Chapter 5 Program History

History of the LTC Partnership Program

In the late 1980s the Robert Wood Johnson Foundation (RWJF) 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 that would encourage the uninsured to purchase long-term care coverage. It was hoped that moderate-income individuals, who faced the greatest risk of future reliance on Medicaid, would cover long-term-care needs through insurance policies.

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

In 1987 the Program to Promote Long-Term Care Insurance for the Elderly was authorized. The Robert Wood Johnson Foundation (RWJF) was charged with providing states with resources to plan and implement private/public partnerships for funding long-term care needs. A primary goal of the Partnership Program was estate preservation, but also to promote an awareness of long-term health care needs faced by individuals as they age. The partnership programs joined the private insurance sector already offering long-term care insurance with the goal of developing high-quality insurance options that would prevent asset depletion and dependence on Medicaid.

Partnership programs protect assets (not income) from the high costs of home care, community care, and nursing home care. Income would still need to be used for the individual's care, but assets would be protected. No policy protects income once benefits are used up and the insured goes on Medicaid.

Between 1987 and 2000, a total of 104,000 applications had been taken and more than 95,000 policies had been sold in the four trial program states: California, Connecticut, Indiana, and New York.

Analysts in the health care industry first recognized the need to develop and promote long-term care policies in the early 1980s. This was about the same time that government realized the need to seek funding solutions for the care of those who were ending up on Medicaid. By the mid-1980s insurance companies were marketing private long-term care policies, although these early policies had several flaws in coverage.

Many were surprised to learn that it was not just the poor who were ending up dependent upon state and federal aid for their long-term health care needs; the middle class were finding themselves quickly impoverished once they entered a nursing home. It took less than one year for many individuals to become poor enough to qualify for Medicaid.

The situation is not expected to improve unless the general population accepts their responsibility by purchasing insurance or providing some financial avenue to pay for long-term care needs. Concern about the financing of long-term care is based on set predictions: the population of chronically ill elderly will inevitably increase with the population of those older than age 80 and with medical advances that enable those with chronic diseases to survive longer. According to a study published by the New England Journal of Medicine, 43 percent of all Americans will enter a nursing home at some time before they die. Of these, 55 percent will stay at least one year and 21 percent will stay at least 5 years. The average stay will last two and a half years. Medicare will pay less than 9.4 percent of the long-term care costs since that program was never designed to cover care in a nursing home beyond a very short period of time.

Medicaid, the program that ends up paying the costs once a person becomes impoverished, is one of the largest items in state budgets. The elderly and disabled population represents less than one-third of the total Medicaid caseload, but consumes over two-thirds of the total program funding for care in nursing homes. Obviously, this is a situation that has the potential of totally draining state budgets as the baby-boomer set becomes elderly.

A number of studies and commissions at the federal and state levels have reported the need for long-term health care insurance development is urgent. Additionally, some broad agreements have been reached, including:

-Delaying the moment at which patients qualify for Medicaid could avoid financial disaster for the patient and their families.

-Preventing financial spend-down, and subsequent qualification for Medicaid benefits, would save public funds.

-Elderly consumers would benefit if risk pooling could be implemented by state legislatures specifically designed to provide a safety net for medically uninsurable people.

Even though these agreements are generally accepted little action has been taken by the public sector. Private long-term care insurance represents more than a $200-million industry, but the coverage is often limited and premium costs are high. As a result, sales of private long-term care coverage have not been as good as analysts hoped for. Only a small segment of the population have actually purchased such coverage; of the total costs of long-term care services, less than 1 percent are covered by private insurance. Our tax dollars still cover the largest part of long-term care costs.

Why haven't more people bought long-term care policies? Most people do not want to go to a nursing home and this may be part of the problem. Some may believe owning such coverage will encourage their family members to use it, versus caring for them at home or in a family member's home. This equates into a lack of education regarding health care at this stage of life. Even when family members are willing to provide care for a long period of time it is not always prudent for them to do so; often it is better for the patient to receive professional care at locations prepared to supply appropriate services.

