

Issue Brief

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KEY POINTS:

- The increasing growth in state Medicaid budgets due in part to the long-term care (LTC) needs of a growing elderly population combined with the low level of penetration into the potential market by private LTC insurance have prompted a number of proposals for reforms in the way LTC is financed in the United States.
- Proposals for reform of the LTC system to provide access to affordable long-term care for the elderly in the United States need to address the seven essential criteria if the reforms are to be of value and to endure for the long term. Any proposal that fails to do so will yield LTC reforms that are less valuable and less likely to endure.
- Some recent attempts at reforming how long-term care is financed in the United States have failed because they did not adequately consider these seven essential criteria. For example, the CLASS Act enacted as part of the Affordable Care Act—and subsequently repealed—failed to consider at least two of the criteria: Affordability and Financial Soundness and Sustainability.



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Essential Criteria for Long-Term Care Financing Reform Proposals

Introduction

The increasing growth in state Medicaid budgets due in part to the long-term care (LTC) needs of a growing elderly population combined with the low level of penetration into the potential market by private LTC insurance, have prompted a number of proposals for reforms in the way LTC is financed in the United States. Proposed reforms can be expected to address both public and private financing mechanisms, as well as mechanisms involving both types of financing.

In 2012, the American Academy of Actuaries hosted a roundtable, “A National Conversation on Long-Term Care Financing,” comprised of stakeholders from public policy, actuarial, research, private provider, and retirement benefits backgrounds to discuss potential reforms to the LTC system. Building further upon that conversation, the Academy’s LTC Criteria Work Group developed criteria in the following areas that should be considered in any discussion on reform:

1. Coverage (with reference to how many individuals are covered by the reform);
2. Comprehensiveness of benefits;
3. Quality of care;
4. Understandability and choice;
5. Affordability;
6. Risk management and cost control; and
7. Financial soundness and sustainability.

This issue brief offers an overview of each area.

The terms “system,” “program,” and “plan” are used interchangeably because the criteria are intended to cover reforms using both public and private financing mechanisms, or hybrid combinations. Furthermore, while “participants” and “members” are terms often associated with public and private programs, they are also used interchangeably to reflect the breadth of possible proposed reforms.

I. Level of Coverage and Attributes

Reform proposals should consider the level and makeup of coverage—how many people are expected to be covered and the attributes of those people. Both the total number of people covered and the attributes of those covered will be affected by whether the LTC system is mandatory or voluntary.

Reform proposals should describe how the LTC system will provide coverage to subsets of the population having different attributes. Subsets of the population will have differing needs for LTC services and differing abilities to pay for such services. Examples of population attributes to consider include:

1. Demographic characteristics, such as age, gender, and marital status;
2. Health status characteristics, such as current general health condition and need for LTC services, and expected future need for LTC services; and
3. Wealth and income characteristics, which could be measured in various ways such as value of assets or lifetime income earned.

Likely the most influential feature driving the number and attributes of people covered under an LTC system is whether it uses a mandatory or voluntary design for providing coverage. Voluntary designs will likely have participation levels below 100 percent, while mandatory designs by definition imply all (or nearly all) individuals are covered under the system. Alternatively, a hybrid system could be constructed that blends features of

both. For example, the system may provide a mandatory component that does not cover all expected LTC needs, with an option to purchase additional coverage on a voluntary basis.

The design of voluntary programs should anticipate not only the expected number of people covered but also the mix of individuals by the population attributes noted above, as the attributes of individuals covered will have a large impact on program costs. Proposed voluntary designs should anticipate enrollment counts for the various attribute groups, and clearly define how they will control costs based on that expected mix of individuals. Design elements that can address this risk include:

1. Underwriting to understand potential current and future LTC needs;
2. Vesting periods before benefits can be accessed to address individuals currently needing LTC;
3. Limiting the target population to those with expected lower LTC needs (e.g., those actively working); and
4. Use of active or passive enrollment (i.e., opt-in/opt-out).

Reform proposals should require performance of sensitivity testing and careful consideration of the interaction of expected enrollment mix, expected LTC needs, and revenue needed to cover those LTC costs.

