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I. ESSAY

Public/Private Partnerships: A New Approach To Long-Term Care

by Nelda McCall, James Knickman, and Ellen Jones Bauer

The lack of comprehensive insurance coverage to pay the long-term care expenses for elderly persons is one of our nation's major social problems. Historically, insurance policies sold to those over age sixty-five to supplement their Medicare coverage, while widespread in popularity, have not covered many of the high-cost events that are hard to finance out of income and assets. Instead, they have focused on high-probability but relatively low-cost events.

Much of the recent interest in long-term care has been at the state level, where Medicaid budgets support almost half of the nation's long-term care expenditures. Other interest has been shown by state insurance regulators and their nationwide organization, the National Association of Insurance Commissioners (NAIC), and by insurers themselves, who have greatly increased their participation in the marketplace. The federal government also has become more involved in these issues. The Pepper Commission has outlined a potential federal legislative solution, as has the Health Insurance Association of America.

Some of the alternatives under consideration involve public programs organized at the federal level, while others involve private insurance instruments. In this essay, we focus attention on one approach to reform that has received little attention in the published literature but that offers some promise of comprehensive protection against the risk of long-term care without requiring extensive new public expenditures. Under this approach, partnerships would blend private and public insurance in a way that offers comprehensive financial protection.

It is not our intent to argue the case for these public/private partnerships; the idea has not yet been demonstrated, so it is difficult to know if this approach is desirable. Rather, our aim here is to describe eight states'
approaches to their public/private partnerships, to encourage consideration of this approach in the evolving national debate over long-term care.

The initiatives in the eight states are supported by grants from The Robert Wood Johnson (RWJ) Foundation under its Program to Promote Long-Term Care Insurance for the Elderly. The program aims to provide older Americans with a means to protect themselves from the impoverishment that often accompanies long-term care. The program also aims to enable states to better control services used by individuals before they become Medicaid-eligible; to create an infrastructure for case management and home and community-based care; and to improve the knowledge base on the use and costs of long-term care services.

The eight states participating in the RWJ program are California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin. These states have conducted planning projects to define their program parameters, within the overall foundation guidelines. Most of the states have enacted the required legislation to begin a demonstration. The most common approach involves a blending of private and public insurance. The private insurance would cover nursing home and home care costs during an initial period of care. The public coverage would cover long-term care expenditures after this initial period, enabling beneficiaries to become eligible for Medicaid without having to spend down their assets to meet standard Medicaid eligibility requirements.

In this essay, we summarize characteristics of these state initiatives based on information collected during site visits and periodic telephone calls to program officials over the past two years. This information gathering was done under funding from The Robert Wood Johnson Foundation. Before describing each of the projects, we first describe the range of federal long-term care reforms currently under consideration.

**Proposed Long-Term Care Reforms**

Current proposals to improve the long-term care financing system come at a time when the public is increasingly aware of the financial risks they face for long-term care. This awareness has no doubt been stimulated by the passage and then repeal of the Medicare Catastrophic Coverage Act of 1988. This legislative fiasco stimulated discussion about the health insurance needs of the elderly and drew seniors and legislators into a dialogue on how these needs could best be met. Potential federal approaches to reform long-term care financing and delivery range from ambitious proposals for universal, comprehensive, public-sector coverage to more modest proposals of regulatory and consumer information reforms.
**Federal approaches.** The current federal approaches can be divided into five groups: (1) proposals that call for a comprehensive program to cover the duration of long-term care; (2) proposals that call for a program to cover the initial cost of long-term care only, called front-end approaches; (3) proposals that call for a program to cover costs of long-term care after the beneficiary has received services for a relatively long time, called back-end approaches; (4) proposals that call for a program to cover home and community-based services only; and (5) proposals that emphasize reform in the existing system but do not call for new federal programs.