As the financial crisis became more evident, the idea of financing long-term care through some type of public-private cooperation gained favor. As a result of state government and insurance company meetings and discussions during the 1980s, a partnership for long-term care needs developed. The Robert Wood Johnson Foundation was attracted by its win-win-win potential. Who wins? Consumers, Medicaid, and private insurers all had the potential to win. RWJF authorized the national program in 1987.

The Robert Wood Johnson Foundation (RWJF) had specific goals:

-Avoiding impoverishment for elderly individuals by guaranteeing some measure of asset protection.

-Providing access to quality long-term care that is appropriate for the individual's medical situation.

-Providing coverage for a full range of home and community-based services.

-Development of a case management infrastructure in which the gatekeeper bears some financial risk in order to prevent excessive or inappropriate utilization (they did not want family members to be able to use this program inappropriately for their ill or frail member).

-Assurance of equity and affordability in the long-term-care-insurance program for lower-income individuals.

Partnership Policy Creation

The national program office is located at the University of Maryland Center on Aging. Their primary responsibilities were to provide leadership and technical assistance for grantee institutions during the planning and implementation stages. They would also offer information to other states that were interested in replicating the public-private partnership programs, or even pursue alternative programs that might appropriately address the situation. Additionally, they wanted to develop and implement some type of media relations strategy that would increase policy sales. Obviously, if consumers did not buy the partnership policies, they would not solve the problem.

The planning phase of Partnership long-term care policies was authorized in 1987 with funding of $3.2 million. The national program office contacted states that had demonstrated a commitment to reforming long-term care financing. Grants were awarded to California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin. These eight states collected and analyzed data from nursing homes, the elderly population, state Medicaid files, and insurers to help them design and price their products and to assess products' impact on costs.

Based on the Brookings/ICF long-term care financing model, which simulates utilization and financing of long-term care services through the year 2020, it was estimated that a national Partnership program involving all 50 states could result in a 7 percent drop in Medicaid's share of the total long-term care bill between 2016 and 2020. Most states do now have Partnership

programs. Since the Partnership program will protect assets (not income), it is expected to be well received in those states that begin to utilize Partnership long-term care programs.

Partnership facts:

-The average age of early Partnership respondents was 58 or 59 years old (depending upon the state).

-Respondents listed their health as primarily excellent.

-The average age of Partnership policyholders ranged from 58 to 63, depending upon the state. California, for example, reported an average age of 60.

-Women purchased more Partnership policies than men.

-The majority of Partnership policy owners were married.

-For most, this was the first time they had bought a long-term care policy of any type.

-In California, Connecticut, and Indiana the majority of policy holders had income greater than $5,000 per month and total non-housing assets of more than $350,000.

The purchase of Partnership policies have increased significantly since the program began, although there were some down periods in sales. Two states reported that they did not feel the decline in sales had anything to do with Partnership plans since all long-term care policy sales were down.

Most of the Partnership policies written were comprehensive, covering both nursing home care and home and community-based care.

State Amendments and Waivers

Medicaid is the largest payor of nursing home bills for the elderly. Medicaid is a joint federal-state program that is financed (on average) 57 percent by the federal government and 43 percent by the states. The individual states administer the program in their state according to their Medicaid state plans, which are set up within broad federal guidelines. States can make changes or innovations that go beyond current state parameters, which is the case with Long-Term Care Insurance for the Elderly initiatives in Partnership participating states. States must have the federal governments' permission to have the federal parameters or requirements changed, even when it benefits consumers.

One approach has been to use waivers of federal requirements. A waiver of Medicaid requirements can be obtained in different ways:

-Federal legislation: a federal legislative waiver is essentially a congressional mandate that gets written into public law.

-Administrative approval: Health Care Financing Administration (HCFA) of the U.S. Department of Health & Human Services administers Medicaid and can grant an administrative waiver of Medicaid requirements. Administrative waivers come in three types:

-Freedom-of-choice waivers
-Home- and community-based-services waivers
-Research waivers, which are typically used to test innovative ideas on a portion of those eligible for Medicaid

Administrative waivers typically have a time limit on their duration and have special reporting requirements.