II. Comprehensiveness of Benefits

Reform proposals should clearly communicate the comprehensiveness of benefits provided by the LTC system—that is, the amount of risk that is covered by the system should be defined clearly, including benefit criteria and benefit limitations. Communicating the comprehensiveness of benefits requires an understanding that the needs of the targeted population vary by geographic regions, as well as transparency in stating the levels and types of

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care being provided. The following concerns should be addressed when determining a proposed reform's level of comprehensiveness. When communicating this comprehensiveness, it is important to understand and communicate how these challenges interact.

- 1. Location of Care**—Where can members receive care? This includes, but is not limited to, nursing homes, assisted living facilities, and care given in the home. Proposals should have clear definitions for the locations of care and for the handling of transitions to different care settings. In addition, proposals should be able to address the continually changing manner of providing care in these settings as well as the future evolution of new and innovative care settings. Future care settings may include alternatives to today's typical home and community care systems, such as those that are modeled after Continuing Care Retirement Communities, those that use new types of informal care, and those that use rehabilitation center/transition care centers, to name a just a few possibilities.
- 2. Eligibility of Care**—When is a member's care covered as part of the proposed plan? Common measurements define the severity of an individual's impairment. For example, eligibility may be defined in terms of an inability to perform activities of daily living or an evaluation of cognitive impairment. Eligibility for care provided in certain settings or locations may depend on the nature or degree of an individual's impairment.
- 3. Limits of Total Coverage**—What are the overall coverage limits, and how do benefits used under the program count toward these limits? This includes clearly defining when coverage starts, the duration of coverage, and how this program will interact with other programs and/or coverages. Proposals should set forth elimination or waiting periods in the program. The duration of coverage can be defined in terms of a maximum dollar amount or in terms of a maximum period of time.

- 4. Limits on the Level of Care Covered**—What are the maximum amounts paid during a specified period of time? Common time periods used for this type of limit have been daily or monthly maximums. Proposals should clearly describe whether the maximums increase with inflation or continue at current levels, and whether they vary by location of care. Proposals should define whether periodic benefits are paid in full or whether the benefits are limited to the actual expenses that the member incurs. Finally, proposals should be clear as to how the benefits are coordinated with other private and public means of payments.

III. Quality of Care

Like many other aspects of life, people contemplating long-term care should evaluate the costs and the benefits of their choices. Quality of care is an aspect of the benefits they choose, and a good reform will offer (1) an ability to assess or measure the quality of the care, (2) incentives to maintain or improve the quality, and (3) a mechanism to make the consumers and the providers aware of the quality of care.

1. Quality Measurement and Assessment Framework (Qualitative and Quantitative)

A standardized framework is needed to monitor and objectively benchmark the quality of the care. For example, Medicare's rating systems (Five-Star Quality Rating System for nursing homes and Home Health Star Ratings for home health care providers) cover a wide range of metrics and could be used as a benchmark for objective standards for all existing types of providers of care. Also, AARP state scorecards offer an objective measure that could be modified to accommodate provider performance.

As types of care and providers of care evolve, a quality measurement and assessment framework should be set up to cover all of them, and be flexible to respond as new locations of care and providers emerge.

Quality measurement should cover multiple domains, including patient and family centeredness, transitional care processes, performance outcomes, safety, timeliness, efficiency, equity, and cost-effectiveness. Patient and caregiver surveys could be an additional source of data.

2. Quality Incentives

Quality incentives should be considered for the overall industry as well as for individual providers. Though not necessarily an exhaustive list, the key incentive targets might include:

- a. The supply of providers in a geographic area (assuming quality depends on adequate supply);
- b. Evidence-based caregiver training (e.g., family caregiver support training for cognitively impaired patients);
- c. Appropriate location of care within a facility or residence;
- d. Appropriate care transition (e.g., reducing re-admission to hospitals);
- e. Consumer transparency related to the structure of the care provided, including expected length of care, location of care policies, and what situations the provider of care could accommodate or not (e.g., assisted living facilities may not be able to provide adequate care for severe conditions);
- f. Suitability and accountability of the provider of care (e.g., consider whether a family member has the capability, credentials, and training to provide care at home); and
- g. Prevention (e.g., fall prevention, safety, wellness management, medication management, and activity level).

