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The key question framing long-term care planning is this: If one incurs medical expenses for which there is no immediate source of financing, how are these costs paid? The ideal solution is one which creates a stream of funds exactly when needed to fund the plan of care: long-term care insurance does this beautifully. Unfortunately, most people do not prepare years in advance like they should, leaving very few choices when a long-term care event occurs. Absent insurance, most of us who one day require extended care will turn to Medicaid. Medicaid is a means-tested program for which one must demonstrate not just medical need, but also financial need. In spite of this, it has become our country’s single largest payer of long-term care expenses, accounting for 40 percent of our $357 billion bill.[[1]](#endnote-1) Medicaid is the only public program that covers long-term care indefinitely.

# Trouble on the Horizon

About twenty-five years ago it became obvious to those who administer the federal/state Medicaid programs that future demand for long-term care was going to become enormous as the population of the United States aged. Fear of being overwhelmed financially by long-term care needs caused the folks who run the Medicaid program to begin searching for ways to proactively address these escalating costs.

As a result, they commissioned a privately-funded study by the Robert Wood Johnson Foundation (RWJF) to analyze the problem and construct a long-term solution. The model RWJF returned was unique: states would promote the purchase of private long-term care insurance as first payor, and should the policy exhaust, then Medicaid would step in as second payor.[[2]](#endnote-2)

The rationale was that—at the very least—Medicaid would benefit by delaying an individual’s need to access help through this public program, because the insurance policy would initially provide another source of funding. In the best-case scenario for Medicaid, the person in need of care would not have to turn to Medicaid at all; the insurance plan would be enough. Thus, the partnership between private insurers and Medicaid was born.

# A Possible Remedy

The solution proposed in the RWJF report in the late 1980s was received with astonishment. Rarely—if ever—do such studies recommend *private* insurance as an answer to a major *governmental* problem.

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Yet, the idea made perfect sense. The best way for Medicaid to avoid mass demand for long-term care reimbursement in the future was to give consumers a better option. In the 1980s,

Medicaid generally steered people toward nursing homes—probably the least desirable long-term care option (this “nursing home bias” continues today). By covering care in all settings (including home and assisted living), private insurance presents an attractive alternative. The RWJF authors thought that private insurance would take care of most long-term care needs. The proposed partnership would return Medicaid to its intended role as the payer of last resort.

Some states thought this was a great concept. Bleeding red ink from their Medicaid programs, these pioneers decided to try to implement the partnership program. RWJF had also volunteered to finance up to eight states to see whether this program had any validity. The following six states accepted the money:

* Connecticut
* New York
* California
* Indiana
* Iowa
* Maryland

Connecticut deserves the lion’s share of the credit. It pushed the envelope on private long-term care insurance, demanding (and getting) a better policy for consumers from insurers.

To be fair, at the time many insurers were still exploring the feasibility of long-term care insurance; its viability and design were still very much up in the air when the RWJF study came out. But if you were an insurer interested in long-term care, how could you not respond to this clarion call? Although the product still needed work, the study outlined how it believed the partnership process should work:

1. The consumer buys a long-term care insurance policy from an insurer through a state’s Long-Term Care Partnership Program. Total coverage available through the plan is, for example, $250,000.

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2. The consumer has a long-term care claim and incurs expenses. The policy reimburses first.

3. The insured consumer utilizes all of the benefits, $250,000.

4. The consumer now applies to Medicaid, which already permits her to keep certain “exempt” assets, such as her home, her car, and personal property). But now, she can protect an additional $250,000 worth of “countable” assets—assets of any kind, including all the liquid assets that Medicaid normally would require you to spend or give away (see Chapter 2 for more details) such as checking and savings accounts, stocks, bonds, individual retirement accounts, pensions, annuities, etc.

5. This makes it much easier to qualify for additional help with long-term care expenses—and simultaneously helps to preserve assets.

