Chapter 4 The Basics of a Partnership Program

The Basics of a Partnership Program

The basic concept behind an LTC partnership program is easy to understand. A partnership program joins a state's Medicaid program with ownership of private LTC insurance in such a way that the state's Medicaid eligibility requirements are modified to provide financial incentives for residents to purchase private LTCI coverage. If the policy holder requires long-term care services, the LTC policy pays out its benefits. Then, in the event the policy holder continues to need care after the policy's benefits are exhausted, or the policy does not fully cover the cost of needed care, the policy holder can apply for Medicaid. However, the standard asset limit that the state Medicaid program would otherwise impose does not apply to the owner of an LTC partnership policy. He or she will be able to keep assets equal in amount to the benefits the policy provided. In addition, these assets are exempt from Medicaid estate recovery upon the policy holder's death.

To illustrate, suppose 63-year-old Jean purchases a qualified LTCI partnership policy. The policy provides a maximum benefit of $75,000. After three years of needing various levels of long-term care, Jean has exhausted her policy's benefits. At that point, Jean could apply for Medicaid. Whereas the Medicaid program in Jean's state would normally require that she have no more than $2,000 in assets to be eligible for Medicaid payment of her LTC costs, her qualified partnership policy enables her to disregard an additional $75,000—the amount the policy paid. Thus, Jean would be able to retain a total of $77,000 in assets and still be eligible for Medicaid. In addition, at Jean's death, the disregarded assets are not subject to estate recovery.

The goal of the long-term care partnership model is to use Medicaid's payment system for LTC services as an incentive for lower- to middle-income individuals to purchase qualified—and affordable—long-term care insurance, thus encouraging them to prepare for the possibility of needing long-term care. In turn, this may prolong or even preclude the need for Medicaid to pay for their long-term care services.

The Pilot Partnership Programs

As mentioned, four states—California, Connecticut, Indiana, and New York—were the four pilot partnership states. These programs began in the mid- and late-1990s. Each of these states designed its own program, working with the Centers for Medicare and Medicaid Services. As a result, two models emerged as a means of defining the partnership benefit:

-dollar-for-dollar method
-total asset protection method

Dollar-for-Dollar Model

California, Indiana, and Connecticut use the dollar-for-dollar method. Under this model, asset protection is equal to the amount of benefits paid from the partnership policy. For example, if Tom buys a partnership policy with a maximum lifetime benefit of $100,000, he would be entitled to up to $100,000 worth of LTC benefits paid by his policy. If additional care should become necessary, he could apply for Medicaid coverage while still retaining $100,000 worth of assets above what the Medicaid program otherwise allows.

The Total Asset Protection Model

New York uses the total asset protection method. Under this model, all assets are protected. This model is generally recommended for those with substantial wealth accumulation. New York policy holders were required to purchase more comprehensive coverage as defined by the state. Policy holders purchasing this type of policy could protect all of their assets when applying for Medicaid once their policy benefits had been exhausted. Those who purchased the state-approved policies qualified for Medicaid without having to meet any of Medicaid's asset criteria. That is, policy holders could protect all of their assets at the time they were deemed eligible for Medicaid.

In 1998, Indiana switched to a hybrid model, whereby insurance citizens can choose between dollar-for-dollar or total asset protection. New York has added a dollar-for-dollar option for LTC citizens. By offering different models, these states give their insurance citizens the option of a lower premium in exchange for less asset protection, or greater asset protection for a higher premium.

It is important to note that in both the dollar-for-dollar and total asset protection models, individuals must still pass Medicaid's other eligibility tests after exhausting partnership policy benefits. In other words, whereas a partnership policy will allow participants to retain a greater level of assets, a participant must still meet Medicaid's general and functional requirements.

Concern over the Original Partnership Program

A few years after the original four state's partnership programs were enacted, Congress began to express concerns. One criticism was that Medicaid would wind up endorsing private insurance products. Another issue was the potential for increased Medicaid spending rather than an intended decline in it—that wealthy individuals or those of above-average means (who were considered likely to purchase LTCI anyway) would participate in the program, retain their assets, and have unintended access to Medicaid services.