3. Quality Awareness

Awareness of the quality of care is needed from both a provider and a patient perspective. Awareness can be achieved with initial education, access to and readability of educational resources, and identification of what types of coverage the patient is eligible to receive. Education and educational resources may include information regarding fall prevention, wellness management, medication management, safety features, the availability of services and providers, and services

that help the provider and caregiver perform their work well for the long term. Educational resources may also make users aware of other services available, whether charitable, publicly operated, or private.

IV. Understandability and Choice

Well-designed reforms will recognize that the needs of individuals and families vary widely. Program benefits may be designed to vary in order to accommodate these differences. For example, a reform may offer optional elimination or waiting periods where the offered choices may be intended to vary depending on differences in individual ability to rely on other resources such as assistance from family members, assets and income sources, or public and private programs.

Simpler reform designs may include very basic coverages and eligibility requirements that do not change over time. These designs may limit user choice, but they may also be simpler to understand and easier to administer. However, if the reform is too basic, those managing it may not have the ability to (1) address unique and changing needs of individuals and families over time or (2) address environmental changes that emerge (such as the economy, government budgets, or cultural values).

More complex reform designs may include the flexibility of the reform to adapt over time. However, the more complex the system, the more difficult it may be for the individual user to understand how the effects of the program may change over time. A complex system may be more difficult to administer.

Complex systems may also make the value proposition more difficult to assess. Complexity is introduced when reforms include many choices for individuals. It may be difficult for individuals to understand which choice might be best for them. Alternatively, allowing more choice within a reform may make it easier for individuals to select a program based on knowledge of their own expected emergence of need. Without sufficient education, it could be difficult to prevent individuals from being inadequately or excessively covered, potentially engendering public distaste for the program or poor results if selection against the program occurs.

Whether the reform establishes a simple or complex system/program, some level of education will be necessary as the reform takes effect and throughout the existence of the program. Any educational tools developed should help consumers understand their needs, the benefits provided by the program, and how their use of the program can affect the cost of the program in the future. If consumers are allowed to modify their choices over time, those eligible for the program need to be reminded or re-educated periodically about these choices. Ongoing choices and the need for education may therefore require administrative staff to help users navigate the system throughout the life of the program.

Consumers may also need help in understanding that specific cost-control features in benefit designs are intended to prevent overutilization that could increase consumers' own costs later. They may need assistance in preventing early use of benefits that they could need later.

Finally, when making a choice within the program, consumers should be able to discern their needs, their circumstances, and the availability of assistance. They can only make appropriate selections when benefit limitations are stated clearly, without ambiguity, and when their cognition is not impaired.

V. Affordability

Affordability varies by level and source of family or individual income, type of coverage, other household expenses, whether the program costs are permitted to change over time, and other factors. Therefore, affordability is a key financial issue for each purchaser. The “purchaser” may be an individual or a family unit. A family unit, frequently having two wage earners, is an important point for consideration because LTC programs could consider the impact of benefits and services on the family unit. Affordability may be usefully described on an after-tax, available-dollars basis including income and assets, both of which will likely change over the life of the purchaser. Households would likely subtract expected amounts spent for necessities

such as food, clothing, shelter, transportation, medical care, and prescription drugs. Their remaining funds drive the ability to pay the LTC program contributions, so that the purchaser may ask, “What part of my/our remaining funds would I be willing to give up as a contribution in order to purchase the LTC benefit?”

Purchasers should consider the continuing affordability of the program over their remaining lifetime. Continued affordability will be influenced by the contribution structure of the program. A program could be designed like Medicare Part B or Part D, with increasing premiums that are redetermined annually, or with a leveled premium structure like that of many insurance products. In the case where the purchaser expects to live on a fixed retirement income without inflation adjustment, the affordability of the LTC program may become strained for them if the program is subject to anticipated continual jumps to higher contribution levels (by design), or unanticipated increases (e.g., rate increases on leveled premiums). Programs without guarantees or limits on contributions or benefits will require purchasers to carefully evaluate their answer to the affordability question over the long term, especially in the case of those with fixed retirement income and when the initial participation decision was based on contribution levels near a purchaser's upper bounds of affordability.

VI. Risk Management and Cost Control

In order for any reform to be sustainable, risk management and cost control elements should be considered. A risk evaluation system should be developed prior to rolling out the program. Cost controls should be established that allow for alignment of interests of all stakeholders. Performance of the program should be evaluated based on the predefined criteria, and cost controls should be modified as needed.