This was a win-win scenario. Medicaid benefits because the consumer relies on insurance proceeds first, thus delaying Medicaid claims for months or even years. The consumer benefits not only from being able to protect assets that would ordinarily have to be disposed of, but also by accessing high-quality long-term care in a setting of her own choice by means of insurance. This arrangement is exactly how Connecticut set up the first Long-Term Care Partnership Program, which became available to Connecticut consumers in late 1991.

This model is called the “*dollar-for-dollar”* model. The amount of Medicaid asset disregard is equal to the dollar amount of LTC insurance benefits paid. Note that asset disregard applies not only to countable assets at the time one applies for benefits, but a second time, during estate recovery. We will see why this is important. New York, another pioneer of this concept, constructed a different model. Concerned with the possibility that an insured might still have to spend down some of her assets to qualify for Medicaid if her dollar-for-dollar partnership plan was too skimpy to cover her entire estate, New York proposed a version called *total asset protection*. The virtue of a TAP plan is that the value of your countable assets are irrelevant.

Then the only question became how much insurance coverage should be required to satisfy a meaningful total asset protection criteria. Eventually New York decided on a minimum of three years of nursing home care benefits, six years of home care assistance, or six years of the two combined (this predated assisted living facilities.) The policyholder was also required to purchase and maintain a minimum daily benefit, which rises with inflation each year ($274 in 2014).[[3]](#endnote-3) New York introduced its Long-Term Care Partnership Program in 1992. It should be noted that since that time, the Empire State has expanded its program to include five total variations, including three TAP variations and two dollar-for-dollar versions.[[4]](#endnote-4)

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California and Indiana followed in 1993. California used Connecticut’s dollar-for-dollar blueprint. Indiana eventually settled on more of a hybrid concept. The Indiana Long-Term Care Insurance Program (initially a dollar-for-dollar model, then changed in 1998) drew a line in the asset sand. In its early years, that line was $140,000: if a Hoosier bought a long-term care partnership insurance policy and its total coverage was less than $140,000, the program would follow the dollar-for-dollar rules, if more than $140,000 it would follow the TAP rules. Not surprisingly, most consumers in Indiana bought enough coverage for the total asset approach. Indiana raises this minimum coverage amount each year; in 2014, the initial limit is $305,603.[[5]](#endnote-5)

These four states were able to launch this exciting new public-private partnership. Iowa and Maryland were in the developmental stages when the curtain came crashing down on this project.

What happened?

# Second Thoughts

Government happened, as it so often does. Earlier it was noted that the RWJF study report and its conclusion (that the best way to protect future Medicaid money from an aging population and long-term care expenses was for individuals to choose long-term care insurance) was a surprise to many. Members of Congress were among those who did not favor this result.

There are those in Congress who distrust private insurance and who certainly do not see it as operating in conjunction with a public program like Medicaid. They believe that public and private programs should remain separate, much like church and state.

In 1993, citing concerns about the appropriateness of using Medicaid funds to promote the Long-Term Care Partnership Program, Congress enacted restrictions on any further development of such state programs. Representative Henry Waxman (D-CA) added an amendment to the federal budget, the Omnibus Budget Reconciliation Act of 1993 (OBRA), which disallowed the future granting of waivers from the Health & Human Services department for the purpose of forming a Long-Term Care Partnership Program.[[6]](#endnote-6)

OBRA ’93 *required* states to implement an estate recovery program: only twelve states reported having had one in effect prior to 1990, although the practice was permitted since 1965.

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The way in which the legislation halted partnership programs involved “asset disregard.” Although a new state was free to go through the process of applying for a Medicaid waiver, approving and allowing partnership policies for sale, and disregarding assets during the Medicaid qualification process, the same assets were *not* excluded during estate recovery. Faced with the prospect of merely *temporarily* protecting your assets, only to have them encumbered by the state after your death, was a deal-killer in most people’s eyes. Until “asset disregard” applied to estate recovery as well, a chill persisted over the partnership program from 1993 on. Politically savvy, Waxman knew that this clause would allow the four states that were currently participating (including his own California) to continue with their partnership programs. Iowa and Maryland were left standing at the altar.

