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Long-Term Care Reform in Hawaii:
Report of the Hawaii Long-Term
Care Commission

Draft Final Report

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Executive Summary

This final report, together with its appendices, is submitted in fulfillment of Act 224, Session Laws of Hawaii 2008, as amended. Act 224 created a long-term care commission to conduct a comprehensive assessment of Hawaii's long-term care system and to recommend changes. Long-term care includes helping people unable to perform daily activities, such as getting dressed, bathing, preparing meals or eating, or taking medications, over an extended period of time. Providers of long-term care include nursing homes, residential care facilities, adult day care centers, and home care agencies. A commission of 15 voting and 5 nonvoting ex officio members was constituted as required by the Act. Although long-term care affects people of all ages and includes people with intellectual and developmental disabilities, the Commission focused on long-term care for older people.

The Problem of Long-Term Care

The long-term care system in Hawaii is broken. Long-term care is expensive and beyond the financial reach of most people. Medicare and private health insurance does not cover long-term care and few people have private long-term care insurance. As a result, if they need extensive long-term care, they must pay out of pocket and if their resources have been depleted, they must turn to the means-tested Medicaid program. Moreover, although progress has been made in recent years with the implementation of the Medicaid Quest Expanded Access program, the financing and delivery system is highly skewed toward institutional care, even though people want to stay in their own homes. Finally, responsibility for long-term care is spread over several state agencies, leaving policy fragmented without a unifying vision.

Most importantly, the aging of the population guarantees that there will be a much greater need for long-term care in the future than there is now. Between 2007 and 2030, the population aged 85 and older, which has the greatest need for long-term care, will increase by almost two thirds. There is no way to provide services for this population without additional sources of financing; it is impossible to serve two-thirds more people within the same level of government spending. Either government will need to spend substantially more for long-term care or other sources of financing will need to be found. To date, little has been done in Hawaii or nationally to plan for this eventuality. The issue of long-term care financing was the focus of the Commission's deliberations.

Commission Recommendations

The current system of financing, organizing, and delivering long-term care satisfies almost no one. The specific reform goals the Commission adopted to guide its deliberations are presented in *Exhibit ES 1*.

The Hawaii Long-Term Care Commission developed recommendations on public awareness and education, private and public financing, the organization of state administrative responsibilities for long-term care. These recommendations are summarized in *Exhibit ES-2*.

Exhibit ES-1. Goals of Reform

- Increase public awareness of long-term care through education
 - Treat the risk of needing long-term care as a normal life risk
 - Protect against catastrophic out-of-pocket costs
 - Prevent dependence on welfare in the form of Medicaid
 - Improve access to long-term care services
 - Make the long-term care system more responsive to consumers
 - Change the balance of institutional and home and community-based care
 - Ensure that long-term care reforms do not increase inequality
 - Design an affordable system, both to the individual and to government, that will bring additional funds into long-term care
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Exhibit ES-2. Summary of Commission Recommendations

- Conduct a long-term care education and awareness campaign
 - Do not enact tax incentives for the purchase of private long-term care insurance
 - Encourage life insurance as a source of private long-term care funding
 - Support funding for Kupuna Care
 - Establish a limited, mandatory public long-term care insurance program in Hawaii
 - Reform the regulation of domiciliary care facilities, including Adult Residential Care Homes, Extended Care Adult Residential Care Homes, Community Care Foster Homes, and Assisted Living Facilities, and nursing homes
 - Consolidate Hawaii state departments responsible for long-term care into a single agency or department to improve accountability, efficiency, and policy coordination
 - Strengthen Aging and Disability Resource Centers and expand their role
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Conduct a Long-Term Care Education and Awareness Campaign

Recommendation: The State of Hawaii should conduct a long-term care education and awareness campaign, with the goal of making people aware of their risks of long-term care, their current financing and delivery options, and the implications for Hawaii of the aging of the population. The main objective of this public education campaign is to educate people about their risks of long-term care and to motivate people to begin planning for how their and their families' potential long-term care needs will be met. The education campaign should be administered by the Hawaii Executive Office on Aging and should be adequately funded by the legislature.

Most people know little about long-term care and some of what they “know” is wrong. For example, in a recent 2011 survey of AARP members in Hawaii, 29 percent of respondents said that they expected Medicare to pay for their long-term care if needed. Unless people have basic information about long-term care—what it is, their risk for needing it, and what it costs—they are unlikely to be motivated to spend time establishing long-term care plans or to be willing to spend significant amounts of money for long-term care insurance.

Do Not Enact Tax Incentives for the Purchase of Private Long-Term Care Insurance

Recommendation: The Hawaii Long-Term Care Commission recommends against enactment of tax incentives for the purchase of long-term care insurance. The Commission recommends that a study be conducted to assess ways to encourage employers to provide and pay for long-term care insurance.

To reduce the net price of private long-term care insurance, some states allow taxpayers who purchase private long-term care insurance to deduct some or all of the cost of the policy from their income for income tax purposes or provide tax credits to purchasers. The Commission recommends against tax incentives for three reasons. First, several studies conclude that state tax incentives are ineffective; they do not significantly increase the number of people with private long-term care insurance. Second, because deductions are worth more to higher income people than to low- and moderate-income taxpayers, most state tax incentives are regressive. One of the Commission's key goals is to ensure that new initiatives do not increase inequality. Third, because tax incentives are provided to all people with private long-term care insurance, they would result in a substantial tax loss that would have to be made up by other tax increases or cuts in other state spending.

Encourage Life Insurance as a Source of Private Long-Term Care Funding

Recommendation: The Commission recommends that life insurance be tapped as a way to finance long-term care. Primarily, the Commission recommends a thorough review of Hawaii insurance law and regulation to eliminate unnecessary impediments and establish regulatory oversight where appropriate, and suggests that consideration be given to mandating the offer of accelerated death benefits in life insurance policies.

Although most people lose their life insurance when they retire, many more people have life insurance than have private long-term care insurance. Two sources of private funding for long-term care using life insurance have been proposed, although they are not much used. First, accelerated death benefits provide some or all of the death benefit while the insured is still alive if he or she needs long-term care or has serious medical conditions. Second, in viatical settlements, individuals needing long-term care or who have a serious medical condition sell their death benefit to a third party in exchange for money while the insured is still alive, usually at a discount. Because of the potential for abuse, the Commission recommends that these settlements be strictly regulated.

Support Funding for Kupuna Care

Recommendation: The Hawaii Long-Term Care Commission recommends continued support for the Kupuna Care program. The Commission recommends that a sliding fee schedule be instituted to generate additional revenue for Kupuna Care, so that it can expand its services. Funds from the proposed public long-term care insurance program may be used to pay the new fees, which would further generate additional revenue for Kupuna Care.

Kupuna Care provides funding for home and community-based services for people who are not eligible for Medicaid. The statewide reach of the program with some flexibility in the counties helps the program meet local needs and provide culturally appropriate services.

Establish a Limited, Mandatory Public Long-Term Care Insurance Program in Hawaii

Recommendation: The Hawaii Long-Term Care Commission recommends, in principle, that Hawaii establish a limited, mandatory public long-term care insurance program for the working population, which would primarily be funded by premiums rather than state general revenues. A final decision on whether to implement a program and on the details of the design would depend on additional financial and actuarial analyses, which the Commission was not able to conduct because of time and cost constraints. The final decision on the program design and whether to implement the program will be made by the Legislature and the Governor.

Many possible program designs are possible to ensure long-term fiscal solvency of the program. The Commission offers the following possible approach for consideration:

- The program would be financed by mandatory premiums paid for by the eligible population. The mandatory premium should be very modest, much below typical private long-term care insurance policies. Except for the proposed study and startup costs, no Hawaii general tax revenue would be used.
- The program would be mandatory for employed individuals, including the self-employed, for adults younger than age 60. No medical underwriting would be conducted.
- Participants would have to pay premiums for 10 years before they would be eligible for benefits.
- Eligibility for the benefit would be limited to people with two or more deficits in the activities of daily living (e.g., eating, bathing, and dressing) or moderately severe dementia, as verified by professional staff.
- The benefit period would be limited to 365 consecutive or nonconsecutive days.
- The daily benefit would be \$70 in cash indexed to increase 5 percent annually. Although the benefit could be used for nursing home care, it is designed primarily to finance home and community-based services.
- Eligibility for benefits would be determined by the Aging and Disability Resource Centers.
- Premiums would be collected through payroll deduction, income tax filings, or periodic invoicing.
- Because the program is mandatory for the eligible population and publicly run, marketing costs would be low, no profits would be necessary, no taxes would be paid, and no agent commissions would be paid. As a result, administrative costs should be much lower than for private insurance.
- The insurance benefits would not be considered income under the Hawaii income tax and, to the extent possible under federal law, would be excluded from income for federal income tax, Medicaid, and other means-tested programs administered by the state.

- Funds from the proposed public long-term care insurance program may be used to pay the new copayment fees that the Commission proposes for Kupuna Care, which would generate additional revenue for Kupuna Care.

Given the limitations of private long-term care insurance, it is highly unlikely that more than a minority of people in Hawaii will ever have private long-term care insurance. To provide something closer to universal coverage, a public insurance program is required. In principle, the proposed public insurance program would be similar to Social Security, which is designed to provide modest income support financed through mandatory contributions by the working-age population. Just as Social Security is not intended to replace retirement savings, the proposed long-term care program would not be intended to provide for all long-term care needs and would supplement, not replace, private initiatives such as private long-term care insurance. With a base of public insurance funding, the private insurance industry may be able to market more affordable voluntary supplementary insurance. The public insurance would provide a measure of financial protection for individuals who are uninsurable. In some respects, the proposed program is similar to the German long-term care insurance program.

Reform the Regulation of Domiciliary Care Facilities, Including Adult Residential Care Homes, Extended Care Adult Residential Care Homes, Community Care Foster Homes, and Assisted Living Facilities, and Nursing Homes

Recommendation: The Hawaii Long-Term Care Commission recommends reform of the system of domiciliary care facilities and nursing homes that would include (1) ensuring that all of the state’s information outlets—particularly the Aging and Disability Resource Center website—provide clear and consistent information about all of the residential care options available; (2) improving the quality of care in domiciliary care facilities by assessing state allocation of responsibilities for quality assurance across departments and reorganizing if necessary; and (3) reviewing the standards and inspection processes for residential care facilities and nursing homes.

Hawaii has a very complex system of community-based residential care settings and nursing homes. Nursing facilities are licensed by the Hawaii Department of Health, and they cannot receive Medicare and Medicaid funding unless they are certified as meeting federal quality standards. Inspections must take place on average once every 12 months. Domiciliary Care Facilities are regulated by the Department of Health and the Department of Human Services. Many stakeholders express concerns about the quality of care provided in residential care settings which they believe is the result of division of responsibility for regulation and oversight by two agencies, inadequate licensing and certification requirements, and insufficient oversight.

Consolidate Hawaii State Departments Responsible for Long-Term Care into a Single Agency or Department to Improve Accountability, Efficiency, and Policy Coordination

Recommendation: The Hawaii Long-Term Care Commission recommends that state government agencies responsible for long-term care should be consolidated to place all responsibilities for long-term care in a single agency or a division within a larger department. The reorganization should be similar to how long-term care responsibilities are organized in Washington, Oregon, and Texas. Among other issues to be decided is whether services for

people with intellectual and developmental disabilities and mental health problems should be included.

Recommendation: Until such time as the reorganization is enacted, the Legislature by concurrent resolution should request the Governor to establish a Deputy Healthcare Transformation Coordinator for Long-Term Care within the office of the Healthcare Transformation Coordinator, who shall be responsible for coordinating all state activities on long-term care related to financing, access, service delivery, and quality assurance. The Deputy Coordinator shall convene a council of agencies responsible for long-term care to develop policies and programs on quality of care, the workforce, educating the public, Aging and Disability Resource Centers, home and community-based services, nursing homes, waitlisted patients in acute care hospitals, Quest Expanded Access, and other long-term care issues. The Deputy Coordinator shall report to the Healthcare Transformation Coordinator, and annually to the Legislature on the state of the long-term care system in Hawaii. The position and office of Deputy Healthcare Transformation Coordinator for Long-Term Care shall terminate when management over all long-term care services is consolidated within a single executive department.

Hawaii long-term care stakeholders almost universally believe that the fragmentation of the long-term care system is a major problem. They contend that there is no real long-term care “system”; every component is designed for a different purpose and the components do not work together. Consequently, the system is so confusing that consumers do not know what resources are available and cannot figure out where to go to obtain the services they need. In the summary judgment of one stakeholder, “The ‘system’ is just a lot of disjointed programs with different eligibility criteria.” Moreover, most stakeholders do not believe that top government policymakers are committed to addressing long-term care issues.

In its review, the Hawaii Long-Term Care Commission found that (1) state government needs to assert stronger leadership over the entire long-term care population, including those not eligible for public programs; (2) the successes or failures of long-term care can contribute to or detract from the success of other programs; and (3) Hawaii’s laws are silent on the subject of leadership over long-term care, but Governor Abercrombie’s appointment of a Healthcare Transformation Coordinator opens the door to new thinking about organizational solutions.

Strengthen Aging and Disability Resource Centers and Expand Their Role

Recommendations: The Hawaii Long-Term Care Commission recommends that (1) the Aging and Disability Resource Centers should be the single point of entry for the new public long-term care insurance program (if established) and for the Kupuna Care program; (2) to conduct their tasks, Aging and Disability Resource Centers will need to obtain and store personally identifiable information and protected health information, and should be funded sufficiently to develop secure information networks, policies and procedures to be in compliance with the requirements of the Health Insurance Portability and Accountability Act; and (3) should the long-term care public insurance program be established, agreement should be reached with trustees of the new insurance program and the Executive Office on Aging so that Aging and Disability Resource Centers would be funded to provide assessment, information, and referral related to the new program.

The Aging and Disability Resource Center program is a collaborative effort of the U.S. Administration on Aging and the Centers for Medicare & Medicaid Services. Their purpose is to simplify and streamline access to long-term care services. Aging and Disability Resource Centers provide states with an opportunity to integrate the full range of long-term supports and services into a single, coordinated system. The target population for Aging and Disability Resource Centers includes individuals of all ages with all incomes and types of disabilities, including serious mental illness and developmental disabilities. Although Hawaii has been working to develop a fully functioning Aging and Disability Resource Center for several years, it currently provides only limited services and information, primarily through toll-free telephone numbers and a website.

Introduction

This final report, together with its appendices, is submitted in fulfillment of Act 224, Session Laws of Hawaii 2008, as amended. Act 224 created a long-term care commission to conduct a comprehensive assessment of Hawaii's long-term care system and to recommend changes. A commission of 15 voting and 5 nonvoting ex officio members was constituted as required by the Act. Although long-term care affects people of all ages and includes people with intellectual and developmental disabilities, the Commission focused on long-term care for older people. The statute authorizing the Long-Term Care Commission can be found in *Appendix A*.

Long-term care includes a wide range of services and supports:

- Assistance with activities of daily living (ADLs). ADLs include eating, bathing, dressing, transferring from bed to chair, controlling bowel and bladder function, and moving about the house safely.
- Assistance with instrumental activities of daily living (IADLs). IADLs include preparing meals, shopping for food and personal items, managing medications, managing money, using telephones, doing housework, and using public transportation.
- Assistance with other activities needed to maintain community living, such as heavy chores.
- Supervision to safeguard health and safety.
- Skilled and unskilled nursing services and rehabilitation services such as physical and occupational therapy to maintain or improve functioning.
- A range of other services and supports needed to function in community settings, such as habilitation and supported employment for persons with developmental disabilities or serious mental illness.

The long-term care system in Hawaii is broken. Long-term care is expensive and beyond the financial reach of most people. Medicare and private health insurance does not cover long-term care and few people have private long-term care insurance. As a result, if they need extensive long-term care, they must pay out of pocket and when their resources have been depleted, they must turn to the means-tested Medicaid program. Moreover, although progress has been made in recent years with the implementation of the Medicaid Quest Expanded Access program, the financing and delivery system is highly skewed toward institutional care, even though people want to stay in their own homes. Finally, responsibility for long-term care is spread over several state agencies, leaving policy fragmented without a unifying vision.

Most importantly, the aging of the population guarantees that there will be a much greater need for long-term care in the future than there is now. Between 2007 and 2030, the population aged 85 and older, which has the greatest need for long-term care, will increase by almost two thirds. There is no way to provide services for this population without additional sources of financing; it is impossible to serve two-thirds more people within the same level of government spending. Either government will need to spend substantially more for long-term care or other sources of financing will need to be found. To date, little has been done in Hawaii or nationally

to plan for this eventuality. The issue of long-term care financing was the focus of the Commission's deliberations.

This report presents the final recommendations of the Hawaii Long-Term Care Commission. The report begins with the goals of reform and a brief overview of the long-term care system in Hawaii, and then presents recommendations on education and public awareness, private long-term care financing, public long-term care financing, delivery system reforms, and reorganization of the administrative agencies responsible for long-term care. Each recommendation includes a background discussion about the issues relevant to the recommendation addresses and the advantages and disadvantages of the proposed approach.

In addition, four reports are appendices to this report, which are available in a separate volume:

- Appendix B: *First Report of the State Long-Term Care Commission to the Hawaii State Legislature* (2011)
- Appendix C: *Overview of Long-Term Care System in Hawaii* (2011), Janet O'Keeffe and Joshua M. Wiener, RTI International
- Appendix D: *Stakeholders' Views of Hawaii's Long-Term Care System: Problems, Solutions, and Barriers to Reform* (2010), Janet O'Keeffe and Joshua M. Wiener, RTI International
- Appendix E: *Assessing Long-Term Care Policy Options in Hawaii: Results from the Hawaii Long-Term Care Survey* (2011), Galina Khatutsky, Joshua M. Wiener, Heather Best, and Joseph McMichael, RTI International

Overview of the Long-Term Care System in Hawaii

Long-term care includes helping people with daily activities, such as getting dressed, bathing, preparing meals or eating, or taking medications, over an extended period of time. Providers of long-term care include nursing homes, residential care facilities, adult day care centers, and home care agencies. In this section of the Report, we summarize the broad outlines of the long-term care system in Hawaii. A detailed description of the long-term care system in Hawaii can be found in *Appendix A, Overview of the Long-Term Care System in Hawaii*.

Demographic Characteristics of Older People

- Like the rest of the country (indeed, the world), the population of Hawaii is getting older. Between 2007 and 2030, the population aged 85 and older, which has the greatest need for long-term care, will increase by almost two thirds.
- There are approximately 22,000 adults aged 25 and older in Hawaii with significant disabilities.

Long-Term Care Services

- Compared to the rest of the country, Hawaii has many fewer nursing home beds per older population. The ratio of nursing home beds per 1,000 people aged 75 and older in Hawaii is about half the national average. Possible reasons for this lower bed supply include the high cost of land and the tradition of three-generation households. As a result of the relatively low bed supply, occupancy rates are high, some high-need patients in hospitals have difficulty obtaining placements, and Hawaii nursing home residents are more disabled than in other states.
- A possible consequence of the limited nursing home supply has been the growth of a complicated and confusing system of residential care facilities, including Adult Residential Care Homes, Extended Care Adult Residential Care Homes, Community Care Foster Homes, and assisted living facilities. Some of these facilities serve people who need a nursing home level of care and receive Medicaid reimbursement for services but not room and board. These facilities are regulated by the Department of Human Services and the Department of Health; some facilities are regulated by both agencies.
- Home and community-based services (HCBS) in Hawaii include a wide range of services including case management, licensed nursing services, nurse aides, adult day care and adult day health centers, home health aides, personal attendants/personal care aides, homemakers, and other community services. The Department of Health is authorized to license home care agencies, but lacks the funds to implement these requirements.

