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Medicaid's Long-Term Care Insurance Partnership Program

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Summary

Under Medicaid's long-term care (LTC) insurance partnership program, persons who have exhausted (or used at least some of) the benefits of a private long-term care insurance policy may access Medicaid without having to meet the same means-testing requirements as other groups of Medicaid eligibles. Currently, Medicaid law allows four states (California, Connecticut, Indiana, and New York) to operate partnership programs. These states disregard some or all the assets of applicants who apply to Medicaid after exhausting their private benefits and exempt these assets from estate recovery after the beneficiary has died. Only persons who purchase pre-approved LTC insurance policies meeting state-defined requirements may participate. The partnership program is intended to encourage persons to purchase LTC insurance who would not otherwise do so, reduce incentives for person to transfer assets to qualify for Medicaid sooner than they otherwise would, and contain Medicaid spending on long-term care services.

According to data provided to CRS by the partnership states, about 181,600 partnership policies (private LTC insurance policies approved by the state to qualify for asset protection should an individual require Medicaid) have been sold. Of all purchasers, 88 persons, or 0.5%, have received Medicaid coverage for their LTC needs. A total of \$2.8 million in assets have been protected for persons in California, Connecticut, and Indiana who have qualified for Medicaid. It is unknown how many persons with policies still in-force will eventually qualify for Medicaid.

The majority of partnership policies purchased offer comprehensive benefits that include coverage of nursing home stays and home care. All of the partnership states require that policies be protected against inflation for at least some of its purchasers. Surveys conducted in California and Connecticut show that almost half of partnership purchasers have assets of greater than \$350,000 and a survey conducted in Indiana shows that 60% of purchasers have assets of greater than that level (excluding the home). In contrast, an average of 20% of purchasers in California and Connecticut have assets of less than \$100,000 (excluding the home). In New York, 8% of purchasers have assets of less than \$50,000.

In response to state interest, Congressional proposals were introduced in the 108th Congress that would have allowed states the option of expanding the LTC insurance partnership program from a four-state model to a nationwide program. The Presidents' fiscal year (2004 and 2005) budgets also included similar proposals. Debate about the partnership program is likely to be continued in the 109th Congress.

This report provides a summary of the experiences of the four states in implementing the partnership program, including data and analysis of participation, policies purchased, and the market for LTC insurance. It also attempts to evaluate the extent to which the asset protection promised under the partnership program is sufficient and necessary to encourage more persons to purchase LTC insurance, and discusses other key issues raised by policymakers and stakeholders concerning the expansion of the partnership program to the national level. Legislative proposals are also described.

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Medicaid's Long-Term Care Insurance Partnership Program

Introduction

In 1988, Alice Rivlin and Joshua Wiener authored a study titled *Caring for the Disabled Elderly: Who Will Pay?*¹ Among other things, the study outlined a theory about the potential for the public sector to aid private markets in assuming a larger role in the financing of long-term care (LTC). At the same time, California, Connecticut, Indiana, and Massachusetts had begun addressing this issue at the state level. Shortly thereafter, the Robert Wood Johnson Foundation gave seed money to some states to develop programs that would integrate public-private partnerships in long-term care financing. The planning grants resulted in the development of long-term care insurance partnership programs that would allow persons who purchase long-term care insurance² to qualify for Medicaid³ coverage of long-term care services without meeting the same asset requirements that other Medicaid applicants must meet.

Implementation of the program, however, required a significant change in federal Medicaid rules. Connecticut was the first state to seek and gain approval (under §1902 authority of the Social Security Act) from the Centers for Medicare and Medicaid Services (CMS, at the time, the Health Care Financing Administration) to amend their Medicaid state plans to disregard some or all of the assets of persons

¹ Washington, DC: Brookings Institution Press, 1988.

² This insurance product provides persons needing assistance with long-term care with protection against the high cost of long-term care services without relying on public sector programs such as Medicaid. Care in a variety of settings may be covered, including nursing facilities, assisted living facilities, or the individual's own home through home health, respite care for caregivers, homemaker and chore services, among others. LTC policies vary with regard to features. These include criteria to qualify for benefits; a waiting ("elimination") period between the onset of qualifying impairments and commencement of payment; dollar limits on payments and possible inflation adjustments of the limits; whether payments are a flat daily amount regardless of expenses or are paid only as reimbursement for approved expenditures; and the length of time over which benefits may be paid (such as one year, three years, or longer).

³ For background and statistical information about the Medicaid program, see CRS Report RL32277, *How Medicaid Works: Program Basics*, by Elicia Herz, Jean Hearne, Julie Stone, Karen Tritz, Evelyne Baumrucker, Christine Scott, Chris Peterson and Richard Rimkunas.

who purchase long-term care insurance policies.⁴ Political debate about the advantages and disadvantages of this partnership program, however, resulted in significant opposition to the use of public funds to support investment in the private market for insurance. As a result, Congress included in the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) a provision limiting approval of Medicaid exemptions for estate recovery⁵ to only those states with approved state plan amendments as of May 14, 1993.⁶ By that date, five states (California, Connecticut, Indiana, Iowa, and New York) had received CMS approval. All of these states, except Iowa, have implemented partnership programs. These four states received assistance from the Robert Wood Johnson (RWJ) Foundation to help design, market, and operate what became known as the LTC insurance partnership programs.

Under Medicaid's LTC insurance partnership program, states with approved §1902(r)(2) plan amendments may extend Medicaid coverage, including long-term care benefits (i.e. nursing home and home and community-based services) to certain persons who have purchased private LTC insurance policies without requiring them to meet the same means-testing requirements applicable to other groups of Medicaid eligibles. During the eligibility determination for Medicaid, these states may disregard either a portion, or all assets, of the Medicaid applicants to the extent that payments have been made under a LTC insurance policy or because an individual has received (or is entitled to receive) benefits under a LTC insurance policy. Upon the death of the beneficiary, the statute also allows these states to exempt either some or all of the individual's assets from Medicaid estate recovery. The grant agreement negotiations with RWJ included a number of additional requirements that have significantly contributed to the current design of the partnership program model. These include minimum criteria which LTC insurance policies must meet to qualify as "partnership policies." States also review and approve each of these policies before they become available on the market. Under the program, participants must still meet certain income and functional eligibility requirements to qualify for Medicaid.

⁴ To qualify for Medicaid, applicants' income and resources must be within certain limits. The specific income and resource limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions. Consequently, those standards vary considerably among states, and different standards apply to different population groups within a state. For many of those groups, states may seek permission under a special provision, Section 1902(r)(2), to use more liberal standards for computing income and resources than are specified within each of the groups' definitions. Under the partnership program, Section 1902(r)(2) is used to ignore or disregard certain amounts of assets, thereby extending Medicaid to individuals with earnings or assets too high to otherwise qualify under the specified rules for that eligibility pathway.

⁵ The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) amended Medicaid law to require that all 50 states and DC seek adjustment or recovery from the individual's estate for medical assistance provided to persons age 55 or older. Mandatory recovery or adjustment is limited to Medicaid payments for nursing facility services, home and community-based services and related hospital and prescription drug services. In addition, states are given the option of recovering funds spent on additional items or services covered under the state's Medicaid plan. The OBRA1993 provision was part of a larger effort by Congress to assure that a person's assets are applied to the cost of care when Medicaid becomes a payer of that care.

⁶ §1917(b)(1)(C) of the Social Security Act.

Through the promise of Medicaid asset protection, the partnership program is designed to encourage people to purchase private LTC insurance when they might not otherwise do so. It is also intended to incur savings both to Medicaid, by delaying or preventing spend-down to Medicaid eligibility, and to individuals, by having them rely on insurance policies to cover LTC expenditures that would otherwise be paid by personal income and savings. The person's protected assets are generally used by the individual to maintain a certain living standard, to pay for care not covered by Medicaid, or to pass on as inheritance to their heirs.

States have used different models for protecting the assets of eligible participants. Connecticut and California adopted a *dollar-for-dollar* model, in which the amount of the assets protected for a participant is equivalent to the value of the benefit package paid by the policy purchased (e.g., \$100,000 of nursing home or assisted living coverage enables that individual to retain up to \$100,000 in assets and still qualify for Medicaid coverage in that state). New York uses a *total asset protection* model in which persons who purchase certain state-approved policies may qualify for Medicaid without having to meet any of Medicaid's asset criteria. Indiana uses a hybrid model, offering both dollar-for-dollar and total asset protection (Indiana switched from the dollar-for-dollar model to the hybrid model in 1998).