There was little anyone could do to move the process forward. Even if Partnership seemed like a good idea, there was not yet any empirical proof of the premise, that Medicaid would save money by individuals owning long-term care insurance that met state conditions. After all, the program was only a couple of years old and no claims had yet been registered. Everyone would have to wait to see how these original four states made out.

Throughout the 1990s and the decade that followed, Connecticut and New York did a great job documenting the results of their Long-Term Care Partnership Programs, including the savings quantified in actual claims. Other states took note, especially those struggling to balance their budgets in the face of growing Medicaid expenditures, and they began lobbying Congress to expand the Long-Term Care Partnership Program.

In 2005, the resulting talks in Congress grew earnest. House and Senate panels heard testimony from the directors of the Connecticut and New York Long-Term Care Partnership Programs to summarize their experiences to date. This effort was reinforced by a Government Accountability Office (GAO) report requested by the Senate that quantified program results to date.

Through December 2004, the GAO documented 2,761 long-term claims in the four states’ Long-Term Care Partnership Programs. Of these, only 119 claimants had exhausted their long-term care insurance benefits and applied for Medicaid assistance—less than five percent. The other 95 percent had obtained enough help from private insurance.[[7]](#endnote-7)

The RWJF study of 1987 had been right! One way to save Medicaid money was to encourage people to use private long-term care insurance as their primary funding

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source rather than rely on publicly-funded Medicaid dollars. The proof was in the numbers, documented by the GAO itself.

State governors continued to pressure Congress to help them with their bottom lines. The result: the Deficit Reduction Act of 2005, formally signed into law by President Bush on February 8, 2006.[[8]](#endnote-8) Long-term care partnerships were back!

# Leveling the Playing Field

The Deficit Reduction Act (DRA) was not only about reopening Long-Term Care Partnership Programs. It also tightened Medicaid eligibility by closing loopholes used primarily by middle-to upper-income individuals who had systematically discovered ways to qualify for Medicaid without sacrificing their assets. For instance, the DRA extended the look back period for asset transfers made for the purpose of qualifying for Medicaid, and for the first time imposed a cap on the amount of home equity considered exempt.

Two decades after the premonitions of the 1980s, Medicaid was the largest payer of long-term care expenses by far. Worse, its effect on total Medicaid budgets was significant, pushing many programs into red ink.

For the record, at this time only seven percent of people in the Medicaid program were using it for long-term care assistance. So what was the big deal? This seven percent accounted for more than half (52 percent) of total Medicaid spending.[[9]](#endnote-9)

Yes, you read that right: seven percent of beneficiaries were using 52 percent of this public program’s money. Fix this, governors reasoned, and you would go a long way toward solving some of Medicaid’s budget problems in the states.

When the DRA became law in February 2006, states started talking about long-term care partnerships again. In contrast to the *ad hoc* development of the original Long-Term Care Partnership Programs, this time there was a formal process for establishing and implementing a program. And it was relatively simple!

States that wanted a Long-Term Care Partnership Program were called on to formally amend their Medicaid state plans to allow insurance policy claim benefits paid out under a long-term care partnership policy to exempt an equal amount of designated countable assets from eligibility calculations should a claimant need Medicaid once a long-term care insurance policy ran out. This “State Plan Amendment” was submitted to the Department of Health & Human Services for approval.

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Next, the law detailed which long-term care insurance policies could qualify for Long-Term Care Partnership Program status.[[10]](#endnote-10) There were three essential policy requirements:

1. Policies must be Tax Qualified (TQ). This had been standard operating procedure since 1996, when Congress passed the Health Insurance Portability and Accountability Act (HIPAA) first establishing such plans. Because TQ policies were the overwhelming choice in long-term care sales (well over 99 percent), this was not a stringent requirement.

2. States had to adopt certain consumer protections which policies would have to include, most notably provisions of the LTCI Model regulations formulated by the National Association of Insurance Commissioners (NAIC). Many states had already done this; others would likely have to pass legislation to this effect as soon as possible if they were interested in creating a Long-Term Care Partnership Program.