Public Funding for Long-Term Care Services

General Cost

- Long-term care services are expensive everywhere, but are particularly costly in Hawaii. For example, the private-pay price for the average private room in a nursing home is almost 50 percent higher in Hawaii than in the country as a whole.

Medicaid

- Medicaid, the federal-state health and long-term care program for the low-income population, is the primary payer for long-term care services. In FY 2008, the state spent approximately \$274 million on long-term care for older people and younger persons with physical disabilities.
- Compared to other states, Hawaii's Medicaid long-term care spending has historically been much more oriented toward institutional services. In 2008, the most current year for which data are available, only 19 percent of Medicaid long-term care services spending in Hawaii for older people and younger persons with physical disabilities, compared to 32 percent nationally. Not surprisingly, then, Medicaid spending for home and community-based services per capita aged 75 and older in Hawaii was half of what it was nationally.
- Medicaid long-term care services in Hawaii underwent a radical change in 2009 with the introduction of Quest Expanded Access, which combined Medicaid primary, acute, and long-term care services for aged, blind, and disabled beneficiaries into a managed care program. Enrollment is mandatory, with beneficiaries able to choose between two managed care plans. By combining medical and long-term care, policymakers hope to create a more efficient and seamless integrated care system, which will have much greater flexibility in meeting the needs of older and younger people with disabilities. Very little public information is available about how the program is performing. However, preliminary data suggest that the demonstration has substantially increased the number of people receiving home and community-based services and modestly reduced the number of people receiving nursing home care.
- In addition to the Medicaid HCBS waivers absorbed into Quest Expanded Access, Hawaii Medicaid operates HCBS waivers: the HIV/AIDS Community Care Waiver program, the Medically Fragile Community Care Waiver program, and the Developmentally Disabled Medicaid Home and Community-Based Services Waiver program.

State Programs

- Similar to other states, Hawaii also operates several other long-term care programs focusing on home and community-based services, which are much smaller than Medicaid home and community-based services. These programs are managed by the Department of Human Services and Department of Health.

- The largest of these non-Medicaid programs, including the entirely state-funded Kupuna Care and those programs funded by the U.S. Administration on Aging, are run by the Executive Office on Aging of the Department of Health.
- The Aging and Disability Resource Center (ADRC) Program is a collaborative effort of the U.S. Administration on Aging and the Centers for Medicare & Medicaid Services. The purpose of ADRCs is to simplify and streamline access to long-term care services. ADRCs provide states with an opportunity to effectively integrate the full range of long-term supports and services into a single, coordinated system. Although the state has been working to develop a fully functioning ADRC for several years, it currently provides only limited services and information, primarily through toll-free telephone numbers and a website. The state currently has a contract with a consultant to upgrade these services.

Intellectual Disabilities/Developmental Disabilities System

- The Hawaii Department of Health administers programs for people with intellectual disabilities/developmental disabilities.
- Like other states regarding services for people with intellectual disabilities/developmental disabilities and unlike services for older people and younger persons with physical disabilities, Hawaii has radically shifted services for people with intellectual disabilities/developmental disabilities from institutions to home and community-based services. For example in 2009, Medicaid's expenditures for the Developmentally Disabled Home and Community-Based Services Waiver were more than 11 times the expenditures for intermediate care facilities for people with intellectual and developmental disabilities.

Problems of the Current Long-Term Care System and the Goals of Reform

The current system of financing, organizing, and delivering long-term care satisfies almost no one. The specific reform goals the Commission adopted to guide its deliberations are presented in *Exhibit 1*.

Exhibit 1. Goals of Reform

- Increase public awareness of long-term care through education
 - Treat the risk of needing long-term care as a normal life risk
 - Protect against catastrophic out-of-pocket costs
 - Prevent dependence on welfare in the form of Medicaid
 - Improve access to long-term care services
 - Make the long-term care system more responsive to consumers
 - Change the balance of institutional and home and community-based care
 - Ensure that long-term care reforms do not increase inequality
 - Design an affordable system, both to the individual and government, that will bring additional funds into the long-term care system
-

Increase Public Awareness of Long-Term Care Through Education

Most people in Hawaii know little about their risk of needing long-term care, what services are available, and the options for financing services. For example, when asked how they would pay for nursing home care or 24-hour home care, nearly half of respondents to the Hawaii Long-Term Care Survey did not know the answer to the question (Khatutsky et al., 2011). It is unlikely that broad changes in long-term care financing or delivery are possible unless the public is better informed about long-term care.

Treat the Risk of Needing Long-Term Care as a Normal Life Risk

Although not often explicitly discussed, perhaps the most important goal of reform is for society to treat long-term care as a normal risk of living and growing old. Fully 69 percent of people who turned age 65 in 2005 will have some long-term care needs before they die; among the 35 percent of older people who will spend some time in a nursing home before they die, about half will reside there for a year or longer (Kemper, Komisar, and Alecxih, 2005/2006). The large expenses of long-term care should not come as an unpleasant surprise that causes severe financial distress to individuals and their families. Currently, the problem of coping with chronic illness and disability is compounded by worries about paying for care. Older people and others fear that if they need long-term care, they will become a burden on their family. People should know how their long-term care expenses will be paid. Mechanisms need to be established so that people will know how to pay for services should they need them.

Protect Against Catastrophic Out-of-Pocket Costs

With very little public or private insurance coverage against the high costs of long-term care, it is not surprising that users of long-term care services often incur very high out-of-pocket costs. The average private pay cost for a year in a nursing home in Hawaii was \$132,860 in 2010 (MetLife Mature Market Institute, 2010). In the Hawaii Long-Term Care Survey conducted for the Commission, about three-fifths of respondents said that they could not afford to pay any of the cost of a year in a nursing home or 24-hour home care (Khatutsky et al., 2010). The costs of long-term care can easily impoverish people with long-term care needs.

Prevent Dependence on Welfare in the Form of Medicaid

A separate but related goal is to prevent people who have been financially independent all their lives from depending on welfare—Medicaid—at the end of their lives. Most people believe that only a small proportion of the population should receive welfare. Yet, in 2010, 70 percent of nursing home residents in Hawaii had their care paid by Medicaid (American Health Care Association, 2010). A substantial portion of Medicaid nursing home residents were not eligible for the program when they were living in the community and turned to Medicaid because they had impoverished themselves paying for long-term care. Medicaid financial eligibility rules are very strict. For example, individuals in Hawaii with more than \$2,000 in financial assets are ineligible for Medicaid (Walker and Accius, 2010).

Improve Access to Long-Term Care Services

Access to long-term care services in Hawaii is limited. On a population basis, the supply of nursing home care is half the supply in the country as a whole (O’Keeffe and Wiener, 2010a). Partly as a consequence, according to some observers, some people needing high levels of care have difficulty gaining access to services, forcing them to remain in acute care hospitals. Similarly, although the Medicaid QUEST Expanded Access demonstration appears to be expanding access to home and community-based services, Hawaii’s Medicaid spending on home and community-based services per 1,000 people aged 75 and older has historically been much less than the national average. Hawaii’s many islands impede access to long-term care services; people are not able to travel from island to island to receive long-term care. To the extent that they must do so, they are separated from their family and friends.

Make the Long-Term Care System More Responsive to Consumers

The financing and delivery of long-term care services in Hawaii and most other places in the United States are fragmented, with a confusing array of programs, funders, eligibility rules, and provider types. For example, Medicaid is the dominant funder, but a very limited amount of long-term care is also funded by Medicare, Kupuna Care, the Department of Veterans Affairs, the U.S. Office on Aging, and other state programs. One of the goals of Medicaid’s QUEST Expanded Access is to create a more seamless system by making one organization responsible for all Medicaid medical and long-term care services for an individual. Similarly, Hawaii’s Aging and Disability Resource Center seeks to provide consumers with a “one-stop shop” for information about long-term care resources, but its services are still fairly underdeveloped, although initiatives are underway to improve them. Closely related to these activities is the

movement to consumer-directed home care, which gives consumers rather than agencies the right to hire, train, schedule, supervise, and fire their workers (Foster et al., 2003; Schore, Foster, and Phillips, 2007; Wiener, Anderson, and Khatutsky, 2007).

Change the Balance of Institutional and Home and Community-Based Services

The overwhelming majority of people who need long-term care live in their homes and want to stay there. In the Hawaii Long-Term Care Survey, only 4 percent of respondents said that they want to be cared for in a nursing home and only 12 percent want to live in assisted living or small group homes (Khatutsky et al., 2010). The overwhelming majority of people want to be cared for at home, either by friends and relatives or by home care providers. Despite these preferences, public expenditures for long-term care for older people are overwhelmingly for nursing home rather than home care. Few data are available to evaluate how the demonstration program is performing, but nursing home use appears to have dropped somewhat and home and community-based services use has increased significantly.

Ensure That Long-Term Care Reforms Do Not Increase Inequality

Access to long-term care services generally varies by payment status. Private pay users generally pay more than Medicaid reimburses and Medicare pays more for skilled nursing facility care and home health care than does Medicaid. As a result, providers, most of whom are for-profit organizations seeking to maximize profits, generally prefer private pay or Medicare consumers over Medicaid or other public program beneficiaries. Thus, private sector initiatives may reduce access for public program beneficiaries unless supply is expanded. However, if private sector initiatives benefit middle-class individuals currently ineligible for Medicaid, then they may improve access for that population.

Design an Affordable System, Both to the Individual and Government, That Will Bring Additional Funds Into the Long-Term Care System

Political reality dictates that any reforms be “affordable” to both users and taxpayers. Although there is little consensus about how much society is willing to pay for long-term care services, there is little doubt that raising taxes to pay for a public program is always difficult, even for popular programs like Social Security and Medicare.

With the aging of the population in Hawaii and nationally, demand for long-term care will increase, as will public and private expenditures. Reforming the system will require additional resources and a key issue is how to obtain them. Additional funding for long-term care can be obtained through general revenue taxes, private insurance, or public insurance. Another key issue is how to convince people either to prepare financially so they can afford to pay privately to meet long-term care needs or to be willing to pay more taxes to support public programs that provide long-term care services.

Education and Awareness Initiative

Education and Awareness Initiative Recommendation #1: Conduct a Long-Term Care Education and Awareness Campaign

The State of Hawaii should conduct a long-term care education and awareness campaign, with the goal of making people aware of their risks of long-term care, their current financing and delivery options, and the implications for Hawaii of the aging of the population. The main objective of this public education campaign is to educate people about their risks of long-term care and to motivate people to begin planning for how their and their families' potential long-term care needs will be met. The education campaign should be administered by the Hawaii Executive Office on Aging and should be adequately funded by the legislature.

The public awareness and education campaign should contain several important messages:

- The likelihood of needing long-term care at some point in each person's life is substantial.
- Everyone should be prepared regardless of age or income level.
- Navigating through the complexities of long-term care at a time when care is urgently needed is stressful; proper planning reduces that stress and leads to better, more appropriate choices.
- Long-term care is expensive and requires financial planning far in advance of the need of services.
- There are resources in the community that can assist with long-term care planning and provide information on multiple options, including private insurance, state initiatives, and government safety net programs.
- Long-term care is not covered by Medicare or regular private health insurance. Medicaid is limited to people who are poor or become poor because of the high cost of health and long-term care services.

State government should approach the private sector to solicit support, sponsorship, and dissemination help for the campaign. If possible, private funds should also be used to expand the reach of the initiative. The Executive Office on Aging should develop a public-private partnership to fund and administer this initiative. It is proposed that that this public awareness campaign should begin in early 2013.

The long-term care education and awareness campaign should invite broad participation from multiple stakeholders in Hawaii. Several private groups should have an interest in supporting such a campaign. For example, long-term care providers would welcome an opportunity to showcase their services as part of the long-term care planning process. Businesses that may be experiencing lower productivity and higher absenteeism as a result of employees providing informal care to elderly or disabled family members may welcome tools to offer employees to address their long-term care needs.

The campaign should include creation or enhancement of websites, brochures, public service announcements on radio and television, and speeches by public officials and private citizens. However, to be effective, this education campaign must go beyond mere advertising and engage individuals and groups with face-to-face communications. The overall message must motivate specific actions by consumers.

Most importantly, the campaign should be designed with the understanding that long-term care elicits a lot of denial and is an uncomfortable topic for many people. The pictures and graphics to be used should strike a balance and include realistic portrayals of long-term care consumers and present images that are culturally appropriate.

Acknowledging the diversity of the targeted audiences, the campaign should consist of the following:

- Broadcast and print public service announcements
- Earned media (media stories) on the current long-term care system, the purpose and rationale for the education campaign, and the role of individuals in planning for their long-term care needs
- Social media outlets such as Facebook
- Meetings where people can have face-to-face discussions about long-term care and options

As a starting point, the initiative could be modeled on the Own Your Future Awareness Campaign, a joint federal-state effort to raise awareness about and planning for long-term care (Long Term Care Group Inc. and LifePlans Inc., 2006). Funded by the federal government, the campaign included a letter signed by the state's Governor that was sent to all households with members who were 45–65 years of age. The letter offered information about the importance of planning for long-term care, including a free planning guide that could be ordered by mail or downloaded from a website. A total of 19 states conducted campaigns.

The campaign should be targeted to three distinct audiences:

- The next generation of long-term care recipients (those aged 45–64) who may not yet realize the importance of long-term care planning and not know the benefits of starting the planning process early
- Current and potential family caregivers who may need help accessing information and would benefit from referral and counseling services
- Current and potential long-term care consumers who may need decision-making support to facilitate their own care such as help with financing or choosing an appropriate care setting.

Finally, the impact of the education and awareness campaign should be independently evaluated for its effectiveness. Possible measurable outcomes include increased awareness of available long-term care services, increase in use of Aging and Disability Resource Centers, number of information kits requested, higher rates of purchasing private long-term care

insurance, and higher savings rates. A pre and post survey of the targeted audiences can be designed to measure such outcomes.

Background

Unless people have basic information about long-term care—what it is, their risk for needing it, and what it costs—they are unlikely to be motivated to spend time establishing long-term care plans or to be willing to spend significant amounts of money for long-term care insurance. Long-term care literacy includes awareness and knowledge about the following:

- Statistical risk of needing long-term care
- Different types and providers of long-term care services
- Cost of long-term care in various settings
- Lack of coverage of long-term care by Medicare and private health insurance
- Different ways to pay for long-term care: insurance, reverse mortgages, savings
- Medicaid’s financial eligibility requirements

General long-term care literacy is low and many people have few opinions about how the system should be reformed. For example, in the RTI Hawaii Long-Term Care Survey, after being provided with a description of the CLASS Act, 30 percent of respondents had “no opinion” as to whether they supported or opposed the legislation. The MetLife Long-Term Care IQ survey (MetLife Mature Market Institute, 2009b) was designed primarily to measure public awareness and knowledge of long-term care issues and facts. Although the 2009 MetLife Long-Term Care IQ survey results indicate an increased understanding of some long-term care issues since 2004 when the survey was originally administered, long-term care literacy was still low with only 21 percent of respondents scoring 70 percent or higher on the 10-item quiz (MetLife Mature Market Institute, 2009). A majority of MetLife Long-Term Care IQ survey respondents (68 percent) correctly identified that “long-term care” refers to assistance with activities of daily living. Older respondents aged 50 to 70 were more likely to define long-term care correctly compared to respondents aged 40 to 49 (74 percent vs. 60 percent). A large majority of respondents (85 percent) knew that Alzheimer’s disease, an accident, or a chronic or disabling condition can lead to a need for long-term care. Only 37 percent of respondents knew that most long-term care is received by people in their own homes (MetLife Mature Market Institute, 2009).

Few people correctly understand the general risk of needing long-term care. According to the MetLife Long-Term Care IQ survey, only 36 percent of respondents correctly answered that about 60 to 70 percent of all people aged 65 and over will need to use long-term care services. More than half of respondents underestimated the risk and only 10 percent overestimated it (MetLife Mature Market Institute, 2009).

A major component of long-term care literacy is understating how much long-term care costs in various settings and who pays for it. Not knowing how expensive long-term care can be, individuals may be less likely to prepare financially to ensure that they will be able to pay for it. Matzek and Stum (2010) reported on financial long-term care knowledge in a random sample of public employees in Minnesota who were offered group long-term care insurance. With a

possible range of 0 to 13, employees scored a mean of 9.31 (71.6 percent correct), displaying moderate levels of long-term care financial literacy. Employees with lower incomes, less education, who were married, and had no living children tended to have lower scores.

An AARP multistate survey of Americans aged 45 and older found that although 60 percent of respondents reported that they are at least “somewhat familiar” with long-term care services currently available and 21 percent said they are “very familiar,” their estimates of long-term care costs were not accurate (AARP, 2006). Only 8 percent of respondents could estimate the monthly cost of nursing homes within 20 percent of the national average cost; fewer than 23 percent could estimate the monthly cost of assisted living, and their estimates for the cost of an in-home visit from a skilled nurse or a home health aide were highly inaccurate. The Kaiser Family Foundation’s National Survey on the Public’s Views on Medicaid (2005) found that only 40 percent of Americans correctly estimated the cost of nursing home care. About one third of respondents underestimated the cost and 16 percent overestimated the cost.

Several studies find that many people think they already have long-term care insurance coverage, either through Medicare or through their private health insurance, even though they do not. In one survey of California voters, 69 percent of respondents were either unsure or inaccurately believed that Medicare covers long-term nursing home care. The survey also found that 78 percent of respondents did not know or were not sure whether Medicare covers in-home long-term care (Lake Research Partners and American Viewpoint, 2010). Only 34 percent of those participating in the MetLife Long-Term Care IQ survey correctly reported that neither Medicare nor health, disability, or Medigap insurance covers long-term care (MetLife Mature Market Institute, 2009). The Kaiser Family Foundation (2007) report on the public’s views about long-term care noted that 23 percent say that a major reason they do not have long-term care insurance is that Medicare will cover the cost of care; other reasons given for not having long-term care insurance include that Medicaid will cover the cost (21 percent) and the expectation that family members will provide care (23 percent).

Additionally, it appears that many people believe they have private long-term care insurance coverage when they probably do not. Fully 29 percent of respondents in the AARP survey reported having long-term care insurance either through work, a private policy, or some other means (AARP, 2006). This percentage is several orders of magnitude higher than industry-based estimates of the number of policies in force. Indeed, the study’s authors concluded that some of the respondents do not understand their insurance coverage.

Lack of knowledge about who pays for long-term care is a consistent finding in multiple studies. The Kaiser Family Foundation (2005) national survey of the public’s views about Medicaid found that only 38 percent of respondents correctly identified Medicaid as the primary source of coverage for low-income people who need long-term care; 32 percent incorrectly believed that Medicare is the main source of coverage for this group; 14 percent said some other program pays for long-term care services and 17 percent “did not know” (Kaiser Family Foundation, 2005). In a recent 2011 survey of AARP members in Hawaii, 29 percent of respondents said that they expected Medicare to pay for their long-term care if needed (Bridges and Pinkus, 2011).