Another approach, the one used for the Partnership program, is through a state amendment to its Medicaid state plan. A state plan amendment may be used in lieu of waivers. States submit their plan amendments to the HCFA requesting permission to alter their Medicaid programs. In this case, the federal role is to approve the modifications (rather than waive compliance with the law) within the existing federal statutory authority. When such amendments are approved the changes become part of the state plan until either the state makes another amendment or until the statutory requirements are changed. Where administrative waivers have a set durational time limit, state plan amendments have no time restrictions and there may be no special reporting requirements.

The first Partnership models required waivers, but later models did not. Models were amended to minimize the need for federal waivers. The plans initiated in early 1988 required a Federal waiver.

Early legislative activity for the waivers included introducing bills specifically aimed at Partnership plans, along with attempts to include waiver language in various budget reconciliation bills. Those efforts never reached the floor of Congress for a vote because a congressional conference eliminated from consideration all budget-neutral items, which included the Partnerships. This decision reflected the need to undo a logjam in the 1989 budget reconciliation process.

Subsequent efforts to revive waiver legislation met with strong opposition led by Democratic Congressmen Henry Waxman of California, Chair of the House Subcommittee on Health and the Environment, which controlled legislation involving the Medicaid program, and John Dingell of Michigan, chair of the House Energy and Environment Committee. They had specific concerns, including the belief that:

-The standards implicit in the waiver request were too lenient

-Private insurers needed to improve consumer protections substantially before playing a major role in public-private partnerships

-Medicaid dollars should go to help only the poor and nearly-poor rather than those with enough assets to purchase long-term care policies

-The direct link between the public and private sectors should be made only with great caution, since direct links might imply extensive public responsibility to ensure the fairness, viability, and quality of the private insurance product

After the political opposition blocked the initial attempts in the late 1980s, the state Partnership program teams shifted to a Medicaid state plan amendment strategy to obtain the required approvals. This was not a fast process. Delays occurred for various reasons, including:

-Insurance regulations governing partnerships in several of the states had to be modified to reflect the Medicaid state plan amendments

-State legislatures usually had to approve the regulation changes and then HCFA had to approve the state plan amendments

In the end, the four states that implemented their partnerships (California, Connecticut, Indiana, and New York) received HCFA approval of their Medicaid state plan amendments.

Due to the delays caused by the Medicaid state plan amendment process and HCFA's separate process needed to approve them, the Robert Wood Johnson Foundation (RWJF) awarded implementation grants to the states one at a time, from August 1987 through December 1988. Normally the national program procedure is to authorize all project sites at once.

The states that had planned to have a Partnership program, but did not implement it, cited political opposition, fiscal constraints, and regulatory barriers as the primary obstacles to doing so.

California, Connecticut, and Indiana based their Partnership plans on a dollar-for-dollar model, although Indiana changed its model in 1998. Under the dollar-for-dollar model, for each dollar of long-term care coverage purchased by the insured from a private insurance carrier participating in the partnership, a dollar of assets was protected from the spend-down requirements for Medicaid eligibility. Therefore, if Joe buys a policy that provides $50,000 in benefits, he is protecting the same amount ($50,000) of his personal assets from the spend-down requirement. Partnerships do not protect Joe's income, just the assets he has acquired.

For asset protection, the consumer purchases an insurance policy that stipulates the amount of coverage that he or she wishes to have. That figure purchased is the amount the insurer will pay out in benefits under long-term care coverage in a nursing home, assisted living, or other qualified service. Once the purchased benefit amount has been fully paid out by the insurer, Medicaid can assume coverage, following application and approval for Medicaid eligibility. The policyholder, as previously stated, would contribute income towards his or her care since only assets are protected by Partnership policies.

Traditional long-term care policies still offer valid benefits, but since they do not protect assets, Medicaid coverage could only begin after the insured had depleted their assets down to approximately $2,000. In other words, after the non-partnership insurance policy had paid out all available benefits, the individual would still have to use all their assets before Medicaid would step in and pay anything towards their medical care. With Partnership policies, special Medicaid

eligibility regulations allow the policyholder to keep assets (not income) up to the level of long-term care benefits they purchased. Since assets are protected only to the level of insurance benefits purchased, the amount of coverage needs to be given great thought. If the Partnership policy benefits expire with the policyholder having assets greater than those protected by the Partnership policy, the insured will be required to spend-down the excess assets prior to qualifying for Medicaid. This does not necessarily mean that he or she should have purchased greater benefits, but it is certainly something to be considered.

