A PREPAID MANAGED APPROACH TO LONG-TERM CARE

by James R. Knickman and Nelda McCall

Prologue: Many people assume that Medicare or supplemental insurance policies will meet their health needs in their declining years. However, if long-term care is needed, the American system of medical delivery often falls short of coverage despite its costly nature. In 1984, nursing home expenditures totaled $32 billion, an increase of 11.1 percent over the previous year. Direct out-of-pocket payments are the source of almost half of total payments to nursing homes, a much higher percentage than for most other medical services. Nursing home costs per individual average $35,000 a year. If a U.S. citizen needs long-term care, the options today for the most part are: pay for it yourself or spend down your resources to a point near impoverishment that qualifies you for Medicaid. Concerned by this gaping hole in health care coverage, SRI International convened a Conference on Private Sector Financing of Long-Term Care in 1984 to discuss what other options may be possible. This article by Prof. James Knickman of New York University (NYU) and Nelda McCall of SRI pulls together some of the more interesting ideas generated at the conference and develops a case for using prepaid capitated health plans to provide long-term care. Knickman, an associate professor at NYU’s Graduate School of Public Administration, developed the paper initially as a discussion document for the SRI conference while on a sabbatical leave. Knickman received his Ph.D. from the University of Pennsylvania’s School of Public and Urban Policy and joined the NYU faculty in 1976. McCall, who has been with SRI for eight years, is director of health policy research and has served as project director for an evaluation of state regulation of Medicare supplemental insurance policies. Her previous experience includes an eight-year stint at the Palo Alto (California) Medical Research Foundation and other health consulting work.
A serious underinsurance problem exists for custodial services delivered to the frail. Because the costs of a year's stay in a nursing home can approach or exceed $35,000, most individuals who need this type of care face impoverishment if they have no private insurance. Even the costs of custodial home care services, which often exceed $10 per hour, are unaffordable when the care needs of a person are substantial.

Unfortunately, very few people have private insurance for long-term care services, and, as is becoming more widely known, Medicare and Medicare supplementary policies cover very little custodial long-term care. Currently, as a nation, we rely on a long-term care financing system that is both expensive for the public sector and unresponsive to those who need it. The frail generally pay for custodial long-term care services with out-of-pocket funds until they become eligible for Medicaid. At this point, after losing financial independence, the elderly in most states can receive services financed by the Medicaid program. The result of this financing approach is very high out-of-pocket payments among the fraildest elderly and substantial levels of Medicaid expenditures. Many of these Medicaid expenditures pay for services delivered to elderly who were not poor before they became frail and who could avoid dependence on Medicaid if private risk-spreading mechanisms were in place.

In 1982, long-term care service costs totaled an estimated $30 billion, with over $27.3 billion spent on institutional care. Public funds financed $15 billion–$13.8 billion by Medicaid—but the remaining $12.3 billion was paid from private funds, almost all of which were out-of-pocket payments by the users of long-term care services or their families. Only $200 million of long-term care costs were paid for by private insurance policies.

Why has the market for long-term care insurance remained so small? First, some look to the lack of demand by potential beneficiaries. This low level of demand is due to the undesirable and frightening nature of long-term care itself, the underestimation of the potential need for long-term care, and the overestimation of Medicare and Medicare supplemental insurance's coverage of long-term care. Second, some look to state insurance regulators, who at times have stifled innovation on policy design and coverage by writing regulations that make it difficult for companies to introduce new products into the market. Third, some blame the structure of the Medicaid program, which has become the insurance of

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last resort for those in long-term care institutions. Fourth, some look to the fear of insurance companies that long-term care coverage could lead to insurance-induced demand. Insurance-induced demand is particularly a fear when the delivery system is fragmented, beneficiaries receive no case management, and a fee-for-service environment includes few incentives for providers to use resources efficiently. These problems have led some private insurers to question whether long-term care is an insurable service.