This general need to address the lack of awareness and understanding of the long-term care issues is particularly salient in Hawaii because of several state-specific factors: (1) Hawaii has one of the fastest growing older adult populations in the nation, and this group accounts for a disproportionate share of long-term care use and expenditures; (2) compared to other states, long-term care costs in Hawaii are particularly high; (3) and planning for long-term care in the state may present additional challenges due to a nursing home bed shortage and the fragmented nature of home and community-based and residential care services.

Advantages

- This option attempts to address the lack of understanding and knowledge about the long-term care system.
- An advertising campaign that educates the people of Hawaii about long-term care risks could motivate some people to plan for their own long-term care needs.
- More far-reaching system reforms are unlikely unless people have a greater understanding of the risks and options for change.
- An educational campaign is relatively low cost, because it does not directly provide services, insurance, or other financing.
- An educational campaign could build on existing national efforts such as the Own Your Future Awareness Campaign and simultaneously incorporate state-specific issues and address local challenges.

Disadvantages

- There is little evidence that long-term care public education campaigns have much impact on behavior.
- Successful social marketing campaigns are generally linked to concrete steps that people can take to address the problem identified. Given the high cost of private long-term care insurance and medical underwriting, it is not clear what people are supposed “to do.”
- Unless carefully designed, the education campaign could be viewed as an endorsement of current long-term care insurance products.
- The complexity of long-term care does not lend itself to a standard education campaign.

Options for Long-Term Care Financing Reform

The debate over long-term care financing is primarily an argument over the relative merits of private versus public sector approaches. Some people believe that the primary responsibility for care of older people and younger persons with disabilities belongs with individuals and families and that government should act only as a payer of last resort for those unable to provide for themselves. Policymakers who hold this view generally advocate private sector initiatives, such as private long-term care insurance, and may advocate tightening eligibility for public programs to prod people to plan for their own long-term care needs. The long-term care financing systems of the United Kingdom, New Zealand, and the United States largely reflect this view (Organization for Economic Co-operation and Development, 2006, 2011).

The opposite view is that the government should take the lead to ensure that all people who need long-term care, regardless of ability to pay, receive the services they need. In this view, long-term care for older people should be treated more like health care for older people and should not require people to be poor or become poor to receive government aid. The long-term care financing systems of Germany, Japan, the Netherlands, and Sweden reflect this view. U.S. policymakers who hold this view generally favor expansions of Medicaid, Medicare, the Older Americans Act, and other public programs and advocate a social insurance program for long-term care. Between these polar positions, many variations are possible.

Public long-term care expenditures are a small proportion of the national economy, accounting for about 1.0 percent of the U.S. gross domestic product in 2005 (Organization for Economic Co-operation and Development, 2011). Countries such as Germany and the United Kingdom that have populations older than the United States spent 0.9 and 0.8 percent of GDP for public long-term care programs for older people in 2007; Sweden and the Netherlands were the outliers, spending 3.5 and 3.4 percent of GDP for long-term care for older people (Organization for Economic Co-operation and Development, 2011). Long-term care is also a small proportion of total health care expenditures. In 2007, health care was 16.2 percent of the overall U.S. economy and long-term care was approximately 6.2 percent of total health expenditures (author's calculations using data from Organization for Economic Co-operation and Development, 2011 and U.S. Centers for Medicare & Medicaid Services, 2011).

With the aging of the population, the percentage of GDP for public long-term care expenditures is projected to double or triple by 2050 (Organization for Economic Co-operation and Development, 2006). Although this change is a big increase in percentage terms, it is a relatively modest change in absolute terms, given the aging of the population. Indeed, between 1999 and 2009, total health care expenditures as a percentage of the U.S. economy increased by 3.8 percentage points, at least twice more than the expected increase in public long-term care expenditures between 2005 and 2050 (Organization for Economic Co-operation and Development, 2011; U.S. Centers for Medicare & Medicaid Services, 2011).

On the other hand, these projections would mean a very large percentage increase in what state governments pay for long-term care as a proportion of their budgets, which would be a strain, especially if people are not willing to pay higher taxes. In addition, long-term care will be needed primarily by older people, who will also require Medicare and Social Security spending.

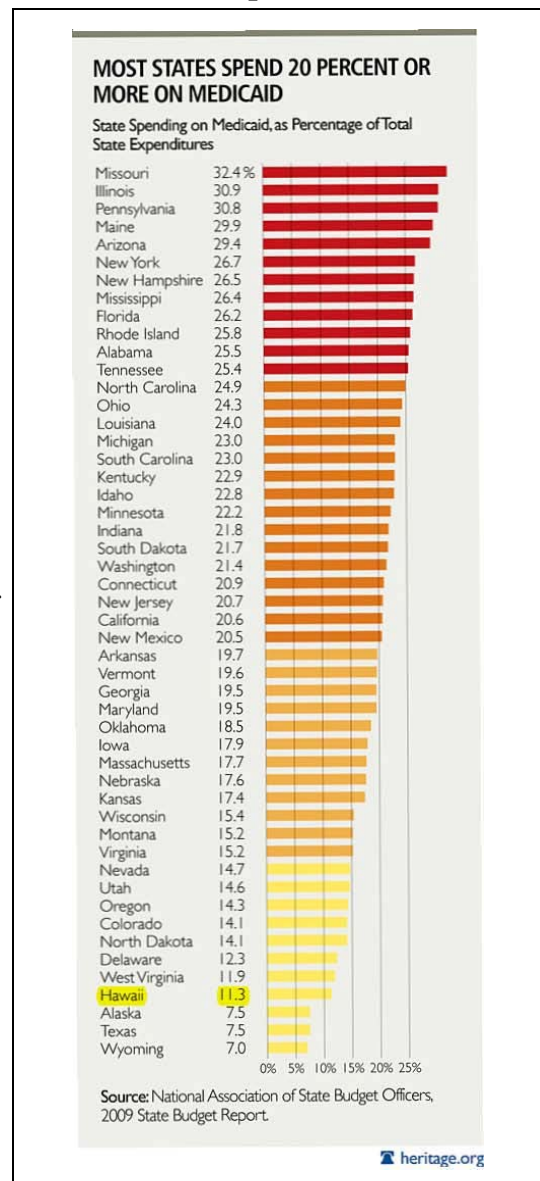
Thus, substantial additional funds will be needed to pay for long-term care services, and many states, including Hawaii, are worried about the long-range impact of an aging population on their budgets.

Medicaid, the major source of funding for long-term care, is a major expenditure for state governments. Although Medicaid expenditures (federal and state shares for all services and populations) accounted for a projected 21.8 percent of total expenditures by states nationally in fiscal year 2010, they accounted for only 13.3 percent of expenditures in Hawaii during that same year (National Association of State Budget Officers, 2010). *Exhibit 2* presents actual state spending on Medicaid as the percent of total state expenditures for fiscal year 2009. Only three states spent a smaller percentage of their state budgets on Medicaid than did Hawaii.

Long-term care for older people and younger persons with physical disabilities accounted for about 22 percent of Hawaii’s Medicaid spending in 2008, the most recent year for which data are available (Burwell, Sredl, and Eiken, 2009). Medicaid long-term care services accounted for about 2.9 percent of total state expenditures, including the federal match, in fiscal year 2010. Thus, in fact, Medicaid long-term care is a small proportion of total state expenditures.

As a means-tested program, people can qualify for Medicaid only if they meet stringent income and asset limits. For older people and persons with disabilities, unmarried Medicaid beneficiaries in Hawaii nursing homes may only retain \$2,000 in assets and must contribute all of their income except for a \$50 per month personal needs allowance toward the cost of care (Walker and Accius, 2010). Because of the high cost of long-term care, there is an incentive for people to transfer their assets to relatives or others to protect their resources and still qualify for Medicaid long-term care benefits. Despite restrictions on transfer of assets, loopholes remain that allow middle- and upper-class people to maintain their resources and still qualify for Medicaid. Although no specific research exists on transfer of assets to qualify for Medicaid in Hawaii, there is a large, rigorous research national literature that finds that transfer of assets is relatively infrequent and usually involves quite small amounts of funds when it occurs (Bassett, 2004; Lee, Kim, and Tannenbaum, 2006; O’Brien, 2005; Norton, 1995; Sloan and Shayne, 1993; Waidmann and Liu,

Exhibit 2. State Spending on Medicaid, as Percentage of Total State Expenditures



2006). The best estimate is that the maximum amount of asset transfer is about 1 percent of Medicaid nursing home expenditures (Bassett, 2004; Waidmann and Liu, 2006).

How policymakers view these projections partly determines what type of financing reform they propose. Advocates for private sector initiatives view these increases and their implications for public spending to be unacceptably high and worry that they will crowd out other worthwhile public spending, especially for younger people. They are unwilling to consider raising taxes to pay for the increased costs and argue that it is imperative to shift as much long-term care cost as is possible to the private sector.

On the other hand, the implicit assumption of advocates for a greater role for the public sector is that these costs are affordable. From their perspective, long-term care is a small portion of the total health care system and even if its proportion doubled or tripled, it would remain a small portion of the health care system. Moreover, from a macroeconomic perspective, it may matter little in terms of the burden to the economy whether services are financed by the public or private sector (Wiener, Illston, and Hanley, 1994). Advocates of mandatory public long-term care insurance argue that offering additional benefits to the population as a whole is a way of building support for the additional revenues that will be needed to cover existing and additional services.

The choice of emphasis between public and private programs also depends on who would benefit and whether they meet specified policy goals. For example, if a large majority of citizens were to purchase private long-term care insurance, then many people would see less need for expanding government programs. Conversely, if private insurance were to prove widely unaffordable or otherwise present barriers—such as medical underwriting—that prevent people from voluntarily purchasing policies, then the case for an expanded public role would be stronger.

Private Sector Initiatives

Private sector approaches are appealing because they reflect the American tradition of individuals taking responsibility for themselves and their families. The classic virtue of the competitive market is its flexibility to adapt to individual needs and wants and to local conditions, a virtue that is mitigated for long-term care insurance by the long lead time between purchase and use of insurance. In addition, some private long-term care insurance advocates hope that private sector initiatives can prevent middle-class people from having to turn to Medicaid when they have spent all of their assets on long-term care services. In addition, if private sector initiatives could prevent middle-class people from having to depend on Medicaid, they might reduce Medicaid long-term care spending.

Over the last decade, the national policy debate on financing reform has primarily focused on private sector initiatives. The marked improvement in the financial position of the elderly over the last 30 years has made it plausible to argue that private sector financing other than out-of-pocket payments might play a significant role in the future financing of long-term care.

A viable private long-term care insurance market, primarily sold on an individual basis, has existed since the mid-1980s. In 2005, approximately 7 million policies were in force, covering about 3 percent of the total American population aged 20 and older; about 10 percent of older people have some form of private long-term care insurance (Feder, Komisar, and Friedland, 2007), compared to 0.2 percent of people aged 20–49. Most policies have limitations in benefits. For example, many policies do not cover lifetime need for services, provide only fixed indemnity benefits rather than payment for all incurred costs, provide benefits that are not inflation-adjusted over time, and do not include a nonforfeiture benefit in case of policy lapse.¹ In recent years, sales have been increasingly to people under the age of 65; in 2009, 81 percent of long-term care insurance purchasers were under age 65 (American Association for Long-Term Care Insurance, 2010). In part, the lack of subscription to private long-term care insurance is a result of the absence of any mandate to purchase (e.g., auto insurance as a precondition of driving or household insurance as a precondition for purchasing a home) or immediate benefit (e.g., health insurance).

In addition, a major reason that relatively few people have private long-term care insurance is that long-term care insurance is expensive, especially for older people with fixed retirement incomes. In 2008, the average premium for private long-term care insurance policies providing a \$150 daily benefit amount, 3 years of coverage, a 90-day elimination period, and 5 percent compound inflation protection, but no nonforfeiture benefit was \$2,329 per year if purchased at age 60 (Tumlinson, Aguiar, and Watts, 2009). In 2009, among people who purchased their policy in the individual market, the average long-term care insurance premium among people aged 55–64 and 65 and over was \$2,200 and \$3,250, respectively (American Association for Long-Term Care Insurance, 2010). Using the National Association of Insurance Commissioners' suitability criteria for purchase of private long-term care insurance (premium not exceeding 7 percent of income and financial assets of at least \$35,000), only 21 percent of people between age 60 and 79 could afford to buy a “mid-range” policy (Merlis, 2003). Thus, projecting to 2018, even with generous assumptions about the willingness of people to pay, private long-term care insurance will remain expensive for most older people (Wiener, Illston, and Hanley, 1994).

Because of the risk of adverse selection, individual long-term care insurance policies are medically underwritten—that is, insurance companies will not sell policies to people they deem as having a high risk of using long-term care services in the relatively near term because of existing health and other problems. Although underwriting practices differ among companies, one study estimated that 28 percent of people aged 65 to 69 could not pass medical underwriting standards (Merlis, 2003). Among applicants for insurance, 9 percent of persons aged 50–59 and 15 percent of persons aged 60–69 were declined coverage as a result of medical underwriting (American Association for Long-Term Care Insurance, 2010).

The limitations of the unsubsidized, individual private long-term care insurance market has led to a number of proposals and initiatives to “jump start” it. These include educating the

¹ For example, 57 percent of policies purchased in 2009 covered 4 or fewer years of care (American Association for Long-Term Care Insurance, 2010). Similarly, although 91 percent of policies purchased during that same year had some inflation protection, only 53 percent of policies purchased provided inflation protection either through 5 percent compound inflation adjustment or a consumer price index inflation adjustment.

public about their risks of long-term care, encouraging policymakers to enact tax incentives for the purchase of private long-term care insurance, and public-private partnerships that combine private insurance with Medicaid coverage.

Exhibit 3 summarizes the private sector recommendations of the Hawaii Long-Term Care Commission and their advantages and disadvantages.

Exhibit 3. Summary of Private Sector Initiatives

Option	Advantages	Disadvantages
Strengthen regulation of private long-term care insurance to better protect consumers	<ul style="list-style-type: none"> • Helps to protect consumers • Low-cost option 	<ul style="list-style-type: none"> • Reduces consumer choices • May raise price of policies by imposing additional requirements, such as inflation protection
Establish a “public-private” partnership	<ul style="list-style-type: none"> • May increase number of people with private insurance • Allows people to receive lifetime asset protection or to protect a substantial portion of their assets (while receiving Medicaid) without buying a long-term care insurance policy that provides lifetime coverage • Reduces price of long-term care insurance by reducing amount of coverage needed • If it successfully encourages additional people to purchase insurance, it may reduce Medicaid costs • Forty-three states are operating or planning to operate “public-private partnerships” 	<ul style="list-style-type: none"> • Experience in other states suggests partnership encourages few additional people to buy insurance • Asset protection and Medicaid coverage may not be what people want from long-term care insurance, making it an ineffective incentive • If it does not successfully encourage additional people to purchase insurance, it may result in additional Medicaid costs • Users tend to have assets greater than \$350,000, much more than the average elderly household

(continued)

Exhibit 3. Private Sector Initiatives Working Group (continued)

Option	Advantages	Disadvantages
Provide tax incentives for purchase of private long-term care insurance	<ul style="list-style-type: none"> • Helps to lower the price of insurance a little, making it more affordable for some • Encourages individuals to take responsibility for their own long-term care needs • Has substantial support among Hawaii state residents • If additional people who buy insurance would otherwise become Medicaid beneficiaries, then there might be small reductions in Medicaid spending 	<ul style="list-style-type: none"> • Empirical evidence suggests that typical state tax incentives do not substantially increase number of people with insurance • Empirical evidence suggests that tax incentives will not produce net Medicaid savings to the state • Tax incentives are typically regressive, benefiting upper-income people more than moderate- and lower-income persons • Tax loss must be made up with tax increases or expenditure cuts elsewhere
Encourage life insurance as a source of private funding through accelerated death benefits (ADB) and viatical settlements	<ul style="list-style-type: none"> • Provides access to an untapped source of private funding for long-term care needs • Many more people have life insurance policies than long-term care insurance policies • Allows policyholders to take responsibility for their own care without total reliance on state programs • May afford individuals with an option for a higher quality of care not covered by state program (e.g., private rooms) • Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the payments from ADB and viatical settlements are excluded from federal income tax if the policyholder is terminally or chronically ill • If heirs do not need money for income replacement, the death benefit may be better spent providing care for the disabled insured 	<ul style="list-style-type: none"> • Most people only have term life insurance, which terminates when people retire; only a small number of people have cash-value life insurance policies that continue into retirement • Most ADB provisions allow access to funds only upon a physician certification that the policyholder is within 12–24 months of death • A fee is usually imposed by insurance or life settlement companies for early access to funds under the policy • Because viatical settlements are not currently regulated in Hawaii, there may be some policyholders who could be victimized by unscrupulous operators unless oversight is established • Redirects insurance proceeds to the policyholder’s current needs, rather than to the heirs • Creation of additional regulatory requirements could be opposed by the insurance industry • Receipt of cash from ADB or a viatical settlement may change the policyholder’s financial status, which could affect their ability to qualify for Medicaid or other means-tested programs

Regulation of Private Long-term Care Insurance

All states, including Hawaii, regulate private long-term care insurance, usually based on the model statute and regulation of the National Association of Insurance Commissioners (NAIC). At least three areas are of concern to consumer advocates nationally—inflation protection, nonforfeiture benefits and premium increases.

The Hawaii Long-Term Care Commission considered but rejected several options to tighten the regulatory standards for private long-term care insurance, believing that consumers should have the maximum number of options.

Inflation Protection

Following existing National Association of Insurance Commissioners model regulations, Hawaii insurance regulations require insurers to *offer* compound inflation adjustment over time, but they allow insurers to sell policies without inflation adjustments if the buyer so chooses.

The Hawaii Long-Term Care Commission considered but voted against making compound inflation protection mandatory, desiring to maintain maximum flexibility for consumers to buy the type of policy that they want.

The Problem of Inflation

Prices for long-term care services rise over time with inflation and historically have increased faster than general inflation. For example, Stewart, Grabowski, and Lakdawalla (2009) estimate that nursing home prices grew 7.5 percent annually between 1977 and 2004. Between 2008 and 2010, the MetLife Survey of Long-Term Care Costs found that average nursing home costs increased 8.0 percent, substantially more than the increase in overall medical care costs (MetLife Mature Market Institute, 2009, 2010). The projected large increase in the number of people needing long-term care and the slow increase in the working-age population is likely to result in staff shortages that will exacerbate future price increases.

Unlike health insurance where benefits are typically a fixed percentage of the allowable costs, private long-term care insurance typically pays up to a fixed amount per home care visit or per day in a nursing home or assisted living facility. Unless there is an annual inflation adjustment, the maximum amount stays the same over time.

Long-term care insurance is typically purchased far in advance, sometimes decades in advance, of using benefits; thus, inflation over time can severely undermine the purchasing power of the policies. For example, assuming a 5 percent annual increase in price of services, a policy bought at age 60 that pays \$4,000 per month for nursing home care needs to pay more than \$10,600 per month at age 80 to retain equivalent purchasing power. In other words, without inflation protection, the purchasing power of the benefit would drop by 60 percent. Without inflation protection, the policyholder's best financial coverage from the insurance is when he or she is young and healthy; the value of the policy declines over time.

Current Private Long-Term Care Insurance Approaches to Inflation

All insurers allow consumers to buy additional coverage in the future at the new attained age, but only if they provide evidence of good health. This approach puts the onus on the individual to monitor long-term prices and to make periodic adjustments. Obviously, it also prevents policyholders who have been ill or disabled from upgrading their policies. Insurers also offer policies that do not increase with inflation over time and several different types of inflation adjustments—compound inflation adjustment (typically 4 or 5 percent annually or tied to the federal Consumer Price Index), simple inflation, and future purchase options.

