



TEXAS HEALTH CARE POLICY COUNCIL

-POLICY PAPER-

AN INTRODUCTION TO LONG-TERM CARE (LTC) INSURANCE
PARTNERSHIP PROGRAMS AS PART OF AN INTEGRATED LTC POLICY FOR TEXAS

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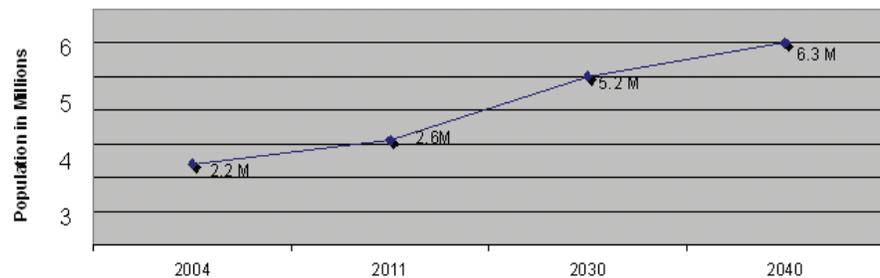
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ISSUE: FUTURE LONG-TERM CARE CHALLENGES

A key challenge facing Texas in the future is providing high-quality care to Texans as they reach 65 years of age and older. According to the Texas Health and Human Services Commission (HHSC), the number of Texans over age 65 is expected to nearly triple, increasing from about 2.2 million in 2004 to 6.3 million in 2040. Long-term care (LTC) spending accounts for over one-third of all Medicaid spending nationally. In Texas, Medicaid pays for 67 percent of all nursing facility care. Without changes to LTC financing and utilization trends, HHSC's current forecast indicates that Texas Medicaid LTC expenditures could triple from \$3.5 billion in 2005 to \$12.5 billion (in constant 2005 dollars) by 2040.

Due to the anticipated increases in the need for LTC and continued dependency on public financing to pay for it, both federal and state policy makers are exploring new approaches to LTC.



Source: HHSC Center for Strategic Decision Support

ONE STRATEGY: LONG-TERM CARE PARTNERSHIP PROGRAMS

One strategy to decrease Medicaid LTC spending has been to encourage individuals to purchase LTC insurance instead of depending on Medicaid. The Deficit Reduction Act of 2005 (DRA), which was signed by President Bush in February 2006, includes several Medicaid LTC services policy changes and provides states with a new public-private approach to crafting LTC policy.

This new approach, which is being referred to as the LTC Partnership programs, would reward Texans who purchase state-approved LTC insurance policies by allowing them to protect some of their assets, should they ever need to use Medicaid to pay for their LTC expenses. The goal of LTC Partnership programs is to shift LTC financing from the public to private sectors so that Medicaid is the payor of last resort rather than the payor of first resort.

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The Texas Health Care Policy Council, with strong technical support from HHSC and the Texas Department of Aging and Disability Services (DADS), prepared “An Introduction to Long-Term Care (LTC) Insurance Partnership Programs as Part of an Integrated LTC Policy for Texas,” a policy paper that includes the following information for state decision makers:

- ★ Current projections for Texas’ elderly population growth, LTC use, and LTC Medicaid budgets in Texas;
- ★ Recent program improvements already implemented by Texas Medicaid;
- ★ A summary of some LTC – Medicaid dynamics affecting LTC policy; and
- ★ A description of LTC Partnership programs and their potential as one component of an integrated approach to address LTC capacity and financing concerns.



KEY FINDINGS

- ★ Over the next 30 years, the number of people over 65 years will nearly triple; Texans over 65 will increase from 2.2 million in 2004 to 6.3 million in 2040.
- ★ By 2030, the oldest baby boomers start to turn 85; the age they are most likely to need long term supports and services.
- ★ Projections for Medicaid LTC support services eligibles increases by 370 percent from 2005 to 2040.
- ★ Medicaid coverage may serve as a disincentive to private purchase of LTC support services.
- ★ Many middle and upper-middle income individuals have used Medicaid for LTC support services.
- ★ Many believe Medicare will pay for LTC support services.
- ★ As a health and social service, LTC support services are relatively unique in reliance on public sector funding.
- ★ LTC Insurance Partnership programs may be an important part of an overall approach that Texas can use to:
 - ★ Increase awareness of LTC insurance.
 - ★ Provide incentives to purchase approved LTC insurance.
 - ★ Support the development of LTC insurance coverage and acceptance of standardized requirements for insurance.
 - ★ Help ameliorate the expected growth in public financing for LTC.

RECOMMENDATION

The Texas Legislature should adopt legislation that would authorize the use of LTC Partnership program policies in Texas and direct the Texas Health and Human Services Commission to develop a mechanism to evaluate and assess the effectiveness of the program.