The first three problems—poor information about coverage, state regulatory policies, and the structure of the Medicaid program—represent important challenges that are beginning to be addressed. The news media, as well as the American Association of Retired Persons, have focused much attention recently on under coverage of the elderly for long-term care. The National Association of Insurance Commissioners has formed a task force to address state regulatory issues in this area, and some states have working groups looking at the interaction between Medicaid rules and private long-term care insurance. In this article, however, we focus on the fourth problem and make the case that prepaid capitated financing through a health maintenance organization (HMO) or other prepaid plan is the most rational approach for expanding long-term care insurance coverage. Prepaid capitated plans can reduce insurance-induced demand by using case management and using the incentives for efficiency associated with capitation. It is also important to note that the integration of acute care and long-term care services in one delivery system may offer the best hope for meeting the special care needs of an elderly population.

In this article, we develop the case for long-term care insurance in a prepaid capitated setting, discuss alternative approaches for prepaid capitated plans to become involved in the financing and delivery of long-term care services, and explore methods for encouraging expanded private insurance for long-term care in prepaid capitated settings.

**A Logical Partner For Long-Term Care Insurance**

In general, the two possible financing instruments that could be used to strengthen the current private long-term care financing system are insurance and cash accumulation plans. Insurance instruments pool the resources of a group of beneficiaries and make payments to support services for those beneficiaries in need. Cash accumulation instruments, on the other hand, require little or no risk sharing but instead provide a mechanism for people to save money that is then available for their future long-term care needs.

Elsewhere, we explore the role of cash accumulation plans which for some elderly could represent an important mechanism for financing cer-
tain types of long-term care services. For many elderly, however, it is not possible to accumulate enough savings to cover the costs of the care needed if they become totally dependent on support services. Spreading these high costs across a group of elderly who will experience a range of needs makes the costs both more predictable and more affordable. This type of risk pooling requires some form of insurance instrument.

To date, most private insurance for long-term care has been sold in the form of indemnity policies. These policies pay a fixed amount per day toward the cost of a given type of long-term care service. The design of these policies has been predominantly shaped by the insurance industry's substantial fear of insurance-induced demand.

This fear has led to the restriction of coverage in most indemnity policies to nursing home services. Private insurers assume that the utilization of institutional services will be less affected by the presence of insurance than will the utilization of home care services because most elderly try to avoid nursing homes no matter what the costs to them. Home care services, by contrast, are desirable, and it can be expected that utilization would increase if the out-of-pocket price decreased. Complicating the coverage of home care is the fact that it is difficult to assess objectively who among the frail elderly need home care services and what volume of services are needed to care for various chronic problems. Add to this uncertainty the role that family support can or cannot play, depending on availability of formal services, and it is easy to sympathize with the plight of actuaries working in this area.

Consumer surveys of the elderly, however, indicate their preference for home care services over institutional services. Many observers identify this mismatch in coverage that the elderly desire to purchase and coverage that insurers desire to provide as the big inhibitor in this market. This mismatch leads logically to prepaid capitated plans as a possible solution. Prepaid capitated plans are in a better position to cover home care services yet curtail the problem of induced demand because capitation principles provide the necessary provider incentives to set up an integrated delivery system that can keep beneficiaries at the lowest level of care possible. The capitation arrangement also provides incentives for a strong case management approach to patient care. By having a specific professional coordinate all the care for the needs of enrollees, a prepaid capitated plan has the potential to create a more personal relationship between the provider/payer and the enrollee while assuring that only necessary and appropriate care is provided. Although studies to date have not definitively shown reductions in institutionalization due to case management, it is logical that case management is more successful at limiting resource use than no management at all.

Existing prepaid capitated plans represent a logical vehicle for the insurance of long-term care in that many plans already have enrolled a
sizable number of Medicare beneficiaries who are accustomed to receiving services in a case-managed setting. These beneficiaries represent subgroups of the population with much better known risk characteristics than those facing a private insurer who markets policies to broader population groups whose health status characteristics are unknown except for information from standard insurance health screens. This factor suggests that adverse selection problems could be better managed in a prepaid capitated setting than in indemnity insurance approaches.

From a prepaid capitated plan’s perspective, the integration of acute care and long-term care service delivery and financing could lead to potential savings on the acute care side. Better attention to long-term care needs could reduce the need for acute care services.

The advantages of prepaid capitated plans as settings for expanded long-term care insurance coverage hold whether the insurance is financed publicly or privately. Given the existing budget constraints of the federal government, it seems clear that even a publicly organized long-term care insurance program would be funded largely through private premiums and existing Medicaid funds. It also is likely that any public program would offer a choice of delivery settings for the insurance coverage. Thus, the fundamental issues of how prepaid capitated plans can become involved in long-term care are similar whether a public financing or private financing approach evolves.