Compound inflation adjustment offers the best protection, but it greatly increases the premium compared to policies without inflation protection. For example, at age 65, policies with 5 percent annual compound inflation protection cost approximately 75 percent more than policies without inflation protection (Coronel, 2004). Although the proportion of policies with inflation protection has increased substantially over time, only 53 percent of policies purchased in 2009 had compound inflation protection or linked increases in benefits to the Consumer Price Index (American Association for Long-Term Care Insurance, 2010).

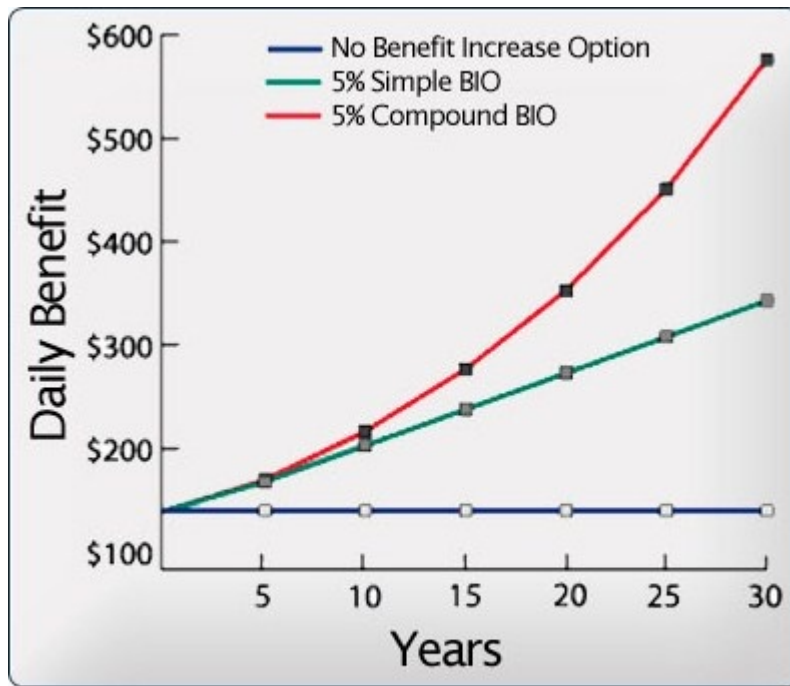
Some companies offer “simple” inflation adjustments where the benefit level increases by a fixed amount each year, usually 5 percent of the initial indemnity value, often for some fixed period of time, usually 20–30 years. For example, a policy that initially pays \$100 a day in a nursing home will increase \$5 a day per year, which represents a declining percentage increase with every passing year.

Although many consumers undoubtedly confuse simple inflation adjustment with compound inflation adjustment, the benefits are dramatically different. For a person who purchases a policy at age 55, a simple inflation adjustment of 5 percent for 30 years will increase the benefit level by only 150 percent by age 85. In contrast, if the price of long-term care services increases at a compound rate of 5 percent a year, it will have increased by 332 percent during that 30-year period. Thus, policies that use simple inflation adjustments do not adequately adjust for the rising cost of long-term care over time.

Finally, many companies offer policies where the insured can periodically increase indemnity benefits without medical underwriting—so-called future purchase options. This additional coverage is purchased at the new attained age and will cost more than if the coverage had been bought when the insured was younger. For example, if a person buys a policy at age 62 that pays \$100 a day in nursing home benefits and if inflation is 33 percent over the next 5 years, then the insured can buy additional coverage of \$33 per day to compensate for inflation but at the price charged 67-year-olds, not 62-year-olds. To retain purchasing power, the premiums at age 82 would be approximately 10 times, in nominal dollars, what they were at age 62 assuming long-term care inflation of 5.5 percent a year (Wiener, Illston, and Hanley, 1994). Even after adjusting for general inflation, premiums at age 82 are likely to be more than four times higher than they were when the insured was age 62. Under the future purchase option, long-term care insurance premiums will increase greatly, but it is unlikely that the incomes of the elderly will increase dramatically as they age.

Exhibit 4 graphically shows the effect of the differences in purchasing power over time provided by no inflation adjustment, compound inflation adjustment, and simple inflation adjustment.

Exhibit 4. Effect of Different Inflation Adjustment Strategies



Source: <http://ltc.com/inflation-protection.cfm>.

Nonforfeiture Benefits

Nonforfeiture benefits provide policyholders with a residual benefit if they drop their policy. The purpose of nonforfeiture benefits is to provide policyholders with some of the benefits of the reserve funds that result from premium payments in excess of their risk of using services. Following existing NAIC model regulations, Hawaii insurance regulations require insurers to *offer* nonforfeiture benefits, but they allow insurers to sell policies without nonforfeiture benefits if the buyer so chooses. Existing regulations do require that policies provide “contingent nonforeiture benefits,” which provide nonforfeiture benefits if policyholders stop paying premiums because of a large increase in the price of the long-term care insurance policies.

The Hawaii Long-Term Care Commission considered but rejected making nonforfeiture benefits mandatory, desiring to maintain maximum flexibility for consumers to buy the type of policy that they want.

If long-term care insurance is purchased at age 65, premiums may have to be paid for 20 years or more until death. If insurance is purchased at younger ages, the insured will have to pay premiums for even longer periods of time. For a variety of reasons, not all people who initially purchase long-term care insurance policies will make premium payments until death; some people will stop paying premiums or “lapse” their policy. Although the proportion of policyholders who drop their policies is less than initially anticipated, analyses by LIMRA International and the Society of Actuaries have found that long-term annual lapse rates are about 2 percent annually, which means that over 20 years, more than half of all initial policyholders will drop their policies (Purushotham and Muise, 2006). Because people who are not policyholders do not receive benefits, the higher the lapse rates, the lower the insurance premiums.

The public policy problem is that policies have level premiums, designed to build up substantial reserves in the early years for payout in the later years. Consumers who decide not to renew their policies will have overpaid in terms of the actuarially fair cost of the protection actually received during the early period when the policy was in effect. With no way to receive back any portion of the premiums they paid in, they will, in effect, be subsidizing the premiums of those policyholders who maintain their policies.

Lapse rates would be a less significant consumer protection issue if insurance policies had nonforfeiture benefits, which allow policyholders who drop their policies to finance a residual benefit with a portion of their accumulated reserves. Nonforfeiture benefits are required in prefunded life insurance products, but few long-term care insurance policies have them. Of concern is that policyholders who lapse are generally poorer, less educated, less healthy, and more likely to be racial and ethnic minorities than those who retain their policies (Konetzka and Luo, 2010). As with inflation adjustment, required nonforfeiture benefits would increase premiums, although by a lesser amount.

Increase in Premiums Among Current Long-Term Care Insurance Policyholders

Closely related to the issue of nonforfeiture benefits, the third area of concern relates to premium increases for existing policyholders. As noted above, premiums are designed to be the same year after year after initial purchase. Although insurance companies may not raise the premiums of individual policyholders, they reserve the right to raise premiums for an entire class of policyholders (e.g., people who bought a certain policy during a particular year) if the policy encounters substantial financial difficulty.

Although large, unexpected premium increases have been an ongoing problem in the industry, over the last year, several well-known insurers, including MetLife, Genworth Financial, and John Hancock, have substantially raised premiums for existing policyholders. Genworth Financial is seeking an 18 percent increase on older policies held by about 25 percent of its customers. John Hancock has filed for permission to raise premiums for about 80 percent of its customers by an average of 40 percent and has also temporarily stopped offering new long-term care insurance plans through employers while it recalculates premiums (Lieber, 2010; Tergsen and Scism, 2010). Insurers have raised premiums partly because they are receiving a lower rate of return on investments than they expected and because fewer people than they anticipated allowed their policies to lapse.

A large increase in premiums can cause financial hardship for policyholders and may lead some to lapse their policies, leaving them with no financial protection or may cause them to substantially reduce their coverage. Insurance regulators generally review the insurance premium rates for private long-term care insurance, both initially and for proposed increases to determine appropriateness. Thus, the large premium increases, in some way, reflect a failure both by state regulators and by the insurance companies to accurately price long-term care insurance policies.

The recent dramatic increase in long-term care insurance premiums among many insurers is expected to result in a large increase in the number of lapses. Thus, some consumer advocates have called for stricter review of proposed long-term care insurance premiums and premium increases. For purposes of long-term care insurance, the Commissioner of Insurance reviews and approves forms, advertising, and an actuarial memorandum that support the proposed rate. This is not a formal rate filing and the statutes stop short of explicit prior approval authority. In practice, the insurers work closely with the Insurance Division and there has never been a case where the insurer used a rate that had not been approved by the Commissioner. Usually, there are some informal communication and negotiation. If the rate appears “excessive, inadequate or unfairly discriminatory,” the insurer is asked to make the appropriate adjustments and refile.

Although the Insurance Commissioner’s authority is informal, the Hawaii Long-Term Care Commission did not vote to increase the Insurance Commissioner’s fiscal oversight over long-term care insurance.

Advantages

- Strengthening private long-term care regulations will help to protect consumers by ensuring that the policies that they purchase actually provide the financial protection that they promise, that they will receive some benefits from the financial reserves of the companies if they have to lapse their policies, and that the cost of the policies will be known in advance.
- Regulatory reform is a low-cost option to implement because it does not directly finance services or provide tax benefits.
- Because long-term care insurance is a particularly complex product that few consumers understand, strict regulation is warranted. Regulations should be designed to maximize information and disclosure to consumers through the already required National Association of Insurance Commissioner’s “shoppers” guide and website, agent education (including continuing education credits), and other means.

Disadvantages

- Stronger regulation will reduce consumer choice. Consumers are already offered compound inflation benefits and nonforfeiture benefits. If they do not want to purchase policies with this protection, they should not have to incur the extra costs.
- Stricter regulation will raise the cost of private long-term care insurance, causing fewer people to purchase policies.

“Public-Private” Partnership for Long-Term Care

In some states, private long-term care insurance is promoted by allowing purchasers of state-approved insurance policies with the ability to retain higher levels of assets for Medicaid than is normally allowed by Medicaid financial eligibility rules. Thus, people can obtain lifetime protection of assets equal to the long-term care insurance benefit amount their policy provides without having to buy insurance policies that cover lifetime benefits. Policies that cover lifetime coverage are much more expensive than policies that cover only 2 or 3 years of coverage.

The Hawaii Long-Term Care Commission considered this option but decided to neither recommend nor oppose this type of public-private partnership for Hawaii. Although it has some features to recommend it, this approach does not appear to be an effective way to increase purchase of long-term care insurance.

Background

A number of policy analysts have suggested a public-private partnership for long-term care to promote private long-term care insurance and to align it with Medicaid. These public-private partnerships have been in effect for more than 15 years in California, Connecticut, Indiana, and New York. In determining Medicaid eligibility, these Partnership programs generally allow policyholders to keep an extra dollar in financial assets for each dollar that their insurance policies pay in benefits. For example, in Connecticut, persons with state-approved private long-term care insurance policies that pay \$150,000 in benefits can keep \$152,000 in financial assets and still qualify for Medicaid once the insurance policy has paid all of its benefits. However, nursing home residents still must contribute all of their income to their care except for a small personal needs allowance before Medicaid will pay. At its core, this approach offers asset protection as its inducement to purchase insurance.

Although the Omnibus Budget Reconciliation Act of 1993 limited this strategy to the four states mentioned above, the Deficit Reduction Act of 2005 removed those restrictions, opening the approach to all states. The Deficit Reduction Act also lowered the consumer protection standards of the policies that had been set by the original four states. For example, all of the original four states required policies to have automatic compound inflation adjustment to the benefit; the Deficit Reduction Act established less strict inflation adjustment requirements. The Deficit Reduction Act requires that Partnership policies sold to those under age 61 provide compound annual inflation protection. The amount of the benefit (e.g., 3 percent or 5 percent per year) is left to the discretion of individual states. Policies purchased by individuals who are over 61 but not yet 76 must include some level of inflation protection, and policies purchased by those over 76 may, but are not required to, provide any type of inflation protection. As of June 30, 2011, 43 states had adopted the Partnership approach, with approximately 630,000 policies in force (California Partnership for Long-Term Care, 2010; Guttchen, 2011; Indiana Long-Term Care Insurance Program, 2010; New York Partnership for Long-Term Care, 2010; Thomson Reuters, 2011).

The key observation supporting these public-private approaches is that insurance covering shorter periods of nursing home and home care is less expensive and more affordable than are

policies covering longer periods of care (Wiener, Illston, and Hanley, 1994). The problem with the current system is that an individual who buys a policy covering, for example, 3 years of coverage, but uses long-term care for 5 years can still lose all of his or her assets. Long-term care insurance policies that provide lifetime coverage are much more expensive than policies that cover only a fixed period of time. For example, for the Federal Employee Long-Term Care Insurance program, a policy covering 3 years of care costs 40 percent less than a policy providing lifetime coverage (Federal Long-Term Care Insurance Program, 2011). These partnership initiatives thus make it possible to obtain lifetime protection of assets equal to the long-term care insurance benefit amount their policy provides without having to buy insurance policies that cover lifetime benefits. Proponents of this approach argue that the goal is not to protect assets, per se, but rather to preserve financial autonomy toward the end of life.

One of the main controversies of this approach is whether this initiative would be budget neutral, would save Medicaid money, or would result in additional Medicaid costs. To the extent that the initiatives are budget neutral, these strategies move toward what economists call “Pareto optimality,” that is, making some people better off without making anyone worse off. Insurance dollars are simply substituted for private asset dollars.

To assess the effect on the Medicaid budget, it is necessary to establish a comparison group. In sum, the answer to the question of whether the Partnerships would save or cost Medicaid money depends on whether the Partnership succeeds in encouraging more people to buy insurance. If the Partnership causes large numbers of additional people to purchase insurance who would not have otherwise purchased the policies, then it is likely, although not certain, that Partnerships would be budget neutral. In this case, the proper comparison is to people without long-term care insurance. For example, people with \$102,000 in assets would have to incur \$100,000 in long-term care costs before Medicaid would provide coverage; with a Partnership for Long-Term Care Policy, people have to use \$100,000 in long-term care insurance benefits before they would become Medicaid eligible. The results are the same, although possible additional use of home care somewhat complicates the calculations.

In contrast, if the Partnerships do not succeed in generating additional purchases of long-term care insurance, then the appropriate comparison group is people who have or would have private long-term care insurance without the Partnership. For this population, Medicaid expenditures could increase. That is because, under current Medicaid rules, insurance purchasers would have to spend down their assets after their insurance benefits are exhausted before qualifying for Medicaid, something that they would not be required to do under the Partnership program. In the example above, without a partnership policy, people with insurance policies that provide \$100,000 in benefits would have to incur \$100,000 in long-term care costs that their insurance policy would pay and then spend down another \$100,000 in their personal assets before Medicaid would provide coverage. Medicaid expenditures are also likely to increase if the insurance coverage is used to pay for home care services that would not otherwise be used by the person without insurance, leaving the insured with less of a financial liability if the person enters the nursing home.

Advantages

- The Partnership brings together the public and private sectors into an integrated system, with the private sector accepting the front-end risk for long-term care and the

public sector accepting the back-end risk. In other words, the private sector would cover relatively short-term coverage (e.g., 1–3 years), while Medicaid would cover the remaining lifetime coverage.

- This approach may increase the number of people who have private long-term care insurance above what might otherwise be the case. The Partnership policies offer purchasers a valuable additional benefit and make lifetime coverage more affordable.
- This strategy allows the insured to obtain lifetime asset protection equal to the long-term care insurance benefit amount their policy provides without having to buy an insurance policy that provides lifetime coverage, thus reducing the price of the private insurance policy needed and increasing affordability for more middle-class people.
- Compared to providing tax incentives, this approach is a relatively low-cost option to promoting private long-term care insurance. If the Partnership can induce people who would not have otherwise purchased long-term care insurance to do so, then some Medicaid savings may result in the future.

Disadvantages

- Although this approach is favored by many policy analysts because it melds the public and private sectors, Partnerships have not significantly increased the number of people with private long-term care insurance. Only modest numbers of partnership policies have been sold in the four states in which the initiative has been offered, despite more than a decade of active promotion and marketing by the respective states. In 2010, there were approximately 259,046 Partnership policies in force in the four states with the longest experience, about 3.2 percent of the population aged 65 and older (California Partnership for Long-Term Care, 2010; Guttchen, 2011; Indiana Long-Term Care Insurance Program, 2010; New York Partnership for Long-Term Care, 2010; U.S. Census Bureau, 2011).
- Even policies that provide shorter periods of coverage may still be too expensive for most people. For example, a policy providing \$200 a day of nursing home and home care coverage for 3 years purchased at age 60, with 5 percent compound insurance protection and a 90-day elimination period (deductible) costs approximately \$3,000 a year for its \$219,000 worth of coverage (Federal Long-Term Care Insurance Program, 2011); a similar policy providing 2 years of coverage would cost \$2,400 a year for \$146,000 in coverage.
- Asset protection may not be a decisive motivator for the purchase of private long-term care insurance. Most surveys of private long-term care insurance purchasers point to less concrete reasons for buying policies, such as retaining autonomy and independence, not being a burden to one's children, and having more choice of providers.
- A core component of this approach is to offer easier access to Medicaid, but older people may not want to be on Medicaid. Indeed, private long-term care insurance is often marketed as a way of avoiding Medicaid.

- Depending on who purchases these policies, who eventually needs long-term care, and what services they use, Partnership policies may not reduce Medicaid costs, and conceivably could even increase them.
- Some opponents argue that it is inappropriate to use Medicaid, a means-tested welfare program, to protect the assets of upper-middle class and upper-income elderly. The majority of purchasers of Partnership policies in California, Connecticut, and Indiana had more than \$350,000 in assets (U.S. Government Accountability Office, 2005a).

Private Sector Initiatives Recommendation #1: Do Not Enact Tax Incentives for the Purchase of Private Long-Term Care Insurance

The Hawaii Long-Term Care Commission recommends against enactment of tax incentives for the purchase of long-term care insurance because they are likely to be ineffective, costly, and primarily benefit upper-income taxpayers. The Hawaii Long-Term Care Commission recommends that a study be conducted to assess ways to encourage employers to provide and pay for long-term care insurance.

Background

A major barrier to the purchase of private long-term care insurance is that it is expensive for many people. Tax subsidies would reduce the net price of the policies, making them more affordable. Standard economics predicts that people will buy more of a good or service if the price is lower.

Tax incentives are typically of two types. The first type are deductions, which allow taxpayers to subtract all or part of the cost of private long-term care insurance policies from their income, which would provide a premium subsidy valued at the marginal tax rate of the household. Because upper-income taxpayers have higher marginal tax rates than lower-income taxpayers, deductions are regressive (i.e., they are worth more to upper-income people than to lower-income people). Income tax rates in Hawaii vary from 1.4 percent to 11.0 percent, depending on income. Thus, the maximum tax benefit available for the highest income people for a \$3,000 policy would be \$330, reducing the cost of a policy to \$2,670.

The other broad approach is to provide a tax credit, which is a direct reduction in the amount of tax owed, for purchase of policies. In theory, tax credits need not be as regressive as deductions. As a practical matter, however, moderate- and low-income taxpayers may not have the cash on hand to pay premiums during the year and therefore would not be eligible to claim a tax credit at the end of the year. The other problem is that unless the tax credit is refundable, it is an ineffective policy for people who do not have a tax liability and, therefore, do not file income tax returns. This is especially an issue for older people, many of whom do not file returns because much of Social Security is not taxable.