AN INTRODUCTION TO LONG-TERM CARE (LTC) INSURANCE PARTNERSHIP PROGRAMS AS PART OF AN INTEGRATED LTC POLICY FOR TEXAS

INTRODUCTION

The aging of the nation's baby boomers, those born between 1946 and 1964, will challenge our capability to provide and pay for long-term care (LTC). The General Accounting Office (GAO) defines long-term care to include "health, personal care and social supportive services in the community, assisted living facilities or in nursing facilities." The GAO estimates that about one-seventh of all those over 65 will need some form of assistance for a long-term physical or mental disability, and over the next 30 years, the number of elderly over 65 will triple.¹

As the baby boomer generation reaches 65 years of age and older, Medicaid programs and state budgets can expect a significant growth in LTC expenditures especially between 2011 and 2040. Medicaid is currently the single largest payor of LTC services in the nation. For 2004, the Congressional Budget Office (CBO) estimated that 35 percent of all LTC for older adults will be paid for by Medicaid, compared to 33 percent in out-of-pocket payments and 25 percent by Medicare, (This is care provided to adults and does not include care provided by family and friends).² The Centers for Medicare and Medicaid Services (CMS) reported that Medicaid contributed more than \$59 billion (43 percent) of the \$139 billion spent nationally on LTC during the 2002 calendar year, with private sources contributing \$56 billion (40 percent) and Medicare \$24 billion (17 percent).³

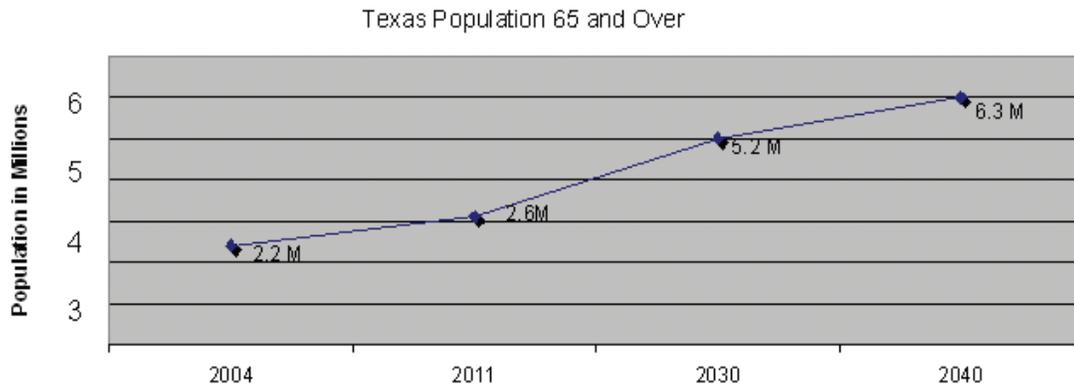
Significant increases in the need for LTC and continued dependency on public financing to pay for it, will challenge federal and state governments to rethink current approaches to LTC.^{4,5} One component of an integrated approach to these challenges may include what is referred to as Long-Term Care Insurance (LTCi) Partnership programs. In these programs, participating states work with insurers to create LTC insurance policies that are more affordable and provide better protection against impoverishment than in non-partnership markets. Once private LTC insurance benefits are exhausted for Partnership beneficiaries, Medicaid pays for subsequent LTC needs and some amount of individual assets are protected.

This paper outlines:

- ★ Current projections for Texas' elderly population growth, LTC use, and LTC Medicaid budgets in Texas;
- ★ Recent program improvements already implemented by Texas Medicaid;
- ★ A summary of some LTC – Medicaid dynamics affecting LTC policy; and
- ★ A description of LTCi Partnership programs, Partnership cost-effectiveness for Medicaid, and Partnership potential as one component of an integrated approach to address LTC capacity and financing concerns.

PROJECTIONS FOR TEXAS' ELDERLY POPULATION GROWTH, LTC USE AND MEDICAID BUDGET

The number of Texans over age 65 is expected to increase from about 2.2 million in 2004, to 2.6 million in 2011 when the first baby boomers turn 65. This group will more than double to about 5.2 million by 2030 as the oldest baby boomers start to turn 85 – the age when they are most likely to need LTC. In 2040, Texas is expected to have about 6.3 million residents who are 65 and older,⁶ half of whom are expected to have some type of disability.



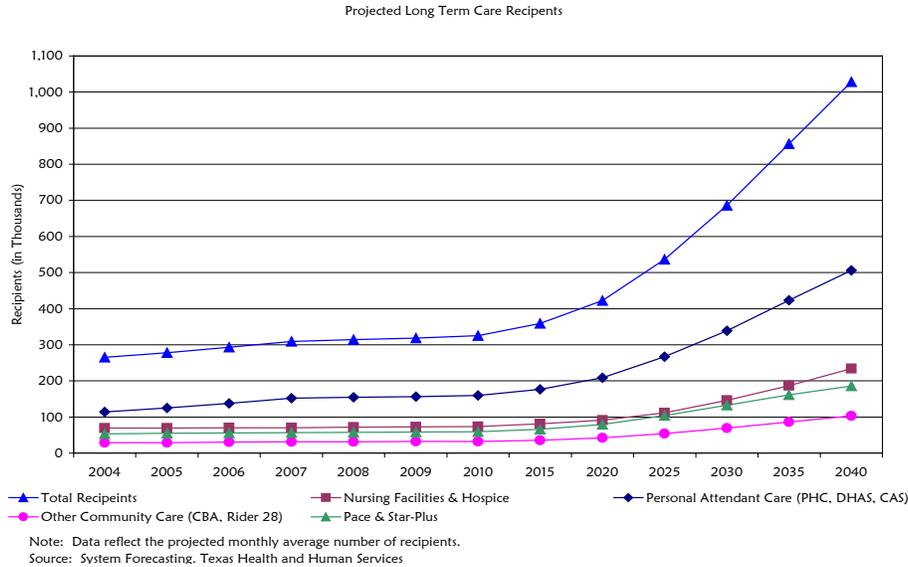
Source: HHSC Center for Strategic Decision Support