In recent years, several non-partnership states have expressed interest in establishing partnership programs and have encouraged Congress to repeal the provision in §1917 of the Social Security Act that prohibits additional states from exempting LTC insurance buyers from Medicaid estate recovery requirements. Further, the National Association of Health Underwriters reports that 17 states have passed enabling legislation allowing each of these states to establish a partnership program when and if federal legislation is changed⁷.

In response to state interest, Congressional proposals were introduced in the 108th Congress that would have allowed states the option of expanding the LTC insurance partnership program from a four-state model to a nationwide program. The President's fiscal years (FY) 2004 and 2005 budgets also included proposals that would have granted states this flexibility. As a result of this broad interest, debate about the partnership program is likely to be continued in the 109th Congress. In large part, disagreement has centered around the following themes:

- the appropriateness of using the Medicaid program — a program designed to serve persons who are poor or near poor with high medical expenses — to promote the expansion of the private sector market for long-term care insurance;
- whether the asset protection promised under the partnership program is a necessary and sufficient incentive to encourage the purchase of LTC insurance by persons who would not otherwise purchase it and

⁷ Kevin P. Corcoran, CAE, Testimony for the United States Senate, Special Committee on Aging, National Association of Health Underwriters, June 22, 2004, at [http://aging.senate.gov/_files/hr126kc.pdf].

allow persons to retain large sums of assets in excess of Medicaid rules that apply to everyone else; and

- whether the program results in Medicaid savings, among others.

To help Congress evaluate these proposals, this report provides a summary of the experiences of four states — California, Connecticut, Indiana, and New York — in implementing the partnership program. It also discusses key issues raised by policymakers, state directors of the LTC insurance partnership programs, and policy analysts concerning the expansion of the partnership program to the national level.

Summary of Findings

The following section presents data available on the partnership programs and discusses selected policy issues regarding the partnership programs and the insurance market in general. This information is based, in part, on the data provided to the Congressional Research Service (CRS) by the LTC insurance partnership programs and CRS conversations with the directors of these programs in spring of 2004.

Partnership Purchasers and Policies Sold

State Program Models.

- Connecticut and California adopted a dollar-for-dollar model.
- New York uses a total asset protection model, but is in the planning stages of adding a dollar-for-dollar option.
- Indiana uses a hybrid model, offering dollar-for-dollar and total asset protection.
- The dollar-for-dollar model allows states to approve more affordable options for lower-income consumers, while total asset protection encourages states to approve policies that are higher in value and thus more attractive to persons with higher incomes.

Partnership Participation.

- About 181,600 partnership policies have been sold; 149,300 are still in-force.
- About 2,200 persons, or 1.2% of partnership purchasers, have received private LTC insurance benefits.
- Of all purchasers of partnership policies, 88 persons, or 0.5%, have received Medicaid coverage of their LTC needs.
- A total of \$2.8 million in assets have been protected for persons in California, Connecticut, and Indiana who have qualified for Medicaid.
- The population of persons age 65 and older living in the Partnership states totaled 7.8 million in 2000. Data collected by states show that 181,623 Partnership policies have been sold in these states since the programs' establishment. Although not all of the persons in this age

category are ideal candidates for LTC insurance, the program has had limited reach.

Target Populations.

- The LTC insurance partnership program was intended to encourage persons to consider the purchase of LTC insurance as an alternative for financing their care. It was especially intended to reach persons with middle and lower level wealth status.
- Surveys conducted of California and Connecticut show that almost half of partnership purchasers have assets of greater than \$350,000 and a survey conducted in Indiana shows that 60% of purchasers have assets of greater than that level (excluding the home). In contrast, an average of 20% of purchasers in California and Connecticut have assets of less than \$100,000 (excluding the home). In New York, 8% of purchasers have assets of less than \$50,000 and 13% have between \$50,000 and \$200,000.
- Regarding income, a significant proportion of buyers have monthly income that exceeds \$5,000 in California (58%) and Indiana (43%). In contrast, more than half of purchasers in Connecticut (57%) have income less than \$2,500.
- Some persons also hoped that Partnership policies would be attractive to younger buyers as well.
- Although data are significantly limited, a comparison of data that are available on the partnership states and data on LTC insurance purchasers in general show that long-term care insurance partnership purchasers may be slightly younger than purchasers of LTC insurance in general.

Features of Policies Sold.

- The majority of partnership policies purchased offer comprehensive benefits that include coverage of nursing home stays and home care.
- Many of partnership policies sold in the four states cover three or more years of coverage (i.e., 64% in California and 94% in Indiana), whereas 36% of policies sold in California and 20% of policies sold in Connecticut cover two or fewer years of coverage.
- All of the partnership states require that policies be protected against inflation for at least some of its purchasers. (This requirement varies in two states by age of policyholder.)

Insurer Participation.

- Under the grant agreement with RWJ, states established procedures requiring insurers to seek state approval of partnership policies before they can be sold in the market.
- The number of insurers selling policies in each of the partnership states ranges from five companies in California to 13 companies in Indiana.

Policy Issues

The Market for LTC Insurance: Market Stability.

The restructuring of the LTC insurance market may impact the stability of LTC products. The following explains some of these market changes:

- In the near future, 90% of the LTC market will be owned by nine companies, consolidating the nation's privately-insured risk across a small number of private sector carriers.
- In recent years, many insurers have applied stricter underwriting practices and raised premiums to limit their exposure to financial risk.
- Most products are sold through the individual market for insurance.
- Insurer insolvencies and carrier acquisitions may pose risks to policyholders.
- LTC insurance premiums can be costly and unexpected rate increases may affect policyholders' desire and ability to continue coverage.

The Market for LTC Insurance: Regulation and Quality.

- Federal regulation of LTC insurance is limited to the HIPAA provisions concerning the tax treatment of qualified LTC insurance policies; California, Connecticut and New York require that all partnership policies meet these HIPAA requirements; Indiana provides consumers the option to purchase either a tax-qualified or non-qualified partnership policy.
- Significant variation exists in the regulation of LTC insurance across states.
- Many states have limited abilities to monitor problems and trends in the marketplace.
- Although many insurers strongly oppose stricter federal requirements on *all* LTC insurance products, some support the adoption of standardized requirements for partnership policies at the national level.

The Market for LTC Insurance: Other Issues.

- Limited claims experience combined with complex risk factors make it difficult for insurers to predict future claims.
- As a result of underwriting factors, not all persons who can afford LTC insurance can obtain it, even if they apply.

The Partnership Program's Interaction with Medicaid

- Providing asset protection to a select group of Medicaid beneficiaries raises equity considerations by treating one group of Medicaid applicants differently from other groups of applicants.
- Limited empirical data are available to demonstrate whether the asset protection promised under the partnership program is a sufficient and necessary incentive to encourage the purchase of policies by persons who would not otherwise purchase them; as a result, asset protection under Medicaid may be extended to some persons who would otherwise never seek Medicaid eligibility to begin with.
- Based on the available data, it is reasonable to conclude that for some, the promise of Medicaid asset protection plays a significant role in the decision to purchase a partnership policy, while for others it plays a smaller role.
- LTC insurance likely prevents spend-down to Medicaid eligibility for some persons, delays it for others, and has little impact on still others.
- A number of states are likely to support a standard reciprocity agreement across states, while some may have reason to oppose it.

Summary of Four States' Experience

The following section describes the asset protection models used by each of the four partnership programs. It also provides a summary of participation data for partnership policies sold thus far and describes the general features of those policies. Finally, a list of those insurers who sell partnership policies in each of the four states is provided.