Current federal law allows qualifying long-term care insurance premiums to be deducted from income as part of medical expenses, but only if total out-of-pocket expenses exceed 7.5 percent of adjusted gross income and only for the expenses that exceed the expenditure threshold. As a result, fewer than 5 percent of all tax returns report medical expenses as itemized deductions (Ignani, 2006). Even for those people able to meet the federal health expenditure threshold, some policyholders are unable to claim the federal deduction because of other requirements that they do not meet. The recently enacted health reform legislation will increase the threshold for tax deductibility of medical expenses from 7.5 percent to 10.0 percent. Because this provision is a deduction rather than a credit, the tax deduction for medical expenses is worth more to upper-income people than it is for moderate-income people who are in lower tax brackets, and it is worth more to moderate-income people than it is to lower-income people.

Under federal law, employers may deduct their contributions toward the cost of private long-term care insurance as a business expense as they do health insurance. In addition, insurance premiums paid on behalf of employees by sole proprietorships, C corporations, S corporations, partnerships, and limited liability companies are also tax deductible as business expenses (Prudential Insurance Company of America, 2011). Despite this incentive, few employers contribute to the cost of private long-term care insurance. The vast majority of employers that offer long-term care insurance to their employees do so on an employee-pays-all basis.

Many states offer some type of tax incentive for private long-term care insurance. In 2006, 23 states and the District of Columbia offered some type of tax incentive: 15 states allowed taxpayers to deduct premiums from income, 6 states offered tax credits, and 2 states offered both (Goda, 2010). The credits are not refundable so do not benefit individuals with low incomes who do not pay taxes. Tax incentives in the form of deductions are generally allowable in addition to the standard deduction, not requiring taxpayers to itemize. Because state tax rates are low in absolute terms, the value of the tax incentives is small, generally in the range of \$30 to \$100 per year on a \$1,000 policy (Nixon, 2006). Only three states provide more than a 10 percent subsidy (Goda, 2010).

The key issue is whether tax incentives are effective and efficient ways to promote the purchase of private long-term care insurance. Tax incentives may or may not induce very many people to change their behavior and purchase private insurance. Tax incentives may or may not be inefficient because benefits may go largely to people who would have bought policies without the subsidy. In such cases, the government cost per additional policy sold may be high.

Advantages

- Tax incentives may help some people to buy private long-term care insurance, who previously may have judged private long-term care insurance to be too expensive.
- Tax incentives lower the net price of private long-term care insurance. Although responsiveness of consumers to variations in the price of long-term care insurance is not known, standard economics predicts that people will buy more of a good or service when prices are lower.
- Tax incentives are easy to administer through the tax system. Especially if Hawaii uses the definition of qualifying long-term care insurance policies established by the federal government, implementing the tax incentives would only require adding a few additional lines on the state income tax form.
- Private long-term care insurance encourages individuals to take responsibility for financing their own care.
- Some advocates of tax incentives argue that, if properly targeted, they can reduce Medicaid expenditures and save state government money by preventing middle- and upper-middle income people from spending down to Medicaid. If private long-term care insurance prevents middle-class people from spending down to Medicaid, then it would increase the amount of funds available for long-term care services.

- Tax incentives for private long-term care insurance have substantial support among people in Hawaii. In the Hawaii Long-Term Care Survey, 80 percent of respondents favored tax incentives for purchasing long-term care insurance (Khatutsky et al., 2010). This was the highest level of support of any option assessed. When asked to choose the single option they most favored, 33 percent of respondents chose tax incentives for private long-term care insurance, which made it the most popular option by a small margin.
- It may be more effective to provide the tax incentive to employers who will provide a long-term care policy as an employee benefit.
- Private long-term care insurance increases the amount of funds available for the long-term care system.

Disadvantages

- To have a major impact on the number of people with long-term care insurance, the tax incentives may need to be extremely large. The limited empirical evidence suggests that state tax incentives will increase the number of people with private long-term care insurance only slightly, although the tax loss will be significant. In one of the first analyses of the impact of tax incentives, using a microsimulation model projecting to 2018, Wiener, Illston, and Hanley (1994) found that a 20 percent nonrefundable federal tax credit would increase the relatively small number of people with private long-term care insurance by only about a third compared to the number of people with private long-term care insurance without a tax subsidy. In a cross-sectional multivariate analysis, Nixon (2006) did not find that offering a state tax incentive was a significant predictor of private long-term care insurance market penetration.
- Using a price elasticity of private long-term care insurance of -0.75 to -1.25 , Feder, Komisar, and Friedland (2007) calculated that a tax deduction for private long-term care insurance might increase the modest number of people with private long-term care insurance by 11 to 19 percent. In an unpublished paper, Kim (2010) found that the estimated price elasticity of long-term care insurance demand is -0.08 , implying that tax subsidies will have a very small impact on the number of people with insurance.
- Similarly, Goda (2010) found that the average state tax subsidy increased private long-term care insurance coverage rates by only 2.7 percentage points, mostly among higher income and asset-rich individuals. Because tax subsidies are unlikely to substantially increase the proportion of people with private long-term care insurance, most of the tax subsidy will go to people who would have bought insurance without the incentive. As a result, the cost per additional person with insurance is likely to be high. Feder, Komisar, and Friedland (2007) calculated that each additional policy purchased would cost between \$1,308 to \$2,125 in lost revenue, a high proportion of the cost of the policies.
- The tax loss caused by tax incentives for private long-term care insurance is not likely to be offset by Medicaid savings. Wiener, Illston, and Hanley (1994) found that the 20 percent tax subsidy in their simulation would not be offset by Medicaid savings within their 30-year simulation period. Goda's simulations of state tax subsidies found that a

dollar of state tax expenditure produces approximately \$0.84 in Medicaid savings, about half of which in Hawaii would result in savings to the federal government. Thus, because the tax incentive would be paid entirely by the state and the Medicaid savings would be shared with the federal government, tax incentives for long-term care insurance would be a net cost for Hawaii. The tax loss would need to be offset either with other tax increases or spending cuts in other services.

- Tax deductions are regressive, providing more benefits to higher income than lower and moderate-income people. Unless refundable, many older people do not qualify for deductions because they pay no federal incomes taxes because of the exclusion of some or all of their Social Security benefits from taxation. Thus, they are likely to increase inequality in access to long-term care services.

Private Sector Initiatives Recommendation #2: Encourage Life Insurance as a Source of Private Long-Term Care Funding

In this option, individuals would be encouraged to tap into their life insurance policies as a source of private funding for long-term care needs. Nationwide, there are an estimated 153 million life insurance policies in force, representing about \$10 trillion in death benefits (American Council of Life Insurers, 2011). Most of these policies are term life insurance, which ends when people leave their job or retire, but many older people have some level of life insurance. Nationally, among people age 85 and older, 51 percent of people age 85 and older had life insurance (RTI International analysis of the 2008 Health and Retirement Study). By contrast, fewer than 8 million individuals hold long-term care policies (American Association for Long-Term Care Insurance, 2010).

Hawaii had more than 709,000 in-force life insurance policies in 2009, compared to 77,344 individuals covered by long-term care insurance in 2010 (American Council of Life Insurers, 2011; personal communication with Kristi Montanelli, National Association of Insurance Commissioners, December 2, 2011). Approximately 5 percent of the state's population has long-term care insurance.

Two sources of private funding for long-term care using life insurance have been proposed, although they are not much used. First, accelerated death benefits provide some or all of the death benefit while the insured is still alive if he or she needs long-term care or have serious medical conditions. Second, in viatical settlements, individuals needing long-term care or who have a serious medical condition sell their death benefit to a third party in exchange for money while the insured is still alive, usually at a discount.

The Hawaii Long-Term Care Commission recommends that life insurance be encouraged as a source of long-term care financing. To determine the viability of accelerated death benefits, the Hawaii Long-Term Care Commission recommends the following actions, mostly by the Hawaii Insurance Commissioner and the Legislature.

- The Hawaii Insurance Code and Administrative rules should be reviewed to identify and eliminate unnecessary hurdles to use of accelerated death benefits for long-term care.
- A statute or Administrative rule to mandate that insurance companies include an offer of accelerated death benefits in their standard policy forms should be enacted. Determine whether mandatory issue should be included and whether a standard for rating this feature should also be included.
- The feasibility of mandating accelerated death benefits as a rider that can be applied to existing policies should be evaluated.
- Minimum requirements for payout under accelerated death benefits should be established.

- Aggressive education of consumers should be conducted about accelerated death benefits and its potential use to finance long-term care, suggesting that they (a) ask for it as an endorsement to the policy if it is not included, and (b) how to exercise their rights to this benefit if applicable.
- Life insurance companies and insurance agents should be encouraged to inform consumers of the availability of this feature.
- Legislation, such as the Life Insurance Consumer Disclosure Model law developed by the National Conference of Insurance Legislators (NCOIL), should be enacted to ensure that consumers have access to information and options to continue their policy before they lapse.
- Business should be encouraged to provide group life insurance to their employees that include accelerated death benefits in their standard policies.

To determine the feasibility of viatical settlements as a source of financing for long-term care, the Hawaii Long-Term Care Commission recommends the following:

- Hawaii law and Administrative Rules should be reviewed to identify and eliminate unnecessary hurdles for viatical settlements.
- Regulatory oversight of viatical settlements should be established. There should be an examination, licensing process, and standards for the sale of viatical settlements by third parties. This regulatory oversight could be a function of the Department of Commerce and Consumer Affairs under the Insurance Commissioner or the Securities Commissioner.
- Consumers will need to be educated about the existence of this source of funds for long-term care needs, and the advantages and disadvantages of this funding source.

Background

Because long-term care insurance has been available for only about 25 years, whereas life insurance has been available for at least 200 years, the public is far more familiar with the need and uses of life insurance. More people are motivated to buy life insurance because of the cost, convenience, and desire to protect/provide for their growing families. For most people, life insurance is income replacement for their families should they die. Moreover, the need is perceived at a younger age when insurance is more readily affordable.

As life insurance policyholders age, their children grow up, become independent, leave home and start families of their own. For their parents, the lump sum payment of life insurance in the event of death becomes less important as an income replacement, especially after retirement. Nevertheless, many policyholders for cash value life insurance policies, having invested significant dollars, continue to pay the premiums.

Certain features of life insurance policies can still help policyholders further protect the family by providing funding for long-term care. These are sometimes referred to as “living benefits.”

Accelerated Death Benefits

Accelerated death benefits (ADB) are provisions in life insurance policies that allow for advance payment of some or all of the death proceeds, sometimes as a percentage of the face value, sometimes as a lien against the full death benefit. These funds can be used to pay for long-term care services. Although some older life insurance policies may not include accelerated death benefits, more insurance companies are making this option available to their policyholders, including both permanent and term life insurance.

There are usually no age or financial status requirements for ADB, but other factors are usually considered. The Interstate Insurance Product Regulation Commission (2007)² establishes five possible triggers for voluntary election of accelerated death benefits:

- A medical condition that is reasonably expected to result in a drastically limited life span for the insured. The company's definition of a drastically limited life span shall have a minimum of "6 months or less" and a maximum of "24 months or less," and shall be specified in the form; and, at the option of the company, may include one or more of the following:
 - A medical condition that requires extraordinary medical intervention, such as major organ transplant or continuous artificial life support, without which the insured would die
 - A condition that usually requires continuous confinement in an institution, as defined in the form, and the insured is expected to remain there for the rest of his or her life
 - A specified medical condition that, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span
 - A chronic illness defined as permanent inability to perform, without substantial assistance from another individual, a specified number of activities of daily living (bathing, continence, dressing, eating, toileting and transferring), or permanent severe cognitive impairment and similar forms of dementia

When activating ADB, the policyholder still owns the policy and, depending on the policy, may have to make premium payments.

Viatical Settlements

A viatical settlement is a contractual agreement between a life insurance policy holder and a third party to provide cash to the policy holder at less than the full value of the policy's death benefits in exchange for the ownership of the policy. The less time the policyholder has to live, the higher the payout. The buyer becomes the owner of the policy, is the named beneficiary, and takes over payment of the premiums.

By "selling" their life insurance policy, individuals agreeing to a viatical settlement gain access to cash for immediate long-term care needs. The third-party buyer is motivated by the

² The Interstate Insurance Product Regulations Commission includes 41 states, including Hawaii, and represents about two thirds of the premium volume sold in the United States.

difference between the immediate payout and the full face value of the policy. The seller is motivated by the availability of immediate cash for long-term care or other purposes.

Advantages

- Provides access to a relatively untapped source of private funding for certain long-term care needs.
- May help some middle-class people from impoverishing themselves to Medicaid eligibility levels when they need long-term care.
- Allows policyholders to take responsibility for their own care without total reliance on state programs.
- May allow individuals to purchase higher quality of care (e.g., private rooms) not provided by Medicaid and other state programs.
- Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), payments from accelerated death benefits and viatical settlements are excluded from federal income tax if the policyholder is terminally or chronically ill.

Disadvantages

- Most life insurance is linked to employment. Relatively few retired older people have life insurance benefits or have life insurance with a significant death benefit. Thus, the amount of money available and the number of people with life insurance policies who are in need of long-term care is likely to be small.
- To the extent that income replacement is still needed by family members after death of the insured, funds will be diverted to other purposes, reducing the amount of money available to heirs.
- Most accelerated death benefit provisions allow access to funds only upon a physician certification that the policyholder is within 12–24 months of death, limiting its utility for persons needing care over a very long period of time.
- There is usually a fee imposed by insurance or life settlement companies for early access to funds under the policy, reducing the amount of money available.
- Since viatical settlements are not currently regulated in Hawaii, there may be some policyholders who could be victimized by unscrupulous operators unless strict oversight is established. These operators may take advantage of desperate people who need immediate cash for medical or long-term care, paying them only a small portion of the value of their benefit.
- Creation of additional regulatory requirements could be opposed by the insurance industry.
- Receipt of cash from accelerated death benefits or viatical settlements may change the policyholder's financial status, which could affect eligibility for Medicaid and other means-tested programs.

Public Sector Initiatives

Private sector initiatives can play a bigger role than they do today, but none of the options described above is likely to result in private long-term care insurance or similar initiatives replacing public financing of long-term care without very large public subsidies for its purchase. An alternative approach is to rely more heavily on the public sector.

For advocates of a greater role for public sector programs, four factors are important:

- Long-term care services are already extensively financed by the public sector. Public sector spending for persons of all ages and types of disabilities (including intellectual and other developmental disabilities) accounted for about two thirds of all national long-term care spending in 2008 (O’Shaughnessy, 2010). In addition, a large portion of out-of-pocket payments are, in fact, contributions toward the cost of care required of Medicaid beneficiaries in nursing homes and not purchases of services by private payers. A heavy role by the public sector in financing long-term care is typical of all developed countries (Organization for Economic Co-operation and Development, 2006, 2011).
- The public sector originated or played an important role in many innovations in long-term care, including consumer-directed home care, cash and counseling programs and policies, money follows the person policies, case management, capitated approaches to integrating acute and long-term care, and third-party funding for residential care facilities such as assisted living. Thus, it is well positioned to lead future innovations.
- The public sector is more likely to be able to address the needs of younger people with disabilities, who accounted for 36 percent of people with long-term care needs in 2000 (Komisar and Rogers, 2003). Medical underwriting for private long-term care insurance products excludes people with existing disabilities and working-age adults are less likely to purchase private long-term care insurance because the risk seems small and far away.
- Tax incentives are expensive and are likely to be regressive or at least not targeted to working- and lower-middle class families who most need the help in purchasing insurance. On the other hand, Medicaid targets a relatively low-income population and Medicare covers virtually all older people regardless of financial status. The relatively low incomes and assets of people with substantial disabilities (Johnson and Wiener, 2006) mean that most additional spending, even under most social insurance programs, would be spent primarily on lower- and moderate-income people with disabilities (Wiener, Illston, and Hanley, 1994).

Opponents of expansion of the public sector in long-term care argue the following:

- The financial burden of existing public long-term care programs, let alone additional ones, will be significantly greater in the future (U.S. Government Accountability Office, 2005b). Although spending for Medicare post-acute and short-term skilled long-term care and Medicaid long-term care is small in comparison to Social Security and overall Medicare expenditures, all of these programs primarily benefit the older population and are mainly financed by the working population. Additional public

spending for long-term care may crowd out expenditures for children, higher education, and health care for the uninsured, among other worthy programs.

- Medicaid already provides a safety net for people who cannot pay the costs of long-term care. People who can pay for their own long-term care should do so.
- Americans have a low tolerance for additional taxation, and will not support higher taxes for long-term care. Higher taxes are already likely to support the existing Social Security and Medicare programs.

Exhibit 5 summarizes public sector options selected by the Commission and their advantages and disadvantages.

Exhibit 5. Public Sector Financing Options

Option	Advantages	Disadvantages
Increase funding for Kupuna Care and similar programs	<ul style="list-style-type: none"> • Provides funding for people not eligible for Medicaid, but not high income • Focuses on home and community-based services • Has broad support among people in Hawaii 	<ul style="list-style-type: none"> • Might increase fragmentation of financing system • Funding for appropriated programs less likely to increase over time than entitlement programs • Program not eligible for a federal match, as with Medicaid • Would require additional government spending; additional spending would require additional taxes or expenditure cuts elsewhere
Mandatory public long-term care insurance	<ul style="list-style-type: none"> • Would provide additional revenue for long-term care • Premiums would be low and more affordable than pure private insurance or CLASS because all working people would contribute • With no medical underwriting, this option would provide coverage for people who are already disabled • Would provide near universal coverage • Would reduce the number of people who depend on Medicaid to pay for their long-term care • Because benefit is limited, leaves substantial role for private insurance • Flexible benefit would expand home and community-based services, reducing institutional bias • Because the insurance is mandatory, administrative costs would be lower than private insurance (fewer marketing costs or profit) 	<ul style="list-style-type: none"> • Because of the difficulty in establishing premiums for long-term care insurance, the state of Hawaii would be exposed to substantial financial risk • Mandatory premiums are taxes, which are opposed by most people in Hawaii • Largely duplicates the existing private long-term care insurance market • Benefit is too low to pay for nursing home care • Benefit is too short (1-year lifetime maximum) to cover risks of long-term care for substantial number of people • Unrestricted cash benefit might be abused

Public Sector Recommendation #1: Support Funding for Kupuna Care

The Hawaii Long-Term Care Commission recommends continued support for the Kupuna Care program. The state-wide reach of the program with some flexibility in the counties helps the program meet local needs and to provide culturally appropriate services. The Commission recommends that a sliding fee schedule be instituted to generate additional revenue for Kupuna Care, so that it can expand its services. Funds from the proposed public long-term care insurance program may be used to pay the new fees, which would further generate additional revenue for Kupuna Care.

Background

Apart from Medicaid, the federal government funds long-term care through a number of appropriated programs, including the Older Americans Act, the Social Services Block Grant, and the Department of Veterans Affairs. The Older Americans Act programs are generally offered without a means test, while services funded through the Social Services Block Grant and the Department of Veterans Affairs are typically subject to limitations on income and assets.