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93)

As a result of these concerns, Congress enacted new laws that restrained expansion of partnership programs beyond the original four states. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) effectively prevented other states from developing partnership programs by changing the conditions under which states could amend the Medicaid asset disregard. Though the original four programs were grandfathered, OBRA required any new partnership program to provide asset disregard only for initial Medicaid eligibility; thus, disregarded assets would be deemed subject to estate recovery at the participant's death. OBRA specified that states were required to recover from a partnership participant's estate an amount equivalent to what Medicaid spent on his or her behalf, including any protected assets under the partnership program. In addition, any state that established an LTC partnership program after OBRA was required to use an expanded definition of "estate" than what was previously the norm.

Therefore, while OBRA did not ban the creation of new state partnership programs, the restrictions it imposed virtually had the same effect. It wasn't until a decade later that state partnership programs began to expand.

The Deficit Reduction Act of 2005 (DRA '05)
The Deficit Reduction Act (DRA) of 2005 ended the barrier OBRA '93 had imposed on partnership programs and opened the door for their expansion across the country. DRA authorized all states to establish partnership programs, defined certain criteria these programs must meet, and removed the requirement that subjected disregarded assets to estate recovery.

The following is the definition of a "qualified state long-term care insurance partnership" program as defined by the DRA:

. . . an approved State plan amendment [to the state's Medicaid laws] . . . that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy. . . .

In other words, if an policy holder under a qualified LTCI partnership policy requires Medicaid assistance after the policy's benefits have been paid, and he or she meets Medicaid's other eligibility requirements, the participant may retain assets equal to the benefits paid by the policy—assets that, without a partnership policy, might have been forced to be spent down. (This is the dollar-for-dollar model.) These assets remain available to the policy holder while receiving Medicaid payment for long-term care services and may be passed on to heirs and beneficiaries after the policy holder's death. They are not subject to estate recovery.

LTC Partnership Policy Standards
Along with creating partnership programs in all states, DRA also outlined specific requirements for all LTC policies sold in conjunction with such programs. All such policies must be tax-qualified and must conform to certain minimum standards set forth in the NAIC's Long-Term Care Model Act and Regulations. Additionally, no state may impose requirements on partnership policies that are not imposed on non-partnership LTCI policies. These requirements and standards will be discussed in detail in a later lesson.

Changes in the Look-Back and Penalty Periods
At the same time it expanded the opportunity for state partnership programs, the DRA tightened the requirements on Medicaid rules for the transfer of assets. Before this act, the look-back period was 36 months. DRA extended this period to 60 months (five years). In addition, DRA changed the beginning date of the penalty period. Before the enactment of the DRA, the penalty period began on the first day of the month during or after which assets were transferred. The penalty period now begins on the later of:

-the first day of the month when the assets are transferred
-the date on which the individual is eligible for medical assistance under the state plan and is receiving institutional care services that would be covered by Medicaid were it not for the penalty period.

It is anticipated that the extension of the look-back period and its redefinition may reduce the improper transfers of assets.

Reciprocity between States
Reciprocity between states is an attractive element of partnerships for citizens, because many do not know where they will reside in future years. The DRA requires standards of reciprocal recognition under which benefits paid under a partnership policy are treated the same by all partnership states. Policy holders in all participating partnership states are able to use their benefits in other partnership states.

To be eligible to participate in another state's partnership program, the policy holder at the time of policy purchase must be a resident of a state sponsoring a partnership program. Also, at the time the Medicaid application is made, the policy holder must be a resident of a partnership state. The policy holder may move to another state after purchasing a partnership policy and insurance coverage would remain in effect. However, only if reciprocity exists between the two states can the policy holder be certain of Medicaid asset protection in the new state.

In the absence of reciprocity, policy holders who move from one partnership state to another could find that, just as when moving from a partnership state to a non-partnership state, their asset protection does not apply in the new state.

Implementing a State Partnership Program
Any state can implement a partnership program. The LTC partnership model generally does not call for alterations in how a state's Medicaid program is administered. It simply requires that the state's Medicaid rules allow for increased asset disregard for those who own a partnership policy. This adjustment is addressed by the filing of a state plan amendment (SPA) with CMS, specifying that benefits paid under a qualified long-term care insurance policy will be disregarded in the state's Medicaid eligibility determination and the estate recovery process. The SPA must also stipulate that the policies serving as the basis for these disregards meet all of the requirements for a qualified LTC policy as specified by the DRA. Policies used in conjunction with a state's partnership program cannot be issued any earlier than the effective date of the SPA. As the partnership program has evolved nationally, many complex issues have surfaced, and others are sure to arise in the future. Some of these are examined in the following sections.

