

# Long-Term Care Partnerships: An Update

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ALLIANCE FOR  
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**T**oday's patchwork of private and public financing of long-term care services is strained, with costs rising for the major payer—the federal-state Medicaid program—and for families of the individuals receiving services.

These cost pressures will only get worse. Between 2005 and 2030, when the youngest baby boomers reach retirement, the population of those age 65 and older will almost double from close to 37 million to more than 71 million, and will comprise almost 20 percent of the U.S. population.

Long-term care costs can be financially devastating for people with modest incomes. In 2006, the average annual cost of nursing home care was \$75,190, and exceeded \$100,000 in some areas. Paying for home care can also be expensive, at an average of \$19 per hour in 2006.

Individuals and their families may assume, or hope, that Medicaid will pick up these costs when the time comes. They may be shocked to learn that persons seeking Medicaid help must usually spend almost all of their life savings on care before they qualify financially.

## **Private Insurance: Part of the Solution for LTC Risks?**

Private long-term care insurance could pay for many long-term care expenses. Yet today, private insurance accounts for only a small fraction of long-term care spending on the elderly—an estimated 3 percent in 2005.

Some possible reasons why:

- ▲ Private insurance for long-term care is a relatively recent insurance product. And many policies purchased years ago have not yet begun to pay benefits, so they don't yet show up in statistics measuring sources of long-term care spending.
- ▲ Many older people believe that Medicare covers long-term care.

- ▲ Some are unaware of their long-term care risks or deny any need to prepare financially for those risks.
- ▲ Policies are expensive. Studies indicate that only 10 to 20 percent of the older population can afford good quality private long-term care policies.

## **Enter: Long-Term Care Partnership Programs**

The Long-Term Care Partnership Program was designed to encourage the purchase of private long-term care insurance. In states where the program is offered, individuals who purchase a policy and use up its benefits can then apply for Medicaid. If these individuals meet Medicaid's criteria for income and degree of impairment, they can receive Medicaid-covered long-term care services—while protecting some or all of their financial assets that would otherwise make them ineligible under Medicaid's means testing requirements.

Assume, for example, that a person buys a long-term care policy worth \$100,000. That person later enters a nursing home, and her policy eventually pays out \$100,000. She can then apply for Medicaid to cover her nursing home bills from then on and, if approved, can protect \$100,000 in assets that would otherwise have had to be liquidated and spent for her long-term care before Medicaid would approve her application.

This arrangement is a "dollar-for-dollar" Partnership. The amount of protected assets equals the amount that the private insurance policy has paid out.

Assets that may be protected under Partnership policies include assets Medicaid would otherwise count, such as cash savings, securities and most property, among other items. Partnership programs do not shelter income, such as Social Security and pension income.

## **Fast Facts**

- ▲ The Robert Wood Johnson Foundation initiated a demonstration program in 1987 to develop an innovative private-public Long-Term Care Partnership Program. California, Connecticut, Indiana and New York set up programs, and still operate them.
- ▲ In 2006, Medicaid officials in 22 states reported that they were planning to implement such programs.
- ▲ Among the goals of the Partnership program are to increase the number of middle-income people buying long-term care insurance policies, to help people buy better long-term care insurance policies, and to reduce cost growth in Medicaid.
- ▲ Buying a Partnership policy that provides a certain dollar amount of benefits will allow the purchaser to disregard assets equal to the insurance payout in applying for Medicaid once the insurance coverage is exhausted.
- ▲ Premiums for Partnership policies differ across states and are based on an applicant's age, medical history and the scope of benefits purchased.
- ▲ Sales of Partnership policies in the four states now opening programs have been relatively modest—249,000 since the Partnerships began, of which 201,000 policies were in force in 2006.

**The Alliance for Health Reform, with support from the Robert Wood Johnson Foundation, held a briefing in November 2006 to examine the Long-Term Care Partnership Program and its likely future. This issue brief draws on information presented at that briefing.**

## Long-Term Care Partnerships— Experience Since Implementation

Partnership states	Program implementation	Policies purchased	Policies in force	Policyholders who received private insurance benefits	Policyholders who exhausted their private insurance benefits and accessed Medicaid
California	August 1994	97,223	81,259	1,270	36
Connecticut	March 1992	42,730	33,952	512	36
Indiana	May 1993	39,063	32,115	391	22*
New York	April 1993	69,690	53,344	1,649	81
<b>Total</b>	--	<b>248,706</b>	<b>200,670</b>	<b>3,822</b>	<b>175</b>

Sources: Partnership program quarterly reports. Data for CA, CT and IN are cumulative through the third quarter of 2006, except for the one figure starred for IN. Data for NY and the starred figure for IN are cumulative through the second quarter of 2006.