An important question, given the clear advantages of prepaid capitated plans for long-term care coverage, is why these plans have not offered this coverage in the past. One prepaid plan we talked to indicated concern with managing these types of services. Reluctance to enter this market is similar to their earlier reluctance to include mental health care. Interest in maintaining competitive premiums and satisfying employer group clients and worried well patients are paramount in many HMO managers’ minds. In an environment of limited resources, some of these managers are increasing the emphasis on introducing cost sharing in current benefit packages rather than expanding coverage to new services—especially when these new services are beyond traditionally defined medical care services. In addition, expansion of the benefit package to include long-term care coverage will increase an HMO’s risk of adverse selection. Individuals who need long-term care services have greater-than-average needs for acute care. If the addition of long-term care benefits leads to greater enrollment by individuals who have higher-than-average risks for both acute and long-term care, this adverse selection could substantially increase an HMO’s costs and ultimately its premiums.

As their populations age and as the older age groups become attractive market segments in many areas of the country, more prepaid plans are beginning to consider expansion into long-term care. The following sec-
tion of this paper describes the involvements in long-term care currently being considered by prepaid plans.

| Current Prepaid Capitated Plan Involvement In Long-Term Care |

Plans considering involvement in long-term care must decide what should be covered, how the benefits will be financed, and what kinds of incentives will be developed to deliver cost-effective care. Currently, three general approaches are being considered. The first is to use the savings from current Medicare contracts to finance some type of long-term care. The second is to offer as a supplement a separate insurance policy to members who might wish to insure against long-term care needs. The third approach is to expand the current prepaid coverage to include long-term care. For each of these options the services to be covered could vary from limited to comprehensive and could include or exclude social support services.

Use of Medicare savings to fund long-term care benefits. Currently, Medicare makes capitated payments to HMOs that have risk contracts. The capitated payments are 95 percent of the adjusted average per capita cost (AAPCC) of providing services to enrolled fee-for-service Medicare beneficiaries in the community. These rates are adjusted for age, sex, institutionalization, and welfare status. Separate AAPCCs are calculated for the aged and disabled.

If a prepaid capitated plan can deliver services at a cost less than the AAPCC amount, then the plan is required to use the savings to expand the benefit package offered to its elderly enrollees. These savings represent an important source of funds that could be used to support long-term care services at no extra premium cost to enrollees.

One HMO in Minneapolis has used these savings to fund expanded nursing home care up to one year for enrollees. Even when savings are not large enough to finance such an extensive benefit, however, it often would be possible to finance more limited care, such as case management services for the long-term care needs of a plan’s elderly enrollees. This type of benefit would represent an important incremental step toward more coordinated acute and long-term care services for the elderly, who often face a fragmented and confusing array of long-term care providers.

It is a relatively risk-free beginning because the costs of case management are predictable. In delivering case management, the plan will secure data on the use of community services and the ability to substitute them for institutional care. This information is essential for the expansion of coverage to these areas.

The use of Medicare revenues for a limited set of long-term care services might be more useful to beneficiaries and the health care services
delivery system in general than using these funds for other acute services, such as pharmaceuticals or vision care. First-dollar coverage on these services is often suggested as the option that Medicare beneficiaries appear to want the most.\(^8\) However, giving beneficiaries first-dollar coverage for these relatively low-cost services will inevitably have undesirable effects on the health care delivery system in general. Not only would the addition of some limited long-term care benefit provide financial support for beneficiaries in need, but it would keep competitive incentives in place by deemphasizing first-dollar coverages.

**Separate long-term care insurance products.** Some prepaid plans are exploring optional supplemental coverage for their enrollees. These policies can be limited or extensive, and can focus only on nursing home services or include some social services. The advantage of considering this type of approach, at least in the short run, is that there are fewer federal and state regulatory constraints to their development. Medicare and Medicaid waivers are not necessary, and the problems associated with conforming to the regulatory requirements of the Baucus legislation can be avoided.

