

Alternative Solutions

LTC Financing: Are We Looking at this the Wrong Way?

Monday March 23, 2015

2:00 – 3:30

ILTCI

15th Annual Intercompany Long Term Care Insurance Conference

Session Participants



- Anne Montgomery, Producer
- Larry Atkins, Speaker
- Lois Simon, Speaker

Alternative Solutions

Commonwealth Care Alliance

**INNOVATIVE APPROACHES TO CARE FOR INDIVIDUALS
WITH COMPLEX CARE NEEDS:
PRIMARY CARE TRANSFORMATION**

Lois Simon, President
Commonwealth Care Alliance



15th Annual Intercompany Long Term Care Insurance Conference

What is Commonwealth Care Alliance (CCA)?



- A Massachusetts, consumer governed, not-for-profit, comprehensive, prepaid care delivery system created in 2003
 - A hybrid of care delivery and payer roles
 - Accountable Care Organization Prototype for Complex Populations
 - Redesigns care by investing in and transforming primary care; enhances primary care and care coordination capabilities through deployment of Interdisciplinary Primary Care Teams
- Mission driven concentration – focuses exclusively on the care of Medicare and Medicaid’s most complex and expensive beneficiaries
- Proven track record for providing high quality care while bending the health care cost curve
- One of the few organizations nationally with depth, longevity of experience and demonstrated success in integrating primary, acute, and long term care services financed by a risk adjusted global capitation

Market Leader in Integrated Care for Dual Eligibles



Senior Care Options Program

- Fully Integrated Dual Eligible Medicare Advantage Special Needs Plan (FIDESNP)
- 6300+ elder members in Greater Boston, W. Mass and North Shore
- \$350M + in annualized blended premium
- 74% of members meet nursing home criteria yet live in the community
- 40+ primary care sites affiliated with 9 hospital systems with integrated, multi-disciplinary primary care teams

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OneCare Program

- Implemented Oct 1, 2013 – first in the nation capitated duals demonstration
- Of three OneCare Plans, CCA has the broadest service area, enrolling beneficiaries in nine counties
- Expected enrollment by end of 2014 of approximately 10,000 One Care enrollees
- Serves dual eligibles under 65 with chronic illness and disabilities, 70% of whom have a behavioral health diagnosis
- Served through a platform of primary care and human service partners, as well as an expanded medical and behavioral health provider network

Commonwealth
Care Alliance

CCA Proven Success: Highest rated FIDESNP and DSNP in the Nation 2011 - 2013



Performance Metrics

CCA - Senior Care Options – launched in 2004:
2 years into program, an independent evaluation (JEN Study) showed SCO enrollees enter nursing facility less often and for shorter durations than control population

Ongoing study and experience shows:

- 66% less likely to enter nursing facilities
- 45-50% reduction in hospitalizations
- Decreasing readmissions and increasing percent of patients dying at home

In a very early (circa 1999-2008) demonstration for complex under 65 Medicaid beneficiaries, avg. PMPM for the most expensive individuals decreased from \$9,000 under FFS to \$2,500 under CCA capitated system

Quality Metrics

- ❑ Overall Plan Rating: ★★★★★
- ❑ Health Plan Rating (Part C):
 - Staying Healthy: Screenings, Tests & Vaccines ★★★★★
 - Managing Chronic Conditions ★★★★★
 - Rating of Health Plan Responsiveness & Care ★★★★★
 - Health Plan Member Complaints & Appeals ★★★★★
 - Health Plan's Telephone Customer Service ★★★★★
- ❑ Drug Plan Rating (Part D):
 - Drug Plan Customer Service ★★★★★
 - Drug Plan Member Complaints, Members Who Choose to Leave, and Medicare Audit Findings ★★★★★
 - Member Experience with Drug Plan ★★★★★
 - Drug Pricing and Patient Safety ★★★★★

Medicare Star Ratings – Highest rated FIDESNP and DSNP in the nation 2011 – 2013 (2014 not yet available)



An Enhanced Primary Care Model

- Clinical model of enhanced primary care involves hands on care by our clinical teams – well beyond “remote” care management
- Robust home visiting program by CCA interdisciplinary teams enhances ability to respond to episodic care needs and averts trips to emergency rooms, prevents hospitalizations and readmissions
- Teams responsible for transitions of care and continuity of care across ALL care settings (home to hospital to sub-acute/SNF to home)

Member Engagement

- Commitment to engaging members in multiple ways:
 - Governance
 - Program Development, Design and Improvement Strategies
 - Individual Care Planning and Self-Management
- Growth and care delivery approach:
 - Enrollment process aimed at diligence in ensuring continuity and comprehensiveness of care
 - We work with providers who are interested in our model of care

Care Delivery Approach and Community Partnerships



Model of Care:

- Integration of care delivery and financing across medical, behavioral health, and long term services and supports
- Individualized person-centered care planning: flexible, responsive, creative solutions
- Interdisciplinary Care Teams
- Continuity of care across care settings: fully supported transitions of care to ensure smooth handoffs
- Enhanced primary care (home visiting capacity, episodic care), care management/coordination – virtual staff model

Our Partners in Care:

- Area Agencies on Aging (ASAP network in MA) and Independent Living Centers (ILCs)
- Human service providers (backbone of residential and community based support for individuals with intellectual disabilities and mental health needs, etc.)
- Housing providers (assisted living, rest homes, skilled nursing facilities, specialized adult foster care/caregiving providers)
- Patient centered medical homes – primary care providers (FQHCs, medical group practices, etc.)
- Transportation, durable medical equipment providers
- Substance abuse providers

The Challenges:

- Primary care is grossly under resourced and poorly designed for those with greatest need.
- 90+% of hospitalizations occur as a result of missed opportunities to effectively manage predictable complications.
- There is no systematic connection between and accountability across medical, behavioral and social support providers leading to fragmented and poorly coordinated care.
- Trusting relationships need to be established to best support and facilitate acceptance of services that may be needed to optimize healthy independent living
- There are MAJOR gaps in the care delivery system for some sub-populations, for those with behavioral health issues in particular.
- Getting the regulatory and financing framework right is a work in progress.

What success can look like – the opportunities:

- **Juanita:** 89 years old; medical fragility, need for close coordination across primary care, specialists, home visiting team and family: *critical partnership with supportive housing*
- **Kevin:** 42 years old; behavioral/substance issues, frequent ER visits/admissions, need for coordination of home care services to support effectiveness of BH/SA interventions: *critical role of Health Outreach Worker*
- **Louise:** 74 years old; significant medical and mental health issues including depression, need for primary care, medication management and diabetes education: *critical role of home based primary care and enhanced role of home care workers*



- **Significant reductions in hospitalization admissions and days***
 - Commonwealth Care Alliance risk adjusted hospital admissions and days, are 52% of the Medicare Dual eligible FFS experience (2009-2012)
- **Significant reductions in hospital readmissions**
 - CMS NCQA Measure: Commonwealth Care Alliance's 2010-risk adjusted 30 day hospital readmission rate = 4% vs. 13% the Medicare Advantage median, > 99th percentile
- **Significant reductions in permanent nursing home placements**
 - Nursing home certifiable elders permanently going to nursing home, 34% of the rate for comparable NHC frail elders**
- **Nine year cost trend significantly below Medicare trend**
 - Avg. annual medical expense increase 2004–2013 = 3.3% Nursing Home Certifiable (NHC) enrollees, 2.6% ambulatory enrollees
- **CMS Quality Star Rating = 4.5 stars 2011–2015**
 - 90th percentile of all Medicare Advantage Plans, 99+ percentile of all Medicare Advantage Special Needs Plans

*Lewin Associates study commissioned by the SNP Alliance of member risk adjusted hospital utilization experience vs. Medicare benchmark

**JEN Associates Study Commissioned by Mass Health, 2009

A Comparison

	FFS Care Avg RS = 1.24	Commonwealth Care Alliance Avg RS = 1.86
% of total “medical spend” for primary care*	4%	12%
% of total “spend” for hospital care FFS Disability population***	43%	16%
Severity adjusted hospital/days/k/yr****	3,383 days/k/yr.	1,622 days/k/yr.
LT nursing home placement by community living NHC enrollees per 100/yr.*****	12.0	4.1
30 day hospital readmission rate*****	20.1%	16.4%

* MedPAC Analysis, Medicare Beneficiary Survey Cost and Use File 2006

** MassHealth, SCO Procurement, Databook 1999-2002

*** Medicaid claims analysis comparable, FFS physical disability population

**** Lewin Associates, FFS hospital admission analysis-Medicare Beneficiary cost and use fill 2007

***** JEN Associates study for MassHealth 2004-2005; includes RNP visits

***** Jencks et al *NEJM*, Vol. 360: pp.1418-1428, 2009

Summary



PROBLEM	OPPORTUNITY
Inadequate, discontinuous, unengaged primary care	Team approach—RN/RNP/SW/BH/PCP Horizontal rather than vertical MD relationship
Inappropriate dependence upon Emergency Rooms for sick/non-emergent issues	24/7 telephonic access to care team, supported by member's clinical record to inform clinical triage and decision making
Difficulty of getting to physician offices/clinics for care; Inability of physician to assess home environment	Capacity for home visits and transfer of clinical decisions to the home or other care settings as necessary; full "picture" of needs
Traditional "disempowered role" of member in the relationship with busy physicians	Meaningful consumer involvement in care management and care design
Fragmented relationships with specialists, hospital and institutional providers	Coherent and fully organized hospital, institutional and specialist network centered around the primary care physician and team
Insurance company "rules" regarding benefit requirements and service authorization	Fully empowered primary care team able to order/authorize all needed services (particularly in home LTSS services)
Lack of continuity and shared information among medical, behavioral health and long term care providers	Fully integrated network of all providers and the primary care team as the "hub" of the wheel to promote information sharing and care transitions
Incoherent "picture" of totality of member's medical, behavioral health and support service needs	Fully integrated clinical record and state of the art data support



HEALTHY IS HARDER FOR SOME. THAT'S WHY WE ARE HERE.