The Robert Wood Johnson Foundation initiated a demonstration of the Partnership concept in 1987. Subsequently, California, Connecticut, Indiana, and New York implemented Partnerships in the early 1990s. In addition to helping individuals meet their long-term care expenses with high-quality policies, the states also hoped they could reduce their Medicaid long-term care cost growth.

All four states require qualified plans to include 5 percent compound annual inflation protection. Importantly, if an individual purchases a policy with adequate compound annual inflation protection, both his or her covered benefits as well as the level of protected assets hold their value over time. With some other plan features, such as the duration of waiting periods before the policy begins paying, state standards vary.

### Post-DRA: Changes in the Partnership Program

For more than a decade, federal rules discouraged states from adopting Partnership programs, because they required states to pursue estate recovery of Partnership-protected assets after a beneficiary's death. But in 2005 Congress gave states the green light to adopt Partnerships, doing away with estate recovery of Partnership-protected assets as part of a larger package of changes included in the Deficit Reduction Act (DRA). Following enactment of the DRA, 22 states reported that they were planning to implement a program.

The DRA establishes a basic framework within which states must operate. A "qualified state partnership" is defined as an approved state plan amendment offering dollar-for-dollar asset protection. More comprehensive policies protecting all financial assets are available only in the four

demonstration states. States with existing Partnership programs are required only to retain their existing consumer protection standards.

During the next few years, decisions at the state level will affect whether and how insurers create Partnership products in many more states, and how consumers will react to them.

At the Alliance briefing, Bonnie Burns of California Health Advocates, a nonprofit organization assisting groups that counsel consumers, said that an important issue for states to decide will be how Medicaid programs will treat payments made by Partnership policies for services and items not explicitly covered by the state's Medicaid programs.

Will Medicaid count such expenses as policy benefits, thus affecting the person's protected assets? Questions will also arise about how state Medicaid programs should handle new kinds of flexible payment models that some policies feature, such as cash payments for services that aren't specified.

In fact, any new Partnership programs are likely to vary considerably from state to state. This may create problems for consumers who purchase a policy in one state and later move to another.

The Department of Health and Human Services (HHS) is charged with establishing a framework for reciprocity—a mechanism for one state to recognize how Partnership policies written in another are treated. But states can opt out of these standards simply by informing the HHS secretary.

### Inflation Protection Softens

All Partnership policies in the original four states include 5 percent compound annual inflation protection. But under the DRA, new states offering Partnership policies have less stringent rules to follow:

- ▲ For purchasers under age 61, some compound annual inflation protection must be provided (no specific percentage).
- ▲ For purchasers 61 to 76 years old, some level of inflation protection must be provided (doesn't have to be compound inflation protection)
- ▲ For purchasers age 76 and older, inflation protection may be offered but is not required.

Inflation protection does significantly increase premiums; for example, a policy with 5 percent compound annual inflation protection purchased between the ages of 40 and 50 carries a premium more than twice as high as a policy without it. For consumers tempted to buy policies with lower, or no, inflation protection, the tradeoff is that they will see their benefits erode dramatically over time. Assuming that the cost of long-term

care continues to increase by 5 percent each year, the real value of a policy with no inflation protection would decline by more than half over 15 years. A person who bought such a policy at age 50 would find it of limited use when benefits were needed 30 or more years later.

The DRA also states that individuals with home equity exceeding \$500,000 (or up to \$750,000 at state option) are ineligible for Medicaid services, even if they have Partnership policies. Individuals who exhaust their Partnership benefits but whose home equity exceeds this threshold may be able to apply to states for a waiver, said another speaker at the briefing, Mark R. Meiners of George Mason University.