Whatever non-housing assets the insured has, he or she will be allowed to keep an amount of assets equal to the amount of long-term care coverage that was purchased through the Partnership program (plus the $2,000 in assets that everyone is allowed to keep). Any income, including Social Security income, pension income, or any non-housing income that is received must be contributed to the policyholder's medical care expenses.

Even though a traditional, non-partnership policy does not protect assets, such policies still have value. The benefits provided by non-partnership policies still allow the insured to keep assets that might otherwise have been spent for medical care – if enough traditional insurance benefits were purchased they might fully cover the care preventing Medicaid application entirely. Even so, it would seem prudent (if the choice is available) to purchase Partnership policies since extra protection for assets come with them.

When the first states introduced Partnership plans, New York chose a different approach. Rather than offer dollar-for-dollar benefits, they chose a program called the total-assets protection model. Under this program, certified policies had to cover three years in a nursing home or six years of home health care. Once the benefits were exhausted, the Medicaid eligibility process did not consider any assets of the insured at all. Protections were granted for all assets, even those far above the amount of protection purchased. Income still had to be contributed to the individual's health care, just as in the dollar-for-dollar plans. Total Asset Partnership plans are more expensive than dollar-for-dollar plans. The Deficit Reduction Act specifies that new long-term care Partnership programs offer dollar-for-dollar models only, not total asset models.

States participating in Partnership plans all conducted extensive promotional and educational campaigns designed to inform the public about the availability of these insurance policies with the goal of increasing sales (which would ultimately relieve the state of some portion of their Medicaid expenditures). RWJF contributed to some of the promotional campaigns by providing contracts with public relation firms. Participating states collected and analyzed sales and marketing data and used the information to evaluate the Partnership programs, making any changes they felt necessary.

Informal versus Formal Care

We usually think of long-term care in terms of formal care (care in an institution) but long-term care can happen anywhere the individual resides, including their home. When care is received at home by family members or friends it is considered informal care.

Most long-term care begins as informal care. Grandma begins forgetting to pay her bills so her daughter takes over that duty. Then Grandma begins to mix up her medications, so her daughter

begins laying them out for her each day and maybe supervising as she takes them as well (to make sure she actually does take them). Grandma begins displaying other issues, such as lack of hygiene or getting lost easily. This might be a gradual slip into cognitive impairment or physical limitations.

Most families initially care for their elderly members. In some cases, they are able to provide care without outside help but in many cases family members eventually need some type of formal care for their ailing members.

Formal caregivers are often paid providers although they may also be volunteers from nonprofit or government organizations, such as meals on wheels. When the beneficiary is able to remain at home there is often a mix of formal and informal care; formal care on a part-time basis (such as visiting nurses) and informal care filling in where necessary by family members. Since family members are often employed it is often necessary to pay formal care providers since there is simply no way for family to care for the patient on a full time basis.

There are various types of both medical and non-medical care and often it is a mix that is required. For example, Grandma might need help with her medications, help bathing, and weekly checkups for her medical conditions to monitor how she is doing. In addition family members might need days off from caring for her.

If it is possible to maintain care at home the cost will be significantly less than moving Grandma to a nursing home or even an assisted care facility. The ability to maintain Grandma in her own home is a significant financial savings. However, as the patient's needs increase (both medical and non-medical) informal caregivers often do not realize the physical and emotional stress that is developing as they try to do everything, while still maintaining their own personal life. Bringing in formal caregivers can allow family members to continue helping, but their help is then more effective. In many cases, keeping informal care available is the key to avoiding institutionalization.

