| | |
|---|---|
| **Folder Title:** | President Barber Conable - General Correspondence - E |
| **Folder ID:** | 30012505 |
| **Series:** | General correspondence |
| **Dates:** | 06/16/1986 - 10/27/1987 |
| **Subfonds:** | Records of President Barber B. Conable |
| **Fonds:** | Records of the Office of the President |
| **ISAD Reference Code:** | WB IBRD/IDA EXC-11-46S |
| **Digitized:** | 04/17/2023 |



E - GENERAL CORRESPONDENCE

THE WORLD BANK
Washington, D.C. 20433
U.S.A.

BARBER B. CONABLE
President

October 27, 1987

Dear Mr. Noel:

I have heard that the Workshop on Financial Reform in Socialist Countries, jointly sponsored by the World Bank and the European University Institute earlier this month, was a great success. I want to thank you for the enormous contribution of your Institute.

The subject of the workshop is of major current concern to the Bank's four member countries represented in Florence -- Poland, Hungary, Yugoslavia and China. One of the things that our socialist members seek from their membership in the World Bank is an opportunity to learn from international experience. We greatly value the assistance of the E.U.I. in providing an opportunity for these countries to discuss their economic problems in a broader European and international context. We hope you will be willing to collaborate with us again in the future.

Sincerely,

Barber Conable

Mr. Emile Noel
President
European University Institute
50016 San Domenico di Fiesole (Firenze)
Badia Fiesolana, Via dei Roccenttini, 9
Italy

TO: Marianne Haug

FROM: Timothy King

Would Mr. Conable be prepared to sign this or a similar letter? The European University Institute has really been very helpful in supporting what was initially a World Bank concept, originally proposed for some EMENA countries and then endorsed by the Asia region for China. Most of the finance and all the day-to-day organization was theirs. Several groups within the E.U.I. were willing to rearrange their own work programs to accommodate the needs of the seminar. Noel is new to E.U.I and this letter would be of great value in showing that its efforts are appreciated. More significantly, the seminar was really very successful and, if encouraged, E.U.I. might be prepared to make further efforts in the future on the Bank's behalf..

October 20, 1987

LM

WORLD BANK OTS SYSTEM
OFFICE OF THE PRESIDENT

RECEIVED DATE : 86/12/30 DUE DATE : 87/01/09
LOG NUMBER : EXC861230018
SUBJECT : Asking for letter of support for nomination to Office of Tech. Assess. Advisory Panel on Alzheimer's
OFFICE ASSIGNED TO FOR ACTION : Mr. Barber Conable E1227

log out - ltr. sent 1/8 logged out 1/15/87

ACTION:

_____ APPROVED
_____ PLEASE HANDLE
_____ FOR YOUR INFORMATION
_____ FOR YOUR REVIEW AND RECOMMENDATION
_____ FOR THE FILES
_____ PLEASE DISCUSS WITH _____
_____ PLEASE PREPARE RESPONSE FOR _____ SIGNATURE
_____ AS WE DISCUSSED
_____ RETURN TO _____

COMMENTS :

Linda -
We hate to but I'd like to do it. Hany could help

Monroe County
Long Term Care Program, Inc.

Piano Works
349 West Commercial Street
East Rochester, New York 14445
(716) 248-3999

send directly to OTA
copy to Eggert

December 23, 1986

Barber B. Conable, Jr.
ATTN: Harry Nicholas
World Bank
1818 8th St., N.W.
Washington, D.C. 20433

Dear Barber:

Would you be willing to write a letter support for my nomination to the Office of Technology Assessment Advisory Panel on Alzheimer's Disease (letter attached). I think I best fit into the category of "experts in financing health and long-term care".

Could you please send the letter to me by January 5, 1987? Thank you for your help.

Sincerely,

Gerry

Gerald M. Eggert, Ph.D.
Executive Director

GME:bmd
Enclosure

P.S. I am also enclosing two recent articles that you might find interesting:

1. Employer Options to Finance Long-Term Care, Business and Health, November 1986.
2. Long Term Care Options, The Internist, September 1986.

JOHN H. GIBBONS
DIRECTOR

Congress of the United States
OFFICE OF TECHNOLOGY ASSESSMENT
WASHINGTON, DC 20510-8025

December 5, 1986

Dear Sir/Madam:

The Office of Technology Assessment (OTA) invites your organization to nominate one, or at most two, individuals for possible appointment to the Advisory Panel on Alzheimer's Disease.

The Advisory Panel on Alzheimer's Disease is a new Panel established by Public Law 99-660, which was signed by the President on November 14, 1986. The panel will advise the Congress, the Secretary of Health and Human Services, and a newly created Council on Alzheimer's Disease composed of representatives from several agencies in the Federal Government. The panel will meet at least twice yearly and will prepare an annual report to be submitted to the Secretary, the Council, and the Congress. The panel will make recommendations about promising areas of biomedical research, identify important topics for health services research, and devise options for financing health and social services needed by individuals with dementia and their families.

Public Law 99-660 directs the Director of OTA to select the members of the Advisory Panel. For this reason, I seek your help in identifying the most knowledgeable and appropriate people for membership, subject to approval by our Board of the selection process.

The Advisory Panel is to include 15 members. Three will be selected in each of the following five categories:

- biomedical research scientists on Alzheimer's disease,
- experts in health services research,
- experts in financing health and long-term care,
- long-term care providers or representatives of their trade organizations, and
- national voluntary organizations.