State Program Models

Under the RWJ grant agreement, the partnership states developed three models for protecting the assets of LTC insurance purchasers. The following is a brief description of these models:

- **Dollar-for-Dollar Asset Protection.** Under this model, the maximum amount of assets (such as savings, stocks, investment property) that may be disregarded during Medicaid's eligibility assessment and that are not subject to estate recovery is equivalent to the total value of benefits paid by the policy purchased. In Connecticut, for example, the minimum daily benefit that can be sold is \$144 per day of coverage. Thus, a one-year policy could pay out \$52,560 (\$144 x 365 days) for an equivalent of \$52,560 in asset protection. The minimum two-year policy would provide asset protection of at least \$105,120, and a minimum three-year policy would provide asset protection of \$157,680. For inflation-protected policies, the value of the benefits and thus the amount of assets

protected grow annually. For example, a policy that pays \$150 per day of coverage would pay \$54,750 for one year if the payout began next week, but \$297 per day at 5% annual compounded inflation adjustment (or \$108,401 for one year of coverage) if the payout began 14 years from now. Under this scenario, a one-year policy would result in a disregard of up to \$108,401 of the participant's assets during the Medicaid eligibility determination as well as an exemption from estate recovery of this amount after the participant's death.

- **Total-Asset Protection.** Under this model, participation is limited to persons who purchase state-approved LTC policies with a minimum benefit package defined by the state. For example, to have all one's assets disregarded in New York, participants must exhaust the benefits from a policy that covers at least three years of nursing home coverage and/or six years of home care coverage where the amount of coverage for two days of home care is equivalent to the amount of coverage for one day of nursing home care. Persons who purchase such policies may qualify for asset protection under Medicaid after private insurance benefits are exhausted and when they meet Medicaid's income and functional eligibility criteria. They are not subject to any of Medicaid's asset requirements.
- **Hybrid Model.** Under this model, the amount of asset protection obtained depends on the value of the benefits exhausted. In Indiana, for example, to qualify for total asset protection participants must exhaust a policy that covers about 4.2 years of nursing home care. In Indiana, this is equivalent to coverage of at least \$187,613 of care for any setting. This minimum criteria is updated annually according to Indiana's average daily nursing home rate (\$121 in 2004) and adjusted for inflation. Any policy of benefit value below this amount would provide a participant with dollar-for-dollar asset protection.⁸

According to some state directors of the partnership programs, the dollar-for-dollar asset protection model allows the state to approve smaller policies that can be more affordable for persons with less wealth. Providing a range of options to consumers with fewer savings (e.g., smaller policies for less asset protection and larger policies for more asset protection), they assert, makes it easier for persons to purchase LTC insurance and makes asset protection accessible to a broader population. It also, according to state directors, helps delay or prevent additional persons from spending down to Medicaid eligibility. According to New York's state director, the fact that total asset protection is tied to larger policies (i.e., three years of nursing home care or six years of home care) tends to make them more expensive.

⁸ Under Indiana's hybrid model, 75% of its 31,042 policies purchased have earned total asset protection, while 25% earned dollar-for-dollar protection. Source: Indiana's partnership program, June 2004.

He argues, therefore, that this model restricts access to those persons with higher income levels and assets who can afford more comprehensive policies. In hopes of expanding access to the partnership program to persons with less wealth, New York is currently considering expanding its total asset protection model to a hybrid model so that persons who purchase fewer than three years of coverage could obtain dollar-for-dollar asset protection.

Most partnership participants who obtain asset protection under Medicaid exhaust their private LTC insurance benefits before qualifying for Medicaid. These persons generally obtain the full asset protection allowed by the policy, or obtain total asset protection (if applicable). However, persons may qualify for Medicaid before exhausting their private benefits in California, Connecticut, and Indiana and still obtain some asset protection, although less than they would have if they had exhausted their entire LTC insurance policy. Persons who apply for Medicaid before exhausting their LTC insurance policies must spend-down to Medicaid income eligibility thresholds and meet the functional eligibility requirements in that state. The amount of asset protection they can obtain is equivalent to the value of private benefits paid out at the point in time in which Medicaid eligibility is established. For this group, Medicaid would cover services not covered by the long-term care insurance policy (possibly adult day care, certain adaptive technologies, certain mental health services, etc.) and the policy would continue to pay benefits until they are exhausted.

Partnership Participation

Under a mutual agreement, the four partnership states maintain quarterly records of program participation, including counts of policies sold, counts of policies in-force, number of persons triggering private benefits, and the amount of assets protected under the program. These data are provided to the states by the insurers that sell partnership policies. The states also track the number of partnership participants that qualify for Medicaid (see **Table 1**).

Since the program's establishment in the early 1990s, 181,623 partnership policies have been sold. About 2,200 persons, or 1.2% of purchasers, have qualified for private benefits thus far. Furthermore, of all partnership purchasers to date, 88 have qualified for Medicaid coverage, constituting .05% of total purchasers. About 82% of policies sold, or 149,300 policies, are currently in-force (**Table 1**). It is unknown how many of these persons with policies still in-force will eventually qualify for Medicaid.

A total of \$2.8 million in assets have been protected for persons who have qualified for Medicaid in California, Connecticut, and Indiana (**Table 1**). Such persons might have qualified after exhausting their private benefits and spending down to Medicaid eligibility thresholds, or they may have become eligible for Medicaid while receiving private benefits. For persons who qualify for Medicaid while receiving benefits from a LTC insurance policy, Medicaid covers only those services not covered by either the policy or Medicare (possibly adult day care, certain adaptive technologies, certain mental health services, etc.). The insurance policy continues to pay benefits until it is exhausted.

According to the most recent data available, \$7 million has been protected in three states by persons who did not qualify for Medicaid before death. Data on the amount of assets protected in New York are not available since the state does not collect such information because all assets of individuals are protected for persons buying partnership policies (**Table 1**).

Table 1. Participation in Long-Term Care Insurance Partnership Program

State	Partnership policies ever purchased (since program's establishment)	Policies in-force (based on most recent data)	Persons who ever receive(d) LTC insurance benefits	Percent of persons who received LTC benefits who purchased a policy	Total count of purchasers who received Medicaid	Percent of purchasers who received Medicaid	Assets protected for persons who received Medicaid ^a	Assets protected for persons Who died before accessing Medicaid ^b
CA (as of 12/03)	63,984	54,632	838	1.3%	21	0.03%	\$1.1 million	\$3 million
CT (as of 12/03)	33,068	26,938	279	0.8%	16	0.05%	\$1.1 million ^c	\$2.5 million
IN (as of 3/04)	31,042	25,998	187	0.6%	13	0.04%	\$0.646 million	\$1.5 million
NY (as of 9/03)	53,529	41,732	896	1.7%	38	0.07%	amount not known ^d	amount not known ^d
Total	181,623	149,300	2,200	Average: 1.2%	88	Average: 0.05%	\$2.8 million (for three states)	\$7 million (for three states)

Sources: CRS survey of states, May and June 2004. Data provided to states by the insurers of partnership policies.

a. The amount of assets protected by persons who purchased partnership policies and received Medicaid.

b. Total asset protection earned that will NOT be accessed due to policyholders demise while receiving the benefit.

c. Total Medicaid asset protection earned by policyholders who have accessed Medicaid or have applications pending per official notice from CT's Medicaid office.

d. Under NY's total asset protection model, all assets are protected.

Target Populations. Combined, the population of persons age 65 and older residing in California (3.8 million), Connecticut (.5 million), New York (2.5 million) and Indiana (0.8 million) was 7.6 million in 2000.⁹ Although many of these individuals are not ideal candidates for the purchase of LTC insurance, either because they have too little or too much wealth, just a small percent (2.4%) have purchased Partnership policies. According to the most recent data available, only 181,623 Partnership policies have ever been sold in these states. Although more than 10 years have passed since the Partnership program's inception, the program is still small and has had limited reach.

The LTC insurance partnership program was intended to encourage the purchase of LTC insurance in general, and especially among persons with middle and lower level wealth status. Some persons also hoped that Partnership policies would be attractive to a younger population as well. Although some data are available demonstrating the asset levels and age levels of partnership policy buyers at the time of purchase, the small sample size of the surveys limits the ability to generalize from these data. Without more information, it may be difficult to determine the extent to which the partnership program is reaching the intended populations in the four states.