The first approach is a comprehensive model that provides universal public insurance for nursing home and community-based services, similar to how health care services are covered under Medicare. Enrollees would pay deductibles and coinsurance and, if they were not poor, would pay some share of the premium costs, but the coverage would be comprehensive over time. The next three approaches also propose new public programs, but with a more limited federal role. All three would typically require some form of beneficiary cost sharing.

The first of the limited public approaches is in the form of front-end coverage. Under this model, the federal government would pay for the first portion of long-term care, such as the first three or six months of care. To supplement the front-end coverage, elderly could purchase private insurance policies or, in some versions of this approach, could purchase a public insurance policy financed entirely or in part by premiums paid by the individual. The second approach is a back-end insurance model. Under this approach, public coverage would not begin until some period after the receipt of long-term care services begins. The waiting period prior to public coverage could be covered by private insurance. The third approach would cover only home and community-based services. The main feature of such a proposal is that it would leave Medicare and Medicaid intact but would extend eligibility for these programs to persons of all ages who meet specified disability criteria.

The final category of Current approaches are those that do not propose new federal programs but rather emphasize reform in the existing system. Current legislative proposals exist to encourage the states to modify insurance regulations and to increase consumer information. Other proposals include clarification of the treatment of long-term care insurance under federal tax law, to afford it the same treatment as basic health insurance. Other tax incentive proposals include efforts to increase limits on individual retirement account (IRA) savings for long-term care and to allow reserves built up in long-term care insurance policies to accumulate without tax, as is the case with some types of life insurance.

Of the five categories of approaches above, four would require a sizable
contribution of new federal funds. Estimates of annual costs range from $5 billion for the more limited approaches to $55 billion for the more comprehensive approach. At this time of federal budgetary distress, there is little consensus about whether new appropriations of federal dollars are appropriate. Also, competing goals for long-term care reform (for example, improved access to high-quality care, equitable availability of care, financial protection for those in need of care, and containing public costs) make it unclear which approach should be taken.

With these conflicting goals, questions inevitably return to who should be eligible for new programs and who should pay. A key criticism of the comprehensive and front-end approaches is that they entail spending scarce public resources on the nonpoor. Some analysts project that these types of programs would help the least-needy elderly and would offer little more help to elderly with modest resources than current public policy offers. Other criticism focuses on approaches that do not cover the entire duration of care, pointing to large gaps in coverage that could prove financially disastrous to those in need of care.

Due to the lack of federal funds and leadership, uncertainty about the correct approach for reform, and uncertainty about who is ultimately responsible for paying for long-term care, it is unlikely that any of the proposals for new federal programs will be enacted in the near future. The most realistic federal proposals are those that focus on improving the regulations and incentives for long-term care insurance. These proposals are more likely to succeed not because they are inherently superior, but because they do not require large new appropriations of federal funds.

The RWJ initiative. Of the federal approaches described above, the RWJ initiative is most similar to the back-end coverage approach. Private payments would initially cover the cost of long-term care services, followed by publicly sponsored coverage that begins after a specified period of time. Unlike the federal approach, where the purchase of insurance to cover the front-end costs would be optional, the RWJ initiative requires that insurance be purchased to guarantee back-end coverage, thus assuring comprehensive coverage over time.

Critics of an insurance approach argue that many older Americans would not be able to afford the cost of a basic long-term care policy. While the states involved in the RWJ initiative plan a variety of interventions to make policies more affordable, it is acknowledged that purchase of these policies may not be appropriate for all individuals. The program seeks to plan for the long-term care needs of a broad group of elderly persons, thus avoiding the impoverishment that has put so much strain on Medicaid. This infusion of new private insurance dollars into the long-term care system could reduce Medicaid's current liability in
such a way that would result in Medicaid budget-neutrality or savings.

Most of the states participating in the RWJ initiative hope to supplement private insurance coverage by expanding Medicaid eligibility for long-term care services. Those who purchase qualified insurance policies would be eligible for Medicaid long-term care services after their private coverage is exhausted, without spending down assets as is typically required to meet eligibility criteria. Such an extension of eligibility requires a federal waiver of Medicaid program rules. Approval of the waiver by Congress was anticipated during the 1990 budget reconciliation process, but it was excluded during the final hours of budget negotiations.