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Alternative Solutions

“MediCaring Communities: A Triple Aim Approach for Frail Elderly Medicare Beneficiaries

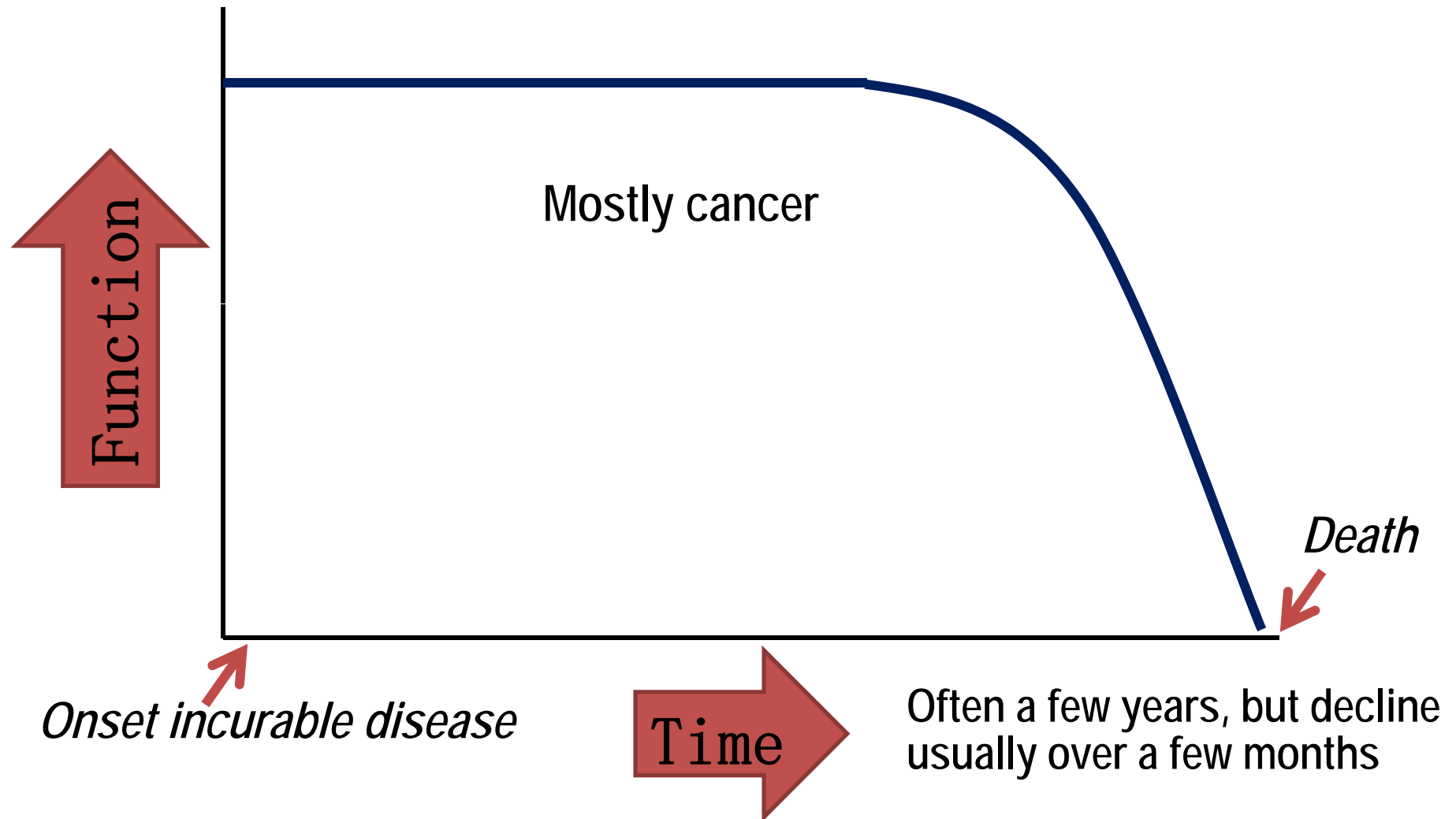
Anne Montgomery

Anne.Montgomery@altarum.org

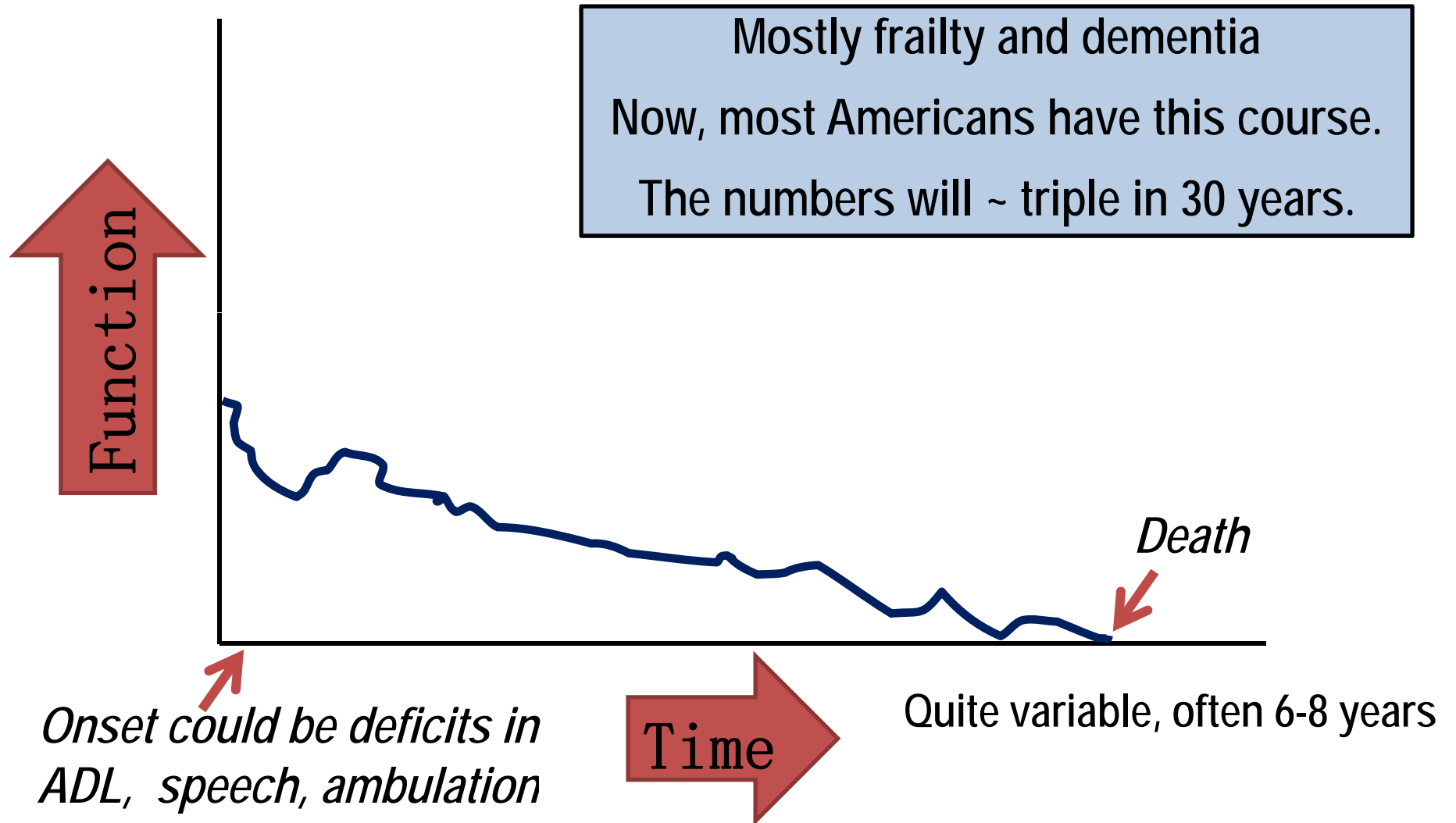
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Single Classic “Terminal” Disease: “Dying”