Increases in Texas residents aged 65 and over will also mean increased Medicaid LTC service needs and expenditures. In Texas, the state and federally funded Medicaid program pays for a significant portion of all LTC services, including nursing facility (NF) care as well as an increasing number of community care programs designed to provide alternatives to institutional care. Medicaid funded LTC services and initiatives for eligible individuals include:

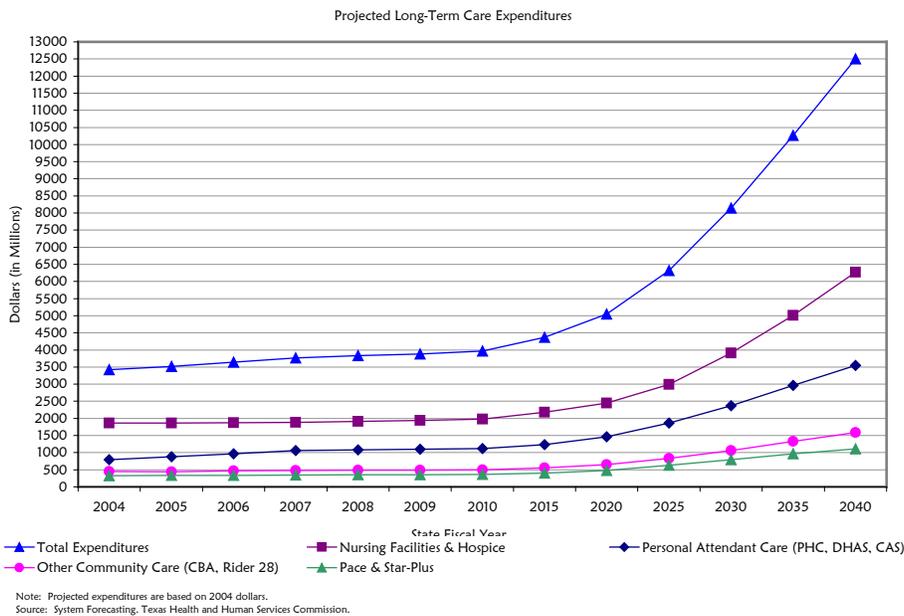
- ★ Services provided in a NF (institutional care including skilled nursing, room and board, social services, medical supplies, etc.);
- ★ Primary Home Care Services (attendant care services);
- ★ Community Attendant Services (attendant care services);
- ★ Day Activity and Health Services (DAHS) (daytime facility-based social services and activities addressing physical, mental, medical and social needs);
- ★ Community Based Alternative (CBA) services (personal assistance, adaptive aids, medical supplies, medical care and therapies as an alternative to NF care);
- ★ Hospice (palliative skilled nursing care including medical, social and support services);
- ★ “Money Follows the Person Rider 28” (a funding mechanism to allow purchase of community services to qualified individuals who transfer out of a NF);
- ★ PACE (Program for All Inclusive Care for the Elderly, services for individuals who meet NF criteria, community-based comprehensive medical, health, inpatient and outpatient care, and NF/acute placement care when necessary); and
- ★ STAR+PLUS (Coordinated Medicaid acute and LTC services delivered in a managed care model).

Based upon the Texas Department of Human Services’ (DHS) 2002 cost report data Medicaid is currently the largest payor for LTC, including coverage of 67 percent of all NF care in Texas. With no significant changes in current policies and payments, the Medicaid LTC budget will increase dramatically over the next 35 years as the number of older Texans increases.

To help illustrate the potential increase in Medicaid LTC costs resulting from the aging of the baby-boomers, the Texas Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS) forecasters estimated Medicaid-funded LTC service use and costs out to the year 2040, when the youngest baby-boomers will be over 75 years old. The estimate assumes program growth based on time-series or historical trends up to 2010, and then project LTC use based on demographics. Forecasters estimated service use for 2010-40 by applying current usage rates of LTC services in elderly age groups to the dramatically increasing number of older Texans in the future. These estimates suggest the number of Medicaid-funded LTC recipients in Texas could increase by 370 percent from about 277,000 recipients in 2005 to 1,028,000 recipients in 2040.⁷



Similarly, the projected costs of Medicaid-funded LTC services, in constant 2004 dollars, could triple, from \$3.51 billion in 2005 to \$12.51 billion in 2040.⁸ The actual cost in 2040 would be greater when increased cost for services would also be included in total costs for providing Medicaid-funded LTC. (These estimates assume no significant changes in current LTC program policy and no dramatic changes in the general health or income of the elderly. Additional detail on the estimate assumptions is included as an appendix to this paper.)