Without the Medicaid waiver, it is uncertain how the states will proceed. Most of the states will have to redesign their programs. It is possible that the states will continue to pursue a waiver through reintroduction of legislation or through administrative approval of the waiver by the Department of Health and Human Services (DHHS). Some states may also pursue contingency plans. New Jersey, for example, has an alternative demonstration plan that does not require a federal waiver.

Review Of The Eight State Programs

The eight state demonstrations offer an opportunity to test the provision of new protection against the risk of long-term care, without requiring extensive new public expenditures. Here, we present the structures of the planned demonstrations, the requirements for insurance products, data analysis activities, and the key features of the demonstrations (case management, management information systems, and education and marketing activities). While not a universal approach, they may be a feasible first step toward long-term care reform.

Most of the states have proposed using private insurance to cover the initial costs of long-term care, with a guarantee of public coverage (Medicaid) after the private coverage is exhausted (Exhibit 1). In these states, coverage for Medicaid long-term care services would be granted without the typical spend-down of assets. States vary, however, on specific aspects of the program, such as the eligible population, the amount of insurance that individuals are required to buy to participate, and the public coverage after private insurance expires.

Eligible population. Eligibility for the program varies across the states (Exhibit 1). Five states—California, Connecticut, Indiana, New York, and Wisconsin—plan a statewide, unlimited enrollment demonstration open to all state citizens who choose to purchase policies. The Massachusetts demonstration focuses on 10,000 citizens (7,500 ages sixty-five to sixty-nine and 2,500 of working age). The New Jersey approach is to focus
<table>
<thead>
<tr>
<th>State</th>
<th>Eligible population</th>
<th>Minimum amount of insurance required</th>
<th>Public coverage after private insurance expires</th>
<th>State subsidies</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>Statewide, unlimited</td>
<td>2 years (approximately $50,000)</td>
<td>Medicaid, IHSS with asset protection equal to amount of qualified insurance payments (^a)</td>
<td>No</td>
</tr>
<tr>
<td>CT</td>
<td>Statewide, unlimited</td>
<td>1 year</td>
<td>Medicaid, with asset protection equal to amount of qualified insurance payments (^a)</td>
<td>No</td>
</tr>
<tr>
<td>IN</td>
<td>Statewide, unlimited</td>
<td>1 year</td>
<td>Medicaid, with asset protection equal to amount of qualified insurance payments (^a)</td>
<td>Under study–For medically uninsurable</td>
</tr>
<tr>
<td>MA</td>
<td>7,500 ages 65–69; 2,500 working aged</td>
<td>Amount purchased with maximum of 5% of income (^b)</td>
<td>Medicaid, automatically, if amount of insurance commensurate with income level when insurance expires (^b)</td>
<td>Indirect–Earlier Medicaid eligibility for those for whom the lifetime benefit policy exceeds 5% of income (^b)</td>
</tr>
<tr>
<td>NJ</td>
<td>10,000 teachers and retired teachers</td>
<td>2 years</td>
<td>Medicaid, with asset protection based on formula applied to amount of qualified insurance (^a)</td>
<td>Indirect–State covers cost sharing for those at or below 200% of poverty</td>
</tr>
<tr>
<td>NY</td>
<td>Statewide, unlimited</td>
<td>3 years</td>
<td>Medicaid, automatically when insurance expires; copayments required (^a)</td>
<td>No</td>
</tr>
<tr>
<td>OR</td>
<td>Oregon employees and retirees, unlimited</td>
<td>2 years or a minimum of $50,000 lifetime maximum benefit</td>
<td>None</td>
<td>Yes–Considering tax credits on premiums</td>
</tr>
<tr>
<td>WI</td>
<td>Statewide, unlimited</td>
<td>1 year</td>
<td>Medicaid, with asset protection equal to amount of qualified insurance payments (^a)</td>
<td>No</td>
</tr>
</tbody>
</table>

**Source:** Interviews conducted by the authors with project staff of the eight states participating in the program.

**Note:** IHSS is In-Home Supportive Services program.

\(^a\) If federal waivers are granted. In New Jersey, if waivers are not granted, no special coverage will exist.