Prolonged Dwindling

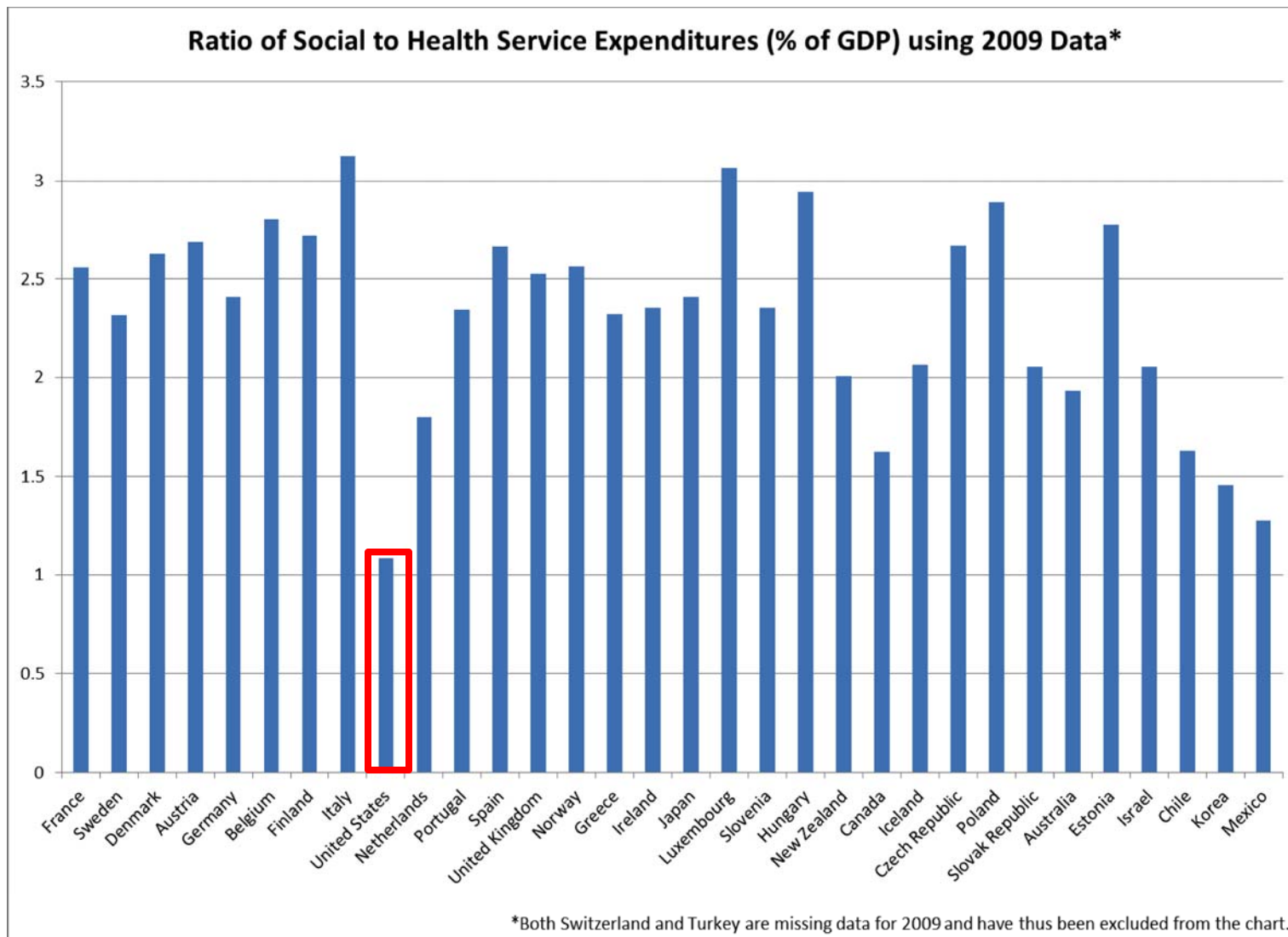


Late-Life Disability, When LTC is Needed



- Average disability – nearly 3 years for those alive at 65
- Very few have long-term care insurance (about 1/10)
- Few have saved enough for average costs
- The Boomer generation has few children, who will be older when caregiving and many of whom will not have adequate retirement security for themselves
- Unacceptable to allow gradual decreases in supports that will end up abandoning basic needs for frail elders
- Possible solution lies in more comprehensive models that are financed with existing programs, shared savings

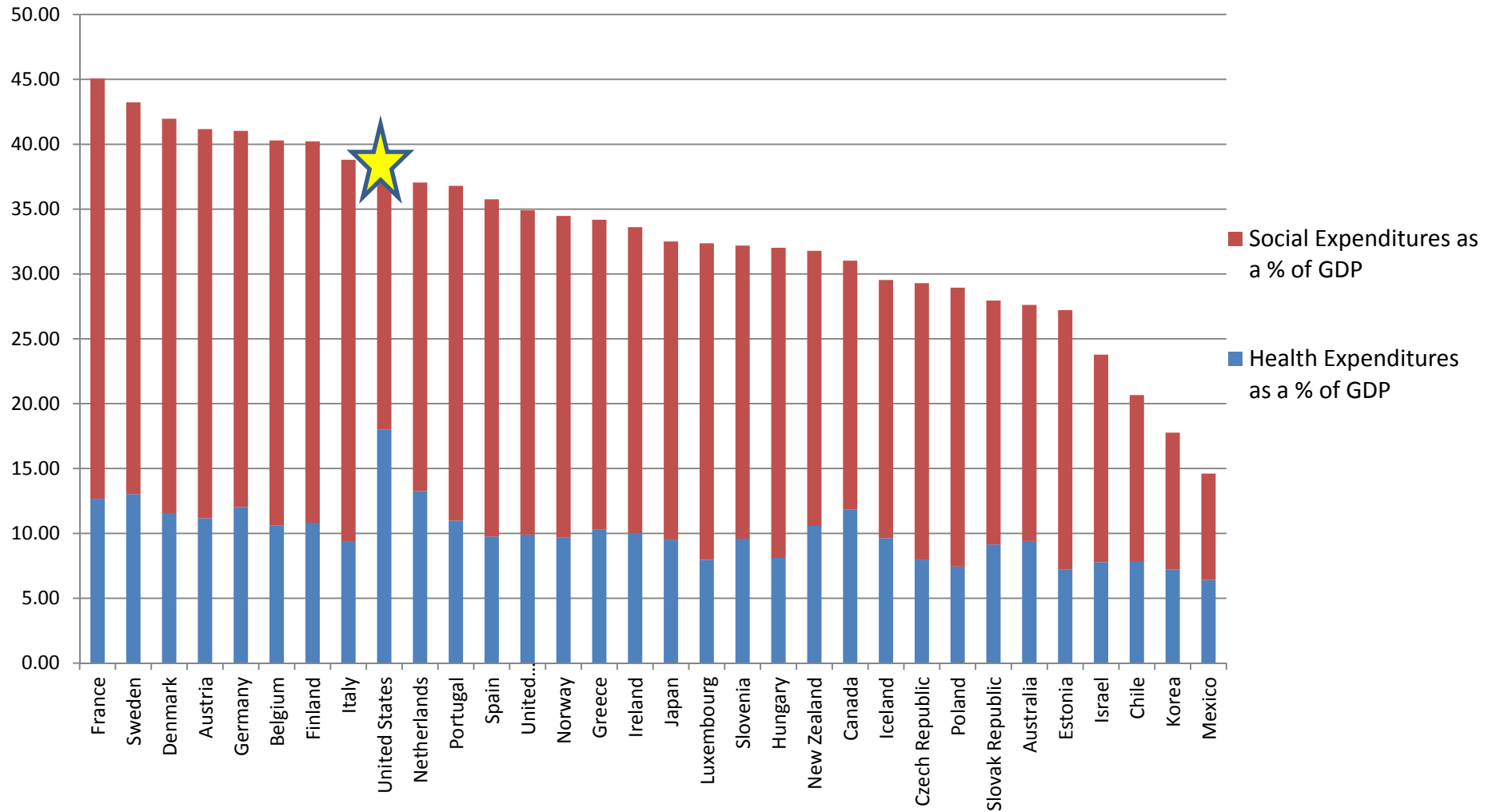
Ratio of Social to Health Service Expenditures Using 2009 Data



United States Ranking in Health vs. Social Spending



2009 Health and Social Expenditures as Percentages of GDP



Source: OECD Health Data 2009, Health Expenditure Dataset, Paris, France (2009)

Also in *The American Health Care Paradox: Why Spending More is Getting Us Less*, by Elizabeth Bradley and Lauren Taylor.

Six Core Elements of MediCaring Communities



- 1. Frail elderly Medicare beneficiaries (and dual eligibles) enrolled in a geographic community: (>65 w/2+ ADLs, dementia, or 80+)**
- 2. Longitudinal, person-driven care plans**
- 3. More efficient medical care tailored to frail elders (including at home)**
- 4. Incorporating health, social, and supportive services**
- 5. Using core funding derived from shared savings in a modified ACO structure or more flexible PACE-without-walls plan**
- 6. Ongoing monitoring and improvement guided by a Community Board**

Piloting A MediCaring Community



- Can use a modified ACO structure that offers enrollment to all eligible and willing frail elders in a given community/area, possibly an expanded “PACE Without Walls,” or other shared savings model
- Many communities have leadership organizations interested
- Raising start-up funds seems possible in many of these communities (social impact bonds, philanthropy, “pay 4 success,” business investment)
- Optimal piloting would have a dozen or more diverse communities

Outcomes Metrics for a Community Dashboard



- Would reflect the concerns of frail elders and families – e.g., out-of-pocket cost burden, reliability of services, caregiver strain
- Would include feedback loops for improvement
- Population-based measures

And note – aggregated care plans give a remarkable population monitoring and planning tool

LifeCourse Goal Manager	4/21/2013	LifeCourse Goal Manager	4/30/2013
LifeCourse Goal 1	"I want to stay in	LifeCourse Goal 1	"I want to stay in my house as long as possible."
LifeCourse Goal 1 Importance	High	LifeCourse Goal 1 Importance	High
LifeCourse Goal 1 Domain	Physical;Psychological;	LifeCourse Goal 1 Domain	Physical;Psychological;Cultural;Financial
LifeCourse Goal 1 Progress Satisfaction	3	LifeCourse Goal 1 Progress Satisfaction	3
LifeCourse Goal 1 Status	Active	LifeCourse Goal 1 Status	Active
LifeCourse Goal 1 Plan	Explore relevant issues	LifeCourse Goal 1 Plan	Explore relevant issues around safety and care needs.
LifeCourse Goal 2	"I want to get off	LifeCourse Goal 2	"I want to get off the pain medications that I have been taking since I had neck and shoulder pain
LifeCourse Goal 2 Importance	Medium	LifeCourse Goal 2 Importance	Medium
LifeCourse Goal 2 Domain	Physical;Psychological	LifeCourse Goal 2 Domain	Physical;Psychological
LifeCourse Goal 2 Progress Satisfaction	2	LifeCourse Goal 2 Progress Satisfaction	2
LifeCourse Goal 2 Status	Active	LifeCourse Goal 2 Status	Active
LifeCourse Goal 2 Plan	LifeCourse Team to gui	LifeCourse Goal 2 Plan	LC Care Team to determine follow up.
LifeCourse Goal 3		LifeCourse Goal 3	daughter would like help monitoring her mother's health, in an effort to avoid another stroke.
LifeCourse Goal 3 Importance		LifeCourse Goal 3 Importance	High
LifeCourse Goal 3 Domain		LifeCourse Goal 3 Domain	Physical;Social;Psychological;Family Caregiver
LifeCourse Goal 3 Progress Satisfaction		LifeCourse Goal 3 Progress Satisfaction	1
LifeCourse Goal 3 Status		LifeCourse Goal 3 Status	Active
LifeCourse Goal 3 Plan		LifeCourse Goal 3 Plan	LC Care Team to explore supportive resources.
LifeCourse Goal 4		LifeCourse Goal 4	daughter would like help planning for her mother's future care needs.
LifeCourse Goal 4 Importance		LifeCourse Goal 4 Importance	High
LifeCourse Goal 4 Domain		LifeCourse Goal 4 Domain	Physical;Social;Psychological;Financial;Family Caregiver
LifeCourse Goal 4 Progress Satisfaction		LifeCourse Goal 4 Progress Satisfaction	1
LifeCourse Goal 4 Status		LifeCourse Goal 4 Status	Active
LifeCourse Goal 4 Plan		LifeCourse Goal 4 Plan	LC Care Team to advise.