Given the challenge of forecasting LTC services use for 35 years, these estimates are intended simply to illustrate the potential impact that the aging of the baby boomers could have on LTC use and Medicaid funding needs in Texas. Nonetheless, these projections mirror national estimates - the CBO projected a similar increase in national LTC expenditures for the elderly; from \$123 billion in 2000 to \$346 billion by 2040.⁹

RECENT MEDICAID LTC POLICY INTERVENTIONS IN TEXAS

The Texas Medicaid program has already developed some successful programs to improve LTC services and utilization. In an effort to support care that more appropriately meets the needs and incorporates the choices of those requiring LTC support, as well as controlling costs of care, Texas Medicaid implemented the Community Based Alternatives (CBA) program statewide in 1995. CBA is a Medicaid 1915 (c) waiver program that offers services designed to meet, in their homes or communities, the LTC needs of individuals who are elderly and physically disabled, delaying or deferring the need for NF services. While not all those who use CBA services would have used NF services, an analysis of CBA suggests that the program will result in a significant decrease in the number of Medicaid recipients in NFs.

Other LTC initiatives and programs include the “Money Follows The Person” option approved by the Texas Legislature in 2001. This funding initiative permits Medicaid clients to leave nursing facilities and receive services in the community. In addition, Texas offers a number of optional Medicaid community care services (i.e., Primary Home Care, Community Attendant Services, Day Activity and Health Services (DAHS)), which provide clients with personal care. DAHS also offers clients nursing services in an adult day care setting. The Program for All Inclusive Care for the Elderly (PACE) offers an integrated community-based approach as an alternative for institutional care, and Texas’ STAR+PLUS Medicaid managed care pilot offers coordinated acute and LTC services through an HMO model. The community-based programs have contributed to keeping the occupancy rate in Texas’ nursing facilities stable. They have also kept people in the community longer, therefore delaying the more costly facility services and shortening the duration of more costly care.

MEDICAID & LTC DYNAMICS

The programs discussed above suggest that well crafted policies can improve care and help to control Medicaid LTC expenditures. However, even if Medicaid programs continue to develop increasingly cost-effective approaches to providing LTC, the anticipated need for LTC services in the future still is likely to overwhelm capacity to provide and pay for services. No single program can provide the integrated, comprehensive approach needed to address LTC challenges created by the interdependent dynamic of health care needs and services, demographics, financing and other factors. Medicaid policies, LTC infrastructure and future funding liabilities are closely interrelated. The following highlights some of these dynamics and their effects on the LTC challenge.

MEDICAID PAYS FOR MOST LTC.

As a safety net initially intended for those with low income, Medicaid has become the primary payor of LTC for all Americans and Texans. Middle and upper class individuals can qualify by protecting their assets through estate planning options or by spending down their assets to meet eligibility criteria for Medicaid LTC services. With these eligibility options, Medicaid pays for more LTC than any other source - well beyond the initial targeted population.¹⁰

MEDICAID COVERAGE CURRENTLY SERVES AS A DISINCENTIVE FOR LTC INSURANCE.

The incentive for individuals to purchase private LTC coverage diminished in part due to asset “spend down” (i.e., the expenditure of assets to the point that remaining assets meet Medicaid eligibility criteria) and the historical use of estate planning options allowed by the federal government (i.e. moving assets to other family members so remaining assets meet Medicaid eligibility criteria), thus qualifying for Medicaid LTC coverage. This dominance likely slowed the development of a viable privately funded market for LTCi.

The Deficit Reduction Act of 2005 included requirements that change asset policy for Medicaid LTC eligibility. These changes were adopted to further delay Medicaid eligibility for individuals who transfer assets at less than market value.

MANY INDIVIDUALS BELIEVE THAT MEDICARE WILL COVER THEIR LTC NEEDS.

Much of the population falsely believes that Medicare offers substantial LTC coverage. According to a legacy Texas Department on Aging (TDOA) survey, 41 percent of baby boomers erroneously believed that Medicare would cover their LTC costs.¹¹ Because they assume their LTC needs are taken care of, fewer individuals take steps to assure that they will have coverage when and if they need it. Education is essential to any integrated approach to LTC policy.

LTC HEALTH CARE IS UNIQUE IN ITS RELATIVE RELIANCE ON THE PUBLIC SECTOR FUNDING.

Physical health, and to a lesser extent behavioral health, are both covered by most employer and other private insurance programs. Employer sponsored LTC coverage is less common. Reliance on public sector funding leads to less public funding available for other programs and priorities.

THE PROVIDER BASE IS LARGELY DEPENDENT ON MEDICAID FUNDING.

Medicaid largely influences the market dynamics of provider supply and behavior, with less private sector funding to diversify and help support a more robust market. Furthermore, if government supported funding levels are inadequate, the provider infrastructure may be at risk and unable to meet the future need for LTC services.

WAGE-BASED SUPPORT FOR LTC FINANCING GROWS SLOWLY, WHILE NEED INCREASES.