New Federal Legislation: The Deficit Reduction Act of 2005

In the spring of 2006 President George W. Bush signed the Deficit Reduction Act of 2005 (DRA 2005) allowing long-term care insurance Partnership models to be used in all 50 states. This Act makes it harder for individuals to give away money and property (lengthening the time period available for asset repositioning from three to five years) before asking Medicaid to pay for their nursing home care, but it also increased the incentives to purchase long-term care insurance. Policies in the new programs must meet specific criteria, such as federal tax qualification, specified consumer protections and inflation protection provisions.

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.

Questions that Remained Unanswered
Some of the concerns that prompted Congress in 1993 to halt further implementation of additional Partnership programs in other states remain relevant. Do Partnership programs really save state Medicaid funds or do only the wealthy buy them? What consumer protections are needed to ensure that policies will provide meaningful benefits when they are needed 20 years from now? Will existing Partnership and non-partnership policies still be affordable in ten to twenty years? We are finding that some currently issued non-partnership policies have become so expensive that policyholders are allowing them to lapse even though premiums have already been paid for many years.

Health Insurance Portability and Accountability Act (HIPAA)
The federal government has recognized the urgency for long-term care insurance. Although funding the cost of institutionalization can be achieved through other means besides long-term care insurance, it is the most logical avenue for most people. As a result of this recognition, in 1996, the U.S. Congress enacted the Health Insurance Portability and Accountability Act, generally referred to as HIPAA. It may also be known as the Kennedy-Kassebaum Bill. President Bill Clinton signed this act into law in August of 1996. It may also be referred to as Public Law 104-191. The entire law is very complex, but for our purposes only the long-term care portion will be relevant.

Congress attempted to fulfill a number of different public policy objectives:

-Classification of long-term care costs as a medical expense thus providing taxpayers some economic relief, but only if they met specific criteria, including the type of policy they purchased.

-Categorized long-term care insurance as accident & health insurance thereby providing clarity as to the tax treatment of premium and benefits.

-Provided the general public with an incentive to purchase this type of product.

Specifically, the IRS defines "qualified long-term care services" as necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services and maintenance and personal care services required by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner.

This definition is very broad. It could include any type of health service. To control when the cost of long-term care services could receive favorable tax treatment, Congress established a trigger basis for initiating benefits by tying services to a state of disability defined as a "chronically ill individual."

A chronically Ill Individual must be certified by a licensed health care practitioner within the previous 12 months as one of the following:

-The insured is unable, for at least 90 days, to perform at least two activities of daily living, called ADLs, without substantial assistance from another individual, due to the loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing, and

continence.

-The insured requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

It is important to note that this standardized definition of a chronically ill person cannot be altered in any way by state law, and it is the only definition allowed to receive the favorable tax treatment for the cost of long-term care services.

Perhaps the most misunderstood aspect of HIPAA is the 90-day certification for activities of daily living. Its relevance to the deductibility of long-term care expenses is clear. Congress intended to limit long-term care costs to those associated with chronic illness. A clinical definition of chronic illness is one that is expected to last 90 days or more. Some expenses for acute or short-term illnesses were already deductible as a medical expense. If policy makers had ignored the distinction between acute and chronic, it would have had the unintended consequence of allowing taxpayers to deduct all their expenses associated with short-term disabilities, due to the vague nature of the definition of qualified long-term care service.

A taxpayer who wishes to deduct qualified long-term care expenses using the ADL definition must have a licensed health care practitioner certify that the insured is likely to need substantial assistance for at least 90 days. It is important to note the requirement concerns the likelihood of needing care, not necessarily the actual receipt of care. In fact, there is no requirement that the person actually receives the full 90 days of care. The insured must be re-certified at least annually.

The IRS Publication 502 stipulates that the 90-day certification period is not a deductible period for people who have long-term care insurance. Long-term care insurance may still pay benefits following the deductible period of the policy, if any, as long as the certification stipulates that the person is likely to need qualified long-term care services for at least 90 days. The certification may also be done retroactively in the event a claim is not filed until after the deductible period in the policy has been met.