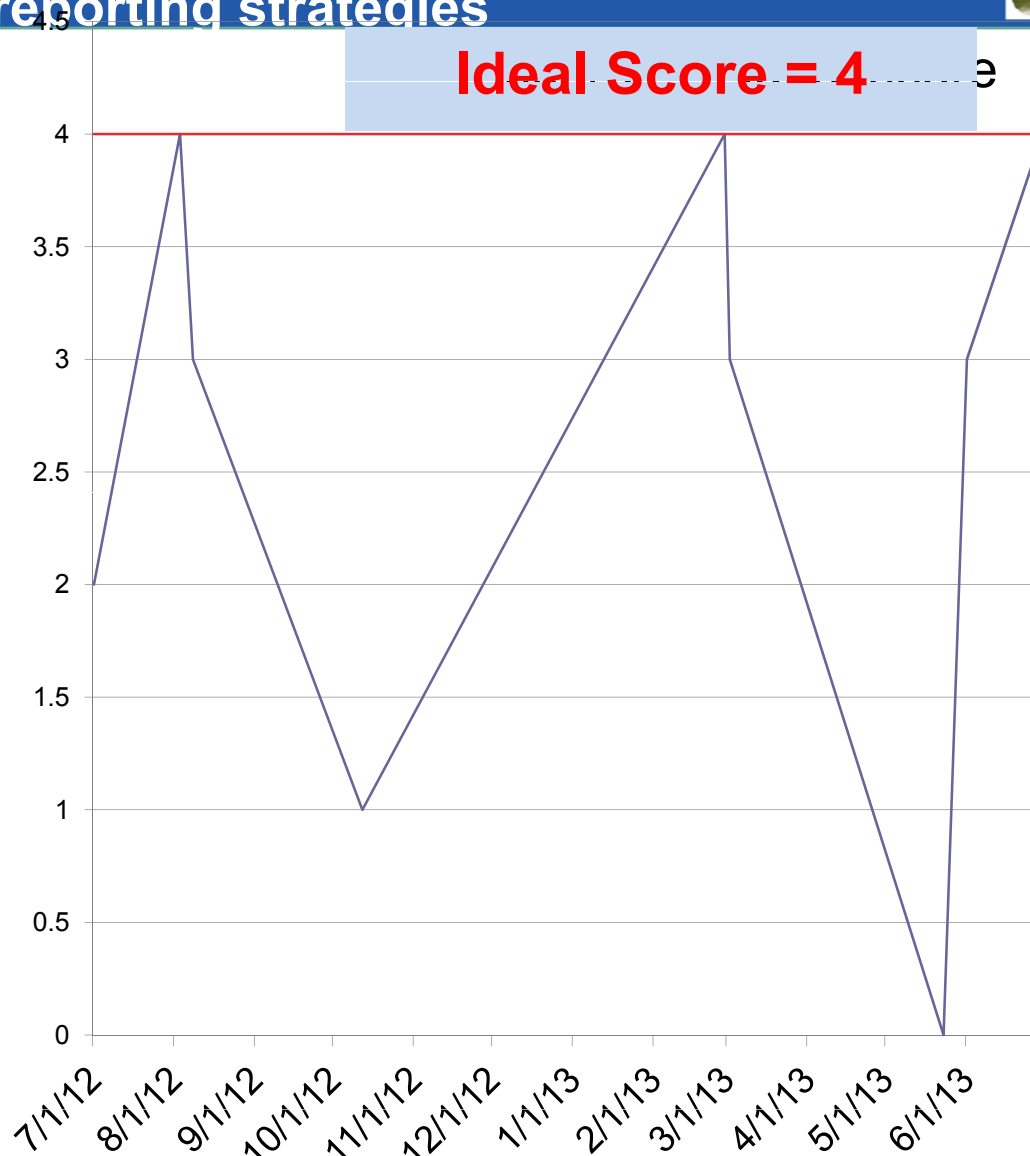
Goals Current State

Patient- Reported Pursuit of Goals

Various intervals, multiple reporting strategies



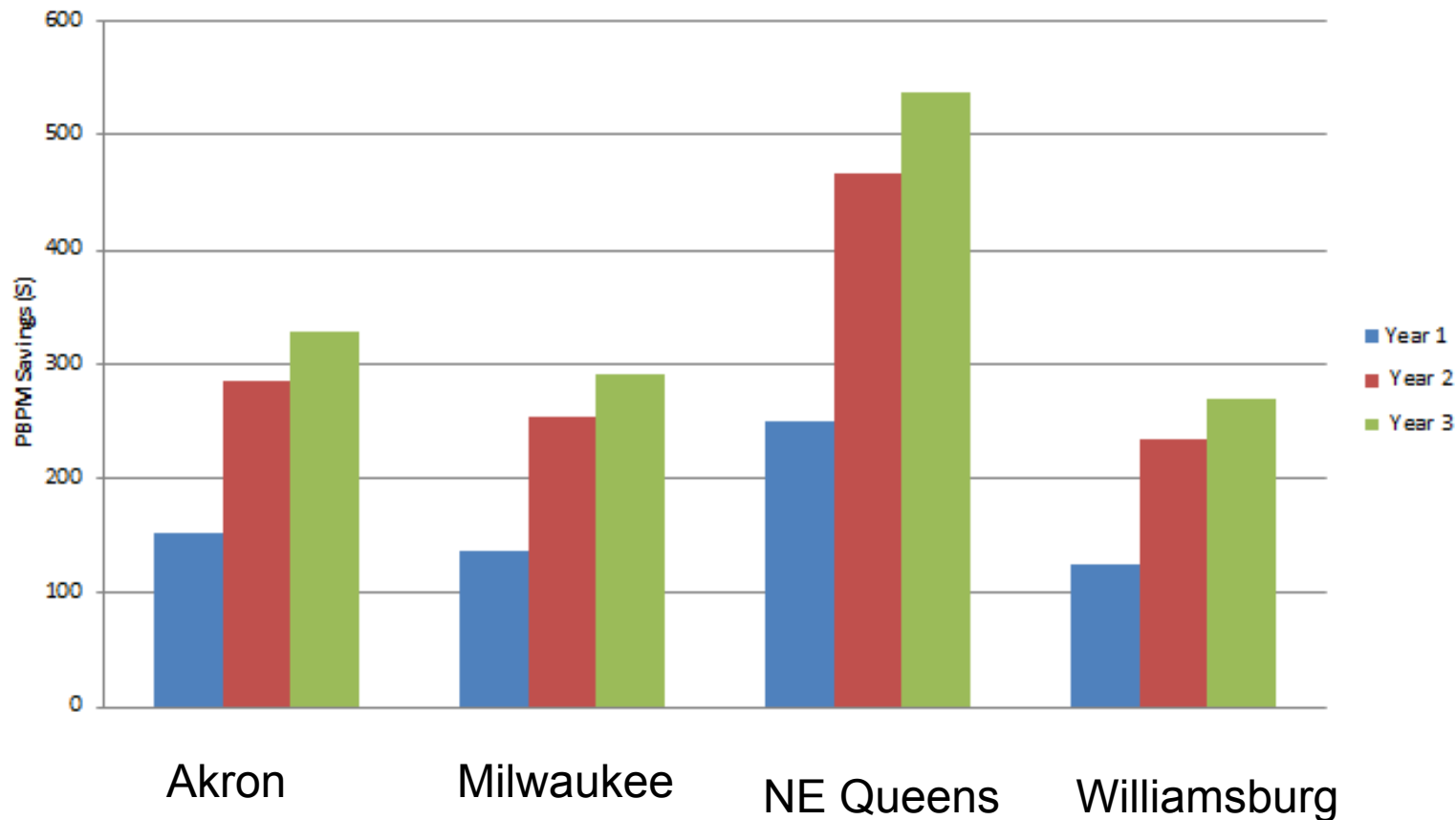
Date	Score
7/1/2012	2
8/3/2012	4
8/8/2012	3
10/12/2012	1
2/28/2013	4
3/2/2013	3
5/23/2013	0
6/1/2013	3
6/30/2013	4



How Much Can MediCaring Communities Save?



PBPM Savings over Time



Are Savings Real?