While national and state demographics point to a significant growth in the need for LTC services, there is a relative decline in the number of individuals in the younger working-age group typically depended upon to support the elderly in families and through public programs. If average incomes of the younger working age group do not proportionately increase to bridge this gap, the shrinking population of the wage-earning age group will exacerbate the challenge to support and finance LTC.

THE LTC INSURANCE PARTNERSHIP PROGRAM

With Medicaid programs and policy playing key roles in the future of LTC services and availability, a broad, coordinated and multi-faceted approach to LTC policy and financing is needed. In combination with Medicaid-based reforms and other efforts, one possible component of an integrated approach to LTC policy is the LTC Insurance Partnership Program discussed below. This program provides incentives for private purchase of LTCi as well as some level of asset protection for Medicaid LTC eligibility. These Partnership programs also offer a private-public approach to crafting LTC policy.

While four states currently have Partnership programs, no additional programs were implemented after California's 1994 program because of restrictions included in the federal Omnibus Budget Reconciliation Act (OBRA) of 1993 (two states with programs under development were protected under grandfather clauses). That law required states to implement estate recovery programs to recoup Medicaid LTC costs from the estates of deceased clients. It conflicted with Partnership policies allowing Medicaid clients (and their estates) to protect some of their assets, and therefore prohibited the implementation of new Partnership programs. Despite being unable to offer this incentive, many states passed legislation authorizing a program in the event that federal law changed.¹²

Congress did take action to allow Partnership programs in the Deficit Reduction Act of 2005, signed into law in February 2006. Section 6021, Expansion of State LTC Partnership Program, specifically allows Partnership programs and asset protection when programs meet certain requirements. States now have an additional policy option to consider as a vehicle for helping to alter and potentially mitigate the social challenges presented by our aging population. States considering pursuit of a Partnership program now possible under the DRA are considering potential cost-effectiveness of the program for Medicaid as well as a broader spectrum of benefits for LTC policy, financing and delivery systems. The following sections provide Program background information and assessments.

BACKGROUND

In 1988, the Robert Wood Johnson Foundation (RWJ) sponsored grants to states to help develop incentives for LTCi programs. The states developed programs called the Partnerships for LTC¹³ and assisted states with the implementation of viable LTCi. Four states (New York, California, Connecticut and Indiana) currently operate such programs.

Under the Partnership programs, states receive federal approval to alter Medicaid eligibility requirements for LTC services. Individuals who choose to participate in these state programs are required to purchase LTCi that covers some identified amount of NF care and/or community care. In return, when their private LTCi coverage is exhausted, these individuals become eligible for Medicaid LTC benefits without needing to spend down their protected assets.¹⁴

Through public-private coordination and collaboration, the Partnership Programs can play a supporting role in addressing future LTC challenges by helping to:

- ✪ Provide consumers incentives to purchase LTCi as a vehicle for asset protection; and provide an alternative to asset protection through estate planning;
- ✪ Encourage development of private sector LTCi products that are reliable, high quality, increasingly affordable, and offer minimum standard benefits and consumer protections to encourage consumers to purchase this relatively new product; and
- ✪ Introduce coordination of a public-private LTCi model that may, over time, help encourage some movement of the LTC financing burden from the public sector to the private sector.

These programs help address the “Catch 22” of developing private LTCi options in which consumers and insurers both face the challenges of purchasing or providing this new insurance product. Consumers are hesitant to purchase relatively new, potentially risky, expensive and perhaps not well-regulated products, in particular if they believe their LTC needs will be covered by Medicare or Medicaid. On the other hand, insurers and agents seeing little demand for LTCi are at the same time faced with: higher costs of marketing and managing related to the market’s early reliance on individual policy sales for LTCi; associated higher costs of medical underwriting to estimate costs for individual policy holders; the challenges of estimating LTC medical care service utilization, cost and associated premiums; and challenges complying with new and evolving state-specific insurance requirements for LTCi.¹⁵

As part of an integrated state approach to LTC policy, the Partnership program is designed to provide incentives both for consumers and insurers. When consumers purchase LTC insurance for defined coverage periods or amounts, some amount of their assets is not counted towards determination of Medicaid eligibility. This allows consumers to protect these assets. Furthermore, with standardized, high quality, regulated benefits, consumers have more confidence in the products they are purchasing.

Insurers benefit because they can offer LTCi with discrete, time-limited coverage periods, in effect using the Medicaid LTC benefit as a form of gap coverage - for benefit coverage beyond the finite amount financed through LTCi. This finite or limited coverage makes premiums more affordable. By providing gap coverage through Medicaid, some of the variability inherent in the LTCi market is controlled which should, other things being equal, result in lower and more predictable premiums. Further, efforts to define product standards and streamline LTC regulations nationally will help insurers. Through education, working with state insurance regulators, and providing consumer and insurer incentives for LTCi, Partnership programs can help provide conditions under which the private insurance sector could develop more affordable, quality products that consumers find valuable enough to purchase in sufficient volume to spread the risk and, in turn, promote greater affordability. The programs therefore can help increase the demand for and supply of LTCi.

