive Care of the Elderly provides a full range of health care and LTCI services under a system of capitated payments from Medicare and Medicaid. PACE is an example of a growing care delivery and financing paradigm which transfers significant risk to predicating PACE sites in exchange for a fixed monthly capitation payment per member per month. Recent legislation has promoted PACE from demonstration to permanent provider status, meaning that the number of PACE sites is expected to grow significantly from the handful that made up the original demonstration.

The Centers for Medicare and Medicaid Services (CMS, formerly known as HCFA, the Health Care Financing Administration) has been busy constructing and implementing PACE site regulations while simultaneously funding research efforts to gain a better understanding of this new approach to care delivery. This is clearly an example of an area where the actuarial profession can play a useful role. Since I first became involved with PACE a few years ago, actuarial involvement in PACE risk classification and rate-setting issues has expanded HCFA's Office of the Actuary to a growing group of actuaries providing advice to existing and emerging PACE sites or to the state Medicaid agencies responsible for setting the Medicaid portion of the PACE capitation.

Medicaid Capitation

A variety of states have implemented capitation arrangements with managed care organizations to provide LTCI services under the Medicaid program.

Wisconsin, a state with which I am quite familiar, is in the midst of developing and testing such a system, called Family Care. One of the key features of Family Care is a county-specific system of managed care organizations (MCOs), each of which contracts to provide LTCI services on a capitated basis for all Medicaid-eligible individuals who elect to enroll in the program in their county.

Wisconsin is grappling with the problem of defining the appropriate basis for the capitation payments to the county MCOs. What information is available regarding each enrollee? What part of this information should be factored into the rate

paid for each enrollee? How frequently should this information be updated after enrollment? These are all questions which would benefit from an actuarial perspective. Wisconsin has recognized the importance of an actuarial perspective on these issues and has contracted for ongoing actuarial advice.

Examples of Low Profile Non-Traditional LTCI

PACE and Wisconsin's Family Care program are examples of high-profile public LTCI risk-transfer programs which, appropriately, attract significant actuarial scrutiny. At the same time, there are other, less obvious, risk-transfer schemes in place and under development which may not be receiving the actuarial attention they deserve.

Consider, for example, the increased use of price-based systems to reimburse nursing facilities and home care agencies for Medicare and Medicaid services. These new pricing systems replace traditional cost-reimbursement systems and pay providers a scheduled rate per resident day or per home care episode, regardless of the costs incurred to provide services. While these rates tend to be risk-adjusted, the risk-adjustment mechanisms are only expected to work well, on average, for large groups of residents.

I am most concerned with the well-being of the providers under these systems. While the payors (CMS and the state Medicaid agencies) have the resources and inclination to obtain the proper advice on rate-setting issues, this may not be true for the providers who bear the risk under these systems. It is true that many care providers are supported by industry organizations such as the American Health Care Association (which represents for-profit providers) and the Association for Homes and Services for the Aged (which represents tax-exempt providers). However, the focus of the support is often limited to an evaluation of the expected rate payment levels versus expected service costs, rather than an assessment of the risk of adverse deviation from these expected levels faced by individual nursing facilities or home care agencies.

Unfortunately, ever-tightening budgets, especially for Medicaid programs, will probably keep the spotlight on payment system rate levels rather than on the volatility of service costs assumed by the providers.

What is the appropriate role of actuaries in this situation?

• Should we lobby for appropriate risk premiums in the payment system rates?

In many cases, the rates are set equal to expected cost levels or to budget-neutral levels relative to the prior cost-based reimbursement system. Such rate levels make no explicit provision for a risk premium to compensate for the risk transferred from the payor to the provider.

• Should we suggest appropriate risk-pooling schemes or stop-loss arrangements?

Such arrangements were employed with new PACE sites. If a provider is not part of a chain, pooling arrangements with other providers may be mutually beneficial. As is the case with the more mature Medicare hospital prospective payment system, maybe the payor should be encouraged to establish a "carve-out" system which reverts to cost reimbursement for residents/patients with very high-cost profiles. This amounts to a form of individual stop-loss protection.

• Should we argue for minimum surplus and reserve standards for nursing facilities and home care agencies?

Regardless of how the prices are set in these systems, should providers be required to establish reserves based upon the evolving cost experience or upon more precise information on the prognoses for residents/patients than is used in the rate structure?

Suppose, for example, a nursing home resident's daily payment rate from Medicaid is a function of his/her health/functional/cognitive status using the Resource Utilization Group (RUG) classification system commonly employed

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by many payment systems. Beyond the resident's RUG classification, suppose the facility is aware of a combination of specific diagnoses which suggest that costs will greatly exceed the expected level for his/her RUG classification. And suppose the facility is small with no hope that there will be enough resident scenarios with lower-than-expected costs to offset this resident's above-average costs. Should the facility be required to establish a "case reserve" for this resident on its financial statements? If so, for what period of time? The remainder of the current rate year (on the basis that the facility could terminate its Medicaid participation) or for all future periods (using a going-concern assumption)?

Should we suggest appropriate minimum surplus requirements for continuing participation (certification) in capitated Medicare or Medicaid programs? How should these levels vary with size of the facility? Can we apply HORBC (health organization risk based capital) standards in these cases?

What role should state insurance departments play in enforcing these reserve/surplus standards? What role should accreditation organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) play in these cases?

• Should we leave it to the accounting profession to identify the actuarial role as it considers appropriate financial reporting requirements under these payment systems?

The accounting profession has pioneered the need for actuarial review in other areas in the past. Is it reasonable to allow the AICPA to establish standards for providers operating under pricing systems and wait for those standards to define the actuary's role in managing care provider financial risk?

• Can we borrow the lessons learned to date from capitation and sub-capitation of acute health care in the managed care community?
Managed care and a wide variety of risk transfer schemes have been employed in the primary and acute health care arena for a longer time than is the case with the LTCI sector. Can any of the guidelines/standards designed to address these questions in that arena be applied to the LTCI counterparts?

I have only started to ponder these questions myself. I hope this discussion will encourage others to give this topic some consideration. □

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A Word from the Editor

by Bruce A. Stahl

One expects variety in a newsletter about an industry that is full of variety. This edition of the SOA LTC Section Newsletter offers just that. If you are interested in product development, consider the lead article; if you are interested in underwriting, consider the jointly authored article by an actuary and two medical professionals on managing risks at an extreme age; if you are interested in actuarial responsibilities, consider the industry update on the Academy practice note addressing the NAIC model regulation rate certification; and if you are interested in less traditional long-term care insurance, consider the article on the role actuaries have in them.

Variety also keeps us busy, and in order to assist with editorial duties, the LTC Section Council has asked Brad Linder of GeneralCologne Re to be the associate editor of the newsletter. He has already helped with ideas for future issues and with contacting potential authors. We look forward to his participation in this endeavor. □

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