- Four communities - 15,000 frail elders as steady caseload
- Conservative estimates of potential savings from published literature on better care models for frail elders
- **Yields \$23 million ROI in first 3 years**

Net Savings for CMS Beneficiaries	Yr 1	Yr 2	Yr 3	3-Yr
<i>Before Deducting In-Kind Costs</i>	-\$2,449,889	\$10,245,353	\$19,567,328	\$27,362,791
<i>After Deducting In-Kind Costs</i>	-\$3,478,025	\$8,463,101	\$17,629,209	\$22,614,284

For more on financial estimates, see <http://medicaring.org/2013/08/20/medicaring4life/>

Genesis of a Community Board



- A county or city government (San Diego)
- A coalition of long-term care and home care providers (Grand Rapids, MI)
- An activist community group (Martha's Vineyard and Frederick County, MD)
- A dominant health care system in partnership with community-based organizations such as Area Agencies on Aging, or from a local provider coalition
- A comprehensive elder care program (e.g., PACE)

- Make it possible for some leadership communities to move ahead and apply for waivers/demonstrations
 - CMMI/CMS – promise of shared savings from Medicare
 - Cooperate with HUD, ACL, and other agencies
- Build the performance metrics we need
 - CMS, ACL, other agencies – to use in care planning, and to measure impact of services in meeting beneficiary's goals, treatment preferences

MediCaring Community Waiver Package Needed for Pilot Testing

No.	Requirement
1	The 3-day hospital stay rule for SNF benefits.
2	Provisions that make it difficult for a person being discharged from a hospital to be admitted to a MediCaring Community.
3	Provisions that require separate nursing staff in home care and hospice.
4	Provisions requiring PACE and hospice to be presented as entire packages, rather than being split up into useful menu items that can be purchased and provided separately.
5	The requirement for MDS and OASIS assessments to be conducted in addition to assessments conducted with the CARE tool (assuming that the CARE is available on-line).
6	Provisions for quality reporting which, absent an adjustment, would require enrollees to be included in standard quality measurement reporting; MediCaring beneficiaries would instead be tallied according to proposed/negotiated quality metrics.
7	Triggering of “inducement” provisions in Medicare Advantage when a MediCaring Community provides services outside of Medicare coverage.
8	Medicare “homebound” rule limiting home skilled nursing or therapy services delivery.
9	Allow Nurse Practitioners to order/authorize home care/hospice services (where legal).
10	Allow ACO (or other type of entity) to recruit/enroll frail elderly Medicare beneficiaries and dually eligible beneficiaries, and organize a coherent community-anchored system.



Alternative Solutions

Disrupting the Conversation: The Future of LTSS Financing

G. Lawrence Atkins, Ph.D.

ILTCI

Colorado Springs, Colorado

March 23, 2015

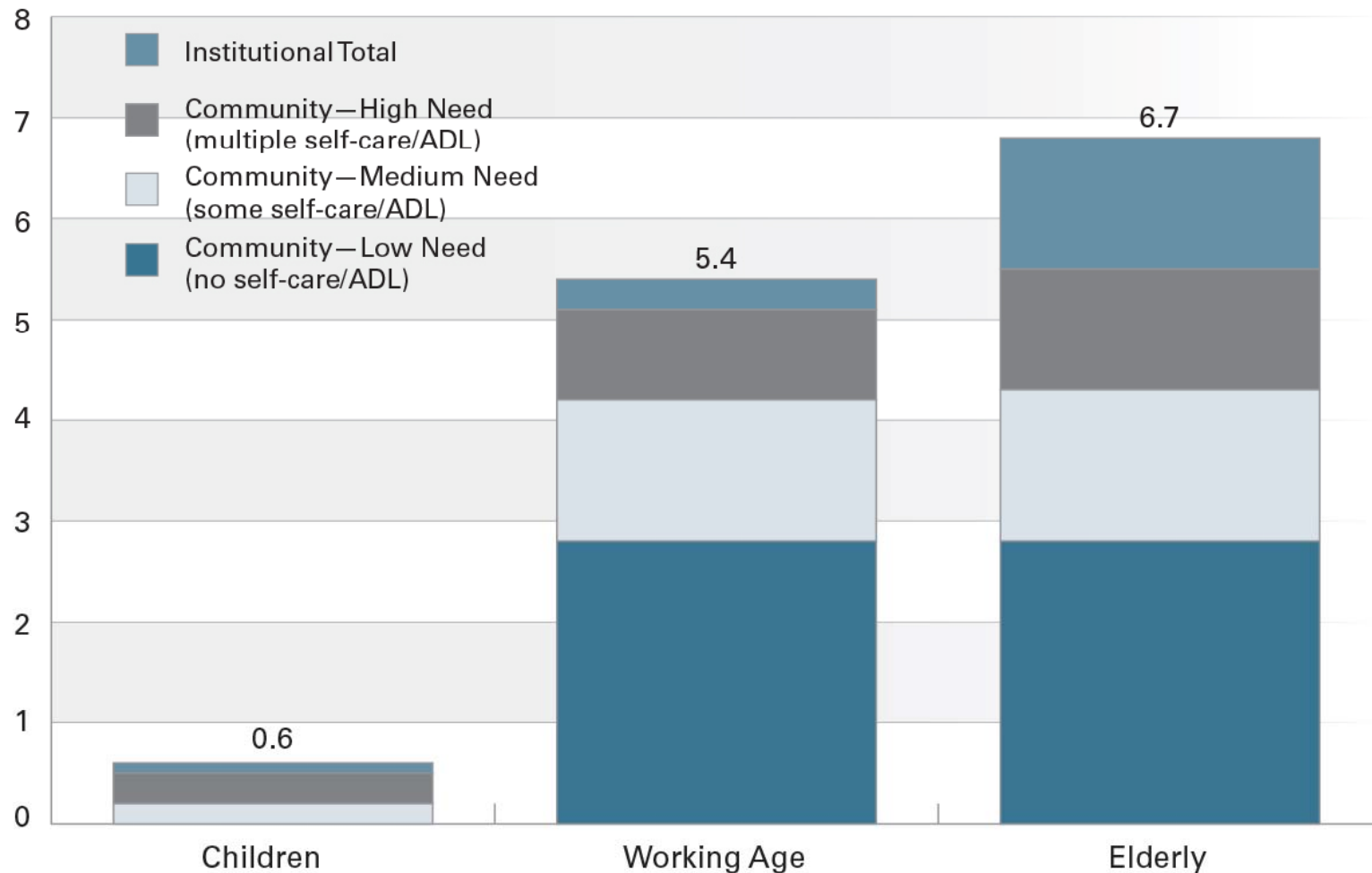


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- 12 million adults (18+) receiving LTSS today.
- More than half (55%) age 65 plus – almost half (45%) age 18-64.
- Recent NHATS data:
 - 7.7 million Medicare beneficiaries 65+ (20%) receive some assistance.
 - Most at home – only 1.1 million in nursing facilities.
 - Only a third (12 million) considered “fully able.”

Need for LTSS by Age & Care Need

Population Needing LTSS, by Age Group and Level of Need (Millions)

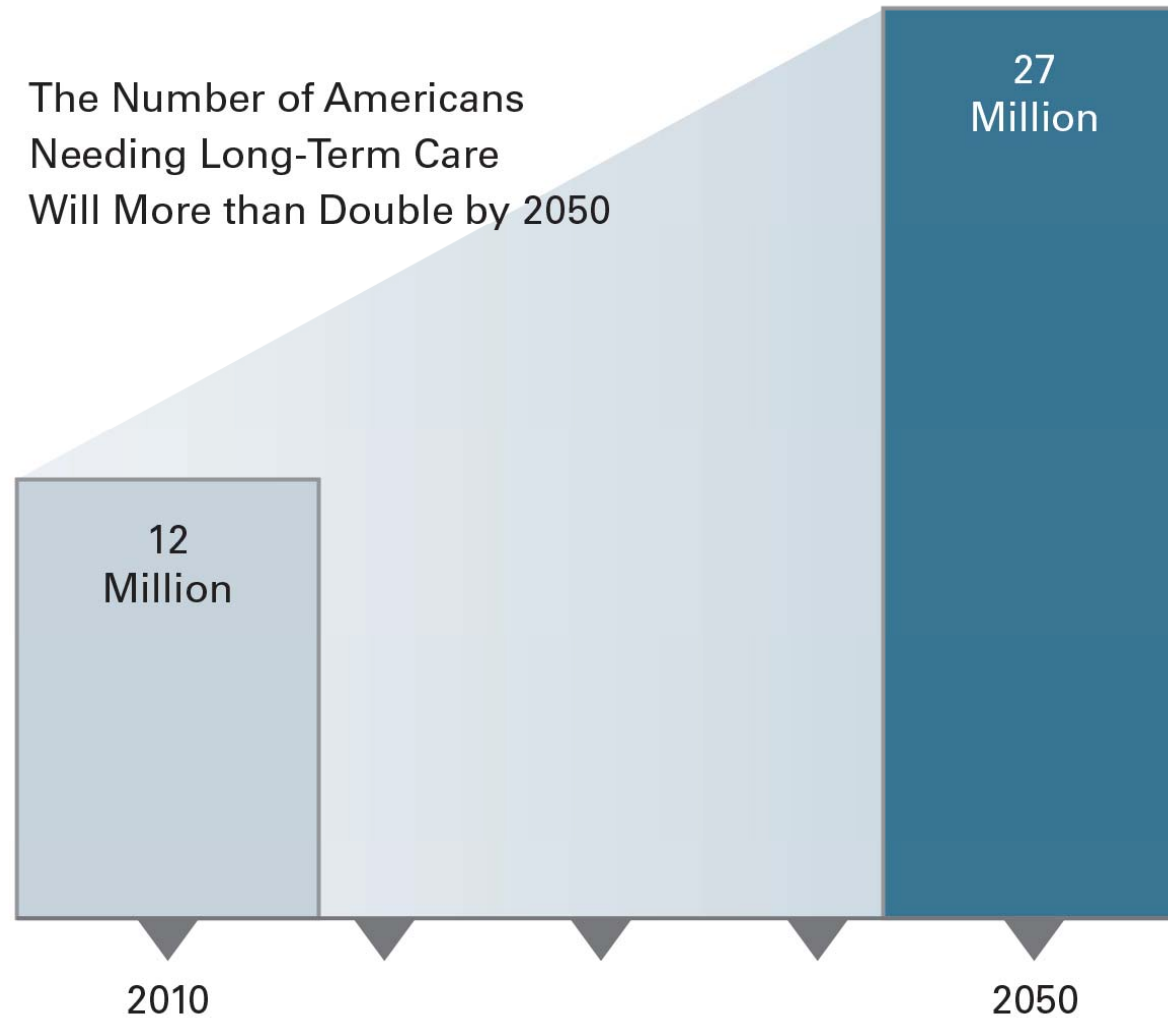


Source: S. Kaye, data from 2012 NHIS, 2010 Census, Nursing Home Data Compendium 2010