A Brookings Institution publication concluded that Partnership programs have been successful in improving LTCi regulation, contributing to the stabilization of LTCi markets and improving the quality of insurance policies for consumers.¹⁶ Part of that difficulty stems from a reported inability, to date, to clearly identify whether or not the Partnership policyholders would have purchased LTCi had there been no partnership.¹⁷

Furthermore, if individuals who buy Partnership policies would have bought other private LTCi with no Medicaid component, there is a potential for increased Medicaid expenditures. If those who buy Partnership policies would not have bought other LTCi, and would ultimately have been eligible for Medicaid, then there is a possibility that the program could reduce Medicaid LTC expenditures. Cost effectiveness is discussed in a subsequent section of this document.

PROGRAM DESIGN

The programmatic and financial impact of Partnership programs depends on the specific design of each program implemented. The National Association of Insurance Commissioners (NAIC) has been increasingly active throughout the “Three Waves” of LTCi history (i.e., three historical periods in the development and evolution of LTCi starting around 1970 through about 2000)¹⁸, providing model state insurance statutes, standards and regulations for LTCi policies and programs.

Standards address topics such as criteria to qualify for the benefit, the benefit structure (NF and/or community care and types of services); guaranteed renewability (i.e., insurers can’t cancel policies because of the enrollees aging or a disability); and exclusions.¹⁹ Design of a standard program model and portability agreements between states - currently being facilitated at the federal level - would help consumers and national insurers understand and more easily implement LTCi programs.²⁰ Other non-regulatory program components such as the use of tax incentives and employee-sponsored programs may also contribute to the successful implementation of LTCi.²¹

One design component that varies in the four existing programs is the amount of asset protection offered. The existing programs use one of three approaches:

- ★ DOLLAR-FOR-DOLLAR: Assets are protected up to the amount the private insurance benefit paid.
- ★ TOTAL ASSET PROTECTION: All assets are protected when a state-defined minimum benefit package is paid.
- ★ HYBRID: Program offers both dollar-for-dollar and total asset protection. The type of asset protection depends on the initial amount of coverage purchased. Total asset protection is available for policies with initial coverage amounts greater than or equal to a coverage level defined by the state.

The following section briefly describes the existing programs and their asset protection models.

CALIFORNIA (DOLLAR-FOR-DOLLAR MODEL)²² IMPLEMENTED AUGUST 1994.

In the California Dollar-for-dollar model, there are two types of policies available. There are policies that cover care in a facility and policies that cover care at home, in the community, as well as residential and NF care.

All California Partnership policies must include the following:

- ★ Automatic inflation protection;
- ★ Deductible that must be met only once in lifetime;
- ★ Care coordination to assist in planning and securing services;
- ★ Waiver of premiums while receiving care in a nursing home or residential care facility; and
- ★ Interchangeable policy benefits so that care is customized to meet individual needs.

CONNECTICUT (DOLLAR-FOR-DOLLAR)²³ IMPLEMENTED MARCH 1992.

Connecticut Partnership policies must provide the following consumer safety features:

- ★ Benefits automatically increase to account for inflation;
- ★ Policies must provide for a broad array of home and community-based services in addition to NF care to include case management services to help coordinate, assess, and monitor services;
- ★ Option of shorter-term coverage;
- ★ 5 percent discount on NF rates; and
- ★ Agents and brokers who sell Partnership LTCi policies must receive special training.

INDIANA (HYBRID)²⁴ IMPLEMENTED MAY 1993.

There are two types of policies available, in the Indiana Hybrid model. A comprehensive policy that includes nursing home and home & community-based care. Facility-only policies provide coverage for only institutional care.

Indiana Partnership policies (both comprehensive and facility-only) must have:

- ★ Guaranteed asset protection for the policyholder;
- ★ Benefits that increase 5 percent compounded annually;
- ★ If covering home and community care, include: home health care, home health aide, attendant care, respite care, adult day care, and case management services;
- ★ Require insurance agents to receive 15 hours of training on LTCi and the Indiana LTCi Program prior to selling;
- ★ Require an adequate minimum daily benefit; and
- ★ Incorporate more consumer protection and disclosure features than other policies.

Indiana Partnership policies are also available for shorter terms, which have lower premiums.

NEW YORK (TOTAL ASSET PROTECTION)²⁵ IMPLEMENTED APRIL 1993.

All New York Partnership policies must have the following minimum benefits:

- ★ Coverage for at least 3 years of nursing home care, 6 years of home care or a combination of the two (where 2 home care days equal 1 nursing home day);
- ★ \$189/day coverage for nursing home care; \$95/day coverage for home care in 2006;
- ★ Inflation protection equal to 5 percent compounded annually;
- ★ Care management: information, referrals, consultation on service needs and benefits;
- ★ 14 days of respite care, renewable annually, to give the at-home caregiver some needed rest;
- ★ 30 extra grace days to pay the premium if the individual has designated someone to be notified if premiums are not paid on time;
- ★ Special consideration for adjustment of premiums/benefits in the event of a national LTC program; and
- ★ Review of denied requests for benefit authorization on a case-by-case basis.