LTCI Partnership Program in Florida
The Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Families, is directed to establish a qualified state Long-Term Care Insurance Partnership Program in Florida, in compliance with the requirements of s. 1917(b) of the Social Security Act, as amended.

(1) The program shall:

(a) Provide incentives for an individual to obtain or maintain insurance to cover the cost of long-term care.

(b) Provide a mechanism to qualify for coverage of the costs of long-term care needs under Medicaid without first being required to substantially exhaust his or her assets, including a provision for the disregard of any assets in an amount equal to the insurance

benefit payments that are made to or on behalf of an individual who is a beneficiary under the program.

(c) Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

(2) The Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Families, and in accordance with federal guidelines, shall create standards for long-term care partnership program information distributed to individuals through insurance companies offering approved long-term care partnership program policies.

(3) The Department of Children and Families, when determining eligibility for Medicaid long-term care services for an individual who is the beneficiary of an approved long-term care partnership program policy, shall reduce the total countable assets of the individual by an amount equal to the insurance benefit payments that are made to or on behalf of the individual.

Home Equity Value and Asset Protection

As noted earlier, Medicaid eligibility requirements impose a $500,000 cap on the equity interest a Medicaid applicant can have in his or her home ($750,000 at a state's option). This requirement was added by DRA 2005. (Previously, the value of a home was not included when determining Medicaid eligibility.) The requirement raises a question with respect to a partnership program: can asset protection be used to increase the home equity value allowance? For example, could someone with a partnership policy providing $100,000 in asset protection (assuming the person does not have $100,000 in assets other than home equity) use that to increase the protected value of his or her home and still qualify for Medicaid? The answer is no.

Exhaustion of Policy Benefits

In some cases, it is possible for a person to require Medicaid assistance before exhausting his or her partnership policy benefits. For example, an individual's cost of care may exceed the daily benefit amount the policy provides. This presents some further complexities to LTCI partnership policies. Medicaid has resolved this issue by allowing individuals' access to Medicaid while the insurance is still paying benefits. In such a situation, policy holders are permitted to protect assets equal to what their policy has paid out to-date. Medicaid pays for care in conjunction with the remaining insurance benefits. Over time, the asset protection amount increases as the insurance continues to pay benefits.

In July 2006, the Centers for Medicare and Medicaid Services supported this position by noting the following:

The DRA does not require that benefits available under a partnership policy be fully exhausted before the disregard of resources can be applied. Eligibility may be determined by applying the disregard based on the amount of benefits paid to, or on behalf of, the individual as of the month of [Medicaid] application, even if additional benefits remain available under the terms of the policy.

However, additional questions were triggered by what the CMS also stated: "The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination." Though this statement seems to suggest that the policy holder must make a choice between the earlier but reduced protection and the later full protection, it is open to interpretation.

It is up to the individual states to determine how they will handle this situation. Some states require partnership participants to exhaust their policy benefits before asset protection will be granted. Other states construe the CMS position to mean that the eligibility process is ongoing, not a one-time determination. The initial Medicaid application and the ongoing re-determination of eligibility are seen as part of an entire eligibility determination process. Consequently, it is possible for an policy holder, while on Medicaid, to continue to accrue a level of asset protection equal to what is eventually paid out over the life of the policy. The asset protection amount is not capped at application. Rather, it has the potential to grow as benefits under the policy are paid out. In this case, the meaning of "[t]he amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination" is the most recent eligibility determination, as many states look upon eligibility as an ongoing process with eligibility reevaluated at certain intervals.

Though an individual may qualify for Medicaid before exhausting the benefits from a partnership policy, Medicaid remains the "payor of last resort." This means that long-term care claims are paid first by the policy (or any other insurance the participant may have) before Medicaid will pay claims.