Similarly, Hawaii operates some state-only funded long-term care programs, of which Kupuna Care is the most important. Kupuna Care is an entirely state-financed program designed to meet the needs of frail older adults who cannot live at home without adequate help from family or formal services. The program was developed by the Executive Office on Aging in partnership with the Area Agencies on Aging to address the growing number of older persons with long-term care needs who are not eligible for Medicaid. The Area Agencies on Aging administer the program. It has annual funding of about \$5 million, which makes it very small compared to Medicaid.

Kupuna Care provides the following services:

- personal care
- adult day care
- assisted transportation
- attendant care (volunteer companion)
- case management
- chore services
- home delivered meals
- homemaker-housekeeper

The four services that account for the bulk of Kupuna Care spending are personal care (28 percent), home-delivered meals (22 percent), case management (20 percent), and transportation (15 percent) (Executive Office on Aging, 2008).

The program has no financial eligibility criteria and services are free to clients, although consumers are asked to make voluntary donations to the service provider. Nonetheless, the program is focused on lower-income individuals. Donations are used to provide services to additional clients.

Clients receiving a single service are assessed by the service provider. Clients receiving more than one service are assessed by case managers. To be eligible for Kupuna Care, individuals must be

- 60 years or older;
- not eligible for services from another public program, such as Medicaid, or already receiving private pay services;
- living in an apartment or house (not an institution, residential care facility, or foster home); and
- impaired in two or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs) or have significantly reduced mental capacity, and have one or more unmet ADL or IADL need.

Advantages

- Because Kupuna Care is funded through direct appropriations, it is subject to direct fiscal control, unlike Medicaid, which is an entitlement program.
- The program provides funding for services to populations who are not eligible for Medicaid, but cannot afford services or insurance on their own. If targeted to people at high risk of institutionalization, the marginal public cost might be reduced because nursing home use may be lessened.
- The focus on home and community-based services would help to address the institutional bias of the current financing system.
- Because the programs are entirely state funded, they are free of federal rules and regulations. Thus, the programs can be designed to meet the needs of individual consumers and the traditions of Hawaii.
- In the Hawaii Long-Term Care Survey, 61.4 percent of respondents favored increasing funding for state programs, such as Kupuna Care (Khatutsky et al., 2011).
- A sliding fee schedule could increase program funding, while still keeping services affordable to clients relative to their income. In 2010, voluntary donations constituted 6 percent of the expenditures for Kupuna Care services (personal communication, John Grant, Community Assistance and Grants management, Hawaii Executive Office on Aging, December 12, 2011).

Disadvantages

- Because the program is not an entitlement, expenditures do not automatically increase as the population in need increases. Funding for appropriated programs tends not to increase with need and inflation over time. Thus, initial gains could be eroded over time.
- Because no federal matching is available, the state would incur 100 percent of the cost.
- Because these programs only fund home and community-based services, they do not help people finance nursing home services.
- Expanding the role of Kupuna Care could increase the fragmentation of the financing and delivery system because they are separate from other, larger sources of financing. The program is currently very small and not a “major player” in the provision of long-

term care services. Some critics argue that services are not well targeted to the population most in need and that the program does not provide a complete package of services needed to keep people from being institutionalized.

- In the Hawaii Long-Term Care Survey, when asked to choose their single preferred option, only 11.7 percent of respondents chose expanding state programs, such as Kupuna Care (Khatutsky et al., 2011).
- Without new sources of revenue, expansion of state long-term care programs may squeeze funding for other state priorities. In the Hawaii Long-Term Care Survey, 57.8 percent of respondents said they opposed raising taxes to pay for expanding access to long-term care services.

Public Sector Recommendation #2: Establish a Limited, Mandatory Public Long-Term Care Insurance Program in Hawaii

The Hawaii Long-Term Care Commission recommends, in principle, that Hawaii establish a limited, mandatory public long-term care insurance program for the working population, which would primarily be funded by premiums rather than state general revenues. A final decision on whether to implement a program and on the details of the design would depend on additional financial and actuarial analyses, which the Commission was not able to conduct because of time and cost constraints. The final decision on the program design and whether to implement the program will be made by the Legislature and the Governor.

In principle, the proposed public insurance program would be similar to Social Security, which is designed to provide modest income support financed through mandatory contributions by the working-age population. Just as Social Security is not intended to replace retirement savings, the proposed long-term care program would not be intended to provide for all long-term care needs and would supplement, not replace, private initiatives such as private long-term care insurance. With a base of public insurance funding, the private insurance industry may be able to market more affordable voluntary supplementary insurance. The public insurance would provide a measure of financial protection for individuals who are uninsurable. In some respects, the proposed program is similar to the German long-term care insurance program (Gibson and Redfoot, 2007).

Many possible program designs are possible to ensure long-term fiscal solvency of the program. The Commission offers the following possible approach for consideration:

- The program would be financed by mandatory premiums paid for by the eligible population. The mandatory premium should be very modest, much below typical private long-term care insurance policies. Except for the proposed study and startup costs, no Hawaii general tax revenue would be used.
- The program would be mandatory for employed individuals, including the self-employed, for adults younger than age 60. No medical underwriting would be conducted.
- Participants would have to pay premiums for 10 years before they would be eligible for benefits.
- Eligibility for the benefit would be limited to people with two or more deficits in the activities of daily living (e.g., eating, bathing and dressing) or moderately severe dementia, as verified by professional staff.
- The benefit period would be limited to 365 consecutive or nonconsecutive days.
- The daily benefit would be \$70 in cash indexed to increase 5 percent annually. Although the benefit could be used for nursing home care, it is designed primarily to finance home and community-based services.
- Eligibility for benefits would be determined by the Aging and Disability Resource Centers.

- Premiums would be collected through payroll deduction, income tax filings, or periodic invoicing.
- Because the program is mandatory for the eligible population and is publicly run, marketing costs would be low, no profits would be necessary, no taxes would be paid, and no agent commissions would be paid. As a result, administrative costs should be much lower than for private insurance.
- The insurance benefits would not be considered income under the Hawaii income tax and, to the extent possible under federal law, would be excluded from income for federal income tax, Medicaid, and other means-tested programs administered by the state.
- Funds from the proposed public long-term care insurance program may be used to pay the new copayment fees that the Commission proposes for Kupuna Care, which would generate additional revenue for Kupuna Care.

The most important question to be answered by the study is: what is the premium required to adequately finance various possible program designs? Among the issues that the proposed study should analyze are the following:

- Minimum and maximum age for employed persons to be eligible to enroll (e.g., ages 30 to 60)
- Definition of “employment” for purposes of determining eligibility (e.g., number of quarters of minimum Social Security income, earning at least \$15,000 a year, or working at least 35 hours per week)
- Minimum period of premium payment before eligibility for benefits (e.g., 1, 5, or 10 years of vesting, 10-year waiting period for full benefits, but partial benefits that increase with period of premium payment)
- Method of collecting premium (e.g., payroll deduction, Hawaii income tax filing, or mailed invoice)
- Length of covered benefit (e.g., 1 or 2 years)
- Amount of the cash benefit, whether it varies by disability level, inflation adjustment over time, and whether there should be restrictions on its use
- Whether people need to pay in for life, until retirement, or until they have paid for a specified number of years
- Whether premiums should be level or increase with inflation over time
- Whether low-income people should be exempted from participation or whether there should be some premium subsidy from general revenues
- How the program should be administered

Background

Given that even under optimistic assumptions, only a minority of Americans will ever have private long-term care insurance, an alternate financing strategy would be to establish a

mandatory public social insurance program for long-term care. The Medicare program currently provides some coverage for skilled nursing facility care and home health on a non-means-tested basis, which provides a precedent for such a program. This strategy offers coverage to all persons who need it, regardless of their financial need. A number of other countries, including Japan, Germany, the Netherlands, some parts of Canada, Spain, Scandinavia, and Korea, have mandatory, universal long-term care insurance programs (Colombo et al., 2011).

Advocates of social insurance see no reason that long-term care should be financed primarily through a welfare program (i.e., Medicaid), while acute care and income support for older people are financed through non-means-tested government programs—Medicare and Social Security. Supporters argue that social insurance is the only approach that guarantees universal or near-universal coverage. That is, social insurance covers the able bodied and the currently disabled, the young, the old, and people of all levels of income and wealth. In this way, social insurance avoids the risk of adverse selection that affects private insurance. Social insurance can also deliberately create a more balanced delivery system by providing broad coverage for home care.

In broad outlines, the proposed program would be modeled on CarePlus, which passed the Legislature, but was vetoed by Governor Lingle in 2003. The 2003 CarePlus Financing Program (HB 1616 and SB 1088) had the following features:

- Everyone aged 25 or over with income above a minimum threshold would have to pay a \$10 monthly premium for the CarePlus public long-term care insurance program. This requirement would include retirees and homemakers. Payment of the premium through payroll deduction would be available; self-employed persons would contribute on their own. The premium would increase with the Consumer Price Index. Administrative costs would be kept low by having the tax department collect the premium and having the same premium for everyone.
- Individuals would have to pay premiums for 10 years before they could receive full benefits, although a partial benefit would be available earlier. The benefit would be portable if the insured moved away from Hawaii.
- Eligibility to receive benefits would be limited to people who need assistance with two or more ADLs or who have substantial cognitive impairment.
- The benefit would be \$70 per day which could be used for any purpose. Benefits would be available for a total of 365 days, which need not be consecutive. The benefit amount would increase annually with the Consumer Price Index.
- An independent Board of Trustees would be appointed by the governor, which would be responsible for the administration of the program and the management of the trust fund.

The proposed program also has some similarities and substantial differences with the Community Living Assistance and Services (CLASS) Act, which was enacted as part of the federal Affordable Care Act of 2010. In October 2011, the U.S. Department of Health and Human Services announced that it would not implement the program because it could not certify, as required by the statute, that the program could be fiscally solvent for 75 years (U.S.

Department of Health and Human Services, 2011). In sum, several of the program's features would require very high premiums that were not sustainable. A key financial problem was that enrollment was not mandatory, but there was no medical underwriting. Thus, the program would be potentially subject to adverse selection that could drive up the cost of premiums. Under the statute, only working people were eligible to enroll, but the definition of working was very minimal. In addition, benefits would be provided on a lifetime basis rather than for a fixed number of years or expenditure level, which would have substantially increased premiums. After paying premiums for at least 5 years, enrollees who met the disability benefit criteria would receive regular cash payments to help meet their long-term care needs. Insurance benefits would have been entirely financed by premiums paid by the insured. However, a very generous premium subsidy would have been provided to low-income workers, financed by other policyholders, another feature that would have substantially increased premiums.

The Commission's proposed public long-term care insurance program would differ from the CLASS Act in five main ways. First, participation would be mandatory rather than voluntary, avoiding the problem of adverse selection. Second, enrollment would be limited to people with a high level of participation in the labor force, limiting possible enrollment by people with disabilities. Third, the benefit would be for one (or perhaps two) years, rather than on a lifetime basis, which would lower premiums. Fourth, the minimum period of premium payment before benefits could be claimed would be longer than envisaged by the CLASS Act. And, fifth, there would be no premium subsidy for low-income people, at least not one financed by policyholders. This, too, would substantially lower premiums.

Advantages

- Mandatory public long-term care insurance is the only option that will provide insurance coverage to a large majority of people in Hawaii. It would provide benefits to people with a wide range of income and assets.
- By restricting enrollment to the working population, it reduces the problem of adverse selection.
- This approach would raise additional revenue for long-term care in a way that spreads the risk over a large population. Because the vast majority of workers will participate and the benefit is modest, the premium may be low enough to be affordable to the vast majority of workers in Hawaii.
- Because this option does not require medical underwriting, it would allow working people with disabilities to obtain insurance coverage if they participate in the labor force.
- By providing an additional source of financing for long-term care, the program would reduce the number of people dependent on Medicaid.
- A benefit of 365 days, while limited, would cover the entire period of long-term care needs of a significant proportion of people with disabilities. For example, approximately 50 percent of national non-Medicare nursing home stays for older people are under 1 year; similarly, about two thirds of home care use is for less than 1 year (Kemper, Komisar and Alecxih, 2005/2006).

- The broad flexibility of a cash benefit would encourage the expansion of home and community-based services.
- Because the program provides only limited benefits, it leaves a significant role for private insurance.
- Because the program is mandatory and publicly run, administrative costs will be lower than for comparable private long-term care insurance and no profit level would need to be built into the premium. Thus, a higher percentage of the premium would be spent on benefits than is spent under private long-term care insurance.

Disadvantages

- Given the difficulty in predicting future long-term care use and expenditures, this public insurance option would represent a substantial financial risk for the state of Hawaii. If premiums are set too low, there will be substantial pressure on state government to pay benefits through increased taxes.
- The premium may be viewed as an additional tax by many people. In the Hawaii Long-Term Care Survey, 57.8 percent of respondents said they opposed raising taxes to pay for improved long-term care services (Khatutsky et al., 2011).
- Support for mandatory enrollment in public long-term care insurance in Hawaii is low. In the Hawaii Long-Term Care Survey, 58.8 percent of respondents said that people should not be required to enroll in the federal CLASS public long-term care insurance option; only 20.1 percent of respondents said people should be required to enroll (Khatutsky et al., 2011).
- Unless the premiums are very low or vary by income level, the premium cost may be burdensome for moderate and low-income people. A tax-supported premium subsidy may be necessary.
- This new program largely, although not entirely, duplicates the existing long-term care insurance market.
- The limited benefit leaves substantial numbers of people who need long-term care for more than 1 year with no coverage. This will be a particular problem for younger people with disabilities who may need long-term care for decades.
- The \$70 benefit is too low to pay for nursing home care in Hawaii. The cost of private pay nursing home care in Hawaii is \$297 per day (Genworth Financial, 2011).
- An unrestricted benefit of \$70 per day might be abused by some people.
- A benefit of 365 days leaves a substantial portion of paid long-term care uncovered, which may result in people still being forced to spend down to Medicaid. For example, about half of non-Medicare nursing home stays for older people last longer than one year (Kemper, Komisar and Alecxih, 2005/2006).
- By restricting enrollment to people who are working, the program excludes the vast majority of nonelderly adults with disabilities, many of whom will continue to have to depend on Medicaid to pay for their services.

- The receipt of cash payments might be viewed as income under federal income tax rules or eligibility rules for means-tested programs, such as Medicaid, Supplemental Security Income, and the Supplemental Nutrition Assistance Program (better known as food stamps).

Options for Long-Term Care Delivery System Reform

Long-term care is supplied by many providers, including nursing homes, home health agencies, home care agencies, homemaker agencies, personal assistants, adult day health programs, assisted living facilities, and many more. Three of the main critiques of the long-term care delivery system are that (1) the system is biased toward institutional care, (2) home and community-based service providers sometimes ignore consumer preferences, and (3) the needs of informal caregivers are not met.

Balance the Long-Term Care System

Probably the most common critique of the long-term care delivery system is its institutional bias. Despite the fact that the overwhelming majority of people with disabilities are at home and want to stay there (AARP, 2003), spending for long-term care for older people is overwhelmingly for nursing home rather than home care. Over the last 10 years, states, in part encouraged by the federal government, have expanded home and community-based services.

Despite improvement in the balance of expenditures, long-term care financing in the majority of states remains heavily tilted toward institutional services, especially nursing home care, although it is becoming less so (Wiener and Anderson, 2009). Although Medicaid home and community-based services for older people and younger persons with physical disabilities have been increasing, only 34 percent of national Medicaid long-term care expenditures for this population were for noninstitutional services in 2009 (Eiken et al., 2010). To achieve their goal of increasing home and community-based services, states have relied largely on Medicaid home and community-based services waivers, which give states much greater fiscal control and allow coverage of a much broader range of services than is possible under the standard Medicaid program. However, waivers require states to limit services to a relatively severely disabled population (i.e., those who meet Medicaid requirements for an institutional level of care).

Consumer Empowerment

Over the last 10 years, states have used the flexibility of Medicaid home and community-based services waivers to experiment with a variety of new service delivery models. A new paradigm of home and community-based services has taken hold drawing heavily on the long-term care systems in Oregon, Washington, and Wisconsin, among others (Wiener et al., 2009). This new paradigm emphasizes consumer choice and empowerment and is embodied in federal and state initiatives to give program participants greater choice of and control over their services, including participant-directed programs, some with individual budgets; nursing facility transition/money-follows-the-person initiatives; and providing services in residential care facilities, including assisted living facilities.

Traditional public home care programs rely on public or private agencies to hire and manage home care workers, schedule and direct services, monitor quality of care, discipline and dismiss workers if necessary, and pay workers and applicable payroll taxes. In the agency-directed model, clients can express preferences for services or workers, but have no formal control over them. This approach to care is based on the assumption that professional expertise and accountability are critical to the provision of good quality care at reasonable cost. At its

extreme, a “medical model” is imposed and individuals with disabilities are considered to be “sick,” as opposed to needing compensatory services, such as help with bathing.

Programs that allow participants to direct their services represent the opposite end of the management continuum from agency-directed services. These programs give participants control over who provides services, when they are provided, and how they are delivered. Typically, participant-directed programs allow the consumer to hire, train, supervise, and dismiss the home care worker. In some programs, participants have flexible individual budgets with which they purchase the goods and services they need.

Residential care facilities, such as assisted living facilities and smaller board and care or personal care homes, are an important and growing component of the long-term care service system. State interest in funding services in residential care settings through Medicaid, through both home and community-based services waivers and the Medicaid personal care benefit, is fueled by a desire to offer a full array of home and community services, reduce nursing home utilization, and achieve the economies of scale of nursing home care without the undesirable institutional characteristics. A recent study estimated that in 2009 there were 39,635 residential care facilities (with at least 4 beds) nationally serving older people and younger persons with disabilities; these facilities had an estimated 1,073,043 beds (Wiener et al., 2010). In contrast, during that same year, there were 15,691 nursing facilities certified for participation in Medicare or Medicaid with 1,708,784 beds (American Health Care Association, 2009).

Informal Caregivers

Family caregivers are the main source of long-term care in the United States and virtually all other countries (Nixon, 2008; Wiener, 2003). It is commonly estimated that family caregivers provide 80 percent of the care of disabled older persons in the United States (Curry, Walker, and Hogstel, 2006). Nationally, in 2004, about 90 percent of older people with disabilities received care from family members (Houser, Gibson, and Redfoot, 2010). Nationally, the economic value of this caregiving was valued at \$350 billion in 2006 (Gibson and Houser, 2007), which dwarfs spending for nursing homes and home care. In the Hawaii Long-Term Care Survey, about 5 percent of respondents reported that they provided care for a younger family member with a disability and about 8 percent of respondents reported that they provided care to an older family member (Khatutsky et al., 2011).

Caregiving can impose substantial burdens on family members, including financial expenses for medical and long-term care services not covered by insurance, reduced hours of work and opportunities for advancement, reduced retirement savings and Social Security income, limitations on the ability to pursue one’s own goals, depression, and health and psychological strain (Nixon, 2008). On average, Hawaii caregivers report spending 22.0 hours per week caring for their parents—more than a half-time job—and spending \$11,656 per year on various expenses. Several trends in society, including high levels of labor force participation by women (who have been the traditional caregivers), high divorce and lower marriage rates, reduced number of children per family, and family mobility are all potential threats to the provision of informal care.

Although informal caregivers provide the overwhelming majority of long-term care to people with disabilities, they receive little financial or government program support. Public programs focus on services to the eligible participant, and generally do not address the needs of family caregivers. The U.S. Administration on Aging's National Family Caregiver Support Program is a relatively rare exception, but was funded at only \$154 million in fiscal year 2010 (U.S. Administration on Aging, 2010). In addition, the U.S. Administration on Aging's Alzheimer's Disease Supportive Services Program (previously known as the Alzheimer's Disease Demonstration Grants to States program) focuses on demonstrating innovative programs for caregivers of people with dementia; it is funded at \$11 million per year. Limited federal and state tax deductions are available for informal caregivers, but they are very restricted in terms of who can qualify and how large a benefit is provided.