As of June 2004, in the four states combined, over 180,000 policies were purchased and approximately 150,000 policies were still active. 1,900 policyholders had received payments and approximately 60 had accessed Medicaid.²⁶

PARTNERSHIP DEMOGRAPHICS AND POLICY PURCHASE OVERVIEW

The GAO prepared an extensive summary and overview of LTC Partnership Programs for the U.S. Senate Finance Committee in September 2005. Some of the findings are included in this paper providing a context for existing policies, purchaser demographics and insurance benefits.

There are currently about 172,500 active Partnership policies in the four states. Most policies are comprehensive and cover facilities and community care (between 88 – 100% of policies in current Partnership states). Most policies were also purchased in the individual market (84 – 100%) rather than through group policies.²⁷

The average age of purchasers at the time of purchase varies from 58 years in Connecticut to 63 years in New York. The range of age of purchasers is from 18 (in California) to 96 (in New York). Each of the four partnership states has purchasers who were as young as 19 and as old as 89. A little over half of the policyholders are female (56–59%), while most are married (70–78%) and nearly all were first time LTCi purchasers (over 92% in each state).

Most policyholders in California, Connecticut and Indiana²⁸ reported having total assets over \$350,000 and a monthly income over \$5,000. The table below identifies the percent distribution for assets and income by state.

Assets	California	Connecticut	Indiana
Over \$350,000	53%	54%	66%
\$100,000 - \$350,000	29%	34%	27%
Less than \$100,000	18%	12%	1%*
Monthly Income			
Over \$5,000	61%	62%	49%
\$2,000 - \$5,000	35%	29%	49%
Less than \$2,000	4%	10%	2%

**7% are unknown in Indiana.*

Partnership policies, like most other forms of insurance, are subject to medical underwriting (assessments of applicants' health status prior to providing coverage). Of the 265,609 policies sold; 42,311 (16 percent) were denied; and 11,326 (4 percent) were withdrawn or pending.

Coverage, and premiums vary by state and by age of purchaser at time of purchase. Daily coverage varied between \$100–\$200 per day depending on whether the benefit was for a NF or community care. Lifetime coverage was most common in California; two-three years of coverage was most common in Connecticut; six years or greater in Indiana; and three years of NF plus six years of community-based care was most common in New York (the minimum required for that state). Average annual premiums ranged from \$1,500 (for a 55 year old in Connecticut to almost \$6,000 for a 70-year-old purchaser.²⁹

To date, only one percent of policyholders have used their Partnership insurance benefits. Of 211,872 policies ever purchased, 2,761 individuals (1.3%) have used benefits. Less than one percent of current policyholders are using benefits (1,209 of 172,477). After using insurance benefits, 251 active policyholders exhausted their benefits. Further, of that number, 119 or 47 percent have accessed Medicaid while 43 percent of those who exhausted their insurance benefits did not access Medicaid.

Assets protected by those who have exhausted their benefits average \$73,000 per person. Those who ultimately used Medicaid protected a smaller average amount: \$69,400 compared to those who did not access Medicaid: \$75,300.³⁰ No data was available on the dollar value of Medicaid services provided to those who exhausted benefits and subsequently used Medicaid services.

PARTNERSHIP PROGRAM AND MEDICAID LTC EXPENDITURES

Although proponents of the Partnership program argue that it would save state and federal programs money,³¹ there is a difference of opinion on how the program will affect Medicaid expenditures. Partnership programs were initially designed to be, at a minimum, budget neutral to Medicaid programs. When the programs were developed in the late 1980s and early 1990s, discussion of tight budgets at state and federal levels precipitated an interest in addressing the costs of Medicaid LTC expenditures.³²

One of the major reasons for developing the Partnership programs and supporting a LTCi market, “was to help people prepare to finance their long-term needs, and in the process, relieve the uncontrolled pressure on Medicaid from the growing use of such services by the nation’s elderly.”³³ Medicaid budget neutrality was a foundational requirement for program development.

The structure of Partnership programs in the DRA was also intended to be at least cost-neutral, requiring a “dollar-for-dollar” asset protection model. Conceptually, both the DRA and early Partnership models were intended to be at least cost neutral to Medicaid.

The program had other goals, which were planned to support overall improvements in LTC services, systems and financing. These included facilitating consumer purchase of private insurance as an alternative to consumers impoverishing themselves (or transferring assets) to qualify for Medicaid coverage.

Although designed to be budget neutral, the net effect of the program is positive. Compared to the case of no insurance, Medicaid is no worse off because the same amount is paid privately on behalf of the individual as when the person had paid out-of-pocket. However, for the consumer the new program means that they do not have to impoverish themselves before they receive assistance from Medicaid.³⁴

With a Partnership program in place and the purchase of LTC insurance, consumers could avoid impoverishment as a criterion for Medicaid eligibility. This focus in early Partnership work was so strong, the program was initially referred to as the RWJ Program impoverishment protection incentive.

Other anticipated benefits included improvements in the LTC delivery system since “[c] are management assistance and preferred provider arrangements under private insurance have the potential to control unnecessary utilization and costs which can help individuals stretch and conserve scarce resources.”³⁵ Providing an alternative way to protect assets without having to transfer them was seen as another benefit.