To nominate someone for membership, please send your nomination to me at the above address, specifying the individual being nominated, the category he or she is being nominated for, and your reasons for believing that the person is appropriate for the Panel. Supporting letters are welcome. Please indicate whether the nomination is an official nomination by your organization. A complete and current resume of the nominee is required. Any other supporting materials you would like to send would be helpful to us in making our selections. A separate letter to OTA from the nominee — indicating that he or she would be willing to accept appointment to the Advisory Panel — is desirable.

Nominations must be received by **Friday, 9 January 1987.** Material submitted with nominations will not be returned. The selections will be announced on or before 12 February 1987.

If you would like additional information, please write to us, or contact Robert Cook-Deegan, Senior Analyst, Biological Applications Program, on 202/226-2034. Questions concerning administrative aspects of the process should be directed to Sharon Oatman on 202/226-2229. I look forward to hearing from you.

Sincerely,

John H. Gibbons

# Record Removal Notice

| File Title | Barcode No. |
|---|---|
| President Barber Conable - General Correspondence - E | 30012505 |

| Document Date | Document Type | |
|---|---|---|
| 05 December, 1986 | CV / Resumé | |

**Correspondents / Participants**

**Subject / Title**
Gerald M. Eggert

**Exception(s)**
Personal Information

**Additional Comments**

The item(s) identified above has/have been removed in accordance with The World Bank Policy on Access to Information or other disclosure policies of the World Bank Group.

| Withdrawn by | Date |
|---|---|
| Sherrine M. Thompson | March 09, 2018 |

# Employer Options to Finance Long-Term Care

BY GERALD M. EGGERT, MEG DELANEY AND BRUCE FRIEDMAN

*Strategies to restructure medical benefits give employers means to offer chronic care coverage.*

AGING REPORT

With the exception of the final so-called safety net provided by Medicaid, virtually none of the U.S. population is insured against expenditures for long-term care. However, there is much that employers can do to protect their employees and retirees from the risk of long-term care expenditures and to help them meet their chronic care needs.

First, in the short-term, employers can provide case management and either offer chronic care benefits or refer employees and retirees to specific carriers of long-term care policies. Second, employers can make significant changes in the financing and design of their company health plans while supporting and helping to develop a prototype catastrophic long-term care insurance policy.

The vast majority — perhaps 99 percent — of what employers pay for health care generally covers only acute and post-acute skilled care. Eastman Kodak Company has a lifetime benefit of $6,000 for active employees and retirees. This only covers a few months of nursing home care at a cost of $60 to $80 per day. However, active employees and retirees differ in the degree of risk for a long-term care event, which increases sharply with age. For example, Charles McConnell of The University of Texas at Dallas has estimated that the risk of entering a nursing home increases from 1 in 200 before age 65 to at least 1 in 2 for those reaching age 65.

Significantly, once care becomes solely or predominantly custodial, company insurance benefits are almost always terminated. To a car accident victim recently discharged from the hospital and beginning an extensive rehabilitation program, the sudden and unexpected withdrawal of health care coverage is devastating. There are ways for employers to extend custodial care coverage. But the decision to do this must be made carefully as there are a number of concerns such as benefit cost, duration, scope of services provided, and the impact of this decision on the provision of these benefits in the future.

*Gerald M. Eggert is executive director and Bruce Friedman is director of research and planning at the Monroe County Long Term Care Program, Inc. in East Rochester, N.Y. Meg Delaney, formerly health issues manager for Hartmarx Corporation, now is an independent contractor in Chicago, Ill.*

### Offering Case Management

Case management is generally defined as including several functions — assessment, plan development, service arrangement and coordination, monitoring, reassessment and quality assurance. Through case management, employers can choose to assist those in need of long-term care, rather than cutting off benefits once patient care needs become exclusively custodial, as would be the case with those who have been discharged from the hospital with ongoing needs.

The first and most traditional model of case management is that which usually is provided to a person living at home, to help that person continue to reside there rather than be institutionalized. In this situation, long-term care case management can go beyond the role of patient advocate to include: arranging but not paying for services; monitoring the patient's condition and delivery of services over time; and recommending changes in the mix of services when the patient's condition changes.

Case management also can be used to expedite discharge from the acute care hospital to less costly settings as the patient's condition becomes appropriate. This function is used increasingly to address the issue of single episode catastrophic high cost illness and trauma such as head and spinal cord injury.

Employers also can use case management to minimize the number of admissions or length of stay of patients who have a chronic pattern of acute care use, such as multiple hospitalizations from a common cause. This can

be accomplished by careful monitoring and substitution of subacute care for acute hospital admissions when appropriate. This type of case management goes beyond utilization review in that the case manager works with the patient as long as the patient remains at risk for multiple hospitalizations. Utilization review usually is concerned with individual episodes of hospitalization, not risk of multiple admissions over time. For example, two conditions for which this type of case management should be especially beneficial are leukemia and acquired immune deficiency syndrome (AIDS).

Although monitoring all patient care may not result in cost savings, employers can realize significant savings by targeting acute care case management to high cost cases. Findings of research by the Health Research Institute show employers can expect to save between 10 percent and 12 percent of claims costs with a case management program. However, because costs of selected conditions such as AIDS, head injury and certain types of cancer are so high, potential savings may be even greater.

*". . .Long-term care case management can go beyond the role of patient advocate to include: arranging. . .for services; monitoring the patient's condition and delivery of services;. . .and recommending changes in the mix of services when the patient's condition changes."*

**Building Chronic Care Into Retiree Plans**

Chronic care benefits can be added to retiree medical plans at relatively low cost by redesigning acute care policies to offset the added expense. Many plans still provide first dollar coverage or do not require premium contributions from enrollees. By removing first dollar coverage, requiring premiums and increasing the deductible by $200 to $300 or more, companies can use the savings to build in a one-to-three-year chronic care benefit giving retirees coverage unavailable through Medicare supplements, health maintenance organizations (HMOs) or other health plans.