\(^b\) Includes annuitization of nonhousing assets.

the demonstration on a group of 10,000 members of the state association for teachers and retired teachers. Oregon is considering offering its demonstration program to an unlimited number of state employees/
retirees and to their spouses and parents.

Insurance requirements. The states have determined the minimum amount of insurance required for individuals to participate in the program. These amounts are typically defined in terms of a specific number of years of nursing home care or its equivalent, ranging from one to three years. The use of less-expensive home care services would extend the private insurance benefit to cover a longer period of time. The requirements of participating insurers will be negotiated between the insurers and the state. In most states, the demonstration will be open to the participation of multiple insurers, and policies will be sold on an individual basis. An exception to this is the New Jersey program, which will select one insurer to offer a group policy to the selected target population.

Insurance policies that are part of the program must meet established standards or be precertified by the state as having benefits equivalent to the established standards. In addition, insurers will be expected to have responsibilities for case management and educational and marketing activities. Insurers will also be expected to adhere to data reporting requirements. Some states have begun to specify the types of data elements to be required by insurers, but most have not developed data definitions at the level of detail required to implement a management information system (MIS).

Public coverage. For most of the planned demonstrations, the major role of the state governments will be to extend Medicaid eligibility to those who purchase qualified insurance policies after their private insurance benefits are exhausted. In California, the public coverage would be a combination of Medicaid for nursing home care and their In-Home Supportive Services (IHSS) program (funded by Title XX) for home health and personal care. All states except Oregon intend to offer Medicaid coverage to policyholders when their private insurance expires (Exhibit 1). Five states (Connecticut, Wisconsin, Indiana, New Jersey, and California) have adopted a direct asset protection approach, whereby policyholders would be able to apply for Medicaid after their private insurance is exhausted and to protect an amount of assets related to the dollar amount of state-approved benefits paid out by the private policy. Once eligible for Medicaid, program participants in these states would be required to apply their monthly income toward long-term care expenses, as is typically required of Medicaid beneficiaries.

The Massachusetts and New York programs will also provide asset protection. However, unlike the states described above, the amount of asset protection is not directly related to the actual amount of private benefits paid out. In these states, if the policyholder has purchased the required amount of insurance, he or she will qualify for Medicaid long
term care services when the private policy is exhausted, independent of the specific amount of assets held at that time. In Massachusetts, individuals will be required to purchase a policy with lifetime benefits. If they cannot afford to buy a lifetime policy, they will be required to buy a policy with premiums equal to a specified percentage of their income (including annuitization of nonhousing assets). In New York, individuals must purchase at least a three-year policy. Both states will require copayments toward the cost of care once eligible for Medicaid.

Oregon is the only state not proposing a program with Medicaid coverage. Rather, the state expects that its public-sector contribution to the partnership will include case management for the insurer(s) by Area Agencies on Aging at a specific rate per case, active marketing of policies to their employees and retirees, and an individual tax credit for purchasing long-term care insurance.

In most states, government involvement will also include the regulation of insurers, approval of case management procedures, provision of consumer education, and collection of data on eligibility for benefits and on utilization and costs of services. Some states have also considered offering subsidies to make the program more affordable to a broader segment of the elderly population. Exhibit 1 shows the current thinking of the eight states on the issue of subsidies.

**Product guidelines.** A main goal of the RWJ program is to encourage the development of high-quality long-term care products. Consistent with this goal, the states have typically adopted the NAIC model standards for long-term care insurance policies. These standards include no requirement of prior hospitalization or institutionalization; coverage for Alzheimer's disease and other organic brain disorders; renewability of policy; preexisting condition restrictions limited to six months; a standard format for the content of an outline of coverage; and a thirty-day free-look period. NAIC's Long-Term Care Actuarial Task Force is currently studying the issues of inflation protection and nonforfeiture benefits, and most states are also developing requirements concerning these issues.