Grandfathered Policies

While questions of tax deductibility follow non-tax qualified LTC policies, tax-qualified long-term care contracts are clearly deductible if specified qualifications are met. Under HIPAA any long-term care insurance contract that meets the Act's requirements will receive specific tax advantages. All other policies are considered to be non-tax qualified. There is an exception, which was made for all long-term care policies issued before HIPAA had been state approved. These policies were "grandfathered" in. Therefore, they are considered tax-qualified even though they did not meet the requirements that were spelled out in the legislation. However if these policies are altered the grandfathered tax-qualified status is lost.

OBRA 1993 Provisions and the Partnership for Long-Term Care

The Omnibus Reconciliation Act of 1993 contained language with direct impact on the expansion of Partnerships for long-term care. The Act recognized the initial four states operating Partnership programs as well as the future program in Iowa and the modified program in Massachusetts.

These six states were allowed to operate their Partnership programs as planned since their state plan amendments were approved by HHS prior to May 14, 1993.

States seeking a state plan amendment after May 14th had to follow the conditions outlined in OBRA '93. There are three sections with specific language pertaining to Partnership programs. Requirements in each section are as follows:

Sec 1917(b) paragraph 1 subparagraph C
Requires any state operating a Partnership program to recover funds from the estates of all persons receiving services under Medicaid. The result of this language is lost asset protection occurring as soon as the insured dies; only while he or she is living are their assets protected from Medicaid recovery. This means assets do not pass on to the insured's heirs. After the participant dies, states must recover what Medicaid spent from the estate, including protected assets under Partnership policies.

Sec 1917(b) paragraph 3
This section prevents any state from waiving the estate recovery requirement for Partnership participants even if they want to in order to promote Partnership plan sales.

Sec 1917(b) paragraph 4 subparagraph B
A specific definition of "estate" was necessary for Partnership participants. Estates:

> -shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law
>
> -any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other assignment.

The above definition may vary from the current definition used by a state for estate recovery. States implementing their Partnership program sometimes found themselves in the position of having to use a more encompassing definition for Partnership participants alone. These post OBRA Partnership states may even have to seek legislative approval to implement the required recovery process for Partnership participants.

Promoting Partnership Long-Term Care Plans
Several organizations promote Partnership plans, including the Center for Health Care Strategies, the National Association of State Medicaid Directors and George Mason University.

There is no doubt that as the numbers of elderly Americans increase, long-term-care (LTC) needs and costs are growing. Many professionals believe that private long-term-care insurance can and should play a more significant role in the financing of home care, community care, assisted living facilities and nursing home services. The hope is that greater use of individually purchased insurance policies will reduce the burden on Medicaid to some degree. State Medicaid programs are the largest payer of nursing home costs since they often serve as the default financier of long-

term care services.

One vehicle designed to encourage consumers to invest in LTC insurance is the expansion of the Partnership for Long-Term Care, developed in the 1980s with support from the Robert Wood Johnson Foundation (RWJF). Through the Partnership program states are promoting 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. Partnership policies encourage individuals to take responsibility for financing their own initial phase of long-term care through use of private insurance and asset preservation.

About 80 percent of those surveyed in the Partnership program said they would have purchased long-term care whether the Partnership program was available or not, since they consider such policies a valuable financial planning tool. The other 20 percent indicated they would have self-financed long-term care if the Partnership plans had not been available (so they would not have bought non-partnership policies) since the need of such care may or may not occur. They purchased the Partnership policies primarily on the basis of asset conservation.

Program Growth

Four states initially implemented Partnership programs in the early 1990s (California, Connecticut, Indiana and New York) and the assumption was that other states would follow. That did not immediately happen however. Citing concerns about the appropriateness of using Medicaid funds for this purpose, Congress enacted restrictions on further development of Partnership programs 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.

There were two different models used for asset protection: dollar-for dollar and asset protection. California, Indiana and Connecticut chose the dollar-for-dollar model. Under dollar-for-dollar, the amount of insurance coverage purchased equals the amount of assets protected from consideration if and when the consumer needs to apply for Medicaid benefits. For example, a consumer who bought a policy with $100,000 in benefits would receive up to $100,000 worth of qualified long-term care insurance benefits. Once the insurance benefits were exhausted, if further care was necessary, the individual would be able to apply for Medicaid coverage, while still retaining $100,000 worth of assets.