Because recent court cases have placed restrictions on employer redesign of current retiree medical plans, building in chronic care benefits with offsetting plan takeaways must be designed primarily for future retirees. Otherwise, employers run the risk of a lawsuit for reneging on promises previously made to current plan beneficiaries.

A design of chronic care benefits at minimum should address the following elements.

• **Coverage Expenses and Eligibility.** Medicare and state licensed nursing homes and home health care organizations that provide a mix of skilled and custodial care services should be included in any chronic care benefit. Less widely available state licensed day care centers also are recommended.

• **Payment Maximums.** Benefit maximums should be used to cap plan expenses. Current long-term care policies use an indemnity approach pegging nursing home and home health allowable charges to a specified amount per day, usually in the range of $40 to $80 daily. Lifetime maximums should be defined by duration of coverage or by dollar limits.

• **Cost Sharing.** Use of elimination periods, deductibles, copayments and premium contributions should be considered to ensure judicious use of benefits.

• **Claim Submissions.** Special claims forms may be required to document physician referral or a home health nurse assessment so that benefit eligibility can be determined by carrier claims staff.

• **Case Management.** This is needed to assure the appropriate mix of services, and to limit services to only those that are necessary and that enhance the quality of care.

Many companies may view provision of chronic care benefits as a risky option due to its potentially large expense and because so little is known about demand and potential for overuse by participants. It also may be subject to prefunding requirements.

On the other hand, this approach gives employers some distinct advantages over carriers in giving retirees valuable benefits at an affordable cost. Most retiree medical plans, for example, have a one time only enrollment requiring individuals to sign up within a specified time after retirement. Yet by offering the plan at the time of retirement and by combining acute and long-term care benefits, widespread early participation can be assured, permitting reserves to be accumulated for use later in the enrollee's lifetime when long-term care is needed.

**Sponsoring Long-Term Care Policies**

Another alternative that employers can take advantage of is the more than 40 long-term care insurance policies currently available. Employers can either contribute to a plan for retirees, paying whatever premium level is in keeping with current practices, or simply refer retiring employees to a plan. Either could be a possible supplement to the company sponsored retiree medical plan. Although most of these policies are currently marketed to individuals rather than groups, there are some carriers that offer this coverage as a group product.

Current long-term care policies typically feature annual premiums that range from $450 to more than $1,600. They include skilled nursing home care, but often provide only limited home care benefits and custodial care.

One of the best reasons to sponsor a carrier plan is to reduce employers' risk. Employers, if they choose, can pay a fixed contribution. This limits their exposure in case the carrier raises the premium. Another advantage is that the employer is free of much of the administrative

burden that usually is involved in the provision of self-insured benefits. Consequently, communications, claims processing, billing and enrollment generally are assumed by the carrier. Finally, unlike employer sponsored retiree medical plans, prospective retirees can sign up at any age.

The primary disadvantages of this approach, however, are the restrictions, such as an Alzheimer's disease exclusion, which bar access to those in substantial need. One of the reasons for these restrictions is adverse selection. If a large proportion of enrollees use the benefits, this will threaten the financial viability of the insurer as well as drive up the cost of the premium. Employers who consider this approach also should verify that coverage is available in every state where their retirees reside, as carriers' policies usually are not offered in every state.

**A Catastrophic Chronic Care Plan**

While there may be an understandable reluctance for employers to offer long-term care coverage, business is in a good position to create a climate in which employees are encouraged to protect themselves financially against the risk of catastrophic chronic care expense. Employers should develop this as a comprehensive plan to help meet the chronic needs of their workers and retirees. The current health care system, in which middle class people must expend the resources accumulated over a lifetime before they qualify for a health financing program for the poor, is unfair and unnecessary. While the number of persons with private long-term care insurance is growing, it is still very small. Some health care researchers estimate that this number ranges from 200,000 to 300,000.

Employers can play a significant role in moving the nation in this direction in several ways. First, business should spearhead legislative efforts to alter existing tax policies that discourage prefunding. Second, employers should encourage and support the development of a prototype, prefunded, catastrophic long-term care insurance policy. Differing substantially from long-term coverage currently on the market, catastrophic long-term care insurance would not be an indemnity product and would have: very deep coverage; extensive cost sharing by the insured; coverage of home care on an equal footing with nursing home care; and case management utilization.

By including younger workers as well as elderly retirees, contributions and/or premiums for such coverage would be minimized for insureds of all ages. This would reduce the risk of adverse selection since the risk of needing long-term care increases with age. The policy would include a service benefit ranging from $500,000 to $1 million. Skilled nursing facility care often costs $25,000 or $30,000 annually, and can run as high as $50,000. Prices vary widely. Nursing home costs in upstate New York range from $60 to $80 per day, while in New York City they can run $150 per day. Nearly one-quarter of all elderly admitted into nursing homes remain in facilities for at least three years. Gary Corliss, an actuary with Aetna Life Insurance & Annuity Co., estimates that 10 percent of Aetna's insureds will remain in a nursing home for more than five years. Very deep coverage is needed for patients with dementing illnesses such as Alzheimer's disease. One-half of individuals with Alzheimer's live more than eight years beyond the diagnosis, often spending a considerable period of time in a nursing home.

The policy also would include a large deductible that would increase with age — $10,000 for those under age 30 increasing by a $10,000 increment for each 10-year age group until it reaches $50,000 for those age 60 and over. According to Carol Leith, an actuary with the New York state insurance department, five different major medical policies (not long-term care policies) with $1 million coverage and a $50,000 deductible are offered in New York for a premium of $120 to $200 per year for persons age 60 to 75.