A risk evaluation system may depend on projection models, sensitivity testing, stress testing, and evaluation of emerging risks used to identify, assess, measure, mitigate, and manage various risks faced by the program.¹ Also, these may be useful in designing and

¹ An actuary performing this work should refer to the applicable actuarial standards of practice (ASOPs), (such as ASOP No. 7, *Analysis of Life, Health or Property/Casualty Insurer Cash Flows*; ASOP No. 18, *Long-Term Care Insurance*; ASOP No. 27, *Selection of Economic Assumptions for Measuring Pension Obligations*; and ASOP No. 46, *Risk Evaluation in Enterprise Risk Management*.) An actuary may wish to consult the [Applicability Guidelines](#) for more information on which ASOPs may give guidance to them on particular types of assignments.

evaluating risk management and controls in LTC reforms. For example, some programs may depend on sound management of the program's assets and liabilities, and projection models will help direct the managers of the program under expected economic environments and help prepare the managers for corrective actions under adverse situations.

Reforms will need to provide benefits that are perceived to be sufficiently comprehensive while at the same time not encouraging overutilization. To control costs, there will need to be features that limit benefits and unintended utilization. The interests of the users of the program and the financiers of the program should be aligned. Care should be taken so that individuals are not able to profit from using services and are not encouraged to use services that may not be necessary. Possible controls may include reimbursing a portion of actual expenditures, rather than paying a stipulated cash benefit, and by not reimbursing for care provided by family members.

Ongoing risk evaluation and management over the program's lifetime is necessary in order to be able to determine whether the program is performing according to expectations. Before a reform is implemented, a pre-planned feedback mechanism that studies the effectiveness of the reform is important. Any ongoing evaluation of the program used to monitor its known and emerging risks should be designed around the controls and risk evaluation that were initially developed and made available as part of the program so that corrective action can be made to the program over time. Corrective actions or controls might include changing the amount of money paid into the program or limiting or changing the benefit payments or eligibility requirements to receive benefits.

As the program matures and is evaluated over time, it will be affected by more factors than those internal to the design and users of the program. It will also be affected by the changing economy, political environment, and demographics of those covered by and contributing to the program. It is possible that some demographic changes can be predicted more accurately than changes to the economy and the political

environment. Whether these changes are predictable or not, various scenarios should be evaluated before implementation so the emerging risks underlying these potential changes can be evaluated and potential controls can be designed so the program can react to any changes in these areas that emerge over time.

Any program that includes long-term projections will require significant assumptions to develop those projections. The assumptions will be developed from available data, and critical judgment will need to be applied to determine when to adjust the assumptions based on emerging experience and the credibility of that experience. An appropriate margin should be applied to the assumptions. An actuary performing this work should refer to the applicable actuarial standards of practice (ASOPs) for guidance.

As part of the initial and ongoing monitoring of a program, clear definitions of relevant statistics are needed; e.g., for such areas as the expected amount of coverage the proposal will provide for the targeted group. For proposals that place limits on the level of coverage, chosen statistics should account for the likely shift in expected use caused by the coverage limits.

VII. Financial Soundness and Sustainability

A new program's financial soundness and sustainability refers to the ability to deliver what is promised, knowing that these promises extend well into the future. The ability to deliver on promises also includes the new program's interface with other existing programs without disturbing the ability of the existing systems to meet their own commitments. Consideration of the following four key questions will help determine whether a program is financially sound and sustainable.

1. **Can consumers be confident that the program will indeed deliver what was promised?**

Sound risk management and cost controls give confidence to consumers that the program will deliver on all of its promised future obligations. The funding structure of the program is important. Because the need for LTC increases with age, there is good reason for the sake of program sustainability

to design the program using systematic prefunded pooling of homogenous risks in which participants make substantial contributions during their working years, continue to contribute during their retirement years, and receive most of their benefits in the last few years of life or possibly die without ever needing LTC. A reasonable fear of consumers is the risk that the program runs out of money precisely at the point where the participants are most in need and unable to care for themselves. This risk can be minimized by designing cost controls into the program. Controls may need to change when the market's environment changes over time. For example, if the reform were to restrict initial underwriting on the future cohorts of applicants, resulting in higher-risk participants, the program would need to address the higher risk with a different control to address the changes brought on by the restricted underwriting. Another hypothetical example would be a modification of certain controls due to advances in medicine, such as a cure for Alzheimer's disease.