Exhibit 2 shows the definition of the insured event, service coverage, and minimum benefits being considered in the eight states. The insured event is usually defined in terms of activities of daily living (ADL) limitations; needing assistance in two ADLs is a common requirement for long-term care services. In most states, the insured event will be used to determine when a policyholder is eligible to receive benefits that will count toward Medicaid asset protection. In New York, a specific insured event will not be defined, but insurers will be expected to develop definitions of the insurable event that will result in covered services for at least individuals who fall into the eleven Resource Utilization Groups.
<table>
<thead>
<tr>
<th>State</th>
<th>Definition of insured event</th>
<th>Service coverage</th>
<th>Nursing home (NH)</th>
<th>Home health (HH)</th>
<th>Personal care</th>
<th>Other</th>
<th>Minimum benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>2 ADLs or cognitive disability&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Residential care facility (required), adult day care (required), respite care (optional)</td>
<td>Nor to exceed 90% of state average for NH; HH 50% of NH rate</td>
<td></td>
</tr>
<tr>
<td>CT</td>
<td>2 ADLs or cognitive disability&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Required</td>
<td>Option required&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Option required&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Option required&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Initially (in 1990): NH—$70/day; HH—$35/day, minimum initial benefits increase by 5% per year</td>
<td></td>
</tr>
<tr>
<td>IN</td>
<td>Medical need, 2 ADLs, or behavioral conditions&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Required</td>
<td>Required</td>
<td>Optional</td>
<td>Adult day care (optional), respite care (optional)</td>
<td>75% of average NH cost at time of purchase (now $50/day), unless actuarial study indicates otherwise</td>
<td></td>
</tr>
<tr>
<td>MA</td>
<td>ZADLs and demonstrated health service need or mental dysfunction&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Required</td>
<td>Required</td>
<td>Optional</td>
<td>None</td>
<td>Approximately 80% of actual costs of care for NH and HH</td>
<td></td>
</tr>
<tr>
<td>NI</td>
<td>2 ADLs or cognitive disability&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Required</td>
<td>Required</td>
<td>Optional</td>
<td>Adult social and medical day care (required), respite care (required)</td>
<td>70% of (usual and prevailing rates) charges up to the maximum daily amounts: $100/day NH, $50/day HH, $25/day adult day or respite care</td>
<td></td>
</tr>
<tr>
<td>NY</td>
<td>ADLs as measured by state RUG&lt;sup&gt;s&lt;/sup&gt; system&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Adult day care (required), respite care (required)</td>
<td>Medicaid NH reimbursement rate (about $100/day in 1990), HH probably 50% of NH rate</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td>Assistance with 2 ADLs&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Adult day care (required), respite care (required)</td>
<td>Monthly maximum benefit (MMB), $1,000–$3,000 depending on premium: Level IV = 100% MMB, Level III = 65% MMB, Level II = 50% MMB, Level I = 35% MMB, Lifetime maximum = MMBx60</td>
<td></td>
</tr>
<tr>
<td>WI</td>
<td>Severe ADL limitations or medical necessity&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Adult day care (required), respite care (required)</td>
<td>$50 per day for NH or HH, reviewed annually by commissioner</td>
<td></td>
</tr>
</tbody>
</table>

Source: Interviews conducted by the authors with project staff of the eight states participating in the program.

<sup>a</sup>Activities of daily living.

<sup>b</sup>Must be offered to purchaser.

<sup>c</sup>Home health aide services include bathing, dressing, and so on.

(RUGs) categories in which resource need is highest.<sup>8</sup>

Most states require policies to cover nursing home care, home health...
care, and sometimes personal care. Several states also require coverage for adult day care and respite care. Minimum benefits being considered are generally defined in terms of a percentage of costs up to a fixed dollar amount per day for nursing home care, with the home care minimum benefits at a reduced amount or a percentage of the nursing home rate.

