Reviewing and Implementing Long-Term Care Partnerships

Long-Term Care Partnership Expansion: A New Opportunity for States

The Center for Health Care Strategies, the National Association of State Medicaid Directors and George Mason University are working to inform states about new long-term-care options made available through the Deficit Reduction Act of 2005. This brief reviews the origins and structure of the Partnership for Long-Term Care program, and presents design and implementation issues for states' consideration.

CONTENTS

As the number of elderly Americans increases, long-term-care (LTC) needs and costs are likely to grow. Many believe that private long-term-care insurance can and should play a more significant role in the financing of home care and nursing home services. Wider use of such insurance could shift the burden from individuals, who are often ill-prepared to pay for such care out-of-pocket, as well as from state Medicaid programs, which often serve as a default financier of long-term-care services.

One vehicle for encouraging consumers to invest in LTC insurance is the expansion of the Partnership for Long-Term Care, a unique insurance model developed in the 1980s with support from the Robert Wood Johnson Foundation (RWJF). Through the Partnership program states promote the purchase of private LTC insurance by offering consumers access to Medicaid under special eligibility rules should additional LTC coverage (beyond what the policies provide) be needed. Medicaid, in turn, benefits by having individuals take responsibility for the initial phase of their long-term care through the use of private insurance. The original demonstration model has been underway since 1992 in California, Connecticut, Indiana and New York. The Deficit Reduction Act (DRA) of 2005 lifted the technical barriers Congress had imposed on such programs, allowing for the expansion of the Partnership to other states across the country.

BACKGROUND

Long-Term Care: Costs and Impact

With the baby boom generation aging and the cost of services going up, paying for long-term care is an issue of pressing importance for policy-makers and individuals alike. While some individuals can count on friends and family to assist with the activities of daily living, many others must determine how to pay for extended home-health services or a potential stay in a nursing facility.

CHCS
Center for Health Care Strategies, Inc.

NASMD
National Association of State Medicaid Directors
an affiliate of the American Public Human Services Association

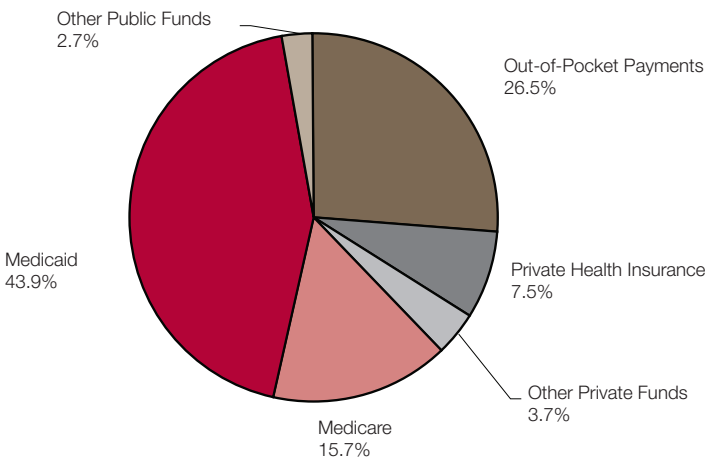
GEORGE MASON UNIVERSITY

Support for this publication was provided by the Robert Wood Johnson Foundation in Princeton, New Jersey.

Expenditures on nursing home care make up the largest part of long-term-care costs in the United States. Almost $122 billion was spent on services provided by free-standing nursing homes in 2005, with an additional $47.5 billion spent on home-health care.[1] Medicaid accounted for the largest share, or 43.9 percent, of the total spent on nursing facilities. Consumers covered an additional 26.5 percent of these nursing home costs out-of-pocket and private insurance covered another 7.5 percent[2] (see figure below).

National Spending on Nursing Home Care By Source of Payment (2005)

(Total = $122 Billion)



Source: Centers for Medicaid and Medicare Services (CMS), *National Health Expenditures.*

For consumers, the likelihood of needing nursing home services is significant. A 65-year-old man has a 27 percent chance of entering a nursing home at some point in his life; a 65-year-old woman faces a 44 percent probability of doing so.[3] With the cost of a private room in a nursing home averaging more than $70,000 per year,[4] the stakes are high, for both state governments, which, on average, spend 18 percent of their general fund budgets on Medicaid,[5] and for individuals, who may be faced with catastrophic costs to cover necessary long-term-care services.

History of the Partnership for Long-Term Care

In the late 1980s the Robert Wood Johnson Foundation supported the development of a new LTC insurance model, with a goal of encouraging more people to purchase LTC coverage. The program, called the Partnership for Long-Term Care, brought states and private insurers together to create a new insurance product aimed at moderate-income individuals or those at most risk of future reliance on Medicaid to cover long-term-care needs.