New York elected to use the more generous total asset protection model, where consumers were required to buy a more comprehensive benefit package, as defined by the state. The state initially 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.

Partnership Participation

The successful implementation of Partnership programs involves several parties, which includes

state policymakers, private insurers and, of course, individuals to purchase the policies.

The process always begins with the state that is the convener of any Partnership effort. This typically involves many aspects of state government. The Medicaid agency, Governor's office, state budget office, state unit on aging, state legislature, and the state's Department of Insurance 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.

The private insurance industry also needs to be involved in the development of a Partnership program from the very beginning. Consumer input is valuable since a policy that no one buys accomplishes nothing. 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 be helpful in designing public awareness or educational campaigns.

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

Public Education

The success of Partnership programs in reducing state long-term care expenditures depend on the program's ability to encourage people to buy them. The consumers they most wish to target are those with moderate incomes and assets. These are the consumers most likely to need Medicaid benefits since they will quickly deplete their assets and their incomes are not high enough to fund the cost of private care. If the Partnership program merely provides "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 considered the best way to attract individuals who would not otherwise purchase LTC insurance, the experience of the demonstration states played a major role. 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. A Congressional Research Service report noted that some Partnership state directors in the original states felt that the dollar-for-dollar model promoted more affordable policies than the asset protection models. It is no surprise that affordable policies attract persons with less wealth.

The DRA specifies that all new LTC Partnership programs use the dollar-for-dollar methodology since they seem to attract those with less income and assets. 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 income and assets; more generous coverage for those with more to protect. In finding a successful balance between coverage and

costs, it will be necessary for the states to develop and implement programs that alert their residents to the possibilities offered through Partnership long-term care programs. This would include educating consumers about the benefits they are purchasing, the level of benefits that will be provided, and what protection might be best for them.

DRA Requirements

Given the complexity of the long-term care insurance industry, and the additional benefits of Partnership programs, many people felt it was necessary to include not only consumer education, but also agent education in the new state Partnership programs. Long-term care policies have so many options, gatekeepers, and limitations that even experienced agents may not be fully educated on these contracts.

The DRA addresses some issues related to education for both consumers and agents:

-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 long-term care and the costs associated with these services. HHS will provide objective information to help consumers plan for the future. The website www.longtermcare.gov was established 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.

Education for both consumers and insurance agents are closely aligned. Insurance agents play a vital role in ensuring that consumers understand their policy options, policy terms, and benefit 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. Simply having a Partnership policy does not guarantee that Medicaid benefits will be available after exhausting Partnership policy benefits. Each individual must still qualify for Medicaid based on their state's income and functional eligibility criteria. 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 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.

Unfair Claim Practices Defined Under the NAIC

NAIC unfair acts:

-Knowingly misrepresenting to claimants or insureds relevant facts or policy provisions that relate to the coverages at issue

-Failing to acknowledge with reasonable promptness the receipt of communications that are pertinent to claims

-Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims

-Not attempting in good faith to settle claims promptly, fairly, and equitably when it is reasonably clear the insurer is liable to pay such claims

-Compelling claimants to institute lawsuits to recover amounts due under policies by offering substantially less than the amounts that claimants ultimately recovered in lawsuits

-Refusing to pay claims without conducting a reasonable investigation of those claims

-Failing to affirm or deny coverage of claims within a reasonable time after completion of the claim investigation

-Settling or attempting to settle claims for less than the amount that a reasonable person would believe the claimant was entitled to receive according to the terms of advertising material that accompanied or was part of an application

-Settling or attempting to settle claims based on an application that was materially altered without notice to, or the knowledge or consent of, the policyowner

-Making claim payments without indicating the coverage under which each payment is being made

-Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form

-In the case of claim denials or offers of compromise settlement, failing to promptly provide a reasonable, accurate explanation of the reason for such actions

-Failing to provide forms necessary to present claims within 15 calendar days of a request for such forms