Oregon is considering paying benefits at four levels based on the level of a person's impairment, regardless of the setting where the care is delivered. The amount of benefit would be a percentage of a monthly maximum benefit and would increase as impairments worsen or increase. The levels of impairment and percentage of monthly maximum benefit proposed are presented in Exhibit 2. Preliminary policy guidelines specify that beneficiaries in Oregon should begin to qualify for benefits at Level I when they require assistance with two ADLs.

Data analysis activities. In planning for the demonstrations, the states have conducted data analyses to help design their benefit structure, price the policies, and calculate the policies' impact on state costs. In conducting these analyses, each of the states used a variety of data sources (Exhibit 3). These included primary data collection supported as part of the demonstration, analyses of existing data files, creation of new linked data files, analyses of national databases, use of existing national models, and development of state-specific models. This activity was of primary importance during the predemonstration phase, as it provided considerable information not formerly known on long-term care use and cost.

Key features of the demonstrations. The Robert Wood Johnson Foundation has identified three key features of the demonstrations in which it has a particular interest. First, most states have spent a significant amount of time working on case management approaches with potential insurers. Each of the states has either an existing case management system or contracts for case management for some or all Medicaid eligible long-term care recipients. Many states had hoped to require that insurers use the existing Medicaid assessment instruments and personnel. Insurers, however, have been reluctant to delegate this case management role to the states. Most states now appear to be moving toward an approach in which insurers would use their own assessment and case management approaches, as long as they meet state requirements.

Second, the management information needs of the demonstrations are nontrivial and are analogous to setting up a data system for a new public program. Over the course of the demonstration, data will need to be monitored to manage the program and to evaluate its effectiveness. The system will include data on nursing home and community care use, supply of long-term care services, and Medicaid use. It will also need information from insurers on policy applicants, case management activities, claims,
Exhibit 3

Data Sources Used By RWJ Programs In Their Planning Phase

<table>
<thead>
<tr>
<th>State</th>
<th>Primary data collection and analysis</th>
<th>Secondary data analysis</th>
<th>Models and special analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>Survey of adaptations by disabled elderly to cope with functional limitations</td>
<td>Aggregate nursing home utilization; National LTC Survey (California sample)–linked with Medicare, Medicaid, death, and tax records; and National Nursing Home Survey (California sample)</td>
<td>Case-based spend-down analysis using National Long Term Care (LTC) Survey linked data</td>
</tr>
<tr>
<td>CT</td>
<td>None</td>
<td>Nursing home, Medicaid nursing home, and home health utilization; PAS linked with Medicaid</td>
<td>Brookings/ICF model; Lifetable spend-down analysis</td>
</tr>
<tr>
<td>IN</td>
<td>Survey of aged population</td>
<td>Aggregate and Medicaid nursing home utilization; PAS linked with Medicaid</td>
<td>State fiscal impact model; state premium pricing model</td>
</tr>
<tr>
<td>MA</td>
<td>None</td>
<td>Nursing home (discharge), home health utilization</td>
<td>Brookings/ICF model; Lifetable spend-down analysis</td>
</tr>
<tr>
<td>NJ</td>
<td>Survey of aged population, survey of target population</td>
<td>Aggregate nursing home utilization</td>
<td>State fiscal impact model</td>
</tr>
<tr>
<td>NY</td>
<td>Survey of nursing homes</td>
<td>Aggregate and Medicaid nursing home utilization; Medicaid patient review instruments</td>
<td>State fiscal impact model</td>
</tr>
<tr>
<td>OR</td>
<td>Survey of target population</td>
<td>Aggregate and Medicaid nursing home and home health utilization</td>
<td>State fiscal impact model</td>
</tr>
<tr>
<td>WI</td>
<td>Survey of nursing home residents, admissions, and discharges: survey of home health agency discharges; and survey of family of nursing home admissions</td>
<td>Aggregate and Medicaid nursing home and home health utilization</td>
<td>State fiscal impact model; state premium pricing model</td>
</tr>
</tbody>
</table>

Source: Interviews conducted by the authors with project staff of the eight states participating in the program.