The Partnership program was designed to attract consumers who might not otherwise purchase LTC insurance. States offer the guarantee that if benefits under a Partnership policy do not sufficiently cover the cost of care, the consumer may qualify for Medicaid under special eligibility rules while retaining a pre-specified amount of assets (though income and functional eligibility rules still apply). Consumers are thus protected from having to become impoverished to qualify for Medicaid, and states avoid the entire burden of long-term-care costs.

Four states–California, Connecticut, Indiana and New York–implemented Partnership programs in the early 1990s. However, Congress, citing concerns about the appropriateness of using Medicaid funds for this purpose, enacted restrictions on further development of the Partnership in the Omnibus Budget Reconciliation Act (OBRA) of 1993. The four states with existing Partnership programs were allowed to continue, but the OBRA provisions ended the replication of the Partnership model in new states.[6]

The four demonstration states used two models of asset protection. California, Indiana and Connecticut chose a *dollar-for-dollar* model. In this scenario, the amount of insurance coverage purchased equals the amount of assets protected from consideration if and when the consumer needs to apply for Medicaid. For example, a consumer who bought a policy with a benefit of $100,000 would be entitled to up to $100,000 worth of nursing home or community-based long-term care. If further care became necessary, the individual would be able to apply for Medicaid coverage, while still retaining $100,000 worth of assets.

In the *total asset protection model,* used in New York state, consumers were required to buy a more comprehensive benefit package as defined by the state. (Initially, the state mandated that Partnership policies cover three years of nursing home or six years of home-health care.) Consumers purchasing such a policy could protect all of their assets when applying for Medicaid.

In 1998 Indiana switched to a hybrid model, whereby consumers could choose between dollar-for-dollar or total asset protection. New York also recently added a dollar-for-dollar option for consumers.

As of 2005 more than 172,000 consumers in the four demonstration states had active Partnership policies.[7] Because the program is fairly young and policies are generally purchased well before they are used, relatively few of the policyholders have actually needed long-term-care coverage. However, of those that have accessed their benefits, the Government Accountability Office reports that, "More policyholders have died while receiving long-term-care insurance (899 policyholders) than have exhausted their long-term-care insurance benefits (251 policyholders), which could suggest that the Partnership for Long-Term Care program may be succeeding in eliminating some participants' need to access Medicaid."[8]

The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 included a number of reforms related to long-term-care services. Of interest to many states is the lifting of the moratorium on Partnership programs. Under the DRA all states can implement LTC Partnership programs through an approved State Plan Amendment, if specific requirements are met. The DRA requires programs to include certain consumer protections, most notably provisions of the National Association of Insurance Commissioners' Model LTC regulations. The DRA also requires that polices include inflation protection when purchased by a person under age 76.

KEY ISSUES FOR CONSIDERATION

Some of the concerns that prompted Congress to halt further implementation of the Partnership in 1993 are still relevant. Do Partnership programs save states money? What consumer protections are needed to ensure that policies will provide meaningful benefits when they are needed 20 years in the future? The following is a brief overview of some of the major issues states should consider when developing LTC Partnership programs.

Coordination with Multiple Stakeholders

The successful implementation of Partnership programs requires the input and effort of a variety of stakeholders–state policy-makers, private industry and consumers.

The state should be the primary convener of a Partnership effort, which will necessarily involve many facets of state government. The Medicaid agency, Governor's office, state budget office, state unit on aging, state legislature, and the Office of Insurance should all provide input on the design of the program. If a state passed enabling legislation prior to the DRA, then modifications to that legislation may be needed to conform to the requirements of the federal statute.

Consumers and the private insurance industry should also be engaged in the development of a Partnership program from the very early stages. Although the DRA mandates a number of consumer protections for Partnership programs, consumer input can be invaluable in helping states determine the best way to implement those protections and whether to offer additional provisions–such as premium protection and non-forfeiture clauses. Consumer groups may also be helpful in designing public awareness or educational campaigns.

The insurance industry plays a key role in underwriting Partnership policies. Insurance companies and the independent agents with whom they work may have extensive experience in the long-term-care insurance market and may be able to provide states with programmatic and fiscal projections, as well as advice on effective marketing strategies for LTC insurance products.

Target Population and State Budget Impact

The success of Partnership programs in reducing state long-term-care expenditures depend on the program's ability to encourage people with moderate incomes, who would otherwise rely on Medicaid for potential LTC needs, to purchase private insurance. If the program serves primarily to provide "substitute" insurance for wealthier individuals, who could otherwise afford to pay out-of-pocket or purchase other private LTC insurance, then state savings will not be realized.

