



A Guide to Long-Term Care for State Policy Makers

THE LONG-TERM CARE PARTNERSHIP PROGRAM

“Financing the increasing demand for long-term care services will be a significant 21st century challenge A key question for policymakers will be to consider what options exist for rethinking the federal, state and private roles in financing long-term care.”

Kathryn G. Allen, Government Accountability Office
April 2005

States have experienced sharply escalating costs in recent years for publicly funded long-term care (LTC) services, particularly through the federal-state Medicaid program for low-income people. Depending on a nursing home length of stay or costly home care, many people, who need LTC are faced with the possibility of exhausting their own resources to pay for services; they then might be forced to turn to Medicaid.¹

One approach states are using to control these costs is to change their service mix by increasing their use of community-based care and reducing reliance on institutional care. Even with alterations in the service mix, however, the need for services is increasing, and states are looking for additional sources of funding for care.

One strategy for expanding the funding base for LTC costs is to encourage the purchase of private long-term care insurance by people who can afford to take greater personal responsibility for protecting themselves against the cost of LTC services. Sales of private long-term care insurance policies have been relatively slow, however, due to several factors:

- Lack of consumer awareness of the many varied products on the market;
- Relatively high costs of comprehensive coverage (competing with consumer expenses for children's education and/or retirement plans);
- Belief that Medicare and/or employer insurance covers long-term care costs;² and
- Consumer uncertainty about their potential future need for LTC.

Private health and long-term care insurance accounted for only 7.2 percent of total LTC funding in 2005, while Medicaid's share was 49 percent. In 2000, 5.8 million LTC insurance policies were in force; in 2002, the number totaled 6.3 million. The insurance

¹ Medicare covers only a brief period of nursing home stay for those who are receiving post-hospital therapy.

² According to a Kaiser Family Foundation survey, one-third of Americans think they have private insurance coverage for LTC; in fact less than 10 percent have such a policy.



industry estimates that less than 10 percent of the population age 50 and older had purchased policies in the 41 states that were surveyed in 2002.

Introduction of the LTC Partnership Program

Despite this generally inauspicious picture for the insurance market, states now have another way to promote the expansion of private LTC insurance—the LTC Partnership Program. With a Partnership insurance policy, the cost of LTC care will be borne by the insurance benefit for some period of time, after which the policy purchaser may qualify for Medicaid coverage without having to spend down his or her own assets.³ As a result, the individual might never apply for Medicaid or could at least delay that application while insurance funds are used. Sales of LTC insurance could be spurred by the incentives individuals have to gain more favorable terms for qualifying for Medicaid and protecting their personal assets. States might then see a reduction in Medicaid spending or at least a reduction in the growth of that spending.

Started as a demonstration project in four states (California, Connecticut, Indiana and New York) in the 1980s, the program was effectively halted by congressional legislation in 1993 that required states to recover from the estates of Medicaid beneficiaries funds spent on their behalf for LTC.⁴ This removed a key incentive—asset protection—for the purchase of a partnership policy.

However, the Partnership option now has been made available to all states through the Deficit Reduction Act (DRA) of 2005, signed into law in February 2006. Partnership programs can be created through a state Medicaid plan amendment. (A number of states had enacted Partnership authorizing legislation in anticipation of a possible change in federal policy. These states were in position to move forward quickly after passage of the DRA.)

The partnership program couples the purchase of long-term care insurance with eligibility for Medicaid coverage for LTC services. With the purchase of a partnership policy, a consumer can become eligible for Medicaid coverage after using the insurance benefits without having to exhaust his or her own assets to qualify for such coverage. Assets equal to the amount expended by the insurance policy are not considered countable assets for purposes of Medicaid eligibility and are exempt from the Medicaid estate recovery provisions. (One significant caveat: Those with home equity exceeding \$500,000 are not eligible for Medicaid even with a Partnership policy, although states may increase that ceiling to \$750,000.)