*"By including younger workers as well as elderly retirees, contributions and/or premiums for [catastrophic] coverage would be minimized for insureds of all ages. This would reduce the risk of adverse selection. . . ."*

The size of the deductible could be lessened with the addition of a large copayment provision, for example, 20 percent or 30 percent of the daily charge. A steep deductible, in addition to the copayment, is needed to discourage unnecessary utilization and keep contributions and/or premiums low. A smaller deductible for younger age groups is necessary to increase marketability to younger individuals because they will not have the assets to pay for a large deductible.

The inclusion of home care benefits in the policy is also crucial. With the tremendous increase in the number of persons age 85 and over and the expected continuation of limitations in the number of nursing home beds for cost containment purposes, substantial home care benefits must be included in the policy to enable the elderly to receive the care they will require. Finally, case management is especially important in this type of policy to limit unnecessary services and coordinate as well as monitor quality of care.

As a major payer of health care, business is in a position to restructure health benefits to include long-term care. These three approaches — case management, building chronic care benefits into retiree health plans and the catastrophic plan — offer employers of all kinds of ways to introduce this coverage prudently at minimal cost. Despite roadblocks created by restrictive tax policies and recent court cases involving retiree benefits, business has the opportunity now to help reshape the financing and delivery of long-term care to both the nation's employees and retirees. ■

# Long Term Care Options

By GERALD M. EGGERT, PhD, and BRUCE FRIEDMAN, MPH

***Among those with long term care needs, only 20 to 25 percent live in nursing homes.***

According to a survey conducted in the late 1970s, general internal medicine has the second highest proportion of encounters with elderly patients among physician specialties (Robert Wood Johnson Foundation, 1981). Cardiology, a subspecialty of internal medicine, has the most; geriatrics was not included. Thirty-five percent of internal medicine encounters were with persons age 65 and over, and of the twelve medical problems/diagnoses that account for the greatest proportion of internists' practice encounters, nine involved patients with a mean age over 55. The top three—essential benign hypertension, chronic ischemic heart disease, and diabetes mellitus—are chronic conditions that require long term management by the physician. With the growth in the number and proportion of elderly, the involvement of internists with the older population will certainly increase.

*Gerald M. Eggert, PhD, is executive director, and Bruce Friedman, MPH, is director of research and planning at the Monroe County Long Term Care Program/ ACCESS in Rochester, New York.*

While a small proportion of the aged require long term or chronic care services, they account for a very sizable proportion of total health and social service expenditures for the elderly. Recent survey data indicate that nearly one out of four elderly persons in the United States is functionally disabled, requiring assistance with activities of daily living (bathing, dressing, toileting and eating), mobility, instrumental activities of daily living (shopping, meal preparation, etc.) or nursing care (Doty, 1986). Several studies have shown that the proportion of elderly who are dependent or require assistance by other persons increases the older the age group (Feller, 1983; Weissert, 1985). Among persons living at home, the proportion of those who need the help of another person increases from 7 percent of persons aged 65-74 to 44 percent of those 85 and over (Feller, 1983).

Nevertheless, among those with long term care needs, only 20 to 25 percent live in nursing homes (Doty, 1986; Weissert, 1985). Even among those with severe limitations, about 850,000 live in the community as compared with some 600,000 in nursing homes. Families and other informal support systems care for about three-quarters of the functionally disabled population living in the community without any assistance from paid caregivers (this category excludes physicians). Among those who are most severely disabled and are living in the community, only 35 percent are cared for by paid caregivers at least part of the time (Liu, Manton and Liu, 1985). While these people seem to be as disabled as those living in nursing homes, they are able to remain at home through the use of community-based and in-home services. Long term placement in a nursing home is the service alternative for a small number of elderly persons. A wide variety of new service options—residential, community-based and in-home—are becoming increasingly available in many communities across the United States.

## Institutional/Residential Care

Institutional/residential care ranges from perhaps the most traditional service for long term care patients—nursing home care—to a "service" that is receiving increasingly greater attention, continuing care retirement communities.

• *Nursing homes* include skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and domiciliary homes for adults. While SNFs provide 24-hour skilled nursing supervision, ICFs offer nursing care, but on a much more limited basis. Domiciliary homes are primarily for persons who have slowed down and can benefit from the supervision of a group living situation, but are not in need of

nursing care. Although there have been many complaints regarding appropriateness, quality and cost of nursing homes, they are the proper alternative for a number of severely impaired persons and do serve a useful function. Many "heavy care" patients can be cared for better and at less cost in a nursing home than in either a hospital or the community. For a patient with dementia, a nursing home may be the only alternative to a situation of overwhelming stress for the family.

• *Enriched housing* provides the residents with assistance in housekeeping, shopping, meal preparation and personal care to enable them to continue to live in the community. Enriched housing may be provided in a multibedroom private house or in an apartment building. However, in an apartment building, enriched housing usually accounts for only a very small proportion of the total number of units in order to minimize an institutional atmosphere.

• *Congregate housing* usually consists of independent apartments that have an intercom or alarm system so residents can summon help in case of an emergency. Congregate or communal spaces are provided as well as the support needed to enable elderly persons to continue to live in their apartments.

• *Continuing care retirement communities* (CCRCs) are facilities that provide their residents with a place of residence (house, townhouse, apartment) and a range of health and social services in exchange for a prepayment and, usually, an additional fee per month. CCRCs are a very welcome development in long term care because they offer a continuum of services usually until the end of life, and can adjust the mix of health and social services as a person's needs change. In selecting a CCRC, one must have a clear understanding of how chronic care services are to be covered—either as a part of the total prepaid package or, increasingly, as an additional charge on top of the monthly maintenance fee.