As states consider the best way to attract those individuals who would not otherwise purchase LTC insurance, the experience of the demonstration states can be illustrative. The two models, dollar-for-dollar and total asset protection, seemed to attract consumers with different levels of assets. To qualify for total asset protection, New York mandated a relatively comprehensive benefit package. This increased the premiums and attracted consumers who were financially better off.[9] A Congressional Research Service report notes that some Partnership state directors in the original states felt that the dollar-for-dollar model promotes policies that are more affordable, and are thus better able to attract persons with less wealth.[10]

The DRA specifies that all new LTC Partnership programs use the dollar-for-dollar methodology. To keep premiums affordable, states should create benefit options that appeal to people with

varying levels of assets: less coverage (and associated asset protection) for those with limited means/assets and more generous coverage for those with more to protect.[11] In finding a successful balance between coverage and costs, states should make every effort to ensure that consumers are well informed about what they are purchasing, the level of benefits to be provided, and what is protected.

Consumer and Agent Education

Given the complexity of the long-term-care insurance choices, and the added intricacy of Partnership programs, many people feel strongly that robust consumer education and insurance agent training should be built into new state Partnership programs.

The DRA addresses some issues related to consumer and agent education:

- The secretary of Health and Human Services (HHS) is required to establish a National Clearinghouse for Long-Term-Care Information that will educate consumers about the need for and costs associated with long-term-care services and will provide objective information to help consumers plan for the future. HHS launched a Web site, *www.longtermcare.gov* to aid in consumer education.

- Partnership programs must include specific consumer protection requirements of the 2000 National Association of Insurance Commissioners (NAIC) LTC Insurance Model Act and Regulation. If the NAIC changes the specified requirements, the HHS secretary has 12 months to determine whether state Partnership programs must incorporate the changes as well.

- State insurance departments are responsible for ensuring that individuals who sell Partnership policies (insurance agents) are adequately trained and can demonstrate understanding of how such policies relate to other public and private options for long-term-care coverage.

Consumer and insurance agent education are closely aligned. Insurance agents play a vital role in ensuring that consumers understand their options as well as the terms and conditions of any given policy. Of primary importance is guaranteeing that consumers understand the criteria that will allow them to become eligible for both private LTC coverage and, if necessary, Medicaid. Consumer advocates point out that exhausting Partnership policy benefits is no guarantee that an individual will qualify for Medicaid: the state's income and functional eligibility criteria must still be met. Consumers should also be aware that, although a Partnership policy may cover home-based care, Medicaid coverage may (depending on the state) only entitle them to care in a nursing facility.

The DRA specifies that "any individual who sells a long-term-care insurance policy under the Partnership receives training and demonstrates evidence of understanding of such policies and how they relate to other public and private coverage of long-term care." To ensure that insurance agents are well schooled in the intricacies of long-term care and the Medicaid program, states may want to require a specific number of hours of training on each. The four current Partnership states require LTC insurance agents to undergo a number of hours of initial training specifically devoted to the Partnership program, in addition to other general training and continuing education requirements.[12]

Inflation Protection

Inflation protection is a provision written into a LTC insurance policy that stipulates that benefits will increase by some designated amount over time. Inflation protection ensures that long-term-care insurance products retain meaningful benefits into the future. Because policies may be purchased well before they are needed, and long-term-care costs are likely to continue to increase, inflation protection can be a key selling point for consumers interested in purchasing private LTC coverage.

The DRA 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 some level of inflation protection.

Two main types of inflation protection used in long-term-care insurance are *future-purchase option* (FPO) and *automatic benefit increase* (ABI).[13] With FPO protection, the consumer agrees to a premium for a set amount of coverage. Every several years, the insurance issuer offers to increase that coverage for an increase in the premium amount paid by the consumer. If the consumer chooses (or cannot afford) to purchase the increased coverage, benefits remain level, even as the costs of long-term-care services increase. The value of $100 per day of coverage may erode significantly over time.

With ABI, the amount of coverage automatically increases by a set amount annually. The cost of those benefit increases are automatically built into the premium when the policy is first purchased, so the premium amount remains fixed. Policies that have ABI protection are generally more expensive up front, but are more effective at ensuring that policy benefits will be adequate to cover costs down the road.

Consumer advocacy organizations and some members of Congress maintain that the intent of the language in the DRA was to require **automatic** compound inflation protection for those under age 61, but some insurers believe that future-purchase option protections can also satisfy the requirement. As of this writing, the Centers for Medicare and Medicaid Services (CMS) has not issued guidance on this matter.

Reciprocity Between States

In 2001 Indiana and Connecticut implemented a reciprocity agreement allowing Partnership beneficiaries who have purchased a policy in one state–but move to the other–to receive asset protection if they qualify for Medicaid in their new locale. Although prior to this agreement the insurance benefits of Partnership policies were portable, the asset protection component was state-specific.[14] The asset protection specified in the agreement is limited to dollar-for-dollar, so Indiana residents who purchase total asset protection policies would only receive protection for the amount of LTC services their policy covered if they moved to Connecticut.