Three strategies for implementation are under consideration. First, the prepaid plan can endorse a plan offered by an insurance carrier. Second, the prepaid plan can develop the plan as a joint venture with an insurance carrier, sharing some portion of the financial risk and delivering some or all of the covered services. Third, the prepaid plan can develop and market its own plan. For the prepaid plans, the choice of how much risk to bear will depend largely on the security of its financial base and its confidence in being able to manage the risk associated with long-term care insurance. For example, a small plan that has little knowledge of expected utilization patterns might be particularly sensitive to the risks of long-term care insurance since a handful of expensive cases could cause severe financial strain. In this situation, a large private insurer is a logical partner because an insurance company can pool the risks from a number of prepaid plans.

A separate long-term care insurance policy, sometimes called a “wraparound” policy, solves a number of implementation problems facing prepaid plans wishing to expand long-term care benefits. Prepaid plans that have risk contracts with Medicare are not permitted to do any health screening of applicants or to charge varying premiums to applicants using underwriting techniques. These restrictions can lead to severe adverse selection if long-term care services are insured. In addition, if a separate wraparound policy is sold, the policy is treated as an independent insurance plan and is not subject to special regulations in place for Medicare supplemental insurance policies. Generally, this means that standard underwriting techniques can be used as is done with existing long-term care insurance policies.
A second attractive feature of marketing a separate long-term care insurance plan is that by making the long-term care coverage voluntary, the prepaid plan does not face the problem of losing potential elderly enrollees who have no interest in long-term care insurance coverage. Offering a flexible menu of benefits at various prices assures that the higher costs of long-term care coverage will not erode the size of the HMO’s market for its acute care coverage.

Private insurance carriers should find prepaid plans attractive places for selling long-term care coverage because of the readily available case management services. As discussed in the preceding section, the managed-care environments of prepaid capitated plans might be the best setting for extensive expansion of long-term care insurance that includes home care coverage and thus is attractive to a large number of elderly.

The actual long-term care insurance policy offered to the enrollees of a prepaid capitated plan could take many different forms. The policy could offer indemnity benefits for a specified set of covered services, as is done by all of the existing private long-term care insurance policies. This would be the logical approach if a prepaid plan only endorsed a policy marketed by an insurance carrier. When a prepaid plan is willing to share some risk, it is possible to cover some or all of the long-term care services on a capitated basis. For example, one possibility is for the prepaid plan to be responsible for case management and then long-term care services up to some maximum liability. After a specified cap is reached, additional services could be covered on a fee-for-service basis, with the insurance carrier bearing the financial burden.

Expanding coverage to long-term care services. Extension of the prepaid model to include long-term care insurance coverage is also being considered as an option for many prepaid plans. Its advantage over other options is that it overcomes the problems of fragmentation of service delivery and financing sources. This coordination of the delivery and financing sources should improve both the efficiency of the system and the ability of the elderly to identify appropriate services. In addition, it should substantially reduce the insurance-induced demand problem through case management and prepayment. It does, however, have more short-run implementation problems because of federal and state regulations.

One model of this kind of integration is the social HMO. It is being tried on a demonstration basis at four sites: Metropolitan Jewish Geriatric Center in Brooklyn, New York; the Kaiser Permanente Medical Care Program in Portland, Oregon; the Ebenezer Society in Minneapolis, Minnesota; and Senior Care Action Network (SCAN) in Long Beach, California. These four sites vary substantially in terms of their organization. They represent a plan sponsored by a comprehensive long-term care provider (Elderplan sponsored by Metropolitan Jewish Geriatric Center);
an established HMO that has expanded its capacity to delivery of long-
term care services (Kaiser is offering Medicare Plus II); a comprehensive
long-term care provider linked with an established HMO (Ebenezer has
joined with Group Health to offer Medicare Partners); and a case
management agency that is using existing acute care and long-term care pro-
dviders to deliver services (SCAN Health Plan). Where partnerships exist,
there is generally risk sharing to provide incentives for efficient practice
patterns among all the providers of care.

The specific features of the policies offered also vary by site. In terms of
coverage, although comprehensive services are offered, the depth of
coverage is limited. All the sites have maximums on their annual bene-
fits. Three of the sites—Elderplan, Medicare Partners, and SCAN—have
the identical maximum annual benefit ($6,250-$7,500, depending on
the site), on institutional care, home- and community-based care, and
total annual benefits. Kaiser’s maximum is 100 nursing home days,
$12,000 in home- and community-based care, and a $12,000 total an-
nual maximum. All plans also have different rates of beneficiary cost
sharing. One plan has maximums on monthly out-of-pocket expenses
for both institutional and home- and community-based care; and one
plan has a maximum monthly out-of-pocket expense on home- and
community-based care only.