## Community-Based Services

Compared with nursing home services, community-based services are still quite limited, especially as a third-party covered service. Nevertheless, the range and number of community-based services have increased substantially during the past decade. Community-based services include such services as health day care, social day care and congregate meals and activities.

• *Health day care* is a program of medically-oriented services provided on a scheduled ambulatory basis for persons who need certain preventive, diagnostic, therapeutic or rehabilitative services.

• *Social day care*, like health day care, is provided on an ambulatory basis, but is not medically oriented. Persons receiving social day care are usually less functionally disabled than those receiving medical day care.

• *Congregate meals and activity programs* can be beneficial to many senior citizens; socialization keeps their spirits up. Simply getting out of the house can be very helpful in preventing depression.

## In-Home Services

Home care services have been growing rapidly in recent years. One measure of this is the 40 percent rise in the number of Medicare-certified home care agencies between 1983 and 1985 (Sandrick, 1986). While in-home services have been provided by local health departments and visiting nurse associations for many years, the growth of proprietary home care agencies is a recent phenomenon limited to the past 20 years. Since the implementation of Medicare's Prospective Payment System, the number of proprietary and hospital-based Medicare-certified home care agencies has doubled (Sandrick, 1986).

Many in-home services are not medical. In fact, the needs of an older person are often non-medical. The delivery of these non-medical services often determines the success of a home care program.

• *Nursing care services* are provided by registered nurses, licensed practical nurses and home health aides.

• *Rehabilitation services* generally include physical therapy, occupational therapy and speech therapy.

• *Personal care services* are primarily services to assist with basic activities of daily living, including toileting, bathing, dressing and eating.

• *Homemaker services* help with a person's instrumental activities of daily living, including managing money, shopping, assisting in the preparation of meals and performing incidental household tasks.

• *Housekeeper/chore services* include cleaning and other light household tasks.

• *Meals on Wheels* are home-delivered meals which include one-third of the recommended daily dietary allowances standard.

## Other Services

• *Respite care* differs from the above services in that it is provided for the patient's informal caregivers rather than for the patient per se. The purpose is to allow the caregiver some time away from caring for the patient in order to alleviate associated stress. Respite care can be provided by admitting the patient to an institution, by arranging care at a community-based facility (similar to day care), or by caring for the patient at home, and can occur for a few hours once a week to allow a short regular respite, for one or two weeks a year to enable the caregiver to take a vacation, or on an emergency basis to prevent caregiver "burnout."

• *Geriatric evaluation programs* are becoming increasingly available to diagnose patients with especially complex interrelationships among multiple diagnoses. Ambulatory assessment programs are now available in the United States as well as more traditional inpatient assessment units modeled after units developed in Britain. Geriatric evaluation programs are now in place at about 70 of the 123 U.S. medical

# SHMOs: A New Experiment in Health Care

Health insurance policies that cover long term care services are rare; Medicare does not cover chronic care services; Medicaid will only pay for continuous long term care in institutions, and only after the patient has become pauperized; and regular health maintenance organizations (HMOs) do not include long term care among their many services. Is there *any* program out there that will provide long term care at a reasonable cost?

The answer is a qualified yes. "Yes," because a new experiment in health care—social health maintenance organizations (SHMOs)—provide long term care to their members; the positive response is "qualified" because there are only four such programs—more accurately, demonstration projects—in the country.

### Services Provided

SHMOs, like HMOs, are capitated, prepaid systems of care, but they go beyond the traditional Medicare benefit package to provide social and medical services such as home care, long term care and disease prevention screening. Unlike other demonstration project HMOs that are trying to enroll larger numbers of seniors, SHMO members are 100 percent senior citizens and all the services are especially geared to their needs.

The comprehensive social and home health services offered help seniors avoid needless hospitalization and nursing home care for both short term and long term illnesses. In addition, SHMOs provide health education and teach seniors self-care skills such as how to take one's pulse, temperature and respiration, how to practice good foot care, how to fix nutritional meals, how to detect mental health problems, and sharpening communication skills.

### The Four Demonstrations

The four demonstration SHMOs nationwide are:

- Elderplan, Inc. (Metropolitan Jewish Geriatric Center), Brooklyn, New York;
- Kaiser-Permanente Medical Care Program, Portland, Oregon;
- Medicare Partners (Ebenezer Society/Group Health, Inc.), Minneapolis, Minnesota; and
- SCAN Health Plan (Senior Care Action Network), Long Beach, California.

The demonstrations—which were started in 1985—come in different shapes and sizes. SCAN in California uses physicians who are members of Greater Long Beach IPA Medical Group, a patient care manager plan sponsored and operated by the medical staff of St. Mary Medical Center (i.e., private practitioners). The Oregon SHMO receives medical care providers from an old-line HMO—Kaiser Foundation Health Plan of Oregon. In Minneapolis, the SHMO uses a staff-model HMO. And in New York, Elderplan has set up a joint venture between a staff-model HMO and a network of geriatric care facilities.

### Who Pays?

All seniors who participate in Medicare Parts A and B or who are Medicare-eligible are eligible to join SHMOs. The ratio of well members to those who are chronically ill is 82 to 18, so that SHMOs really don't run the risk of being stuck with a majority of very ill members. Medicare pays the SHMOs 100 percent of the average cost it pays for traditional health care for seniors living in that geographic area (other HMOs receive 95 percent). Similar payments are made by states for Medicaid enrollees. In addition, monthly membership fees run from $25 to $40, and members must also pay some modest copayments and deductibles.