Income and Assets of Purchasers. Surveys conducted by three partnership states provide some data on the income and asset levels of buyers at the time they purchased partnership policies. Data show that almost half of partnership purchasers in California and Connecticut have assets, excluding the home, of greater than \$350,000 (46% and 48% respectively) and 60% of purchasers in Indiana also have assets of greater than this level. Many purchasers also have assets of greater than \$100,000 (79% in California, 82% in Connecticut). In contrast, an average of 20% of purchasers in California and Connecticut have assets of less than \$100,000 (excluding the home). In New York, .8% of purchasers have assets of less than \$50,000 and 13% have between \$50,000 and \$200,000.

Regarding income, a significant proportion of buyers have monthly income that exceeds \$5,000 in California (58%) and Indiana (43%). In contrast, more than half of purchasers in Connecticut (57%) have income less than \$2,500. According to these data, Connecticut has had the greatest success in encouraging persons with lower income to purchase partnership policies. In Indiana, 17% of purchasers had monthly income less than \$3,000, 34.5% had monthly income between \$3,000 and \$5,000, and 43% had income of greater than \$5,000 (**Table 2**).¹⁰

⁹ U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, 2000 Census of Population and Housing, 1990 Census of Population and Housing, Small Area Income and Poverty Estimates, County Business Patterns, 1997 Economic Census, Minority- and Women-Owned Business, Building Permits, Consolidated Federal Funds Report, 1997 Census of Governments.

¹⁰ NY has not conducted a purchaser survey since 1995. The state is therefore not included in **Table 3**.

Survey data by America's Health Insurance Plans (AHIP) includes demographic information of 2,728 LTC insurance purchasers from 12 companies in 2000.¹¹ The AHIP surveys shows a similar trend for other long-term care insurance buyers, with 71% of respondents reporting liquid assets (excluding the home) of \$100,000 or greater and 29% of respondents reporting liquid assets of less than this amount. In addition, many survey respondents (42%) reported monthly income of greater than \$4,167 (\$50,000 per year), with 17% of respondents reporting having income at or below \$25,000 (\$2,083 per month).¹² The AHIP survey is not nationally representative.

**Table 2. Income and Assets at Time of Purchase
(Purchaser Surveys Conducted by States)**

State	Average monthly household income	Total assets (excluding home)
CA n = 629	Less than \$2,000: 5% \$2,000-\$5,000: 37% Greater than \$5,000: 58%	Less than \$100,000: 21% \$100,00-\$350,000: 33% Greater than \$350,000: 46%
CT n = 699	Less than \$2,500: 57% \$2,500-\$5,000: 14% Greater than \$5,000: 14%	Less than 100,000: 19% \$100,00-\$199,999: 17% \$200,000-\$350,000: 17% Greater than \$350,000:48%
IN n = 576	Less than \$3,000: 17% \$3,000-\$5,000: 34.5% Greater than \$5,000: 43% Unknown: 5.5%	Less than 50,000: 0.8% \$50,000-\$199,999: 13% \$200,000-\$350,000: 21% Greater than 350,000: 60% Unknown: 5.2% (Own home: 94%)

Sources: Purchaser Survey 2002, California Department of Health Services, California Partnership for Long Term Care: Annual Report, Oct. 2003; Annual Report for The Connecticut Partnership for Long-Term Care Research: Evaluation Studies. July 1, 2001-June 30, 2003. Issued Oct. 2003; and Indiana Purchaser Survey 2002 of 576 respondents.

Note: Variations in data reported reflect differences in the way each state collects and reports data. NY has not conducted a purchaser survey since 1995 and is thus not included in this table.

Without a larger sample size of partnership purchasers, it is still difficult to know the extent to which the program has been successful in reaching persons with middle- and lower-wealth status. However, it is logical to assume that the amount of insurance an individual purchases is at least, in part, related to the amount of financial protection a consumer needs. Under this assumption, lower-priced policies (e.g., one-year and two-year policies) would more likely be purchased by persons with fewer assets to protect, while larger policies (e.g., three-year, four-year, five-year or lifetime policies) would more likely be bought by persons with more assets to protect. As discussed earlier, the majority of partnership policies sold in all four

¹¹ Health Insurance Association of America by LifePlans, Inc., "Who Buys Long-Term Care Insurance in 2000? A Decade of Study of Buyers and Nonbuyers,." Washington, DC, Oct. 2000. May include responses from buyers of non-partnership and partnership policies.

¹² Ibid.

states cover three or more years of coverage and 20% of policies sold in California and Connecticut cover two or fewer years of coverage. In addition, 80% of buyers in Indiana purchased coverage of five or more years.

Age of Purchasers. Encouraging the purchase of younger buyers would both broaden the risk pool for insurers and help make prices more affordable for consumers. A comparison of data on the partnership states and data on LTC insurance purchasers in general shows that partnership purchasers may be slightly younger than purchasers of LTC insurance. **Table 3** presents demographic data on partnership purchasers at their time of purchase. Data were provided to CRS by the four partnership states. The four states used two units of measurement to report the age of partnership purchasers, median age and average age. The median age of purchasers in California is 61, with 71% of purchasers between the ages of 54 and 74. In New York, the median age is 64. The average age of purchasers in Connecticut and Indiana is 58 and 62 respectively.¹³ According to information provided to CRS by the state director of Indiana's partnership program, 53% of all purchasers bought at age 65 or younger. The AHIP survey shows that the average age of these purchasers was 67.

Data reported on the gender and marital status of partnership policies are consistent with data reported by AHIP. More than half of partnership purchasers included in the AHIP survey are female and more than two-thirds are married.

**Table 3. Demographics of Partnership Plan Buyers
(at time of purchase)**

State	Age	Gender	Marital status
CA (as of 12/03)	Median Age: 61 Ages 55-74: 71% Other ages: 29%	Female: 59% Male: 41%	Married: 69% Not Married: 30% Unknown: 1%
CT (as of 12/03)	Average Age: 58	Female: 56% Male: 44%	Married: 79% Not Married: 12% Widowed: 8%
IN (as of 3/04)	Average Age: 62 (Age range: 19-90)	Female: 57% Male: 43%	Married: 77% Not Married: 22% Unknown: 1%
NY (as of 9/03)	Median Age: 64 Minimum Age: 19 Maximum Age: 93	Female: 60% Male: 41%	Married: 71% Not Married: 26% Unknown: 3%

Sources: Data provided to CRS by partnership states.

Note: Variations in data reported from each state reflect differences in the way each state collects and reports data.

¹³ Two of the states, Indiana and New York, report purchasers of age 19. These purchasers are likely to be few in number.

Features of Policies Sold

Partnership buyers, like buyers of long-term care insurance in general, have a number of options to choose from when buying their policies. This discussion provides a brief summary of the features of policies sold.

Covered Benefits. The majority of partnership policies ever purchased offer comprehensive benefits that include coverage of nursing home stays and home care. For example, 94% of policies sold in California, 99% of policies sold in Connecticut, 86% of policies sold in Indiana, and nearly 100% of policies sold in New York, cover both nursing home care and home care (**Table 4**).

Length of Coverage. Many partnership policies sold in the four states cover three or more years of coverage (i.e., 64% in California and 94% in Indiana), whereas 36% of policies sold in California and 20% of policies sold in Connecticut cover two or fewer years of coverage. In contrast, only 6% of Indiana's policies sold cover two or fewer years (**Table 4**). Under New York's total asset protection model, all policies must cover at least three years of nursing home coverage and/or six years of home care coverage, for which payment for two days of home care must be equivalent to one day of coverage in a nursing home. (In 2003, minimum nursing home coverage per day in New York was \$163, and minimum home care coverage per day was \$82).

Elimination Periods. The majority of policies sold in California, Indiana and New York include riders with at least 90-day elimination periods for nursing home coverage (**Table 4**). Such elimination periods restrict the first day in which benefit payments can begin to 90 days (100 days in New York) after an individual meets the functional eligibility criteria needed to trigger private benefits, meaning that coverage begins on the 91st day. This feature is intended to increase the product's affordability and reflects consumers' expectation that either Medicare will cover the first 90 days of needed care if an individual is hospitalized or in a skilled nursing facility and/or consumers will be able to afford to pay for such care out-of-pocket. In Connecticut, only 43% of persons purchase policies with a 90-day elimination period in nursing home care.