Since enrollment in the social HMOs is voluntary for the elderly living
in each of the four communities, the demonstration sites wished to pro-
tect themselves against adverse selection. To reduce this risk, each social
HMO has established, under a Medicare waiver, a quota of severely
impaired and moderately impaired elderly who can join the plan. A
severe impairment is defined as the need for assistance in activities of
daily living or being bedbound. A moderate impairment is an impairment
that requires the person to stay at home most or all of the time.

Privately paid premiums, ranging from $29 to $49, plus Medicare and
Medicaid finance the plans. Waivers from the federal government were
necessary to make public financing possible. Medicare is paying for Med-
icare beneficiaries’ acute care services at the rate that would be expected
if enrollees were treated in fee-for-service settings. They use a modified
AAPCC that reimburses social HMOs at 100 percent of the AAPCC,
rather than the 95 percent Medicare risk contract HMO reimbursement.
The amount is increased for social HMO enrollees who, according to
state nursing home admission standards, are at risk of institutionaliza-
tion. Long-term care costs are covered by the plan’s premiums and the
savings associated with the efficient delivery of acute care services.
Medicaid-eligible elderly also can participate in the demonstration; each
state has negotiated a capitated rate for a package of acute care and
long-term care services comparable to the existing set of services covered
by the state’s Medicaid program.
The four demonstrations also receive stop-loss insurance from the federal government during the first years of operation. The type of protection varies from site to site, with some sites having protection on an individual enrollee basis, while others are protected on aggregate losses exclusively. In every case, the sites and third parties would share in losses to some point, above which the sites would be completely protected. This arrangement maintains incentives for preventing losses but assures that none of the four organizations would experience severe financial losses if the demonstration were financially unsuccessful.

Efforts were made to set the premiums low enough to ensure plan marketability. The premiums ($29-$49 per month) were below those of some existing long-term care indemnity policies, but these existing policies provide more extensive coverage for institutional nursing home care. This lack of catastrophic nursing home coverage may have had some impact on the early enrollment in the social HMOs. This is especially the case with Medicare Partners in Minneapolis, Minnesota, which is in direct competition with another Twin Cities HMO that is offering more comprehensive institutional nursing home coverage than the social HMO coverage at a lower monthly premium.

Also having some impact on the rate of early enrollment is the lack of familiarity by community Medicare beneficiaries with the HMO concept and the specific HMO being marketed. This lack of familiarity probably explains some of the slowness of enrollment in Elderplan in Brooklyn and the SCAN Health Plan in Long Beach.

Expansion Of Prepaid Capitated Plans Into LTC Insurance Plans

Although growth in the number of prepaid plans that offer some form of long-term care coverage can be expected in coming years, substantial growth probably will occur only if some key prerequisites are met. The most important ones are better information to guide the behavior of both potential enrollees and insurers, supportive state and federal regulatory behavior, and a restructuring of the Medicaid program.

Better information. The market for long-term care insurance, whether delivered in a prepaid setting or an indemnity setting, is plagued by inadequate information on both the demand and supply sides. On the demand side, both the elderly and nonelderly are inadequately informed about the coverage for long-term care provided by Medicare and private Medicare supplementary insurance plans, both of which cover only limited amounts of institutional care and only when the care is rehabilitative in nature and associated with an acute health care problem.

Many people also fail to understand the spend-down rules of the Medicaid program, which makes Medicaid a very unattractive alternative to middle-income and wealthy elderly who have assets they would like to
retain. In addition, many elderly seem to underestimate the probabilities that they will need some form of expensive long-term care services until these needs are very close at hand.

Each of these information problems leads the elderly and nonelderly to undervalue long-term care insurance. Until the financial risks for the elderly and their families become more clearly understood, it is likely that long-term care insurance will remain a “tough sell.”

In the case of insurers, the information problems involve very scarce actuarial data about the long-term care utilization patterns of an elderly population. To price an insurance policy correctly, actuaries need to estimate utilization of both institutional and noninstitutional services for various age, sex, health status, and regional subgroups of the population. Ideally, this information should be known, not just for one year but over the expected lifespan of cohorts of the elderly.