Delivery System Reform Options

Exhibit 6 summarizes the delivery system reform option chosen by the Commission and its advantages and disadvantages.

Exhibit 6. Delivery System Option

Option	Advantages	Disadvantages
Reform regulation of domiciliary care facilities and nursing homes	Would rationalize fragmented regulation of diverse facilities, improve quality, and make regulation more effective	Bureaucratic reorganization and additional regulation could be time consuming and does not guarantee improved quality

Delivery System Option #1: Reform the Regulation of Domiciliary Care Facilities, Including Adult Residential Care Homes, Extended Care Adult Residential Care Homes, Community Care Foster Homes, and Assisted Living Facilities, and Nursing Homes

Reform of the system of domiciliary care facilities would include (1) ensuring that all of the state’s information outlets—particularly the Aging and Disability Resource Center (ADRC) website—provide clear and consistent information about all of the residential care options available; (2) improving the quality of care in domiciliary care facilities by assessing state allocation of responsibilities for quality assurance across departments and reorganizing if necessary; and (3) reviewing the standards and inspection processes for residential care facilities and nursing homes.

Background

Hawaii has a very complex system of community-based residential care settings (O’Keeffe and Wiener, 2010a). These include Adult Residential Care Homes (ARCHs), Extended Care Adult Residential Care Homes (EC-ARCHs), Community Care Foster Family Homes (CCFFHs), and assisted living facilities. Unless specifically licensed or certified to provide a higher level of care, these homes provide room and board, supervision, and limited assistance with personal care and health-related needs.³

³ The complexity of Hawaii’s system stems in part from the use of a single term to describe multiple residential care settings and the use of different terms to describe the same setting. For example, even though some ARCHs and EC-ARCHs are large facilities serving 20 or more residents, the Hawaii Department of Human Services’ website uses the program name “Adult Foster Care Program” to cover services provided in ARCHs and EC-ARCHs, as well as CCFFHs. The website also states that the Department of Human Services’ Adult and Community Care Services Branch licenses adult foster homes through its Residential Alternatives Community Care Program. Yet ARCHs—which are part of Department of Human Services’ Adult Foster Care Program—are licensed by the Department of Health.

Prior to 2009, Medicaid paid for services in these residential care settings through two home and community-based services waiver programs. In February 2009, the Section 1115 Medicaid research and demonstration program QUEST Expanded Access (QExA) was implemented and Medicaid residential care services are now paid through the managed care programs established under the demonstration.

Nursing facilities are licensed by the Hawaii Department of Health, and they cannot receive Medicare and Medicaid funding unless they are certified as meeting federal quality standards. Inspections must take place on average once every 12 months. Because of the heavy reliance of nursing homes on Medicare and Medicaid revenues, almost all nursing homes nationally participate in the two programs. Federal standards, survey processes, and enforcement mechanisms overwhelmingly dominate the quality assurance system for nursing facilities.

Adult Residential Care Homes

ARCHs are licensed by the Hawaii Department of Health. In addition to room and board, ARCHs provide limited assistance with ADLs, custodial care, and supervisory oversight. Type I ARCHs care for up to five residents in a private home; Type II ARCHs care for six or more residents in larger, more institutional settings that may care for as many as 50 to 60 residents (Hawaii Long-Term Care Association, undated). Medicaid does not pay for services provided in ARCHs. Residents either pay privately or turn over their Supplemental Security Income (SSI) federal benefit plus state supplement payment (minus a \$50 personal needs allowance) to the provider. In 2011, the state had 248 Type I ARCHs with 1,135 beds and 4 Type II ARCHs with 92 beds (Hawaii Department of Health, Office of Health Care Assurance, 2011).

Extended Care Adult Residential Care Homes

EC-ARCHs are licensed by the Department of Health but the Department of Human Services oversees placement and case management services to Medicaid-eligible clients in these settings. To receive these services, individuals must be eligible for SSI, Medicaid, or other financial assistance from the Department (Hawaii Department of Human Services, 2010).

EC-ARCH operators must meet additional Department of Health staffing and other requirements to be allowed to offer expanded services and accept residents who need nursing home level care. EC-ARCHs serve both private pay residents and those who are Medicaid eligible. Type I EC-ARCHs may serve up to two residents (out of five) who need a nursing home level of care. In Type II EC-ARCHs, only 20 percent of the residents can need a nursing home level-of-care (Center on Disability Studies, 2010). In 2011, the state had 225 Type I EC-ARCHs with a capacity of 1,109 beds and 20 Type II EC-ARCHs with a capacity of 306 beds (Hawaii Department of Health, Office of Health Care Assurance, 2011).

Community Care Foster Family Homes

CCFFHs are certified by the Department of Human Services to serve both private pay residents and Medicaid-eligible residents who meet the state's nursing home level-of-care criteria as certified by a physician. Medicaid-eligible and private pay individuals entering a CCFFH must have a case manager from a Department of Human Services-licensed Case

Management Agency coordinate their health and long-term care services and ensure that their health care needs are met.

CCFFHs are certified for one, two, or three individuals and are required to serve at least one Medicaid-eligible resident. If a CCFFH is certified for two or three persons, the home is allowed to have one private-pay, non-Medicaid-eligible individual in addition to the Medicaid-eligible resident. A CCFFH may accept a second private-pay individual if certain conditions are met.⁴

As of January 2011, there were 1,053 facilities with a capacity of 2,444 beds (Eastlack, 2011). Monthly Medicaid reimbursement rates differ by the level of care required: \$724.48 for Level I clients and \$1,222.92 for Level II clients. The monthly room and board payment for Medicaid-eligible residents was \$1,278.90—the amount of the SSI federal benefit payment plus the state supplement. Residents turn over their SSI payment to the facility to pay for room and board, except for a small personal needs allowance. Thus, facilities serving Level I facilities received \$724.48 plus \$1,278.90 or \$2,003.38 per month minus the personal needs allowance.

Assisted Living Facilities

Assisted living facilities are licensed and regulated by the Department of Health. As noted above, they are one of three types of residential care settings permitted to serve individuals who meet the state's nursing facility level-of-care criteria. Assisted living facilities differ from other types of residential care facilities in that they are required to provide apartment units with cooking facilities (which may be removed if the resident cannot safely use them). These facilities provide room and board, health care services, and personalized supportive services to meet individual residents' needs. In 2010, Hawaii had 11 assisted living facilities with 1,872 units (Hawaii Department of Health, 2010). Some independent living retirement facilities are converting a section of their buildings to assisted living to accommodate individuals who need assistance.

According to a recent study, the state agency responsible for enforcing building codes is requiring assisted living facilities that meet the R-1 (residential apartment) code to serve only residents who are ambulatory and can evacuate in an emergency (Mollica, Sims-Kastelein, and O'Keefe, 2007). Providers contend that enforcement of this requirement limits their ability to implement other aspects of the regulations that support aging in place.

Residents of assisted living facilities who are Medicaid eligible and meet the state's nursing home level of care criteria can receive home and community-based services through the QExA program. Medicaid covers services in three of these settings for individuals who need a nursing home level of care: CCFFHs, EC-ARCHs, and assisted living facilities. In accordance with federal law that limits certain reimbursement to institutions, Medicaid does not cover room and board in these settings.

⁴ Community Care Foster Care Family Homes, Act 13, Session Laws of Hawaii (SLH) 2009. For additional information, see http://hawaii.gov/dhs/protection/social_services/adult_services/CCFFH%20Factsheet%201.6.10.pdf.

Quality Problems with Community Care Homes

Many Hawaii stakeholders express concern about the quality of care that these facilities provide and proposed strategies for improving the quality of care that they provide, including the following (O’Keeffe and Wiener, 2010a):

- Provide more training for adult residential care homes’ staff and more oversight of the services they provide
- Improve case management for residents of expanded adult residential care homes and foster care homes who meet nursing facility level-of-care criteria to help ensure that their needs are being met
- Develop a systematic mechanism to screen adult residential care home and foster care home provider applicants for licensure
- Consider specialized licensing to address the needs of particular populations and residents with higher acuity

To address the overlapping oversight of community care homes, some stakeholders recommended revamping the current regulatory system. First, to ensure coordination across levels of care, they recommended that regulation of foster care homes, adult residential care homes, and expanded adult residential care homes be consolidated into a single agency. Second, to end what they saw as artificial distinctions across facilities, they proposed substituting the three current types of residential care with a single model of residential care with multiple tiers to serve residents with low to high levels of need, and reimbursement rates tied to these tiers, allowing for a better match of reimbursement and need.

Many stakeholders express concerns about the quality of care provided in residential care settings—particularly ARCHs and EC-ARCHs—which they believe is the result of division of responsibility for regulation and oversight by two agencies, inadequate licensing and certification requirements, and insufficient oversight (O’Keeffe and Wiener, 2010a). Responsibility for regulating Hawaii’s residential care facilities is divided between the Department of Health and the Department of Human Services, which have significantly different regulatory and service philosophies.

CCFFHs, which serve individuals with a nursing home level of care, are certified by the Department of Human Services, using a social model of care. Assisted living facilities, which may also serve individuals who need a nursing home level of care, are licensed by the Department of Health. ARCHs, which serve individuals who do not need a nursing home level of care, are licensed by the Department of Health, which uses a medical model.

Several stakeholders noted that some of the requirements for ARCHs are more stringent than for foster care homes even though the latter serve Medicaid waiver clients and the former are not permitted to (O’Keeffe and Wiener, 2010a). The 2002 auditor’s report concluded that the additional stringency was appropriate because ARCHs are facilities that serve a larger number of people than foster homes. However, many ARCHs serve five or fewer individuals in what were private homes. EC-ARCHs, which may also serve individuals who need a nursing home level of care, are licensed by the Department of Health but the Department of Human Services oversees

placement and case management services to Medicaid-eligible clients in these settings. EC-ARCH operators must meet additional Department of Health staffing and other requirements to be allowed to offer expanded services and accept residents who need nursing home-level care.

The Hawaii Department of Health and the Department of Human Services employ different approaches for ensuring quality of care and dealing with complaints. Some stakeholders believe that having two different state agencies regulating residential care facilities leads to inconsistencies in oversight that fail to protect residents. Nonetheless, a 2002 state auditor's report recommended against consolidating oversight into a single agency for a variety of reasons. One reason was that the overlap in responsibilities between the agencies would continue because the single state agency responsible for administering the Medicaid program (the Department of Human Services) would inevitably continue to have some oversight responsibility for Medicaid clients in the three types of settings in which they are served as required by federal law—even if all three were licensed/certified by the Department of Health.

Advantages

- Residential care facilities are difficult to regulate because they have some characteristics of nursing homes and some characteristics of private homes. A careful review of the allocation of responsibilities and standards and procedures for quality assurance could result in better quality care.

Disadvantages

- Reorganizations are time consuming and disruptive to the organizations involved. Merely shifting responsibilities may not result in better quality assurance. Likewise, the state is unlikely to devote substantial additional resources to monitoring these facilities.

Reorganize and Consolidate Administrative Functions Related to Long-Term Care

Most states do not have integrated administrative and budget structures for long-term care. Instead, administrative responsibilities for long-term care financing, budgeting, program development and policy, reimbursement, provider entry, operations, and quality assurance are typically allocated across many different state agencies, resulting in fragmented policy development and accountability. Thus, for example, Medicaid home and community-based services waivers may be administered by the Department of Public Welfare, while home and community-based services funded by Title III-B of the Older Americans Act may be administered by the Department of Aging, with little coordination between the two programs, even though the two agencies may pay for similar services to overlapping populations.

Reorganization Recommendation #1: Consolidate Hawaii State Departments Responsible for Long-Term Care into a Single Agency or Department to Improve Accountability, Efficiency, and Policy Coordination

The Hawaii state government agencies responsible for long-term care should be consolidated to place all responsibilities for long-term care in a single agency or a division within a larger department. The reorganization should be similar to how long-term care responsibilities are organized in Washington, Oregon, and Texas. Among other issues to be decided is whether services for people with intellectual and developmental disabilities and mental health problems should be included.

Until such time as the reorganization is enacted, the Legislature by concurrent resolution should request the Governor to establish a Deputy Healthcare Transformation Coordinator for Long-Term Care within the office of the Healthcare Transformation Coordinator, who shall be responsible for coordinating all state activities on long-term care related to financing, access, service delivery, and quality assurance. The Deputy Coordinator shall convene a council of agencies responsible for long-term care to develop policies and programs on quality of care, the workforce, educating the public, Aging and Disability Resource Centers, home and community-based services, nursing homes, waitlisted patients in acute care hospitals, Quest Expanded Access, and other long-term care issues. The Deputy Coordinator shall report to the Healthcare Transformation Coordinator, and annually to the Legislature, on the state of the long-term care system in Hawaii. The position and office of Deputy Healthcare Transformation Coordinator for Long-Term Care shall terminate when management over all long-term care services is consolidated within a single executive department.

Background

Hawaii state government is organized along a traditional model. No one person or agency is responsible and accountable for all long-term care policy, financing, and delivery. The Hawaii Department of Human Services is responsible for acute and long-term care Medicaid for all populations, child and adult protective services, vocational rehabilitation, and services for the blind. The Hawaii Medicaid program, Med-QUEST, in the Department of Human Services administers the QUEST Expanded Access program, which is a managed care program that

covers both acute and long-term care services. In addition, the Department of Human Services administers the Chore Services for Community Long-Term Care Program and the Senior Companion Program.

The Hawaii Department of Health is responsible for licensing and inspecting nursing homes, home health agencies, home care agencies,⁵ some residential care facilities and intermediate care facilities for persons with intellectual disabilities. As part of the Department of Health, the Executive Office on Aging administers Kupuna Care, U.S. Administration on Aging–funded programs (including various home care programs, nutrition programs, the Long-Term Care Ombudsman program, and the National Family Caregiver Support Program), and the Aging and Disability Resource Center. The Department of Health also administers non–Medicaid-funded adult mental health and developmental disabilities programs. State Health Planning and Development Agency, which administratively attached to the Department of Health, reviews certificate of need applications. None of these administrative structures is focused exclusively on long-term care.

Responsibility for residential care facilities in Hawaii is especially complex:

- Adult Residential Care Homes, Assisted Living Facilities, Adult Foster Homes, and Developmental Disabilities Domiciliary Homes are licensed by the Hawaii Department of Health.
- Expanded Care Adult Residential Care Homes are licensed by the Department of Health, but the Department of Human Services oversees placement and case management services to Medicaid-eligible clients in these settings. Medicaid pays for services in all of these settings.
- Community Care Foster Family Homes are certified by the Department of Human Services.
- Although responsibility for licensing and certification for residential care facilities is divided between the Department of Health and the Department of Human Services, the Department of Human Services is responsible for paying for services used by Medicaid-eligible persons in Extended Care Adult Residential Care Homes, Community Care Foster Family Homes, Assisted Living Facilities, and Developmental Disabilities Domiciliary Homes.⁶

In their interviews with Hawaii long-term care stakeholders in February and March 2010, RTI International found that stakeholders almost universally believed that fragmentation of the long-term care system was a major problem (O’Keeffe and Wiener, 2010b). There was no real long-term care “system”; every component was designed for a different purpose and the components did not work together. Consequently, the system was so confusing that consumers did not know what resources were available and could not figure out where to go to obtain the

⁵ Although a 2009 law requires licensure of home care agencies, it has not been implemented because of lack of funding.

⁶ Only about 80 people out of the more than 2,600 persons serviced by the Medicaid developmental disabilities Medicaid home and community-based services waiver live in Developmental Disabilities Domiciliary Homes.

services they needed. In the summary judgment of one stakeholder, “The ‘system’ is just a lot of disjointed programs with different eligibility criteria.” Moreover, most stakeholders did not believe that top government policymakers were committed to addressing long-term care issues.

In its own work, the Commission found that top government leaders or policymakers were unable to provide answers to basic questions that one might expect a top manager or planner concerned with the overall long-term care system to know. For example, there is not an agreed-upon estimate of the number of people in Hawaii with two or more problems performing the activities of daily living, a common standard of need for government and insurance programs. As a result, there is no consensus on what the level of need is and how well the state is doing in meeting that need.

In its review, the Hawaii Long-Term Care Commission found the following:

- State Government needs to assert stronger leadership over the entire long-term care population, including those not eligible for public programs. The state’s attention to long-term care is focused on the administration of the Medicaid Quest Expanded Access program for older people and persons with disabilities and on the enforcement of basic standards of quality applicable to long-term care providers. However, the Quest Expanded Access program is available only to Medicaid beneficiaries and because neither the state nor Medicare provides significant long-term care programs, the vast majority of people with long-term care needs have to navigate and pay for long-term care services on their own. Nationally, only 28 percent of older people living in the community with problems performing three or more activities of daily living were Medicaid beneficiaries in 2002 (Johnson and Wiener, 2006).
- The successes or failures of long-term care can contribute to or detract from the success of other programs. Hawaii’s long-term care programs do not operate in isolation. Long-term care affects acute care and vice versa. For example, Hawaii has a much lower supply of nursing home beds relative to its elderly population than other states (43.4 nursing home beds per 1,000 persons aged 75 and older, compared to the national average of 88.9; O’Keeffe and Wiener, 2010a). Partly as a result, hospital patients with high levels of impairment and extensive nursing needs often cannot be discharged because no nursing or care home will take them. The result is that the acute care hospital must continue to care for the “waitlisted” patient at a financial loss until the patient can eventually find a place in the long-term care system.

On the other hand, there is also opportunity to leverage Medicaid expenditures, including long-term care. When Medicaid is added to other state health care spending, such as the Employer Union Health Benefits Trust Fund, the total amount accounts for a significant portion of overall health care spending. This total spending provides Hawaii State Government with an opportunity to demand greater savings, efficiency, and improved care through the weight of its aggregated purchasing power.

- Hawaii’s laws are silent on the subject of leadership over long-term care, but Governor Abercrombie’s appointment of a Healthcare Transformation Coordinator opens the door to new thinking about organizational solutions. In July 2011, Governor Abercrombie designated a Healthcare Transformation Coordinator to recommend

Consolidating the state's fragmented long-term care system under single, cohesive leadership within a single executive department would be a desirable first step in dealing with long-term care's challenges. Over the near term, however, such a goal may not be practically attainable owing to the way the responsibilities for long-term care have been distributed among different sections of the Department of Health and the Department of Human Services, not to mention the important responsibilities now being developed within the county governments with Aging and Disability Resource Centers. Even if a political willingness to consolidate long-term care responsibilities under single management existed, a period of planning, negotiation, and transition would need to occur. In the interim, the appointment of a long-term care coordinator within the Office of Healthcare Transformation Coordinator reporting to the Governor may be an incremental way of connecting long-term care's fragmented administrative system.