3. Most important, these TQ policies also had to include specific protection against inflation when purchased by someone under the age of seventy-six. For those sixty and younger, inflation protection had to have a compounding feature (with each state setting its own floor). For people between ages sixty-one and seventy-five, some level of inflation protection was required (again, up to the states). For those aged seventy-six and older, inflation protection would be optional.

# Win-Win

The insurance industry was delighted with this portion of the legislation because very little had to be done to make long-term-care-partnership-eligible policies available to consumers. They were, in effect, already selling policies that conformed to these requirements.

The Deficit Reduction Act of 2005 stated that all future Long-Term Care Partnership Programs would be *dollar-for-dollar* models similar to those that Connecticut and California had adopted. (California, Connecticut, Indiana and New York are now referred to as the four grandfathered Partnership states—their rules remain unique and distinctive; none of the DRA regulations pertain to them.)

There was a rush to implement these partnership programs before Congress changed its mind as it had once before. By the end of 2006, Idaho, Minnesota, and Florida had each filed amendments to their Medicaid state plans to enable Long-Term Care Partnership Programs. Others quickly followed suit during 2007. As of this writing, over forty states have enacted a Long-Term Care Partnership Program, making it a large part of the long-term care insurance landscape today.

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To sell a Partnership policy, you must be appropriately trained in the explanation and sale of not only long-term care insurance, but also a state’s Medicaid program, the interaction between the two, and alternative funding sources. NAIC formalized this as an initial eight-hour training class followed by ongoing four-hour refresher training every two years. This insurance product can be quite complex, so the education requirement is both justified and necessary; thousands of agents and advisors have undergone this training in the last few years. Because the difference between a Partnership policy and traditional policy can come down to the choice of inflation protection, many carriers now require *all* their producers to demonstrate proof of LTC training prior to solicitation, not just those wishing to sell Partnership.

One disadvantage of Partnership revealed by the four pilot states was that it essentially required a buyer of a long-term care partnership policy to indefinitely reside in the state of purchase. This was because the purpose of the policy, in addition to paying for long-term care expenses in the venue of one’s choosing, was to ease the strain on one’s state Medicaid budget. This meant that if a Connecticut resident purchased a long-term care partnership policy and then retired to Florida, application to Medicaid had to be made to *Connecticut’s* Medicaid plan, which would require the claimant to utilize Connecticut services. Thus, the retired Floridian—while otherwise being able to exercise all features of her LTC insurance policy in Florida—would have had to reside in Connecticut to take advantage of the asset disregard benefits for Medicaid purposes.

The Deficit Reduction Act and the new partnership program solved this problem by creating reciprocity between participating states. They recognized that the new Program could never expand nationally without it. Today, unless it opts out, if a state offers a Long-Term Care Partnership Program, it will honor the partnership policies purchased in other states. (Of the new crop of DRA states, Wisconsin opted-out temporarily until fixing a technicality within their own regulations after which they restored reciprocity in 2010.)

The four grandfathered states were not altered by this legislation. Still, there was great interest in reciprocity, and to date Connecticut, Indiana and New York have all filed revised State Plan Amendments with HHS, and been granted reciprocity with their DRA neighbors.[[11]](#endnote-11)

What is reciprocal is honoring the asset disregard of the underlying partnership policy. However, should the time come, the transplanted resident must still meet the Medicaid eligibility requirements of the state to which that person has moved, not the original state where the policy was purchased.[[12]](#endnote-12)

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Currently, the process looks like this for consumers:

1. You live in a state that offers a long-term care partnership policy.

2. You review your needs (with a financial advisor) and determine that you have sufficient assets to protect.

3. Part of your evaluation is whether long-term care insurance is the proper way to protect these assets. If so, you can buy a policy that is considered long-term care partnership-eligible. The policy will come with a form that designates it as such.

4. You buy the long-term care partnership policy.

5. Later, you have a long-term care claim. You apply and are approved for benefits under the long-term care partnership policy.