Care Needs will Grow



The Number of Americans
Needing Long-Term Care
Will More than Double by 2050



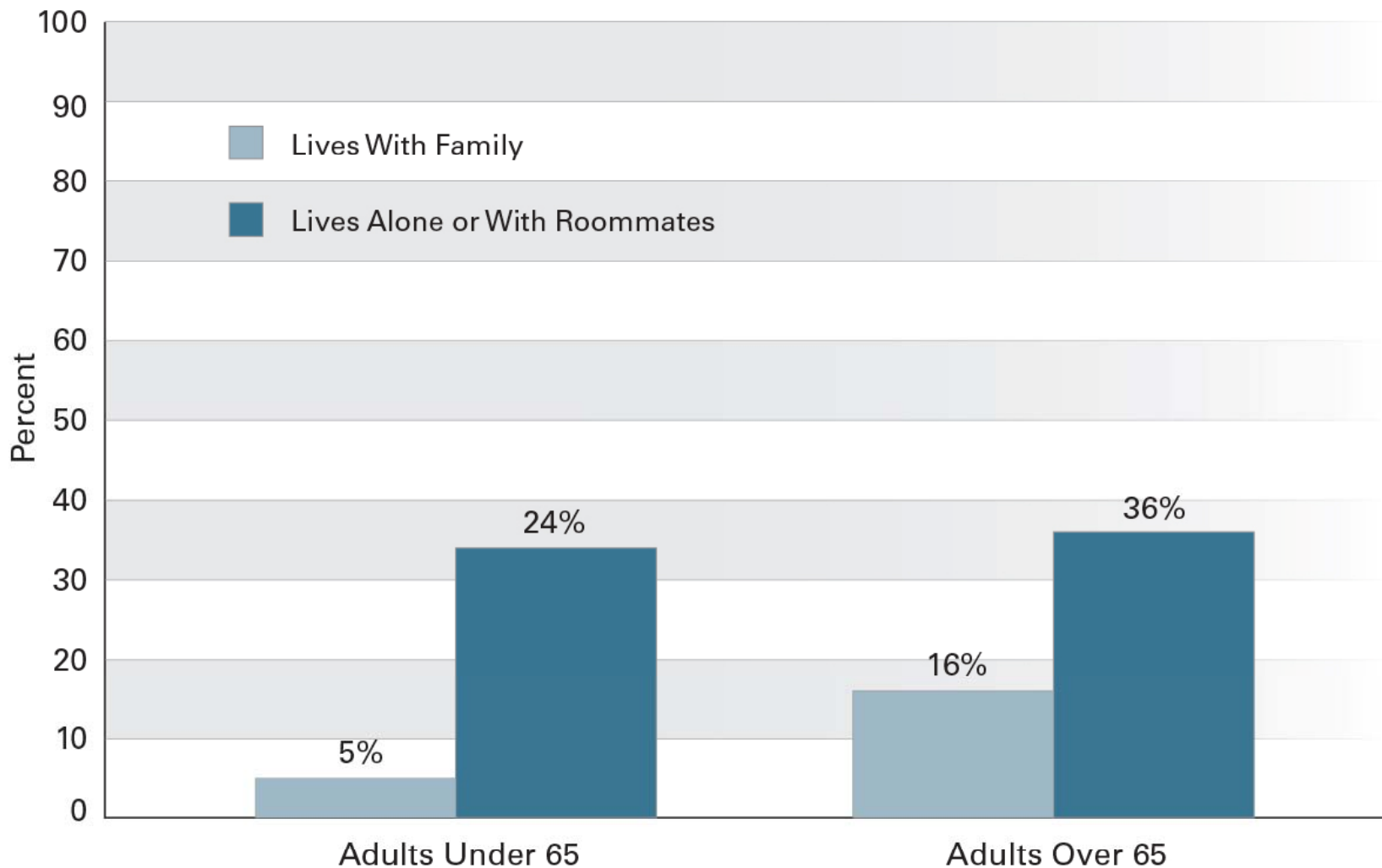
Source: S. Kaye, C. Harrington, and M. Laplante (2010). Analysis of 2005 SIPP, 2007 NHIS, 2007 ACS, 2004 NHHS, and the 2005–2006 Medical Expenditure Survey

- Most LTSS is provided by family caregivers:
 - 42 million family caregivers on any given day (2009).
 - Among seniors with disabilities living at home:
 - 2/3 get care only from a family caregiver.
 - 1/4 get care from both a family caregiver and a paid caregiver.
 - Less than 1/10 get care only from a paid caregiver.
 - Family caregiving is more the norm for younger persons with disabilities.
 - AARP projects a substantial decline in the pool of family caregivers over the next 20 years.

Paid Care Use by Age and Living Arrangement



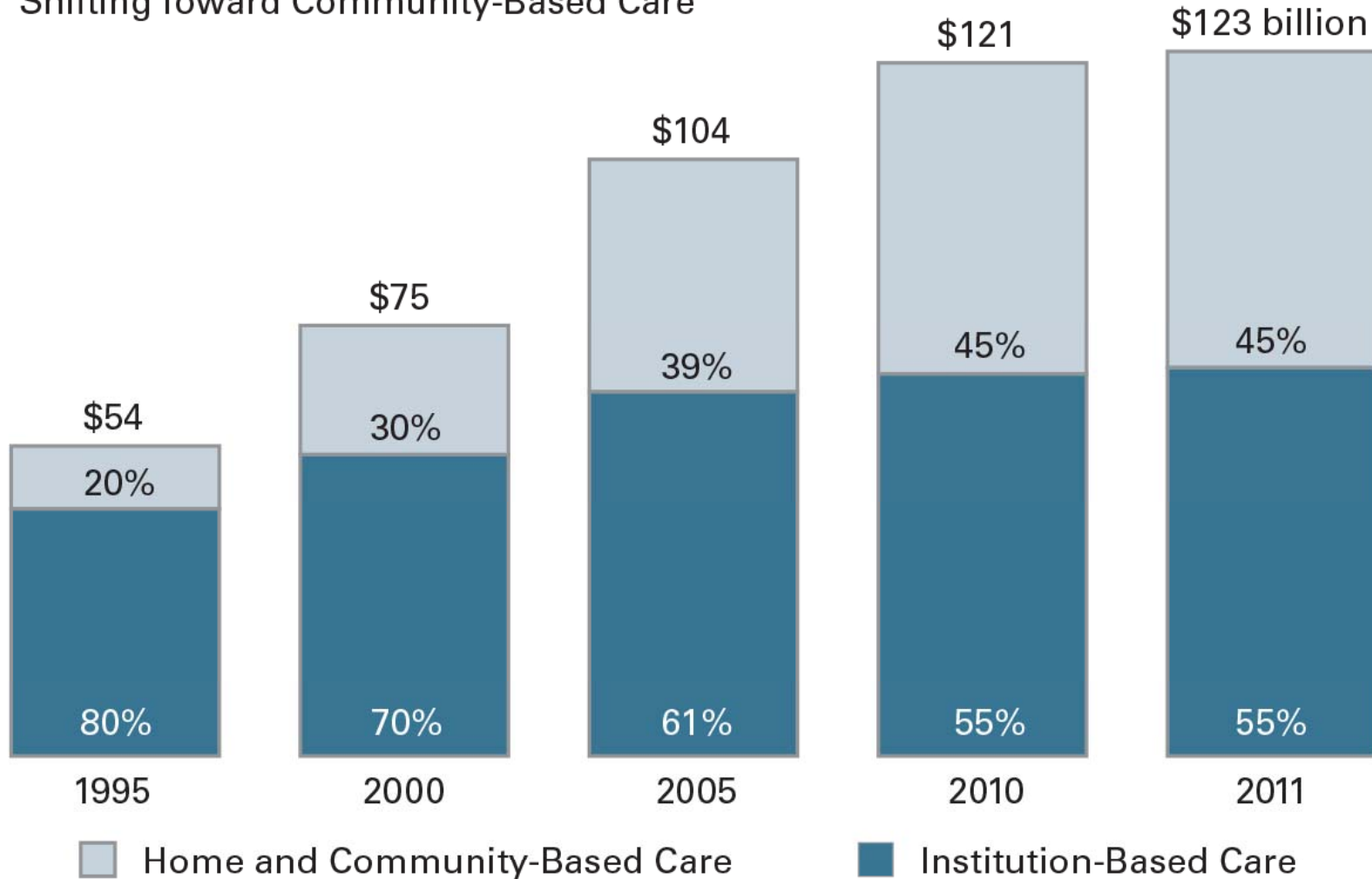
Use of Paid Help Among Community-Resident Adults Needing LTSS



Source: S. Kaye, analysis of 2010 SIPP data

Trends in Medicaid LTSS Spending

Medicaid Spending on Long-Term Care Has Been Shifting Toward Community-Based Care



Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of CMS-64 data

Paid LTSS is Expensive



- Average cost of a shared room in a nursing facility is \$77,380 a year (includes housing, meals and services).
- In-home care is more expensive on an hourly basis (\$20/hour compared to \$8.83/hour in a nursing facility) – and the beneficiary provides own housing and meals.
 - People remaining at home generally get by with less care.
 - Often use paid care to supplement support and services from family and friends.