Non-Forfeiture. Non-forfeiture protection allows policyholders whose payments lapse to be eligible for coverage with the same or smaller level of benefits, reduced lifetime maximum amounts, and or shortened benefit periods. Only one state, California, requires that all policies sold include a non-forfeiture clause. The majority of policies, 99%, sold in Connecticut and Indiana have no non-forfeiture protection. In New York, about half have no protection and half have protection that allows for policyholders to continue coverage with a shortened benefit period (**Table 4**).¹⁴

¹⁴ Unless the shortened benefit period paid out is equal to or greater than NY's minimum total asset protection requirements of three years of nursing home care and/or six years of home care, an individual who triggers this non-forfeiture clause would not be eligible for total asset protection.

Inflation Protection. All of the partnership states require that partnership policies be protected for inflation for at least some of its purchasers (**Table 4**). To be approved as partnership-qualified, Connecticut and Indiana require that all partnership policies be protected for inflation for all purchasers. California, however, requires that only those policies sold to persons age 70 and younger be protected against inflation, and New York requires that only policies sold to persons age 80 and younger be protected against inflation.

Policy Type. Most policies sold in the partnership states are sold through the individual market (**Table 4**). Directors of partnership programs speculate that the group market, particularly the employment-based market, will expand in future years.

Table 4. Features of Partnership Policies Purchased

State	Covered benefits	Length of coverage	Elimination period			Non-forfeiture	Inflation protection	Policy type
CA- as of 12/03	% of policies with comprehensive benefits: 94% % of policies with nursing home only: 6%	1-<3 years: 36% 3-<5 years: 33% 5 years: 4% Lifetime: 27%	(Data from quarter ending 12/03) 90 days: 72% 60 days: 1% 30 days: 27% 0-15 days: <1%			required	5% annual compound inflation adjustment required for age 70 and under; companies may offer a 5% annual simple adjustment to applicants over age 70	100% individual products
CT- as of 12/03	% of policies with nursing home and home care: 99% % of policies with nursing home only: 1%	1-<2 years: 20% 2-<4 years: 47% 4-<5 years: 9% 5+ years: 8% Lifetime: 16%	Days	Nursing home	Home care	99% had no non-forfeiture protection	100% of policies include one of three state-defined options for inflation protection	Individual: 83% Group: 17% (cumulative)
			90	43%	40%			
			60	8%	8%			
			0	1%	23%			
			Other	48%	29%			
IN- as of 3/04	% of policies with comprehensive benefits: 86% % of policies with nursing home only: 14%	1-<3 years: 6% 3-<5 years: 14% 5+ years: 69% Lifetime: 11%	For nursing home: 90+ days: 59% 30 days: 20% Other: 21% For home and community-based care: 90+ days: 35% 30 days: 18% 0 days: 38% Other: 9%			99% had no non-forfeiture protection	5% annual compound inflation required	Individual: 96% Group: 1% Organization-sponsored: 3%

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State	Covered benefits	Length of coverage	Elimination period	Non-forfeiture	Inflation protection	Policy type
NY- as of 9/03	Almost 100% of policies sold covered nursing home care and home care	Minimum of three years of nursing home coverage and/or six years of home care coverage required	100 days: 76% 30-99 days: 12% Up to 30 days: 14%	Shortened benefit period: 52% None: 48%	5% compound inflation required for under age 80; Age 80 and above: 77% purchased none and 24% purchased 5%	Individual: 90% Group: 5% Organization sponsored: 5%

Sources: Data provided to CRS by partnership states.

Notes: Comprehensive benefits — includes coverage of nursing home care and home care. Inflation protection — inflates the daily pay out amount *and* the total value of the policy's benefits.

Key: NH = nursing home; HC = home care.

Insurer Participation

Partnership policies must be approved by the state before they can be sold in the market. This requirement was part of the grant-making agreement between RWJ and the partnership states. No such requirement is found in the Social Security Act. The number of insurers selling policies in each of the partnership states ranges from five companies in California to 13 companies in Indiana. The following is a list of companies that sell state-approved partnership policies in the four participating states:

- **California (five companies).** California Bankers Life and Casualty Company; California Public Employees' Retirement System (PERS); GE Capital Assurance (formerly AMEX); John Hancock; New York Life Insurance Co. (third quarter 2003);
- **Connecticut (eight companies).** Bankers Life & Casualty; CUNA Mutual; GE Capital Assurance; John Hancock; MedAmerica; MetLife; Monumental Life; State Farm (as of 5/04);
- **Indiana (13 companies).** Bankers Life and Casualty Company; CNA (Continental Casualty Company); CUNA Mutual Life Insurance Company; GE Capital Assurance Company; John Hancock Life Insurance Company; Life Investors Insurance Company of America; MedAmerica Insurance Company; Metropolitan Life Insurance Company; Monumental Life Insurance Company; Mutual of Omaha Insurance Company; Penn Treaty Network America Insurance Company; State Farm Mutual Automobile Insurance Company; Transamerica Occidental Life Insurance Company (as of 3/04); and
- **New York (12 companies).** American Progressive Life & Health Insurance Company of N.Y.; CNA Insurance Companies; Consec Life Insurance Co. of NY; First Fortis Insurance Company; GE Capital Life Assurance Co. of NY; John Hancock Life Insurance; Massachusetts Mutual Life Insurance; MedAmerica Insurance Co. of NY; Metropolitan Life Insurance; Mutual of Omaha; The Prudential; TransAmerica Life Insurance Company (as of 1st Quarter 2003).

Policy Issues

This section discusses several key concerns and questions raised by policymakers and their staff concerning the expansion of the partnership program to the national level. To the extent that it is available, data are provided to address to the relevant policy questions.

The Market for LTC Insurance

Market Stability. In assessing a possible expansion of the partnership program, some policymakers have expressed significant concern about the stability of the market and the reliability of products. Current information pertaining to these issues may be relevant to legislation concerning the partnership program.

The LTC insurance market in general (not limited to the partnership sellers and products) has undergone significant changes in the past three decades and these changes have had an impact on policies' design and prices. In the very earliest years of the new LTC insurance market in the 1980s, many new carriers entered the market in search of new revenues. At that time, products were available primarily on an individual basis and insurers saw large average annual increases in enrollment from previous years.

In the 1990s, insurers began to offer lower-priced policies designed to squeeze competition out of the market and attract buyers.¹⁵ Group policies were offered for the first time. Fraud also became apparent during this decade with some companies low-balling premiums (selling policies at inappropriately low rates, then closing enrollment in that policy, and raising rates for these policyholders), or using loose underwriting practices (e.g., charging rates that do not cover the known risk factors of the group, then raising rates after less healthy persons have purchased the policy).¹⁶ During this decade, profits for many companies decreased significantly and a number of carriers began to exit the market.

In recent years, the market's restructuring has taken a different shape. Now carrier consolidation is more prevalent¹⁷ and insurers are using stricter underwriting practices and raising premiums to try to limit their financial risk. In the near future, nine companies will hold more than 90% of the LTC insurance market, consolidating the nation's privately-insured risk across a small number of private sector carriers.¹⁸ For example, the bulk of New York's LTC insurance sales are with just three companies (John Hancock, GE Capital Life Assurance Co., and MedAmerica Insurance Co. of America).

¹⁵ The Forbes Consulting Group, Inc., "Long-Term Care Insurance Thought Leader Report," Lexington, MA, Nov. 2003, at [<http://www.westlandinc.com/ForbesLTC.pdf>].

¹⁶ Mila Kofman and Lee Thompson, "Consumer Protection and Long-Term Care Insurance: Predictability of Premiums," *Georgetown University Long-Term Care Financing Project*, Mar. 2004.

¹⁷ For example, General Electric Capital acquired LTC insurer Amex Life and the LTC insurance portfolio of Travelers Life and Annuity; John Hancock acquired Time/John Alden/Fortis, which was then acquired by Manulife Financial; and Aegon acquired Transamerica, including its LTC insurance business. Acquisitions of LTC insurance carriers may allow acquirers to renegotiate certain terms of in-force LTC insurance policies. This could lead to premium increases in certain states.

¹⁸ The Forbes Consulting Group, Inc., "Long-Term Care Insurance Thought Leader Report," Lexington, MA, Nov. 2003, at [<http://www.westlandinc.com/ForbesLTC.pdf>].