### Future of the Program

The demonstration project directors are very enthusiastic about the SHMOs and are excited about how much they have been able to help the senior citizens in their programs. But the projects have not been free of problems. Seniors have not been joining the programs in droves, as first anticipated. One of the reasons for the apparent lack of interest in the program stems from the lack of information—and from the misinformation—many seniors receive about paying for long term care. Many of the elderly don't want to spend the "extra" money to join a SHMO because they believe Medicare and "Medigap" insurance will pay for all their long term care needs.

While aggressive marketing could conceivably turn around shaky enrollment numbers, other problems may be more difficult to resolve. The demonstration projects are scheduled to end in 1988; if deemed successful, Congress could enact legislation for such programs nationwide. However, from the beginning the Reagan Administration has not been very supportive of the SHMO experiment. In 1984, after four years of planning and millions of dollars of foundation money preparing the four SHMOs, the Office of Management and Budget (OMB) refused to waive the Medicare and Medicaid laws to allow the demonstration programs to go forward. OMB opposed the waivers because of concerns that the costs would be uncontrollable and that the SHMO benefit package would set a precedent for permanent expansion of Medicare benefits. The waivers were awarded only after Congress ordered them released under the Deficit Reduction Act of 1984.

OMB is still closely watching the SHMOs. Whether or not such programs survive after 1988 will depend on their ability to attact a large group of senior consumers who are willing to pay an "extra" monthly fee for the services, and their ability to provide a complete health package for seniors at a cost that doesn't exceed the public costs of Medicare and Medicaid. —*MMB*

schools (Epstein, personal communication, 1986). Expansion in the numbers and size of these programs is essential if complex geriatric evaluation capability is to become available in all parts of the country.

• *Rehabilitation services* are also becoming increasingly available in the United States. Such services are needed not only to restore functioning ability to the greatest extent possible for persons who have experienced an acute illness or accident, but also to maintain an adequate level of functioning for chronically ill persons at home or in a nursing home. Including such disciplines as physical therapy, occupational therapy and speech therapy, rehabilitation services should be available to patients throughout the entire continuum of care, from the acute hospital to in-home services. Significant growth in rehabilitation services has recently been occurring in acute care hospitals because of incentives in Medicare's Prospective Payment System (Williams, personal communication, 1986). The provision of rehabilitation services to the elderly as early as possible in their acute hospital stay is desirable because the functional capacity of older persons deteriorates rapidly when they are kept in bed (Williams, 1985).

## Availability of Services

The above array of services is not always available in many, perhaps most, areas of the United States. Availability is determined primarily by perceived need, third-party payor funding policies and local patterns of health care delivery. Since Medicare is primarily an acute and limited post-acute program, Medicaid is for the indigent, and private third party payors cover little but Medicare deductibles and coinsurance (very little private long term care insurance is offered), many services, especially community-based services, are not always available.

Information on what is or is not available at the local level can usually be obtained by contacting the local health department, visiting nurse association or area agency on aging. At least limited amounts of these services are sometimes available free of charge for those in need of in-home evaluation or for uninsured patients who are unable to pay.

## Case Management

How does an internist know what is available in his or her geographic area? How does he or she direct a patient to the right service providers? How does the internist arrange for the proper mix of services for a long term care patient who can continue living at home, but whose condition may vary over time, necessitating a change in services on a timely basis? How is this done taking into consideration the lack of non-institutional service reimbursement by Medicare, the often limited resources of elderly patients and the always limited time of the physician?

**A wide variety of new service options—residential, community-based and in-home—are becoming increasingly available in many communities across the United States.**

The range and amount of services offered in most communities are certain to increase greatly in the near future. As Medicare's Prospective Payment System pushes patients out of the hospital earlier, we have seen a number of responses by hospitals and other organizations. As mentioned above, the number of Medicare-certified hospital-based and proprietary home care agencies has doubled in the past two years. Hospitals in some rural areas have introduced swing beds—beds that are used as acute hospital or SNF beds depending on patients' needs, demands on the facility and bed availability. Other hospitals have developed Extended Care Units (ECUs) or have entered into arrangements reserving beds in SNFs for discharged hospital patients. As Medicare patients enroll in HMOs in the future, there will be continued pressure to shorten stays in hospitals and provide more out-of-hospital care. Paul Ellwood of Paul Ellwood and Associates, Excelsior, Minnesota, is predicting a nearly 50 percent drop in hospital utilization during the next ten years (*Hospitals*, 1986). If he is anywhere close to being on target, this will mean tremendous growth in out-of-hospital services, with concomitant pressures on internists to coordinate services for elderly patients.

One answer is case management. Case management for long term care services was first developed in the United Kingdom, although the British do not call it "case management." Community nurses are commonly attached to general practice surgeries and health centers, where they coordinate primary medical care with nursing and social support services (Barker, 1985). It is difficult to say exactly where and when the term "case management" was coined in the United States, but case management has been practiced to some degree by physicians, hospitals, social workers and mental health professionals for some time. It was developed as a separate, designated function for long term care during the 1970s at the sites of community-based long term care programs such as Triage in Connecticut and ACCESS in Rochester, New York.

Case managers (generally either nurses or social workers) employed by these programs helped develop care plans for their patients, arranged for ser-

*Figure 1.*

## ACCESS: Select Services

A. **Comprehensive Plans.**
These plans are designed for clients who need a complete range of care services—both in an emergency and on a continuing basis.

1. **Crisis Services:** All necessary assessments, planning, and service arrangements for clients who require urgent response and care.
2. **Recovery and Supportive Services:** A continuing plan designed especially for clients who recognize that their long term care needs will change over time, and for families who cannot be near a relative in need of care. This plan includes an initial evaluation and the following ongoing services:
   - Care management—care-quality monitoring, reassessments, and modification of the individual care plan;
   - Benefits analysis—evaluation of insurance benefits, and help in cutting Medicare, Medicaid, and private insurance "red tape;"
   - Claim filing services—for up to $5,000 of health care bills;
   - A 24-hour-a-day "hot line"—for urgent needs, any time of the day or night.