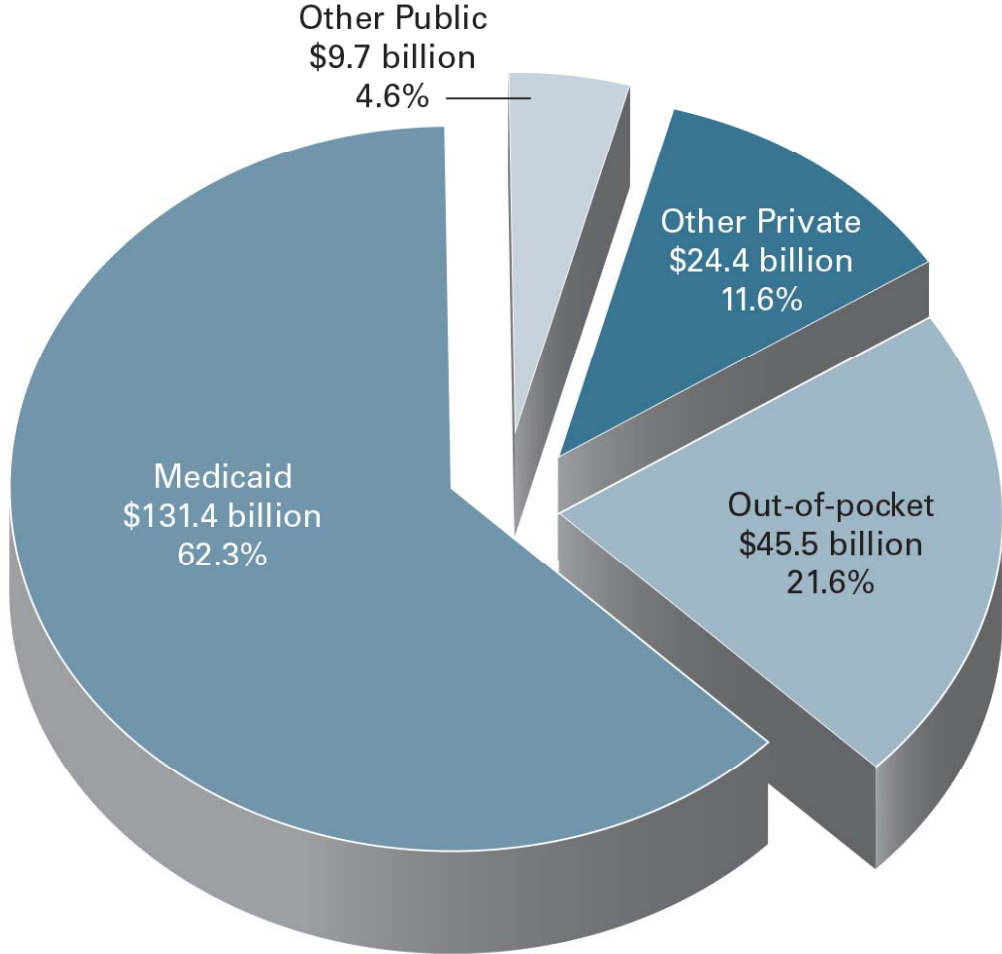
Financing Today is Largely from Medicaid



- Over 60% of LTSS is paid for today by Medicaid.
 - LTSS is 1/3 of Medicaid spending
- 22% of LTSS is paid for out-of-pocket.
- 12% of LTSS is paid by insurance or other private sources.
 - Only 10% of the potential market age 50+ has purchased private long-term care insurance

LTSS Expenditures by Source, 2011

LTSS Expenditures by Source, 2011



Source: National Health Policy Forum, based on data from 2011 National Health Expenditure Accounts

The LTSS Financing “Crisis”



- The Medicaid burden on state budgets (including LTSS) will grow substantially – just from the demographic shift.
- Family caregiving will become less available due to demographics.
- Most people reaching age 65 today are not prepared to finance an expensive or lengthy period of LTSS – Future generations will not be better prepared.
- Younger disabled adults have few options for LTSS assistance other than what is available through Medicaid – if they leave the workforce.

We Have Been Looking at it the Wrong Way



- We think of LTSS as an isolated set of services -- that need separate financing (e.g., Older Americans Act services, LTCl) and a unique delivery system (and then we underfund the services).
- We think of it as an individual and family responsibility, and expect individuals to exhaust their resources to pay for it.
- We think of it as a longitudinal exercise over a lifetime – like saving for retirement or buying life insurance.

We Have Been Looking At It The Wrong Way



- We think of it as problem for the elderly – and ignore the half of the population that has little chance to prepare individually.
- We link LTSS (Medicaid) to income support (SSDI and SSI) – which forces persons with disabilities to leave the workforce to qualify (rather than get the assistance they need to work).

Private LTCL & Personal Savings Not Enough



- Built on an individual insurance model –
 - Adverse selection risk
 - Medical underwriting – covers those least likely to need it.
- Very sensitive to interest rates and other fluctuations in the economy
- Can only cover the intermediate area of risk
- Savings for LTSS unlikely given low savings rates and inadequacy of retirement income savings.
- Hybrid models make it more attractive, but still only of value to a small subset of the population

It's Time to Re-think LTSS Financing

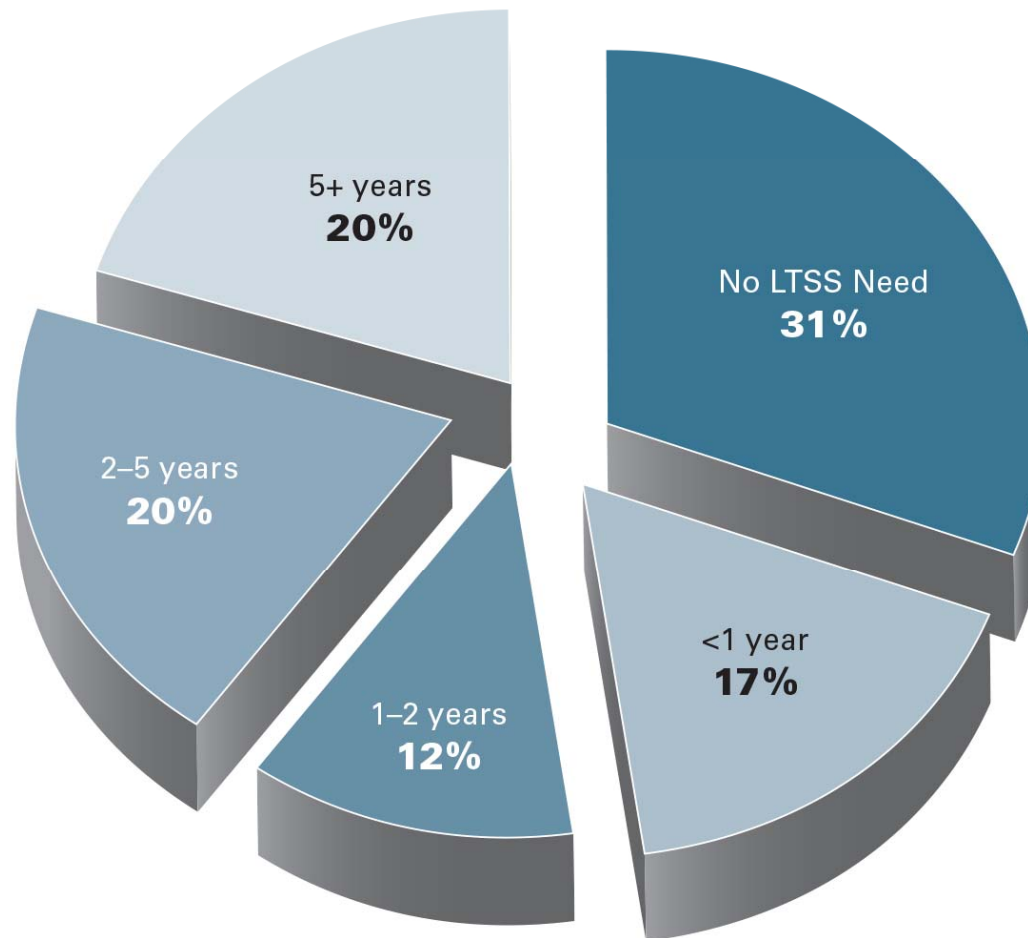


- Three tranches of risk:
 - Small amounts of care/short duration
 - The front end of the risk
 - To supplement family caregiving or assist with IADLs
 - Many can self-insure this.
 - Intermediate range of care
 - One-to-five years
 - Greater acuity in-home or in a nursing facility
 - Insurable risk – the area of focus for private LTCI
 - Catastrophic risk
 - Long duration/high expense (e.g., Alzheimer's)
 - Private insurers moving away from unlimited coverage
 - Impact on assets and independence
 - An area for social insurance