Under this more consolidated market structure, each firm maintains influential market power and the insolvency of one or more of these firms could lead to market disruptions and higher premiums. On the other hand, market consolidation could concentrate LTC policies with the stronger companies and allow these carriers to spread risk across larger policyholder pools. Consolidation could also lead to administrative efficiencies, possibly controlling costs and improving claims processing and other operational expenses. John Hancock, MetLife, Prudential, and Unum/Provident, for example, have merged their operations supporting group and individual LTC products.¹⁹

One major issue growing out of market consolidation involves carrier insolvencies and the impact these insolvencies have on policyholders. In recent years, for example, two of the largest LTC insurance carriers, Conseco and Penn Treaty, became insolvent. One possible outcome of carrier insolvencies is that policies of insolvent carriers are transferred to other insurers in the state (a practice known as assumption reinsurance). Under this scenario, policyholders continue paying premiums for their LTC insurance policies, yet they pay them to the new carriers. For these policies, contracts remain intact under the new insurer, but policyholders could be affected by premium increases.

A second possible outcome of carrier insolvencies poses greater risks to policyholders. Under this scenario, instead of transferring contracts to another carrier in the state, policies from the insolvent carrier might be terminated. This could occur after an insolvent insurer's assets are liquidated by a state insurance regulator. Policyholders generally receive compensation for some amount of the policy's value, but must reenter the market to obtain a new policy, if they choose to do so. To obtain a new policy, consumers would again be subjected to underwriting and current market rates. Given that consumers would have aged since their first policy purchase and may even have experienced a change in health status, it is possible that they would find premiums to be higher than they were under their old policies. For some, the new prices may be unaffordable. Insolvencies in the LTC insurance market raise concerns about companies that may be growing without sufficient capital.

Predictability of Future Claims. Limited claims experience combined with complex and changing risk factors makes actuarial predictions of future claims experience difficult for insurers. For example, over the past decades lapse rates have decreased from 15-16% to around 2%. Another factor that makes predicting future claims difficult is the changing designs of the LTC insurance products themselves. This relatively new product has largely changed from a nursing home only product from the 1970s and 1980s to a product offering benefits that include nursing home care as well as home care and assisted living. Fewer claims data are available from the newer comprehensive policies as many purchasers have not yet submitted claims. These factors expose insurers to greater risk and encourages them to price products more rationally and conservatively.

Regulation of the LTC Insurance Market. Some members have expressed concerns about the regulatory environment for LTC insurance. Some have also

¹⁹ Ibid.

expressed reservations about whether the Medicaid program should be used to encourage the expansion of the LTC insurance market that is unevenly regulated and places buyers at risk for premium increases. This section discusses these concerns.

Federal oversight of long-term care insurance is largely limited to provisions established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). HIPAA established new rules regarding the tax treatment of LTC insurance and expenses, and defined the requirements for a tax-qualified LTC insurance policy.²⁰

LTC insurance products are largely regulated by states. Every state and the District of Columbia has some laws governing LTC insurance. Many of these laws reflect guidance provided by the National Association of Insurance Commissioners (NAIC), an organization of state insurance regulators. This guidance, provided in the form of a Model Act and Model Regulations for LTC insurance, addresses a number of areas, including (1) suitability (standards to help applicants decide whether a policy is appropriate and affordable); (2) replacement (standards designed to help applicants decide whether they should replace an old policy with a new one); (3) prohibition against post-claims underwriting (standards to prevent insurers from performing underwriting after a policy has been purchased and a claim has been filed); (4) benefit triggers (standards specifying minimum benefit triggers), among others.

While many state laws and regulations are based largely on the NAIC standards, others have adopted only some of these standards.²¹ A 2002 study by the Lewin Group (based on a survey of insurance departments of 49 states and the District of Columbia) suggests that there is significant variation in regulatory practices across states, and that many states have a limited ability to monitor problems or trends in the marketplace.²² It also suggests that many states make approvals for rate increases based on inadequate information and that a number of states may lack the necessary authority or resources to stop rate increases.²³

California, Connecticut, New York, and Indiana have strong regulatory oversight of partnership policies, compared to other states' regulatory oversight of LTC insurance products. According to partnership directors, this is largely a result of problems identified with products over the years and the requirement (agreed upon in the original program design with RWJ, not written into statute) that state commissioners approve all plans before they can be deemed eligible to participate in

²⁰ For more information on HIPAA's LTC provisions, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by Hinda Chaikind, Robert Lyke, Stephen Redhead, and Julie Stone.

²¹ Report from the National Association of Insurance Commissioners, Aug. 2003.

²² CA declined to participate.

²³ Steven Lutzky, Lisa Maria B. Alecxih, and Ryan Foreman, "The Lewin Group. Long-Term Care Insurance: An Assessment of States' Capacity to Review and Regulate Rates," *AARP Public Policy Institute*, Washington, DC, 2002.

the partnership program. According to state officials from the partnership states, the need to approve plans has provided a catalyst for increased consumer protection requirements and more comprehensive oversight of the LTC insurance market, in general, and the partnership market, in particular. A state official from Connecticut, for example, explains that about 20% of LTC plans offered in Connecticut prior to the implementation of the partnership plan included compound inflation adjustment. As a result of increased attention to partnership policies in the state, he explains, Connecticut now requires that all partnership policies include protection against inflation. Now, not only do 100% of the partnership policies include inflation protection, but about 60% of non-partnership policies sold by partnership-participating carriers include inflation protection as well.²⁴ California, Connecticut and New York²⁵ also require that all partnership policies meet the HIPAA requirements for favorable federal tax treatment. Indiana provides consumers the option to purchase either a tax-qualified or non-qualified partnership policy.

Despite increased attention to oversight by partnership states, little information is available about the extent to which these states track problems with insurance products after they are approved; oversee insurers', carriers' and agents' marketing practices; and evaluate the suitability of the products purchased (e.g., do products purchased provide adequate coverage or must policyholders make large out-of-pocket expenditures to cover the difference between the benefit payments and the actual cost of services).

National Standards for LTC Insurance Products. The current political environment may make imposing stricter federal standards on LTC policies difficult to enact. Part of this difficulty is a result of opposition from insurers concerning stricter oversight of LTC insurance products in general. Although many insurers strongly oppose stricter federal requirements on *all* LTC insurance products, some support the adoption of standardized requirements for partnership policies at the national level. These insurers assert that such standards would facilitate their ability to develop a single partnership product that can be marketed in each state, without having to modify each policy to comply with state's separate laws and regulations. This, they assert, would free insurers from the burdensome responsibility of designing a distinct product for each state and would provide them the opportunity to compete with each other for the sale of similar products.

The partnership states themselves have also come together to develop recommendations for regulations that could be part of a national model. A summary of these regulations can be provided upon request.

Affordability of Premiums. One of the key issues in considering the role private insurance can play in long-term care financing is affordability. Long-term care insurance can be costly, with premiums depending greatly on the benefit packages purchased and the age of individuals at the time of purchase (generally, the older the individual, the higher the premiums). According to an AHIP survey in

²⁴ Phone conversation with the director of Connecticut's LTC partnership program (May/June 2004)

²⁵ NY requires that all policies issued post-1997 meet these HIPAA requirements.

2002, substantial increases in premiums can be seen when compound inflation and/or nonforfeiture riders are added to the policies. **Table 5** shows the findings from the AHIP survey of 11 of the top 13 LTC insurance sellers in 2002.

Table 5. Average Annual Premiums for Top Long-Term Care Insurance Sellers in 2002

Age	Base	With 5% compound inflation protection	With a nonforfeiture benefit	With compound inflation protection and nonforfeiture benefit
40	\$422	\$890	\$537	\$1,117
50	\$564	\$1,134	\$715	\$1,474
65	\$1,337	\$2,346	\$1,646	\$2,862
79	\$5,330	\$7,572	\$6,479	\$8,991

Source: America's Health Insurance Plans, *Long-Term Care Insurance in 2002: Research Findings*, Washington, DC, June 2004.

In recent years, policymakers, analysts and consumers have raised concerns about rate stability. A 2004 report by HIAA explains that the average change in premiums of policies sold in 2002 by top sellers compared to policies sold in 2001 was about 5%.²⁶ For the period between 1999 and 2002, the average change in premiums of policies was less than 1% for different age and policy categories.²⁷ However, it is still possible that some firms may be more likely to raise premiums than others. Unexpected rate increases may affect a policyholder's desire and ability to continue the policy.