These data do not exist in available data sets. Some pieces of the information exist in different places, but more effort is needed to develop the comprehensive utilization portrait that is required for a private insurer or prepaid plan to manage its potential risks. The absence of these data is one of the compelling reasons that led to the federal government’s provision of stop-loss protection to the social HMO demonstrations. Without adequate actuarial data or without some protection from financial ruin, few organizations want to take the risks required to enter this market.

**Supportive regulatory environments.** By focusing only on consumer protection concerns, state and federal regulatory policy could stifle the fledgling market for long-term care insurance. One example of this problem is the Medicare rule that precludes health screening and underwriting by prepaid capitated plans reimbursed on a risk contract. If an HMO cannot exclude from long-term care coverage enrollees who are already in a nursing home, or at least limit their numbers, premiums would have to be set very high. Premiums could become so high that it would be logical for only the institutionalized to participate. Thus, although the principle of open enrollment appears attractive, in practice it could undermine the implementation of long-term care insurance.

In the case of state regulations, many features of regulatory policy can stifle the insurance market. Rules about minimum benefit standards can make it difficult for insurers to experiment incrementally in this market with limited insurance packages. Minimum loss ratio laws and rules that govern the treatment of reserves can affect the ability of insurers to expect adequate profits in a market that includes substantial risk for the insurance firm.

Currently, many states are considering special laws that would guide regulations of long-term care insurance. In addition, a task force of the National Association of Insurance Commissioners is working on a model
law that states could consider. In one sense, these are positive steps because special laws could make clear that the regulatory concerns with long-term care insurance are not identical to those with the mature markets for health and casualty insurance. There is danger in passing special laws for long-term care insurance at this time, however, because in many states consumer protection concerns could completely overwhelm industry viability concerns. The most constructive approach in an evolving market as important as this one is for regulatory behavior to emphasize consumer disclosure and financial viability and to avoid regulatory straightjackets that would prevent continued experimentation with and evolution of products.

Restructuring Medicaid. The most important stimulant of the private insurance market would be some integration of private insurance and the Medicaid program. With some creativity, this integration could lead to both Medicaid savings and much more satisfactory financial protection.

One possibility is to integrate private insurance and the Medicaid program by making any elderly person who buys a private long-term care insurance policy with a specified minimum set of benefits exempt from the Medicaid spend-down rules after the private insurance benefits are exhausted.\(^{10}\) As long as the savings in Medicaid funds caused by the presence of private insurance exceed the revenues lost by waiving spend-down rules, Medicaid programs would experience a net gain.

Although data on how much long-term care is purchased during the spend-down process are unavailable, indirect evidence suggests that, at least in the most generous Medicaid states, spend-down payments represent a relatively small proportion of total long-term care expenses. In California, for example, it is estimated that the state Medicaid program pays for three-fifths of all nursing home expenses in the state.\(^{11}\) Thus, as long as private insurance would pay for at least two-fifths of the expected nursing home costs, the Medicaid program could reduce its overall expenditures for nursing home care. In New York, the Medicaid share of nursing home expenses is close to 90 percent of statewide nursing home costs.\(^{12}\) Thus, in New York the Medicaid savings could be substantial. Nationwide, the average Medicaid share of nursing home expenses is approximately 50 percent.\(^{13}\)

For this integration of Medicaid and private insurance to work, it is essential that the total costs of long-term care not greatly exceed current costs of long-term care paid with private funds. Insurance-induced demand must be avoided, or aggregate expenses must be contained by greater substitution of lower cost home care services for institutional services. As argued above, it is most likely that this goal can be achieved if private insurance evolves in a prepaid capitated setting where case management and the incentives of capitation can lead to efficient allocation of long-term care resources.
The value of being able to avoid impoverishment in the event of the need for long-term care services would be quite high for many elderly and would represent a much larger incentive for purchasing long-term care insurance than currently exists. Private long-term care insurance could be seen more in terms of asset protection than as actual coverage for long-term care, which many elderly perceive as being covered by Medicaid in any event. This integration of Medicaid and private insurance would also give the elderly some guarantee that the private policy they purchase will have value to them. In this new market, many elderly fear that it will be difficult to collect money from an insurer or that the insurance policy will be cancelled unexpectedly.