The Demonstration State Models

California and Connecticut adopted a dollar-for-dollar model for their partnership programs. This is how it works.

³ A person must meet financial standards that require low income and minimum assets to qualify for Medicaid. Thus, those whose assets are above the limit must “spend down” or exhaust those assets to pay for their care before they are eligible for Medicaid coverage.

⁴ Some policymakers questioned whether the Medicaid program, developed as a safety net for low-income people, should help shelter assets of wealthier individuals. Another issue was the potential risk to states of increased Medicaid LTC expenditures through the Partnership mechanism.

- A person buys a long-term care insurance policy worth \$150,000 for any type of LTC coverage (that would cover either home or nursing home care). If the individual later needs care, the policy would pay out the \$150,000 in benefits.
- Should the individual still need services after the insurance benefits have been exhausted, he or she then could apply for Medicaid coverage for further services without having to spend down \$150,000 of personal assets to qualify for Medicaid. This individual would thus “protect” \$150,000 of personal assets by the purchase of \$150,000 worth of insurance coverage.

In addition to the dollar-for-dollar model, Indiana and New York allow a total assets model.

- In Indiana, those who purchase coverage equal to or greater than a “State-set dollar amount” (\$217,186 in 2007) may earn total asset protection after they exhaust policy benefits in that amount.
- In New York, if an individual purchases a policy with a minimum duration of three years of nursing home care or six years of home care, after those benefits have been paid out, he or she need not spend any of his or her assets to qualify for Medicaid coverage, no matter how large the remaining assets are.

California, Connecticut and Indiana allow insurance companies that participate in the partnership program to offer either comprehensive policies (nursing home and home care) or facility-only policies. Minimum daily benefit amounts are specified for each type of care in Connecticut for example, at \$167 per day for nursing home and \$83.50 for home care. New York allows two types of policies under the total asset model and two types under the dollar-for-dollar model. For example, one could purchase 1) a total asset policy covering three years of nursing home care or six years of home care or 2) a policy covering four years of nursing home care or four years of home care.

Insurers must meet a special set of criteria before they are allowed to sell these policies. A total of 20 insurers have been approved by the four demonstration states.

Features of the Partnership Program under the DRA

By 2006, more than 20 states had passed legislation authorizing establishment of partnership programs or were planning to implement Partnership programs. Under existing federal law (the Health Insurance Portability and Accountability Act of 1996), long-term care benefits received under a tax-qualified policy are not taxable. The DRA permits a state to file an amendment to its Medicaid plan indicating how its approved tax-qualified LTC policies would become partnership policies and meet the criteria specified in the DRA.

A qualified plan must meet the following requirements.

- A policyholder must be a resident of the state when coverage becomes effective, and
- The policy must meet National Association of Insurance Commissioners (NAIC) model standards adopted by the NAIC in October 2000.

Other significant features of the DRA in regard to Partnerships including the following.

- A “qualified state partnership” is an approved state plan amendment that offers dollar-for-dollar asset protection. (Protection of all financial assets is available only in the original demonstration states.)
- Inflation protection must be offered but can be geared to a person’s age. For example, compound annual inflation protection must be provided for those under age 61, but if a purchaser is between the ages of 61 and 76, policies need offer only some level of inflation protection. Policies are not required to offer inflation protection for those age 76 and older at date of policy purchase. (Policies in the four demonstration states offer 5 percent compound inflation protection, but the DRA gives states the discretion to set the benefit level.)
- Fifteen million dollars is provided over five years for a National Clearinghouse for LTC Information to educate consumers about the program. An awareness campaign will be undertaken in pilot states and will be expanded by providing information electronically.

The Robert Wood Johnson Foundation, which funded the four demonstration states, is providing start-up money and technical assistance for 10 states to implement new Partnerships. The states are Arkansas, Colorado, Georgia, Michigan, Minnesota, Oklahoman, Ohio, South Dakota. Texas and Virginia.

How should state legislators view the Partnership program?