Once a policy is purchased, premiums must remain fixed throughout the policyholder's lifetime, unless a carrier receives approval from a state insurance commissioner to raise rates for all policyholders in a particular class. Premium increases of policies already sold may also vary by state. Some states may be more likely to approve insurers' requests to increase rates than others states. Approval decisions are based, in large part, on the standards adopted by each state.

Although the oversight of LTC insurance premiums can help prevent unnecessary premium increases, it may also encourage plans to be more conservative than they might otherwise need to be. For example, rather than take the risk of applying to the state regulatory agency for approval of a future rate increase if it becomes necessary, an insurer may seek approval one time, but at a higher premium level than necessary, to hedge its future risk.

²⁶ America's Health Insurance Plans, *Long-Term Care Insurance in 2002: Research Findings*, Washington, DC, June 2004.

²⁷ Health Insurance Association of America, *Long-Term Care Insurance in 2000-2001*, Washington, Jan. 2003.

The Suitability of Products Purchased. Another concern of policymakers is the risk that private sector insurers and agents, eager to earn profits and commissions (respectively), will inappropriately sell products to persons with low incomes and assets who cannot afford to pay premiums long-term. Persons who become unable to pay the premiums will have their policies cancelled. Under these circumstances, the insurer would gain premium revenue without having to pay benefits.

A related concern is that persons with lower incomes may purchase policies that are inadequately valued, so that the cost of the LTC benefits needed will exceed the amount paid by private benefits. (For example, if the policy purchased covers \$150 of nursing home care per day, but nursing home care for that individual costs \$250 per day, then the policyholder would be required to make up the difference.) This is particularly troublesome for lower income persons who may not be able to afford to pay the difference in cost. For these persons, the purchase of inadequate policies could lead to the rapid spend down of a policyholder's income and assets (other than those protected), leading policyholders to meet the financial eligibility criteria for Medicaid sooner than they otherwise would with better coverage.

On the one hand, the pay out of the LTC insurance policy toward the cost of care for these individuals would delay their spend down to Medicaid, even if the pay-out is insufficient to cover all of the individual's care costs. On the other hand, the fact that private LTC benefits are counted as income when determining Medicaid eligibility could disqualify an individual from meeting the necessary income standards to qualify for Medicaid, depending on the income counting rules used by the state to determine Medicaid eligibility. Such persons would not be able to obtain sufficient care through their LTC insurance policies and might not be able to afford to cover the costs of their care with their personal income.²⁸ The directors of the partnership programs argued that as oversight of LTC insurance policies improves, this problem is decreasing in prevalence.

Partnership states have attempted to address these concerns through regulatory standards concerning suitability and minimum benefit packages. Statutory or regulatory language concerning how partnership policies are marketed, sold and regulated could also address some of these concerns.

²⁸ For example, such a person could be determined ineligible for Medicaid in a state that uses the Medicaid nursing facility rate when calculating an applicant's spend down. States that cover nursing facility care under their medically needy programs have the option of using either the Medicaid or private pay (e.g., private insurance or out-of-pocket) nursing facility rates as a standard for determining an applicant's eligibility. This means that states compare a person's monthly income to the cost of nursing home care in that state, either in terms of the total amount that would be paid by Medicaid for a month (Medicaid rate) or the total amount that would be paid by the private pay rate. Often the Medicaid monthly rates are lower than the rates paid by private insurance or out-of-pocket. When the Medicaid rate is lower, it is harder for applicants to spend-down to the required level. (In general, if an applicant's income minus the cost of the Medicaid reimbursement or private pay rate, whichever is used by the state, exceeds the state income limit, then the applicant cannot qualify for Medicaid coverage of institutional care under a medically needy option.)

Insurer Underwriting. Individual policies are sold with substantial “underwriting” — meaning the carrier requires detailed information regarding one’s medical history. (Group policies may or may not be sold with full or partial underwriting.) Underwriting is used by insurers to protect against the “adverse risk selection” that can occur if individuals buy policies when they know or suspect that they may soon need to make use of the insurance. Age is another major factor considered by insurance companies in coverage because the probability of claims is highly correlated with age. As a result, not all persons who can afford LTC insurance can obtain it, even if they apply. For example, of the 31,151 applications that were received in the decade between April 1, 1992 and June 30, 2002 in Connecticut, 3,640 (11%) were denied.²⁹ Of the persons denied, 29% had hypertension either prior to or at the time of the survey, 14% had cancer in the past (3% at the time of the survey), 20% had arthritis in the past (24% at the time of the survey), 14% had a stomach condition in the past (4% at the time of the survey), and 17% had a heart condition in the past (11% at the time of the survey). In California, for example, of the 73,809 applications received for partnership policies (as of September 2003), 12,857 applications (17%) had been denied since the program’s establishment.³⁰ Of the 36,474 applications received in Indiana (as of 3/04), 5,142 applications (14%) were denied.³¹ Persons who are denied coverage are forced to apply their savings to cover the cost of their care and cannot benefit from the asset protection offered to healthier persons under the partnership program.

The Partnership Program’s Interaction with Medicaid

Equity within the Medicaid Program. Providing asset protection to Medicaid beneficiaries who purchase LTC insurance reflects policies that differ significantly from Medicaid’s general policies on eligibility. Medicaid is a program for the poor or for persons who have become poor. Eligibility for the program is designed to allow only persons with a small amount of assets, generally \$2,000, to qualify for coverage. Medicaid law also contains rules that are designed to prohibit persons from transferring assets in order to qualify for coverage sooner than they otherwise would. Some say that the purpose of these provisions is to assure that limited federal resources are available only for those in need. By disregarding additional assets of partnership participants, some say that the program violates these principles.

Providing special treatment to purchasers of partnership policies also raises equity concerns because it treats one group of Medicaid applicants differently from other groups of applicants. Under the partnership program, persons who can afford LTC insurance benefit from partial or full asset protection. Rather than depleting their assets on their care to qualify for Medicaid, these persons can retain some or all

²⁹ Annual Report for The Connecticut Partnership for Long-Term Care: Evaluation Studies July 1, 2001-June 30, 2002. Issued Oct. 2003.

³⁰ California Partnership for Long-Term Care, July-Sept. 2003: Quarterly Report, Third Quarter 2003, Report No. 37, at [<http://www.dhs.ca.gov/cpltc>].

³¹ Information provided to CRS by the state director of the Indiana LTC partnership program.

of their assets and use them to either maintain a certain living standard and/or pay for care not covered by Medicaid. While not all of these assets may be protected by the partnership program, some amounts will not be applied to the cost of care in the event that Medicaid begins to cover expenses. Furthermore, some or all of this group's protected assets are exempt from Medicaid estate recovery so they may pass on their assets to their heirs. Persons who cannot afford LTC insurance, who purchase a non-partnership LTC insurance policy, or who are denied coverage by LTC insurers, on the other hand, would be required to meet Medicaid's strict asset requirements and be subject to Medicaid estate recovery.

The Role of Asset Protection. The partnership program is intended to result in Medicaid savings by delaying or preventing spend-down to Medicaid eligibility for those persons who can afford private coverage. This could serve to free some of Medicaid's resources for use by persons with greater financial need. The following discussion explores claims made by partnership proponents that the program's asset protection: (1) provides an incentive to persons to purchase private insurance; and/or (2) helps "save" Medicaid expenditures.³²

Asset Protection as an Incentive to the Purchase of Insurance. Limited empirical data are available to demonstrate whether the asset protection promised under the partnership program is a sufficient and necessary incentive to encourage the purchase of policies by persons who would not otherwise purchase them. The partnership states have attempted to test the reliability of these claims through small-sample surveys of partnership purchasers. The following is a brief description of what they found:

- **California Purchaser Survey.** A 2002 survey in California found that three principal reasons motivated the 629 survey respondents in 2002 to purchase partnership policies. They were: (1) to pay for future services (90%); (2) to protect the spouse and family (81%); and (3) to protect the assets of the purchaser (74%). Slightly under 25% of respondents stated that they purchased a policy as an alternative to transferring assets. Further, respondents were asked to rate the relative importance of specific partnership policy features when selecting their policy. Findings show that 79% of respondents felt it was important or very important to have the state seal of approval on the policies and 82% felt that Medicaid asset protection feature was important or very important.³³
- **Indiana Purchaser Survey.** A 2002 survey in Indiana found that four principal reasons motivated the 576 survey respondents in 2002 to purchase partnership policies. They were: (1) to pay for future LTC services (88%); (2) to protect assets (86%); and (3) to protect spouse and/or family (86%). About 40% of respondents also said

³² It is also intended to discourage persons from transferring their assets to qualify for Medicaid sooner than they otherwise would.