6. The insurer processes your claim, keeping track of the total amount of policy proceeds that are paid out to you.

7. You exhaust your policy proceeds *(not required in most states)* and then decide to apply for Medicaid for additional assistance.

8. The insurer reports to your state Medicaid division the total amount of benefits paid out for you under the policy. When evaluating your eligibility for Medicaid benefits, Medicaid will exclude from your countable assets an amount equal to the total benefit payments you received.

9. Note: Partnership policies protect only assets, not income. You must still meet Medicaid’s income eligibility requirement, and medical eligiblity requirement (which may differ from the LTC insurance policy under which you were previously collecting benefits).

The question now is do advisors have to be sure every long-term care insurance policy they sell is eligible for partnership status?

The answer is no. Sometimes the long-term care partnership policy is too expensive for your client (by virtue of additional age-appropriate inflation protection). Many times your middle- and upper-class client will not be contemplating future Medicaid enrollment; after all, the goal of private insurance is to keep our clients *off* of Medicaid. On the other hand, if it’s possible to ensure that your policy has partnership status, by all means do so.

Just remember that the underlying LTC insurance is doing most of the heavy lifting. Remember the GAO report cited above: only five percent of partnership claimants eventually enrolled in the Medicaid program. The underlying private insurance plan was enough.

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The Long-Term Care Partnership Program is not guaranteed to exist forever—nor is Medicaid, a point stressed all too often in the ongoing Washington, D.C., budget fights. So, if it is impossible to have your client’s policy certified as partnership-eligible (usually because the cost of the required inflation option is more than he or she can afford), don’t sweat it. When we have to make compromises in LTC insurance planning, it’s wise to take a *“*something is better than nothing*”* approach with our clients.

1. “Five Key Facts about the Delivery and Financing of Long-Term Services & Supports,” Kaiser Family Foundation, 09/13/13. http://kff.org/medicaid/fact-sheet/five-key-facts-about-the-delivery-and-financing-of-long-term-services-and-supports/. Data for FY 2011. [↑](#endnote-ref-1)
2. Information provided by the Center for Health Care Strategies (www.chcs.org). [↑](#endnote-ref-2)
3. This schedule is posted for the upcoming ten years at http://www.nyspltc.org/agents/benefits.htm. [↑](#endnote-ref-3)
4. A side-by-side comparison can be found here: http://www.nyspltc.org/expansion.htm [↑](#endnote-ref-4)
5. Indiana Long-Term Care Partnership Program, Total Asset Chart. Available at http://www.in.gov/iltcp/2358.htm. [↑](#endnote-ref-5)
6. “Long-Term Care Partnership Expansion: A New Opportunity for States,” Issue Brief (May 2007): 3. [↑](#endnote-ref-6)
7. U.S. Government Accountability Office, Overview of the Long-Term Care Partnership Program (September 2005): 31–4. Available at http://www.gao.gov/new.items/d051021r.pdf. [↑](#endnote-ref-7)
8. The Deficit Reduction Act of 2005, Pub. L. No. 109-171 (2006). [↑](#endnote-ref-8)
9. Anna Sommers, Mindy Cohen, and Molly O’Malley, “Medicaid’s Long-Term Care Beneficiaries: An Analysis of Spending Patterns,” Issue Paper (November 2006). Available at http://www.kff.org/medicaid/7576.cfm. [↑](#endnote-ref-9)
10. Joanie Rothstein, “Long-Term Care Partnership Expansion: A New Opportunity for States,” Issue Brief (May 2007): 3. Available at http://www.chcs.org/media/Long-Term\_Care\_Partnership\_Expansion.pdf . [↑](#endnote-ref-10)
11. It’s worth remembering that DRA states operate only on a “dollar for dollar” model, so an Indiana or New York policyholder with “total asset protection” who moves to a DRA state will only receive “dollar for dollar” credit. [↑](#endnote-ref-11)
12. Cameron B. Waite, “Selling Long-Term Care Partnership Policies,” Life Insurance Selling (August 2008): 69. [↑](#endnote-ref-12)