David Colby of the Robert Wood Johnson Foundation, said broad expansion of the program won't happen overnight, despite widespread state interest. "It's a fairly complex approach to implement," he said, adding that having "planted the seed for this idea" in the late 1980's, the Foundation will provide additional start-up money and technical assistance for 10 states to implement new Partnerships.

### **Has the Partnership Program Fulfilled Its Promise?**

Some experts believe that the Partnership program has made progress toward meeting its goals. For example, the original four states have been modestly successful in promoting higher quality insurance products with inflation protection. As of mid-2006, about 240,000 Partnership policies had been sold, and about 194,000 were in force. (See table, "Long-Term Care Partnerships – Experience Since Implementation.")

But although sales increased initially each year when the programs were launched, they later leveled off. (In California, growth was significantly higher and peaked later, in 2003). These Partnership policies represented a small fraction of the total number of long-term care policies sold in the four states.

Another goal of the Partnership program is to attract moderate-income purchasers, those most in danger of exhausting their savings and other assets in order to qualify for Medicaid. Here, too, the record in the four states shows mixed results. Although some purchasers have modest incomes, the policies appear to have attracted wealthier buyers. In the three states that have surveyed a sample of Partnership policyholders—California, Connecticut and Indiana—the majority reported their total assets were greater than \$350,000. Roughly half of the policyholders in each of these three states also reported average monthly

household incomes of greater than \$5,000.

Although most Partnership applicants have been able to purchase insurance, it also bears noting that 16 percent of individuals who applied were denied coverage during the medical underwriting process, during which private companies assess the health and future risk, or "insurability," of individual applicants.

With regard to the cost impact on Medicaid, it is still difficult to assess whether the Partnerships will make much of a dent. The typical lag between when a policy is purchased and benefits are exhausted can be decades. Through mid-2006, fewer than 4,000 Partnership policyholders had claimed benefits, and only 174 had accessed Medicaid after exhausting their Partnership benefits.

Partnership directors, however, assert that their programs have already produced savings for Medicaid and, indeed, some factors point in this direction. Policyholders who access their private insurance benefits, for example, do not tend to exhaust them (they are more likely to die while receiving the private benefit than to access Medicaid).

### **Will States Seek to Make Further Improvements?**

Consumers purchasing Partnership policies or any other type of long-term care insurance policy face complex decisions. They need to understand the scope and flexibility of covered benefits, minimum daily benefit amounts, elimination periods (sometimes called waiting periods or deductibles), inflation protection and whether to include non-forfeiture features (which pay out benefits even if the policy lapses).

Unfortunately, some of the key terminology in policies varies from company to company. This creates extra challenges for consumers, who may not clearly understand the consequences of their choices. Moreover, many purchasers are likely to rely on the advice of agents, who have their own interests and may not be particularly well informed about how long-term care insurance relates to Medicaid.

Also, the National Association of Insurance Commissioners calls for insurers to offer "meaningful" inflation protection—e.g., through policies featuring 5 percent compound annual inflation. As noted, the DRA dilutes that protection requirement. DHHS officials concede that some states may wish to offer compound inflation protection that exceeds the federal requirements, and that such requests (in the form of Medicaid plan amendments) may be approved.

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For the sources used in writing this issue brief, please email to [info@allhealth.org](mailto:info@allhealth.org).

The Alliance is a nonpartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation's health care problems and the trade-offs posed by various proposals for change.

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### Looking Ahead

Early supporters of the Partnership program did not propose the program as a comprehensive solution to all long-term care needs. They did hope that the program would fill a financing gap in providing services for middle-income older people who have resources (assuming they purchased a policy when they were relatively young, and when they were healthy enough to pass medical underwriting tests).

Critics of the program argue that more needs to be done to help millions of Americans who may never purchase private long-term care insurance. These critics assert that for too many seniors, such coverage is fundamentally unaffordable. Nonetheless, after

many years, Congress has failed to enact comprehensive federal legislation to spread the risks of long-term care broadly across society.

It is too early to make solid predictions about whether the role of Partnerships in financing long-term care services will expand significantly during the next several decades. But it is clear that states have a major role to play in determining how well Partnerships will serve consumers' needs for long-term care services, and how well the Partnerships will interact with Medicaid.

Cautioned California's consumer advocate Bonnie Burns, "As these Partnerships expand, there needs to be strong state oversight ... We need to take the time to do this right."

### Expert Sources

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