Alternatively, a pay-as-you-go system makes use of young and healthy participants effectively paying the current costs of the participants receiving benefits. More precisely, costs from the generally older participants in need of LTC can be funded by the contributions of all the participants. This design allows the older members of the first cohort to claim benefits with a lower level of contributions than under the prefunding design.

Another alternative may be a partially prefunded system that attempts to buffer some of the risk of a pay-as-you-go system by accruing sufficient funds to meet established sustainability criteria. However, any program that is not fully prefunded may need to address a changing mix of contributors and benefit users if it is to be sustainable into the future.

2. Is the program too complex or too simplistic?

The level of program complexity generally depends on its design. While prefunding and pay-as-you-go systems are considered comparatively simple, a partially prefunded design can be quite complex,

as such a system depends on defining the relative size of the prefunding component. Pay-as-you-go or fully prefunded programs may become more complex if they are likely to evolve into a partially prefunded design over time. For example, a program that is characterized as prefunded but is projected to run out of funds in, say, 75 years, would be properly described as being only partially prefunded. Programs having changing mixes of prefunding and pay-as-you-go could be complex. Other design considerations that influence the complexity of any insurance-based program include benefit triggers, definition of qualified locations of care, elimination period definitions, and many other product-specific options. The amount of choice provided to participants complicates accurate forecasting of the level of future benefits, and an assessment of the program's sustainability may be affected by the ability (or inability) to reasonably predict future benefits resulting from their choices.

3. Does the financial program make appropriate use of the funds invested?

Sound investing of the program funds enhances the performance of the program, which is particularly important for programs that have an appreciable degree of prefunding. Choices for investments will depend on whether the program is private or public, with greater restrictions likely on the options for public programs (based on observation historically of public programs). The options for private programs, absent regulatory restriction, allow greater flexibility in investment options, which means that the trade-off between risk and return becomes a more important consideration when evaluating financial soundness and sustainability of the program.

4. Can the designers ensure that the program interacts well with existing private insurance and public programs?

Part of the complexity of designing a new LTC program is that there is currently in place a patchwork of existing programs. Public programs, including Medicaid, Medicare, and

those administered by the Veterans Health Administration, and others jointly cover close to two-thirds² of the cost of formal LTC services being provided today. These programs combine with existing inforce insurance coverage provided by private LTC insurers and include a small percentage of “public/private partnership” policies. Thus, critical questions come into play: How is any new program to interact with these existing public and private programs? Is the new program intended to displace all or part of the existing programs? Is the new program intended to provide coverage to persons not currently covered by any existing program? How do definitions of a qualifying event vary between programs? Are participants in existing programs penalized by the reform?

Conclusion

Some recent attempts at reforming how long-term care is financed in the United States have failed because they did not adequately consider these seven essential criteria. For example, the CLASS Act³ enacted as part of the Affordable Care Act—and subsequently repealed—failed to consider at least two of the criteria: Affordability and Financial Soundness and Sustainability.

This issue brief identifies and discusses the seven essential criteria for LTC reform proposals: Coverage, Comprehensiveness of Benefits, Quality of Care, Understandability and Choice, Affordability, Risk Management and Cost Control, and Financial Soundness and Sustainability. Proposals for reform of the LTC system to provide access to affordable long-term care for the elderly in the United States need to address the seven essential criteria if the reforms are to be of value and to endure for the long term. Conversely, any proposal that fails to do so will yield LTC reforms that are less valuable and less likely to endure.

Furthermore, the criteria often rely on three activities: adequate education of the consumer, awareness of any alignment or misalignment between the interests of consumers in the program and the interests of those financing the program, and, from an actuarial perspective, sensitivity testing (testing the impact of alternative assumptions). When a proposed reform’s conformity to the seven essential criteria is evaluated, these activities will be useful in helping the reform to achieve the ultimate goal of providing necessary and adequate care to the elderly in the population.

The American Academy of Actuaries has unique expertise to advise and assist public policymakers with aspects of these criteria related to risk and financial security issues.

² *The Long-Term Care Financing Crisis*, by Diane R. Calmus. Center for Policy Innovation; Feb. 6, 2013.

³ Community Living Assistance Services and Supports (CLASS) program.

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