Types of Services and Asset Disregard

Another issue is whether special limits should be placed on the types of services the LTCI policy pays for. For example, Mike's policy pays for assisted living, but he lives in a state that does not cover assisted living as a Medicaid benefit. Should Mike gain asset protection for the money spent during his time in the assisted living facility?

It was determined yes. This situation is no different from one in which Mike might have used his own money to pay for care in the assisted living facility, which might have impoverished him and qualified him for Medicaid anyway.

However, using benefits under a partnership policy for services not covered by Medicaid does not mean that Medicaid will cover those services once it begins payment on the policy holder's behalf. In our example, Mike would not receive Medicaid payment for assisted living, because assisted living is not a Medicaid-covered benefit in his state. Upon Medicaid eligibility, Mike would have to choose between using his protected assets to continue to pay for assisted living himself, or agree to receive care as allowed by Medicaid in his state.

Tracking Protected Assets

As with all applicants for Medicaid, asset identification for partnership participants is part of the eligibility process. The total amount of assets that must be spent down before a partnership participant is eligible for Medicaid must be determined in conjunction with:

-the assets that are non-countable under Medicaid (household belongings, burial plots, one automobile, etc.);

-the standard asset allowance normally allowed by Medicaid (typically $2,000 to $3,000 for single applicants);

-the asset allowance that is available to a community spouse, if the applicant is married; and

-the amount of protected assets as per the dollar-for-dollar partnership policy payout allowance.

Tracking protected assets for Medicaid eligibility when the policy holder has a partnership policy can be a difficult task. Some states require that Medicaid recipients actually designate the specific assets that are to be protected. Once the initial amount of protected assets is identified and Medicaid eligibility is established, states can use periodic eligibility re-determination tests to assess the beneficiary's financial transactions during the current interval. Typically, if a protected asset is sold or transferred, then the original protected amount is reduced for both asset disregard and estate recovery.

Insurers that sell LTCI partnership policies must assist in this tracking process. So that an policy holder's partnership participation is recorded and his or her assets protected, the insurer must report to the state Medicaid agency when a partnership policy is sold, when the policy pays benefits, the amount paid, and when such policies terminate.

Realities of State Partnership Programs

It is anticipated that LTC partnership programs will provide at least a partial solution to the critical problem of funding long-term care costs. However, these programs have their limits. Citizens who are considering these plans and producers who sell policies for these plans must understand the following:

-Partnership participation does not automatically guarantee enrollment in Medicaid or the payment of Medicaid funds once a policy's benefits are exhausted. The policy holder individual must still meet Medicaid requirements for eligibility—medically, functionally, and financially

-Partnership protection does not alter the fact that Medicaid remains the payor of last resort. Even if an policy holder qualifies for long-term care Medicaid payments while receiving policy benefits, benefits payable from the policy must be applied before Medicaid assumes any payments.

-Partnership participation protects assets, not income. Once a partnership participant qualifies for Medicaid, a large part of his or her income must be directed to paying for the costs of his or her care.

-Partnership participation may not protect all of an individual's assets. Because protection is limited to the amount of benefits paid under the policy, any assets the participant has above this amount may have to be spent down for the participant to qualify for Medicaid. (Total asset protection is limited to partnership programs in New York and Indiana.)

-Partnership participation does not guarantee that the policy holder will be able to receive care in his or her home or in a facility of his or her choosing. If and when a partnership participant turns to Medicaid, he or she may be forced into another facility or be required to forego home care.

-Partnership participation does not guarantee that future Medicaid eligibility requirements will be the same. Income and asset requirements could be more stringent in years to come, making it more difficult to qualify for Medicaid benefits.

-Partnership participation does not ensure that asset protection will be available if the participant moves to another state that does not have a partnership program or does not have a reciprocity agreement with the original state. Furthermore, reciprocity between states for partnership protection of assets does not ensure that the requirements for Medicaid eligibility will be the same in each state.

Summary

The long-term care partnership model presents insurance citizens with a means of preparing for their long-term care needs while still having the assurance that Medicaid will be there for them if necessary. The risk of impoverishment is significantly reduced for partnership policy holders; because they can trust that their assets will not be totally depleted before Medicaid assistance is available. Any state may implement a partnership program. Insurers must follow state and federal guidelines to sell partnership policies.