Duration of LTSS Need for Persons Turning Age 65



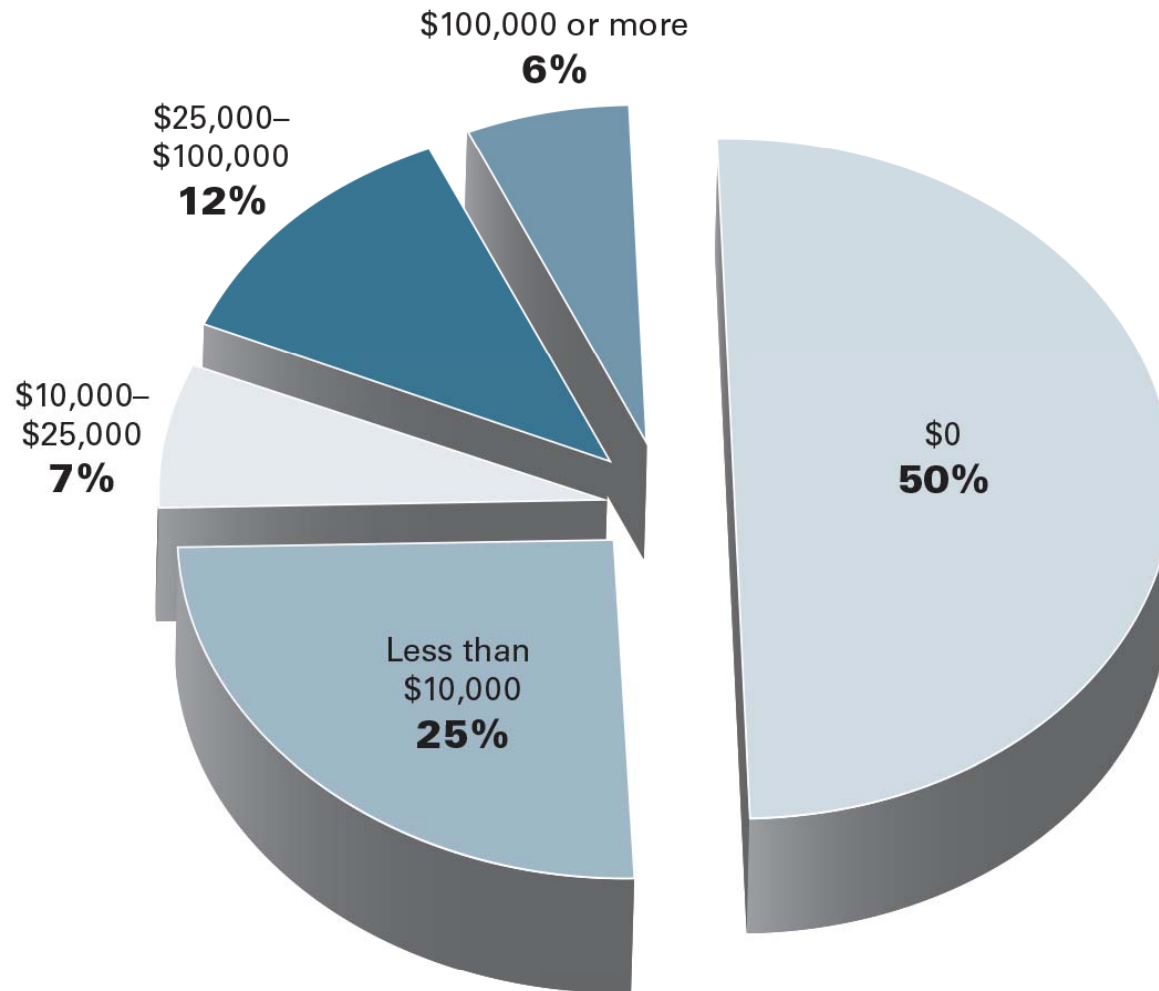
Duration of Expected Future LTSS Need for Persons Turning 65



Source: Kemper, Komisar and Alecxih, 2005. Outputs of model using March 1993 and March 1994 CPS data

Distribution of Duration: Expected Lifetime LTSS Expenditures

Distribution of Future LTSS Expenditures for Persons Turning 65, All Sources



Source: Kemper, Komisar and Alexih, 2005. Outputs of model using March 1993 and March 1994 CPS data



- Seniors
- Physical Disability
 - Early onset
 - Late onset
- Mental Illness/Substance Abuse
- Intellectual/Development Disabilities (ID/DD)

Basic Principles for Financing LTSS



- Family caregiving is the foundation. We have to improve support for family caregivers and keep them in the game.
- Individual responsibility is an important component. We have to encourage individuals to use their housing and investment assets, savings, and private insurance to cover initial costs.
- We have to look to public programs to step in when the risks are too great, to reduce uncertainty, cap the risk, and provide a safety net.

Catastrophic Insurance is the First Step



- The most extreme risk cannot be insured in a private market. Insurers now cap their exposure.
- Catastrophic insurance would pool the highest risk after a defined point (e.g., number of years of LTSS, dollars expended).
- Insuring the most extreme risk would encourage carriers and others to assume the risk below the cap.
- A public role is necessary – to pool the risk and insure the most extreme risk.
- It can be structured as reinsurance, or a federal risk pool for insurers.
- Public catastrophic insurance could be funded in part through Medicaid savings.

Individuals can Assume the Front-end Risks



- The short-term and less expensive care in the initial period can be “self-insured” – funded through individual assets – or can be covered through private insurance.
- Medicaid would remain the safety net for those with few individual resources.

Private Insurance as Group Insurance



- True group insurance avoids the hazards of individual insurance.
- Elements of group insurance
 - Involuntary (random) assignment to the group mitigates adverse selection – group forms for reasons other than the insurance in question.
 - Large groups enable coverage of high risk individuals without underwriting.
 - Insurance covers the group and its members – individuals covered only by virtue of membership in the covered group.
 - Shifts from individual accumulation – future event (life insurance model) to group participation – current event (health insurance model).

- Can spread the risk across a large universe – younger and older workers – without the need to mandate.
- Applies to current needs (avoids the “two generation” problem of an accumulative model).
- Can meet the needs of younger disabled workers as well as seniors.
- Is not limited to individuals with greater amounts of disposable income.
- Can easily integrate with Medicaid and help finance the Medicaid burden.

LTSS Integration: A New Way to Insure the Intermediate Risk



- Integrated LTSS will enable health plans to provide LTSS to better manage complex care patients and lower acute care costs.
- The cost of added services and supports could be offset by acute care savings and provided within the existing health care premium (to a point).
- Members of integrated health care systems could receive LTSS at no added premium cost.
- Community Based Organizations struggling with limited Older Americans' Act dollars could do better financially by sharing savings with health

Incentives in LTSS Integration for Appropriate and Efficient Use



- A universal public program for the intermediate risk would be overwhelmed by “moral hazard” and the “woodwork effect.” Policing it would be expensive and error prone.
- Capitation or sharing risk between health plans and LTSS organizations would encourage efficient use of LTSS resources.
- The large group model would eliminate the need for underwriting or denying coverage.

LTSS Integrated Plans can Provide a Solution for Under 65 Disabled



- Predicated on a public catastrophic plan.
- Including services for younger adult disabled enables the risk to be spread across all members' premiums.
 - True large group insurance
 - No need for a mandate
 - Benefits available to current workers rather than deferred to old age
- Including LTSS in a managed care context enables the insurer to manage care for the whole patient – managing the LTSS expenditures to ensure they yield health cost benefits overall.

LTSS Included in Health Plan Premiums can Reduce Pressure on SSDI and Medicaid



- Working disabled could benefit from LTSS provided through their employer-provided or Exchange-based health plan.
- Assistance would be available to maintain workforce attachment rather than requiring disability to qualify for income support in order to get LTSS benefits.

Integrated LTSS Would Also Enable Immediate Benefits For Current Retirees



- The life insurance/savings model that emphasizes asset accumulation over a lifetime does not help the current generation of retirees or the younger adult disabled.
- The large group health insurance model can provide benefits for current generations of retirees and for younger disabled.
- Large group insurance insures the group as a whole, not individuals and can pay benefits to current enrollees even as people move around.

- Potential to reduce Medicaid costs
- Ability to capture within an integrated benefit the acute care savings from the use of LTSS.
- True large group insurance (insuring the group as a whole) eliminates the “risk premium” making this the most affordable way to provide coverage.

- Everyone will not be in an integrated health plan –
 - Need to protect plans from selection against the pool of those who are in Integrated LTSS.
 - Need to set the incentives to encourage enrollment in integration.
 - Need to improve private LTCI and opportunities for accumulating assets to insure financing for LTSS benefits for those who remain in Fee-For-Service.
- Integrated LTSS still has to make the business case – to prove itself.

Where Do We Go From Here?



- Finish developing modeling to estimate costs of a catastrophic insurance program and other approaches.
- Build the business case for LTSS Integration – demonstrate the ability to lower total health costs by provided well-managed LTSS.
- Ensure there are adequate measures and safeguards in integrated plans for outcomes and quality.
- Build broad stakeholder support for a single proposed solution that does not require huge additional revenues.
- Demonstrate models that can work at the state level.
- Develop Hill champions and build a constituency for a solution.

Contact Information



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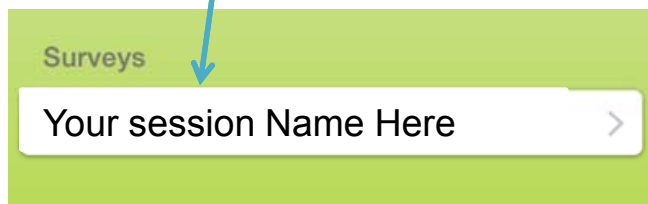
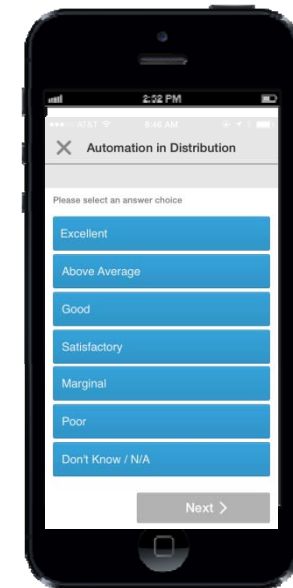
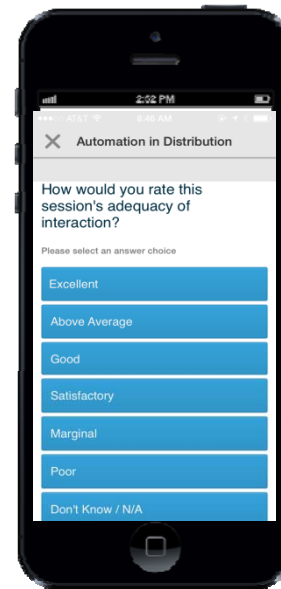
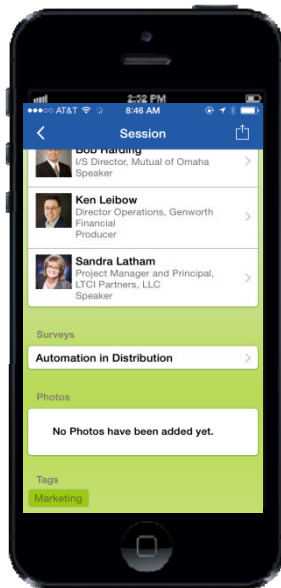
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