The actual design of an integrated Medicaid and private insurance policy could take many forms. A state Medicaid program could contribute a capitated amount to a prepaid capitated plan that when added to the private premium, would cover the expected costs of a set of services equivalent to current Medicaid coverage. Or the private plan could be administered separately from the Medicaid plan, with the latter taking over service payments after private insurance benefits are exhausted. It is also possible to mandate various amounts of private coverage, depending on an elderly person’s income and asset levels, in order to qualify for the waiver of spend-down rules. The wealthier could be expected to pay more for private coverage because for them the value of avoiding the spend down would be far greater than for the elderly with few assets to protect.

**Conclusion**

This article makes the case for prepaid plans to cover long-term care, outlining several options and describing implemented programs and some long-run reforms that will aid the market in the development of these products. The social HMO demonstrations described earlier are an important breakthrough. However, without continued demonstrations and evaluations of alternatives to the existing system, little can be accomplished. But, it is critical that a test of the use of case-managed settings for long-term care not be restricted to this one model. Other innovative concepts are being considered in a variety of different settings.

One serious impediment to their implementation, however, is the fear of adverse selection—the fear that only the frailest elderly will choose to purchase a voluntary plan. Even though many of the leaders of HMOs and insurance companies think that a broad group of elderly would be interested in such coverage, the consequences of being wrong are sobering to fledgling HMOs and cautious insurance companies.

To stimulate such innovation, some consideration should be given by private foundations and the federal government to the provision of stop-
loss insurance which would make payments after financial losses reached some specified threshold. The financial protection that stop-loss insurance would offer is important because without such protection, insurers will charge very high premiums to compensate for unknown risks. Unfortunately, if high premiums are charged, only the sickest elderly would purchase the insurance. Thus, the fear of adverse selection by insurers could be a self-fulfilling prophecy.

In return for the stop-loss insurance, groups would be required to provide uniformly reported information on the structure of their plans, beneficiaries’ demographic and health status characteristics, utilization of services, and costs of providing the services. These data would be available for evaluation and provide the experience data necessary to adequately price a wide range of long-term care services.

The current long-term care system in this country is intolerable. The advances of American medicine in the last quarter of a century and the changes in the family structure of the average American family have dramatically altered the needs of older Americans. Although these developments have generally improved the quality of life, they have also brought with them a growing need to rationalize the way we think about and deliver health care. Systems of care that do not emphasize cost-effective treatment and insurance for care that does not promote efficient delivery can no longer be afforded.

Determining how our society will provide and finance long-term care in the future is a critical need. Although we all believe that it is important to finance needed long-term care services for our elderly, it is also necessary to do this in such a way that emphasizes appropriate care for those in need. Finding the solutions to this problem is difficult but not beyond our reach; expanding prepaid capitated plans to include long-term care will help to begin the process.
NOTES
1. Except for care delivered as part of demonstration projects, the Medicare program supports long-term care only when it is aimed at rehabilitation or recuperation rather than when it is custodial in nature. Medicare also limits its reimbursement for institutional care to 100 days. The first twenty days are paid in full. A copayment, currently $61.50, is required for days twenty-one through 100. The full cost of home health care services is covered as long as the service is rehabilitative and the beneficiary is home bound.
6. Although many prepaid plans are reimbursed not under TEFRA contracts but under a direct-dealing or GPPP arrangement, a TEFRA contract does permit the use of savings below the capitated amount to provide other services to beneficiaries.
9. The Baucus legislation, Section 507 of Public Law 96-265, was enacted in 1980. It established a mechanism for voluntary certification of Medicare supplementary policies in states that did not have legislation in force in accordance with the NAIC model standards for Medicare supplementary insurance policies. It resulted in state statutes being enacted in all but four states. These model statutes defined minimum loss ratio requirements, minimum benefit standards, policy definition rules, policy provision restrictions, disclosure provisions, and renewability requirements. Long-term care insurers generally want to avoid the regulatory requirements of policies considered to be “Medicare supplements,” especially the requirement that such a policy have an anticipated loss ratio of 65 percent or higher.
10. We would like to acknowledge Arthur Ericson of Prudential, who suggested to us the idea of linking the purchase of private insurance and the waiver of spend-down rules.