B. **Specialized Plans.**
These plans are designed for those clients who do not require a comprehensive service plan, but need special assistance to supplement their ability to care for themselves.

1. **Nursing Home and Other Residential Care Placement Services:** Assistance in the entire placement process, including determination of the appropriate level and design of care; financial preparation; nursing home applications; pre-placement visits; and follow-up evaluation of placement.
2. **Benefits Analysis Services:** A plan designed to help clients afford long term care, while protecting their assets as much as possible. Services include:
   - Evaluation of the client's health insurance policies, as well as those of his or her family;
   - Help in dealing with Medicare, Medicaid, and private insurance "red tape," including eligibility requirements;
   - Appropriate legal, accounting, and financial referrals.
3. **Claim Filing Services:** Claim filing for clients who have received bills from Medicare, Blue Cross and Blue Shield, private insurers, and health care providers.
4. **Custom Services:** Special arrangements to meet other needs as they are identified, as in cases where:
   - A family cannot be present to follow the progress of a relative's care;
   - Clients—or their families—need help relocating into, or out of, the Rochester area;
   - Respite care is needed;
   - Disabilities and catastrophic illnesses, such as Alzheimer's Disease, head injuries, spinal cord injuries, and chemical abuse, require extremely specialized care.

vices, monitored the delivery and quality of care, and arranged for reassessments on a scheduled basis or when the patient's condition changed, after which the case manager would then arrange for a new package of services. Obviously, this is a very time-consuming activity that requires intimate knowledge of local long term care services and providers as well as knowledge of third party payor policies, procedures and regulations. It takes a skilled professional to work with the physician, patient and family in such a manner that the needs and desires of all parties are met, maximum third-party reimbursement is obtained, and the patient's assets are protected to the greatest extent possible.

While long term care case management in the United States was originally developed for long term care demonstration projects, many State governments saw its value and created programs for their Medicaid long term care programs. More recently, in conjunction with the previously mentioned increase in home care, there has occurred tremendous growth in private case management organizations (Interstudy, 1986). With the conclusion of our Medicare demonstration program, we at the Monroe County Long Term Care Program, Inc. (ACCESS) have developed a private pay program, ACCESS:Select, to go along with our Medicaid program. ACCESS:Select provides the services listed in Figure 1; these are billed on an hourly basis, as a package or on an annual retainer.

A growing number of ACCESS:Select referrals are being made by internists. Case management organizations can be especially valuable to internists, as case managers work with physicians, patients and families to arrange and coordinate long term care services and negotiate third party payor "red tape." By "putting all the pieces together," the case manager can take a considerable burden off the physician and the physician's staff. The case manager can assist the patient and the family by protecting patients' assets. As health care delivery, organization and financing becomes even more confusing in the future with enrollment of Medicare patients in HMOs (with differing benefit

*(continued on page 28)*

THE WORLD BANK
Washington, D.C. 20433
U.S.A.

BARBER B. CONABLE
President

May 27, 1987

Dear Mr. Johnson:

Thank you very much for your letter inviting me to speak to the Economic Club of Detroit at a luncheon meeting to be held on October 19th.

As my assistant has informed you, my current travel schedule for the fall includes a trip to Asia during late October/early November. For this reason, it will not be possible for me to participate on your program schedule this fall.

I appreciate your offer to include me as a speaker on your program, and hope there will be another opportunity. I understand your Club meets for lunch on Mondays between Labor Day and the end of May. This information will be helpful in determining any possibility for next spring.

Sincerely,

Barber Conable

Mr. Wesley R. Johnson
President
The Economic Club of Detroit
920 Free Press Building
321 W. Lafayette
Detroit, MI 48226-2755

JGrenfell

MEETING SLIP

DATE: JAN 29

TIME: 6:30 - 9:30

PLACE: WESTIN HOTEL.

SUBJECT: ECONOMIC CLUB.

ATTENDING: MR + MRS

REQUESTED BY: LINOWES.

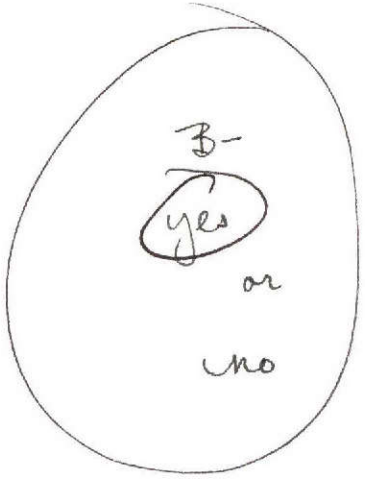
REMARKS:

BLACK TIE DINNER

LM

WORLD BANK OTS SYSTEM
OFFICE OF THE PRESIDENT

RECEIVED DATE : 86/12/30 DUE DATE : 00/00/00
LOG NUMBER : EXC861230021
SUBJECT : inv. to Economic Club of Washington's dinner on Jan. 29
James Baker to speak.
OFFICE ASSIGNED TO FOR ACTION : Mr. Barber Conable E1227




ACTION:

_____ APPROVED
_____ PLEASE HANDLE
_____ FOR YOUR INFORMATION
_____ FOR YOUR REVIEW AND RECOMMENDATION
_____ FOR THE FILES
_____ PLEASE DISCUSS WITH _____
_____ PLEASE PREPARE RESPONSE FOR _____ SIGNATURE
_____ AS WE DISCUSSED
_____ RETURN TO _____

COMMENTS :

MR. ONLY

# THE ECONOMIC CLUB OF WASHINGTON

1155 15th Street, N.W.
Washington, D.C. 20005
(202) 223-4560

December 23, 1986

Mr. Barber B. Conable
President
World Bank
1818 H Street, N.W., Room E 1227
Washington, D.C. 20433

Dear Mr. Conable:

As President of the Economic Club of Washington, I am pleased to invite you to the Club's mid-winter Dinner on Thursday evening, January 29th. Our speaker on this occasion will be Secretary of the Treasury James A. Baker, III. Secretary Baker's views on such matters as financing the Federal budget deficit, the third world debt crisis, the balance of payments, and the international monetary system are likely subjects for discussion.