Unfair Claim Distributions

Policyholders have the right to expect their insurers to handle valid claims in a fair manner. Of course, the claims must comply under the benefits purchased in the policy, but when it is a valid claim insurers have the responsibility of responding in a timely and responsible manner. Most states have rules that prohibit unfair claim practices. Here are some examples of unfair claim practices:

-Attempting to settle a claim based on an application which the company has changed without the insured's knowledge or permission;

-Delaying a claim investigation by requiring unnecessary reports or documents;

-Failing to act promptly after receiving information concerning an insurance claim;

-Failing to comply with prompt claims investigation standards;

-When applicable, failing to pay a claim quickly, fairly and equitably;

-Failing to promptly settle claims where liability is reasonably clear under one portion of the policy to influence settlement under any other portion of the insurance policy coverage;

-Failing to promptly and clearly explain the basis in the policy or the law for either denying a claim or offering a compromise settlement;

-Discouraging a policyholder from using arbitration;

-Misrepresenting significant facts or insurance policy provisions;

-Refusing to keep an insured informed of claim developments within a reasonable time after receiving a completed proof of loss statement;

-Denying claims without a reasonable loss investigation;

-Offering very low settlements to encourage insureds to sue; and

-Settling claims for amounts that are lower than a reasonable person would expect.

Policy Benefits are Chosen at the time of Application

The type of benefits available in a long-term care policy will depend in part on what the individual

chooses at the time of application. He or she determines the types and extent of the policy's coverage; the more benefits chosen, the more expensive the policy will be.

Mandatory Protection in Partnership LTC Policies

In Partnership policies some types of coverage are mandatory, such as inflation protection. Inflation protection has recently gained recognition for its value as costs have sharply risen. An inflation provision 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.

FPO and ABI

There are two main types of inflation protection used in long-term care insurance plans: future-purchase options (FPO) and automatic benefit increase options (ABI). Under FPO protection the consumer agrees to a premium for a set amount of coverage. At specified intervals (such as every two years, for example), the insurance issuer offers to increase existing coverage for additional premium. If the consumer declines the increased benefits (or cannot afford to buy them) policy benefit levels remain the same, even though costs for long-term care services may be increasing. A policy purchased to pay a $100 daily benefit may not be adequate ten years later. On the other hand, it may be better to have a $100 per day benefit than none at all.

With ABI, the amount of coverage automatically increases annually by a contractually specified amount. 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) have not issued guidance on this matter.

Suitability Forms and the NAIC Model Regulations

"Model Regulations" mean the NAIC Long-Term Care Insurance Model Regulation, Model #641, as adopted by the NAIC on September 1, 2000, including all amendments.

Suitability Form Requirements:

Long-Term Care Insurance Personal Worksheet:

-The standards for the Personal Worksheet must be at least those prescribed in Appendix A of these standards, and the text used may not be less than 12-point type (this text is in 12-point type).

-The insurance company may request the applicant to provide additional information to comply with its suitability standards.

-The Rate Increase History section of the Personal Worksheet must accurately list each premium increase the company has instituted on the worksheet and similar policy forms in any state during the last 10 years. The list must provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The company must provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The company may provide, in a fair manner, additional explanatory information as appropriate. Supporting documentation for each state validating the Rate Increase History section of the Personal Worksheet must also be included with the filing.

Unfortunately applicants are not always willing to provide requested financial information; when this occurs, agents and insurers are not responsible for unsuitable decisions made by the buyers, but agents and insurers must still follow all suitability guidelines as much as possible.

Reciprocity between States

In 2001 Indiana and Connecticut implemented a reciprocity agreement between them 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. Prior to this agreement asset protection did not transfer outside of the state where the policy was purchased, although the Partnership insurance benefits were portable. The asset protection specified in the agreement are 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.

An individual who has not yet retired may not know where he or she will reside in future years so reciprocity is an attractive feature. 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.

State Funding

States already face huge financial stress as the baby boom generation ages. The Center for Health Care Strategies (CHCS) launched an initiative designed to help states take advantage of new opportunities through the DRA. The Long-Term Care Partnership Expansion project was underwritten by the Robert Wood Johnson Foundation.

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 policymakers.

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.