What are the advantages and disadvantages of the program to a state that wants to control its long-term care costs and also offer consumers a way to protect their assets against high LTC expenses? The role LTC insurance can play in the state will vary, depending upon the proportion of people who can afford it and choose to buy it. Potential benefits and challenges are discussed below in more detail.

Potential Benefits

- Purchase of Partnership insurance policies could lead to new sources of funding for long-term care and could help reduce Medicaid spending on LTC or reduce the rate of growth of that spending if purchased by people who otherwise would have turned to Medicaid. Connecticut officials in 2006 estimated that the state has saved \$3.75 million (half of which accrues to the federal government) since the program’s 1992 inception in the state.⁵
- Individuals who have assets they want to protect for their families will be in a better position to do so with a partnership policy.
- The DRA requires that federal standards be developed for portability of partnership policies across states—reciprocity by which one state recognizes another state’s partnership policies. (States will be able, however, to opt out of the standards.)

⁵ America’s Health Insurance Plans estimates that expanded LTC partnerships could lead to federal budget savings of \$6 billion annually (using constant 2005 dollars) by 2050.

Potential Challenges:

- Partnership policies in the four original states have not attracted many purchasers. Sales of partnership policies reached 249,000 in 2006, with 201,000 still in force. One possible reason is that some policies have been costly because the states imposed stricter requirements on these policies than are imposed on regular LTC insurance. However, sales of LTC insurance in general have been sluggish. Developing strategies to induce more people to buy coverage may be difficult.
- Since the experience of the four demonstration states is limited, no clear evidence yet exists on whether the Partnership programs reduce Medicaid spending or the rate of growth of that spending. As of 2006, a total of almost 4,000 policyholders in the four states had received benefits from their insurance; only 175 had accessed Medicaid coverage. States may have difficulty developing solid estimates of fiscal impact on Medicaid expenditures.
- Given the age at which most people are likely to purchase a policy (mid-50s to 60s), cost savings from the program probably will not accrue for one to two decades. However, a state will incur immediate administrative costs to establish requirements for providers, educate consumers, and modify state Medicaid eligibility requirements. One state estimated that it would cost more to administer the program than it could be expected to save in Medicaid benefits for at least the first decade of program operation.
- Many of the people encouraged to buy a Partnership policy may have bought LTC insurance on their own.⁶ With a Partnership policy, however, they will be able to tap Medicaid to pay for their care after the insurance benefits have been paid out. This could increase Medicaid rolls with people who would not otherwise have been beneficiaries. States will need to devise and implement strategies that target those consumers who otherwise would have accessed Medicaid for their care.
- For consumers, Partnership programs do not automatically ensure Medicaid coverage after the insurance benefits have been used. They still must meet a state's Medicaid income and functional eligibility requirements. States may want to align their eligibility requirements with those of private insurers, to the extent possible. Consumer education will be key to helping people understand the costs and coverage of these policies.
- The Partnership connection with Medicaid does not necessarily mean that the cost of purchasing a policy is affordable for many consumers. Age at purchase and policy features affect the cost. States may want to determine the feasibility of subsidizing premium costs for certain consumers.

Resources

America's Health Insurance Plans Center for Policy and Research. "Long-Term Care Insurance Partnerships: New Choices for Consumers – Potential Savings for Federal and

⁶ The majority of the policyholders in California, Connecticut and Indiana reported total assets greater than \$350,000. Roughly half the policyholders had average monthly household incomes of more than \$5,000.

State Government.” January 2007. <http://www.ahipresearch.org/PDFs/IssueBriefSavingsfromExpandedLongTermCarePartnerships1-24-2007.pdf>.

Mark R. Meiners, Center for Health Policy Research and Ethics, George Mason University. <http://www.gmu.edu/departments/chpre/research/PLTC/index.html>.

Robert Wood Johnson Foundation. “Long-Term Care Partnership Expansion: A New Opportunity for States.” May 2007. http://www.rwjf.org/files/publications/other/Longtermcare_052007.pdf.

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