The Economic Club of Washington provides a forum for top business leaders to meet with senior government officials and representatives of the diplomatic community to exchange views on timely economic issues.

The Dinner will be held at The Westin Hotel (2401 M Street, N.W.). A reception will begin at 6:30 p.m., followed by dinner at 7:15 p.m. Secretary Baker's remarks will be followed by a question and answer period, which will conclude promptly at 9:30 p.m. For those wishing to stay, a cordial hour will follow the program. Dress is black tie.

Space is limited so please RSVP as soon as possible and no later than January 20th. Substitutions cannot be accepted. Please call us at 639-5100 with your reply.

I hope you will be one of our distinguished guests at this stimulating and thought-provoking evening.

Sincerely,

R. Robert Linowes
President

DATE: 7/7/86

~~BBC~~

JWS Do you think BBC should see these people again? NO

Judith

Isaac

Vivek

Linda

Myra

Jenny

REMARKS

no response needed

says BBC

7/8

John Bohn, Chairman of the ExIm Bank requests an appointment with BBC - about 30 minutes - to discuss the role of the two banks. A meeting was scheduled a couple of weeks ago, but BBC had to cancel.

Contact: Victoria Guthrie 566-8144

7/11 @ 9 a.m.

follow up to BBC's mtg.

776

THE EXPERIMENT IN INTERNATIONAL LIVING
SCHOOL FOR INTERNATIONAL TRAINING

OFFICE OF THE PRESIDENT

June 26, 1986

Mr. Barber Conable, Jr.
President
The World Bank
1818 H Street, N. W.
Washington, D. C. 20433

Dear Mr. Conable:

Thanks very much for your willingness to meet with the leadership of the United States Voluntary Agency community to discuss how The World Bank and the PVOs might be able to be more mutually useful in our common mission of development assistance.

I found your comments about the way some Congressmen looked at lobbying by American volunteers particularly interesting, because I have sometimes felt that the staff of The Bank perceive PVOs in much the same way: as a somewhat unruly group of people who can only upset an orderly approach to doing a difficult job.

Be that as it may, I'm sure that approaches can be identified that will meet the needs of both the PVOs and the staff of The Bank. The professional staff of InterAction will be in touch with your Office to follow up on identifying new ways of working together.

I was also interested to learn that your daughter Jane participated in two programs of The Experiment in International Living. Over the years we have expanded significantly beyond our original focus on student exchange, and are now intensively involved in refugee and development assistance. The enclosed materials on The Experiment and the School for International Training might give you a bit more idea of our current work.

Thanks again for your interest in identifying means for greater collaboration between The Bank and indigenous and international PVOs.

Sincerely yours,

Charles MacCormack
President

Enclosures

KIPLING ROAD
BRATTLEBORO
VERMONT
05301 0676
USA

TELEPHONE
802 257 0326
802 257 7751

CABLE
EXPERIMENT
BRATTLEBORO
VERMONT

TELEX
6817462
EXPER UW

June 20

## Export-Import Bank of the United States (EXIMBANK)

1. Eximbank is an important source for cofinancing IBRD-assisted development projects, given the wide range of capital goods and sources which are produced in the US. According to information presently available[1]/ the Eximbank provided nearly US$1 billion in cofinancing for 14 projects over the ten-year period of FY76-85. It was the second largest source of cofinancing after the Japanese Eximbank which provided cofinancing of US$1.4 billion for 22 projects during this period.

2. Presently, only a small proportion (5-7%) of the medium and long-term credits extended by Export Credit Agencies (ECAs) of industrial countries to developing countries are used for cofinancing IBRD projects. In the last four years, we have held extensive consultations with ECAs and their guardian authorities and have agreed on a number of steps which could be taken to enhance the scope for cofinancing.

3. The Eximbank's interest in working more closely with the World Bank has grown in the recent years and extends both to sharing information on economic prospects of selected countries and also to cofinancing of selected projects. In December 1985, at their request, we arranged a one-day seminar to familiarize their regional staff with our operations in six countries of interest to them in Sub-Saharan Africa (i.e. Kenya, Zimbabwe, Botswana, Cote d'Ivoire, Cameroon and Nigeria).

4. At the recent May 1986 meeting, which we had convened with 17 OECD ECAs and their guardian authorities, the focus was on the role export credits can play in the adjustment process initiated by highly indebted countries with assistance from the IMF and the Bank. The US representatives (both from Treasury and Eximbank) supported proposition that IBRD/IMF adjustment programs could provide a basis for ECAs to review/enlarge credit cover. The need for an intensified consultative process between the World Bank and ECAs was also appreciated. (The operational procedures are now being firmed up.) The Eximbank representative also expressed an interest in instituting bilateral consultative arrangements with the World Bank so that they could pursue cofinancing opportunities more systematically. We have asked for an early meeting to discuss this further.

---

1/ Source wise information on export credit cofinancing is incomplete and is only available for about half the number of cofinanced projects.

VPCOF
June 16, 1986
WSTambe:mo