Note: PAS is preadmission screening (data).

and administrative costs. States are just beginning to develop the MIS requirements at the level of detail necessary to begin implementation.

Third, of considerable importance to the demonstrations are education and marketing activities. If the marketplace is to function effectively, potential purchasers must be well informed. The insurance market for the elderly has historically been one in which accurate dissemination of information has been problematic and in which consumers have had poor knowledge of their coverage. Educating consumers is a pressing issue for states. Three kinds of activities are being discussed with respect to education and marketing: public information campaigns to increase general information (newspapers, radio, television, posters, brochures,
bus signs, and public forums); counseling (training existing health benefit counselors, training and having available long-term care health benefit counselors, and toll-free telephone hotlines); and working with insurers to prepare educational marketing materials.

**Summary And Discussion**

During their planning phase, the eight demonstration states have analyzed their own and others' data to help define their required benefit structures, to help price policy features, and to calculate the impact of policy ownership on state costs. Some of them have worked very closely with insurers in this process. In addition, planning a demonstration of this kind has required participation of multiple government agencies in all states. Representatives of Medicaid, aging agencies, social service agencies, and insurance departments have played active roles. New databases have been created, and alliances within government agencies and between states and insurers have been forged.

Although the states differ in the specifics of their approaches, they generally focus on a model of front-end long-term care insurance and back-end Medicaid coverage. Only Oregon is currently thinking about a model without Medicaid involvement. Most states will be open to participation of multiple insurers, and policies will be sold on an individual basis. Policy requirements vary in the minimum term of coverage (one to three years) and the exact coverage required. Products are required to cover nursing home care, to cover or have an option to cover home health care, and, for six of the eight states, to cover some personal care.

Four of the eight states are considering direct or indirect premium subsidies for low-income individuals. Minimum nursing home benefits and home health benefits have been defined. Policies must meet these or equivalent standards. Insurers will also be responsible for case management and educational and marketing activities, and be required to adhere to data reporting requirements. Data required will include information on policy applicants, case management activities, cost of services, and administrative costs.

As the nation begins a dialogue on socially desirable models for reforming long-term care, state-based models of public/private partnerships should be recognized and considered. We cannot report on the ultimate desirability of these models, as they have not yet been demonstrated, but we believe that knowledge of this approach can be beneficial to policymakers seeking solutions to the difficult problem of long-term care financing and delivery.
The authors appreciate the assistance and helpful comments they received on an earlier version of this essay from Joel Cantor of The Robert Wood Johnson (RWJ) Foundation, Mark Meiners and Hunter McKay of the RWJ project’s national program office, and the project directors and staff of the eight participating states. We also thank Jon Tomlinson for his editorial assistance.

NOTES


2. As of June 1990, 126 companies sold policies, a more than sevenfold increase since 1984. D. Johnson, Health Insurance Association of America, presentation to Annual Meeting of the RWJ Program to Promote Long-Term Care Insurance for the Elderly, New York, 5 October 1990.


4. Aiding the states in this effort is the national program office at the University of Maryland directed by Mark R. Meiners and Hunter L. McKay. For a summary of the eight state projects prepared by the national program office, see A Multistate Initiative: Program Summary (Center on Aging, University of Maryland at College Park, October 1990). Also, see M.R. Meiners and H.L. McKay, “Developing Public-Private Long Term Care Insurance Partnerships,” Pride Institute Journal 8, no. 4 (1989); and M.R. Meiners and H.L. McKay, “Private vs. Social Insurance: Beware the Comparison,” Generations (Spring 1990).


8. RUGS are the basis for Medicaid nursing home payments in New York. A Patient Review Instrument (PRI) is completed for all who request nursing home care in New York to categorize them into RUGS.