Reciprocity is an attractive feature for many consumers, especially those who do not currently know where they will reside in future years. The DRA requires the HHS secretary (in consultation with National Association of Insurance Commissioners, policy issuers, states, and consumers) to

develop standards of reciprocal recognition under which benefits paid would be treated the same by all such states. States will be held to such standards unless the state notifies the secretary in writing that it wishes to be exempt.

LOOKING AHEAD

Many states are interested in the opportunities related to expansion of the Partnership model. Before the passage of the DRA, 21 states had anticipated a change in the law and proposed or enacted authorizing legislation.[15] A recent survey of state Medicaid directors found that 20 (of 40 total) respondents indicated that they planned to propose a Long-Term Care Partnership program within the year.[16] As momentum behind the program grows, the issues and considerations outlined here, as well as others raised by consumer advocates, state budget officials and those who purchase Partnership policies will need to be carefully examined to determine the ultimate outcomes of this unique and innovative policy option.

RESOURCES FOR STATES

The Center for Health Care Strategies (CHCS) has launched a new initiative designed to help states take advantage of new opportunities made available in the DRA. The Long-Term Care Partnership Expansion project is being underwritten by the Robert Wood Johnson Foundation. Ten states will receive technical assistance to develop new Partnership programs.[17]

George Mason University has served as the national program office for the original Partnership for Long-Term Care program and continues to provide the latest in research knowledge on Long-Term Care Partnerships to health care policy-makers.

The National Association of State Medicaid Directors (NASMD) is available to assist states with concerns or questions regarding the Partnership program implementation process. NASMD will continue to periodically survey states to gather implementation status updates and lessons learned to inform other states.

Contacts for More Information

- Center for Health Care Strategies: Joanie Rothstein *jrothstein@chcs.org* and Kathy Moses *kmoses@chcs.org*
- National Association of State Medicaid Directors: Ilana Cohen *icohen@aphsa.org*
- George Mason University Center for Health Policy Research and Ethics: Mark Meiners *mmeiners@gmu.edu*

Acknowledgements: This brief was authored by Joanie Rothstein at CHCS, with input from Mark Meiners at George Mason University, Ilana Cohen at the National Association of State Medicaid Directors, as well as Kathy Moses and Stephen Somers at CHCS.

ENDNOTES

[1] Centers for Medicare and Medicaid Services. *National Health Expenditures Aggregate Amounts and Average Annual Percent Change, by Type of Expenditure: Selected Calendar Years: 1960–2005.* Available at *http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.*

[2] Centers for Medicare and Medicaid Services. *Nursing Home Care Expenditures Aggregate, Per Capita Amounts, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970–2005.* Available at *http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.*

[3] Brown J and Finkelstein A. *The Interaction of Public and Private Insurance: Medicaid and the Long Term Care Insurance Market.* National Bureau of Economic Research, Working Paper 10989, December 2004.

[4] Genworth Financial. *Genworth Financial 2006 Cost of Care Survey: Nursing Homes, Assisted Living Facilities and Home Care Providers*, March 2006.

[5] Smith V et al. *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Budget Survey, State Fiscal Years 2006-2007*. Kaiser Commission on Medicaid and the Uninsured, October 2006.

[6] George Mason University, Office of Research, Partnership for Long Term Care. Available at *http://www.gmu.edu/departments/chpre/research/PLTC/overview.html#highlights*.

[7] Government Accountability Office. *GAO-05-1021R.* Washington: GAO, September 9, 2005.

[8] ibid.

[9] Ahlstrom A, Clements E, Tumlinson A, et al. *The Long Term Care Partnership Program: Issues and Options.* Washington: The Brookings Institution and The George Washington University, December 2004.

[10] Stone-Axelrad J. *Long-Term Care Insurance Partnership Program.* Washington: Congressional Research Service, 2004.

[11] Ahlstrom et al., op. cit.

[12] Information from state LTC Partnership Web sites.

[13] *Long-Term Care Insurance Partnership Programs: Important Issues for State Implementation.* AARP Public Policy Institute, December 2006.

[14] *Indiana Long-Term Care Web Site*, January 29, 2007. Available at *http://www.state.in.us/fssa/iltcp/reciprocity.htm.*

[15] Stone-Axelrad J, op. cit.

[16] AARP Public Policy Institute. *Long Term Care Insurance Partnership Programs Fact Sheet FS124.*

[17] *NASMD Fall 2006 State Medicaid Directors Survey.*

[18] More information on the Long-Term Care Partnership Expansion can be found at *www.chcs.org*.

Robert Wood Johnson Foundation

Route One and College Road East
P.O. Box 2316
Princeton, New Jersey 08543-2316
www.rwjf.org

May 2007