Possible Models of Reorganization

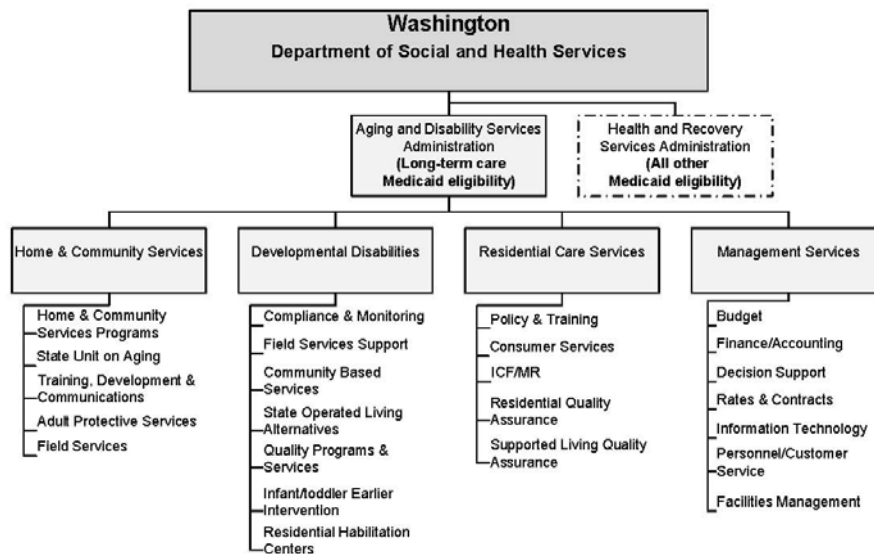
State initiatives to improve administrative coordination and decisionmaking can be classified into three models—cabinet, umbrella, and consolidation (Armour-Garb, 2004):

- Under the cabinet model, existing cabinet-level agencies (e.g., aging, health, public welfare, human services) retain their long-term care responsibilities but work with an official interagency coordinating committee. This structure requires the least amount of administrative reorganization, but its success depends on personal effort and consensus, because no one person is empowered to make decisions. This is the model of the Deputy Healthcare Transformation Coordinator for Long-Term Care within the office of the Healthcare Transformation Coordinator.
- In the umbrella model, all long-term care services are provided under one single organization, usually a department of health and social services. Different long-term care programs and functions operate in various divisions within the umbrella department. However, organizational units are usually not organized in such a way as to put all long-term care functions in one agency within the department. Each program may have its own independent department-like functions, often linked to funding requirements (e.g., Older Americans Act, Medicaid). Typically, there is a secretary who is administratively over the individual agencies, but he may or may not have substantial decisionmaking authority. Moreover, this official has authority over many program areas and is usually not focused on long-term care.
- In the consolidation model, all or almost all long-term care responsibilities, both institutional and home and community-based, are located within one new agency or a division of a larger department. The consolidation model usually requires major governmental reorganization. This model is used in Oregon, Washington, and Texas

(Expert Panel to Review California Department of Aging Structure, 2004; Kane et al., 2006). In this configuration, the head of this organization, by definition, focuses on long-term care issues and has the authority to make almost all decisions related to long-term care (subject to budget constraints). Subunits of the agency are typically organized around broad types of services, such as home and community-based services and nursing homes, and all functions related to those services are located within that subunit. In its purest form, responsibility for nursing homes for overall policy, rate setting, Medicaid eligibility, quality assurance, and certificate of need would all be located within a single subunit of the agency. The underlying assumption is that consolidating authority and responsibility in a single organizational structure substantially enhances administrative efficiency and accountability. It also guarantees that a senior official is focusing on long-term care.

As an illustrative example, *Exhibit 7* presents the organization of the Aging and Disability Services Administration within the Washington Department of Social and Health Services. The Aging and Disability Services Administration is divided into four main divisions—home and community-based services, community-based developmental disability services, residential care services, and management services (including budgeting and rate setting). The Administration is also responsible for conducting functional assessments for determining eligibility for Medicaid home and community-based services waivers.

Exhibit 7. Organization of the Aging and Disability Services Administration within the Washington Department of Social and Health Services



Source: Little Hoover Commission (2011).

Advantages

- The potential advantages of greater consolidation of administrative and budgeting functions include more consistent goals for the long-term care system, enhanced

accountability for decisions and outcomes, more consistent policymaking, enhanced ability to move funds from institutional to noninstitutional services, and improved access to services (Fox-Grage, Coleman, and Milne, 2006).

- One person would be accountable for all of long-term care, regardless of funding sources and eligibility. This would enhance policy coordination, speed decisionmaking, and focus attention on tradeoffs among policy options. Consolidation promotes a consistent, consumer-focused vision across all long-term care services and supports. This vision for long-term care gives the agency purpose and objectives in replacing a provider-based system with a person-centered system. The person-centered system can be designed to meet the needs of the individual consumer rather than focusing on paying provider claims.
- The need for interagency coordination would be reduced or eliminated, speeding decisionmaking and making it less likely that initiatives would falter because of inaction by another agency.
- Fewer decisions would require interagency coordination because decisionmaking authority would be located within a single agency.
- Consolidation reduces the fragmentation of services for different population groups. Older persons and other persons with disabilities can often use the same administrative and service delivery system. This reduces duplicative administrative costs and allows scarce resources to be spent on services rather than administration.

Disadvantages

- Bureaucratic reorganizations are administratively disruptive and can be both demoralizing for staff and time consuming. If managed poorly, they can divert staff time and energy from improving programs and systems to issues of how the agency will be organized.
- Unless the reorganization is quite radical, it is unlikely to substantially affect policy coordination, decisionmaking, and accountability.
- Barriers to consolidation can include difficulty serving multiple populations with different concerns and funding streams, agency turf battles, consumer and policymaker fears of rigid government, and resistance from consumer groups who fear losing their relationships with established bureaucracies (Fox-Grage, Coleman, and Milne, 2006).
- Depending on what populations are included, responsible staff may not have the substantive expertise necessary to meet their needs. Staff who are experts on disability among older people may not understand disability among younger people and people with intellectual disabilities or mental health problems and vice versa.
- Separating long-term care from acute care is inconsistent with QUEST Expanded Access, which combines responsibility for Medicaid acute and long-term care services for older people and younger persons with disabilities into a single managed care organization. For the older population, Medicaid primarily pays Medicare cost sharing and covers a few acute care services that Medicare does not, but for younger people with disabilities who are not Medicare eligible, Medicaid pays for all acute care

services in addition to long-term care. Moreover, the Centers for Medicare & Medicaid Services is increasingly interested in policy initiatives that integrate acute and long-term care services and financing. The Hawaii Department of Human Services has submitted a letter of intent to the Centers for Medicare & Medicaid Services indicating its interest in demonstrations that would integrate Medicare and Medicaid for people dually eligible for both programs. Thus, it may be more meaningful to reorganize around populations rather than services.

Reorganization Recommendation #2: Strengthen Aging and Disability Resource Centers and Expand Their Role

The Hawaii Long-Term Care Commission recommend that (1) The Aging and Disability Resource Centers should be the single point of entry for the new public long-term care insurance program (if established) and for the Kupuna Care program; (2) to conduct their tasks, Aging and Disability Resource Centers will need to obtain and store personally identifiable information and protected health information, and should be funded sufficiently to develop secure information networks, policies, and procedures to be in compliance with the requirements of the Health Insurance Portability and Accountability Act; and (3) should the long-term care public insurance program be established, agreement should be reached with trustees of the new insurance program and the Executive Office on Aging so that Aging and Disability Resource Centers would be funded to provide assessment, information, and referral related to the new program.

Background

The Aging and Disability Resource Center (ADRC) program is a collaborative effort of the U.S. Administration on Aging and the Centers for Medicare & Medicaid Services (CMS). The purpose of ADRCs is to simplify and streamline access to long-term care services. ADRCs provide states with an opportunity to integrate the full range of long-term supports and services into a single, coordinated system (U.S. Administration on Aging, 2010).⁷ The target population for ADRCs includes individuals of all ages with all incomes and types of disabilities, including serious mental illness and developmental disabilities. Although Hawaii has been working to develop a fully functioning ADRC for several years, it currently provides only limited services and information, primarily through toll-free telephone numbers and a website.

ADRCs provide information and assistance to individuals in need of services, to professionals seeking assistance on behalf of their clients, and to individuals planning for their future long-term care needs. In some states, ADRCs also serve as the entry point to publicly administered long-term supports including those funded under Medicaid, the Older Americans Act, and state revenue-funded programs.

⁷ U.S. Administration on Aging. (2010). *Aging and Disability Resource Centers*. Washington, DC: U.S. Department of Health and Human Services. Available at http://www.aoa.gov/AoAroot/AoA_Programs/HCLTC/ADRC/index.aspx#purpose.

In 2005, an ADRC development grant funded by the U.S. Administration on Aging and CMS was awarded to the Hawaii Executive Office on Aging in partnership with the Hawaii County Office of Aging and the City and County of Honolulu Elderly Affairs Division on Oahu. These two counties served as the original ADRC pilot sites. Hawaii's ADRC is a collaborative project funded by the U.S. Administration on Aging; CMS; the State of Hawaii, the counties of Kauai, Maui, and Hawaii; and the City and County of Honolulu. All four counties have operational ADRCs.

Hawaii's ADRC has a website—www.hawaiiadrc.org—which is a one-stop source for long-term care information and services for older adults, people with disabilities, and caregivers who need assistance.⁸ The website was developed by the City and County of Honolulu Elderly Affairs Division in conjunction with Kaua'i County Agency of Elderly Affairs. Additional state funding expanded the website to include all four counties. The website's main page directs users to information for four counties: Hawaii, Honolulu, Kauai, and Maui. In addition to this website, individuals can contact any local ADRC site operated by the county AAAs by phone or in person for further assistance. Although the website provides limited information to individuals who are computer literate and have access to a computer, it cannot address the needs of people with limited English language skills and those who cannot use computers.

The Hawaii County ADRC is a physical location where people can go to receive help in person. With additional funding support from Hawaii County, a physical site in Hilo was renovated to co-locate the Hawaii County Office of Aging and other aging and disability agencies onsite. The ADRC brings together several county and private programs serving seniors and individuals with disabilities, including the Adult Community Care Services Section of the State Department of Human Services, the ARC of Hilo, Services for Seniors, Hawaii County Nutrition Program, Coordinated Services for the Elderly Program, the Senior Employment and Training Program, the Legal Aid Society of Hawaii, the State Department of Health's Adult Case Management Program, the Alzheimer's Association, and the University of Hawaii at Hilo School of Pharmacy.

The Hilo site is open to the public to obtain information about and assistance to obtain a wide range of services such as adult day care, transportation, Medicaid services, legal aid, respite care, and other community programs for elders and people with disabilities. Additional ADRC sites are planned for the Hamakua district of the Big Island, and the rural communities of Waianae, Hauula, and North Shore on Oahu.

Advantages

- ADRCs are established programs designed to provide information and referral to people in Hawaii regardless of their eligibility for Medicaid.
- The proposed expansions of the roles of ADRCs are consistent with the U.S. Administration on Aging's vision for ADRCs.
- There will be time (at least 10 years) for the ADRCs to develop the required capacity.

⁸ Information about the ADRC is taken from <http://www.hawaiiadrc.org/about-us.aspx>.

Disadvantages

- The proposed expansions of the roles are ADRCs are far beyond their current capacities. Except for the Hilo site, the ADRCs are primarily websites and telephone assistance. They currently have little capacity to conduct the types of assessments required for the administration of a long-term care insurance program.
- The ADRCs are administered by the counties, rather than the state. As such, they have little incentive to rigorously assess applicants for long-term care insurance benefits. In fact, it is in the interest of the county to have as many people qualify for benefits as possible.

Conclusions

Although long-term care has traditionally been viewed as an insolvable issue, it is actually one of the more tractable social problems facing Hawaii. Indeed, unlike crime, poverty, and racism, reforming long-term care has a range of known and feasible solutions. The question is whether we as a society have enough political will and ingenuity to choose among them and put an improved system into place.

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Appendix A: Act 224

A BILL FOR AN ACT

RELATING TO LONG TERM CARE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 PART I. FINDINGS AND PURPOSE

2 SECTION 1. The legislature finds that virtually all of
3 Hawaii's elders want to age-in-place at home rather than in a
4 care home or institution, and that many elders will require more
5 intensive services and caregiving at the end of their lives.

6 Over the years, a number of initiatives have been undertaken to
7 begin the needed transformation of the services and programs
8 that support seniors and persons with disabilities in Hawaii,
9 such as Quest-Ex, the expansion of Kupuna Care, the Aging and
10 Disability Resource Center, and the Going Home Program.

11 However, the State of Hawaii has not taken a comprehensive look
12 at needed systems reforms, nor developed a solid plan about how
13 to prepare for the future service needs of these rapidly
14 expanding, vulnerable populations.

15 The legislature further finds that the costs of
16 institutional care have escalated beyond the financial means of
17 most elders. The State's portion of medicaid expenditures has



1 increased steadily over the years and is projected to increase
2 significantly as baby boomers begin to retire. As Hawaii's
3 population ages, the number of frail and disabled individuals
4 will also increase, placing a precipitous demand on the need for
5 long term care services, as well as significant cost pressures
6 on the state budget. The legislature therefore finds that there
7 is a need to plan for the future to make quality long term care
8 services as accessible, efficient, and effective as possible.

9 The legislature further finds that it is necessary to
10 explore public and private sector approaches to support payment
11 for long term care services, which can assist elders to
12 age-in-place and prevent the State from becoming fiscally liable
13 for unsustainable costs under medicaid.

14 The purpose of this Act is to establish long term care
15 policy goals and guiding principles, and establish a long term
16 care commission to identify needed reforms of the long term care
17 system, research program changes and resources necessary to meet
18 the State's long term care public policy goals, and explore an
19 array of funding options that may help support the provision of
20 long term care services in the future.

21 PART II. LONG TERM CARE POLICY GOALS

22 AND GUIDING PRINCIPLES



1 SECTION 2. To make possible the array of services that are
2 necessary to meet the long term care needs of Hawaii's elders
3 and persons with disabilities, the following shall be the long
4 term care policy goals of the State of Hawaii:

- 5 (1) Encourage the planning of and provision for a
6 continuum of care, up to and including the end of
7 life;
- 8 (2) Coordinating referral, case management, and service
9 delivery through co-location and other means;
- 10 (3) Strengthening family caregiver support systems to
11 encourage aging-in-place;
- 12 (4) Stimulating workforce development and training
13 programs to expand the number and capabilities of long
14 term care service providers;
- 15 (5) Developing financial mechanisms to help Hawaii's
16 families meet the cost of long term care;
- 17 (6) Increasing public resources to expand home and
18 community-based care options;
- 19 (7) Fostering public understanding of caregiving issues;
20 and



1 (8) Encouraging research and education on aging, long term
2 care, and related subjects through the University of
3 Hawaii system.

4 SECTION 3. The development of a long term care system in
5 Hawaii shall also be guided by the following principles:

- 6 (1) Consumers should have as much choice as possible in
7 the selection and use of services;
- 8 (2) Services should be accessible and foster the level of
9 self sufficiency desired by the consumer;
- 10 (3) Programs and services serving all seniors and disabled
11 populations should be accountable, cost effective, and
12 provide quality care;
- 13 (4) All services should be organized and administered in a
14 way that fosters efficient use of limited state
15 resources;
- 16 (5) Consumers should have access to information to help
17 them make timely and appropriate decisions when
18 needed;
- 19 (6) Health, long term care, and social services should be
20 connected through the use of preadmission screening,
21 standardized assessments, care planning, coordination,
22 and case management; and



1 (7) Technology should be used to improve accountability,
2 efficiency, quality of care, and to help keep people
3 in their homes.

4 **PART III. LONG TERM CARE COMMISSION**

5 SECTION 4. (a) There is established a long term care
6 commission within the University of Hawaii college of social
7 sciences public policy center for administrative purposes. The
8 commission shall:

- 9 (1) Identify problems with current long term care
10 capacity, programs, and services;
- 11 (2) Develop a five-year comprehensive long term care plan
12 to accomplish long term care policy goals that, when
13 implemented, will ensure the availability of a full
14 continuum of institutional and community-based
15 services, including benchmarks to evaluate
16 accomplishments for each year;
- 17 (3) Research public and private financing options and
18 develop recommendations about financial resources,
19 including a mix of public and private financing,
20 necessary to achieve needed state long term care
21 reforms and state public policy goals;



1 (4) Monitor federal legislation for changes that may
2 impact the program and adjust the long term care plan
3 accordingly; and

4 (5) Collaborate with interested stakeholders, including
5 community coalitions or organizations concerned with
6 educating the public regarding long term care.

7 (b) The long term care commission shall consist of:

8 (1) Five members appointed by the governor;

9 (2) Five members appointed by the president of the senate;

10 (3) Five members appointed by the speaker of the house of
11 representatives; and

12 (4) Five non-voting, ex-officio members, who are the
13 directors of the following departments, or their
14 designees, and who shall collaborate with and support
15 the work of the commission, as requested:

16 (A) Department of commerce and consumer affairs;

17 (B) Department of health;

18 (C) Department of human services;

19 (D) Department of labor and industrial relations; and

20 (E) Department of taxation.

21 (c) Members shall have a background in business,

22 economics, finance, management, health care, long term care,



1 social services, or public policy development, or be an advocate
2 for or consumer of long term care services. Members of the
3 commission shall be appointed as soon as practicable, but by no
4 later than September 30, 2008. Any vacancies occurring in the
5 membership of the commission shall be filled for the remainder
6 of the unexpired term in the same manner as the original
7 appointments.

8 (d) A simple majority of voting members shall constitute a
9 quorum, whose affirmative vote shall be necessary for all
10 actions.

11 (e) The members shall serve without compensation, but
12 shall be allowed necessary expenses incurred in the performance
13 of commission duties.

14 (f) The University of Hawaii college of social sciences
15 public policy center shall convene the first commission meeting
16 as soon as practicable, but by no later than November 1, 2008.
17 At this first meeting, the commission shall elect from among its
18 members a chairperson, who shall convene commission meetings,
19 and a vice chairperson, and shall adopt rules for the conduct of
20 its work.

21 (g) The long term care commission shall:



- 1 (1) Submit an interim report to the legislature no later
2 than February 28, 2010, describing the progress made
3 in the development of the five-year plan and
4 preliminary proposed system reforms; and
- 5 (2) Submit a final report to the legislature no later than
6 September 30, 2010, which shall include the final
7 five-year plan, how the reforms will be prioritized
8 and phased in, and a description and final
9 recommendations regarding the financing of long term
10 care services, including support for caregivers.
- 11 (h) The long term care commission may:
- 12 (1) Conduct or initiate studies as it deems necessary; and
- 13 (2) Hire staff and contract with third parties to conduct
14 studies, including an actuarial study, as it deems
15 necessary for the purpose of evaluating various
16 options about systems reforms and about how to help
17 State residents pay for needed long term care and
18 supportive services in the future. Any contract
19 executed pursuant to this subsection shall be exempt
20 from chapter 103D, Hawaii Revised Statutes; provided
21 that any such contract is approved by the commission
22 in an open meeting.



1 (i) The University of Hawaii college of social sciences
2 public policy center shall provide administrative and policy
3 support to facilitate the work of the long term care commission.

4 (j) The term of the long term care commission shall expire
5 on November 30, 2010.

6 SECTION 5. There is appropriated out of the general
7 revenues of the State of Hawaii the sum of \$100,000 or so much
8 thereof as may be necessary for fiscal year 2008-2009 for the
9 long term care commission.

10 The sum appropriated shall be expended by the University of
11 Hawaii for the purposes of this Act.

12 SECTION 6. This Act shall take effect on July 1, 2008.

APPROVED this day of , 2008

GOVERNOR OF THE STATE OF HAWAII