³³ "Purchaser Survey 2002," CA Department of Health Services, CA Partnership for Long Term Care: Annual Report, Oct. 2003

that seeing their parents or other relatives use LTC services also encouraged them to purchase LTC insurance. Fifteen percent of respondents stated that they purchased a policy as an alternative to transferring assets.

Further, respondents were asked to rate the relative importance of specific partnership policy features when selecting their policy. Findings show that 67% of respondents felt it was important or very important to have the state seal of approval on the policies, 67% felt that Medicaid asset protection feature was important or very important, 83% felt that it was important or very important that the policy included home care, and 77% felt it was important or very important that the policy included inflation protection.³⁴

- ***New York Purchaser Survey.*** A 1995 survey in New York found that three principal reasons motivated the 2,794 survey respondents to purchase partnership policies. They were: (1) to protect their assets; (2) to remain financially independent and (3) to cover the cost of LTC. Respondents also stated that additional considerations included lifetime coverage available through asset protection under Medicaid; the state's seal of approval offered on partnership policies, and the state's monitoring process established to review insurer denials of requests that benefits be paid. In addition, 25% of respondents stated that in the absence of partnership policies they would transfer their assets and depend on Medicaid if they were to need LTC.³⁵
- ***Connecticut Purchaser Survey.*** A 2001-2002 survey in Connecticut found that three principal reasons motivated the 699 survey respondents to purchase partnership policies. They were: (1) to pay for future services (88%); 2) to protect spouse and family (87%); and 3) to protect their assets (84%). Slightly under 31% of respondents stated that they purchased a policy as an alternative to transferring assets. Further, respondents were asked to rate the relative importance of specific partnership policy features when selecting their policy. Findings show that 89% of respondents felt it was important or very important to have the state seal of approval on the policies and 91% felt that the Medicaid asset protection feature was important or very important.³⁶ When probed further about the role of Medicaid asset protection in making their decision to purchase, 83% of respondents said that they considered purchasing LTC insurance before hearing about the partnership; 66% said that

³⁴ IN Long-Term Care Insurance Program — Policyholder Survey. Data is a compilation of all 2002 survey data.

³⁵ 1995 survey of 2,794 NY partnership purchasers.

³⁶ Annual Report for The CT Partnership for Long-Term Care: Evaluation Studies, July 1, 2001-June 30, 2002. Issued Oct. 2003.

the partnership program influenced their decision to purchase; and 72% said that they would have purchased LTC insurance without the partnership.

These findings suggest that for most respondents, the asset protection promised by LTC insurance *in general* played a significant role in encouraging persons to purchase insurance. However, the data do not show that it was sufficient and necessary to encourage the purchase of LTC insurance without the existence of other motivating reasons. On the contrary, the data suggest that Medicaid asset protection is just one of several motivating reasons that can lead a person to purchase insurance. Without more data, it is reasonable to conclude that for some, the promise of Medicaid asset protection plays a significant role in conjunction with other motivating reasons, while for others it plays a smaller role.

Policymakers have also expressed concern about the partnership program providing asset protection to persons who would otherwise have purchased insurance without it and/or to persons with high wealth status. The broad criteria for obtaining asset protection under the partnership program could allow this to occur. On the other hand, if savings from the partnership program occur as a result of delaying or preventing Medicaid enrollment, these savings could also be used to cover additional persons under Medicaid who cannot afford LTC insurance.

Asset Protection versus Medicaid “Savings”. Supporters of the partnership program assert that the purchase of LTC insurance delays or prevents spend-down to Medicaid eligibility and that this, in turn, saves Medicaid funds that otherwise would have been spent on care for these persons. Proponents assert that proof of this can be seen by state data showing that few qualified LTC policyholders end up accessing Medicaid coverage for their LTC needs (see **Table 1**). Opponents, on the other hand, note that the program is only in its early phase of operation, and as policyholders age, the population of persons who spend down to Medicaid will grow.

A small study conducted by California’s partnership program attempted to calculate the impact of asset protection on California’s Medicaid budget. The study was conducted of 18 partnership participants who eventually qualified for Medicaid. Combined, these persons had a total of \$347,600 in assets, or \$19,000 each on average, at the time they met the requirements for their private LTC insurance benefits. Without the existence of their partnership LTC policies, California assumes that the assets of these individuals would have been used to cover the cost of their nursing home care. At the average Medicaid nursing home rate of \$4,415 per month in California, these funds could have paid for a total of about 78 months of nursing facility care, or fewer than five months on average per person.³⁷ In total, the 18 individuals used 466 months of nursing home care, or slightly fewer than 26 months per person. All of these months were paid by their LTC insurance policies.

³⁷ In reality, these individuals would have been subject the private nursing home rate that for many, would have been higher, and resulted in fewer months of private coverage.

To determine how much California's Medicaid program would have paid for nursing home care if these 18 individuals had sought Medicaid coverage instead of LTC insurance, California multiplied its monthly Medicaid rate (\$4,415) by the total number of nursing home months used by the 18 individuals (466 months) minus the spend down months (78 months). It then subtracted the income of the eligible individuals' that would have been applied toward the cost of their care. Through this analysis, California estimated that the existence of the private policies resulted in \$1.3 million that Medicaid might have paid had these individuals sought Medicaid coverage for their nursing home coverage instead of private LTC insurance coverage. It is important to note, however, that this study provides no information about whether these individuals transferred assets before applying for Medicaid.³⁸

Reciprocity between and among States for Partnership Policies.

Since the establishment of partnership programs, some partnership participants who have interest in moving out-of-state have expressed concern that other states' Medicaid programs cannot offer them the same asset protection that is offered by their home states. These individuals assert that without interstate reciprocity agreements that allow them to protect their assets after they change states in a manner consistent with their former state's partnership policies, they would be forced to live out their retirements in the same state in which they purchased their partnership policies. Connecticut and Indiana have received CMS approval to enter into a reciprocal agreement so that each state honors the commitment of dollar-for-dollar asset protection offered by the other state. If partnership policies were made widely available across the nation, reciprocity between and among states would need to be addressed either at the federal or state levels.

A number of states are likely to support a standard reciprocity provision. For many states, a reciprocity provision would offer their partnership participants freedom to live out their retirement in a different state, thus relieving some states of the potential financial strain to their Medicaid programs. Other states, especially those that attract large numbers of retirees, such as Florida, Arizona, California and Nevada, may oppose such a provision as it could increase the risk that those states would be obligated to pay the Medicaid long-term care expenses of more individuals than they might otherwise pay. Without more data showing whether the program incurs savings or costs to the Medicaid program, it is possible that those states with high numbers of retirees may be hesitant to enter into a reciprocity agreement with other states. Furthermore, if wider implementation of the partnership program occurs giving states the choice to use either a dollar-for-dollar model and/or a total asset protection model, reciprocity between states with different models would be difficult.

Legislative Proposals

Two identical congressional proposals were introduced in the 108th Congress that would have repealed the provision in §1917 of the Social Security Act that prohibits additional states from exempting LTC insurance buyers from Medicaid estate recovery requirements. **S. 2077**, introduced by Senator Craig, and **H.R. 1406**,

³⁸ Summary of study provided to CRS by the CA LTC partnership program.

introduced by Representative Peterson, would have repealed the provision requiring states to have state plan amendments approved as of May 14, 1993, and would have allowed states the option of seeking or not seeking estate recovery from persons who purchase LTC insurance policies.

In addition, the President's FY2004 and FY2005 budgets proposed to eliminate the legislative prohibition against developing more partnership programs and considered these provisions to have no cost to the federal budget.

It is likely that the additional proposals will be introduced in the 109th Congress.