EARLY PROGRAM COST-EFFECTIVENESS SIMULATIONS

In the early development of Partnership models, RWJ worked with the Brookings Institute LTC Financing Simulation Model to develop simulation modeling to assess the program’s cost-effectiveness. Based on two different scenarios and a detailed set of assumptions, the simulation concluded that there would be savings to Medicaid, a reduction in out of pocket payments, a slight reduction in Medicare payments and an increase in private LTC insurance payments for LTC services. The following table highlights the differences over time (assuming the program started in 1990) of selected five-year averages between payments (by payor source) in the absence of a Partnership program and payments assuming a Partnership was in place.

The numbers in the chart reflect the changes in the base LTC spending scenario developed by RWJ (without a Partnership program), and estimates of the impact of a Partnership program. The analysis projected that Medicaid would have a reduction in LTC payments of almost 7 percent, or \$5.4 billion dollars per year (average annual). Out of pocket expenditures were anticipated to decline by nine percent and insurance coverage to increase by nearly 16 percent

Diff.	Total		Medicaid		Medicare		Other Payor		Out of Pocket		LTC Insurance	
	\$*	%	\$	%	\$	%	\$	%	\$	%	\$	%
1986-1990	0.1	0.0	0.0	-0.1	0.0	0.0	0.0	-0.1	-0.2	-0.1	1.4	3.7
1996-2000	2.5	0.0	-1.0	-3.1	0.1	-0.2	-0.2	-0.4	-4.7	-8.9	7.3	11.0
2006-2010	6.4	0.0	-3.5	-6.8	0.1	-0.3	-0.4	-0.1	-4.8	-8.8	13.7	15.1
2016-2020	8.5	0.0	-5.4	-6.8	0.3	-0.2	-0.8	-0.9	-7.2	-9.0	19.9	15.5

with implementation of Partnership programs.

* All dollars are in billions and are constant 1989 dollars.³⁶

Reflecting changes in the insurance environment, an additional analysis by RWJ included adjustments based on:

- ⊛ An assumption that over time, fewer individuals would have pension income (from 80 percent of individuals to 60 percent); and
- ⊛ An assumption that individuals with higher average lifetime income are more likely to enter a NF than those with lower than average lifetime income. The assumption is based on a conclusion that individuals with an ability to pay out of pocket for some time are more likely to be admitted to nursing homes.

Under this amended analysis, savings to Medicaid were smaller but still significant at \$4.8 billion (a reduction of about 6.2 percent in Medicaid LTC costs). Out of pocket savings were greater: \$9.8 billion annually in 2016 - 2020 and a reduction of about 11.2 percent in out of pocket payments annually compared to no Partnership program.³⁷

This initial RWJ/Brookings analysis provided an early estimate for potential Medicaid cost savings. In the years since this simulation was created and run, many of the simulation variables and data have changed, and Partnership states no longer look to the model as the best assessment of current program savings.³⁸ Beyond the initial projected estimates, the four current states each report cost savings to their programs. These are described below.

NEW YORK

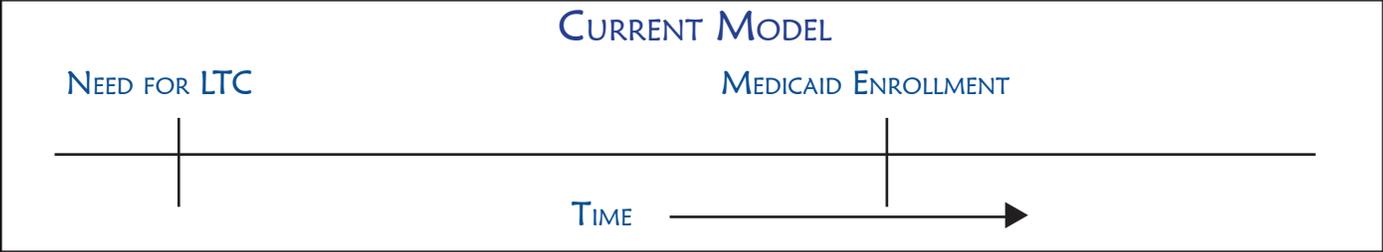
When New York first assessed the potential cost-effectiveness of a Partnership Program, it utilized NF population and payment source data. New York found that private pay patients who entered NF used private funding for, on average, 10 months of their nursing home stay before reverting to Medicaid eligibility and Medicaid payments. Individuals stayed in the NF, on average, 2.5 years, or 30 months. Based on this information, New York concluded that the Partnership would save the Medicaid program money if private insurance coverage was substituted for Medicaid coverage for the remaining of the average 2.5 years of individuals' NF stays. To be conservative, New York required that Partnership benefits cover a minimum of three years of NF stays.³⁹ New York concluded that substituting private insurance for Medicaid LTC coverage would save Medicaid funds, as long as, on average, the LTCi covered anticipated LTC costs.

CONNECTICUT

Connecticut assesses on-going cost effectiveness through a conceptual model informed by actual survey data. The model assumes that individuals fall into groups that, under the Partnership, would either potentially cost Medicaid more money, save money or be budget neutral.

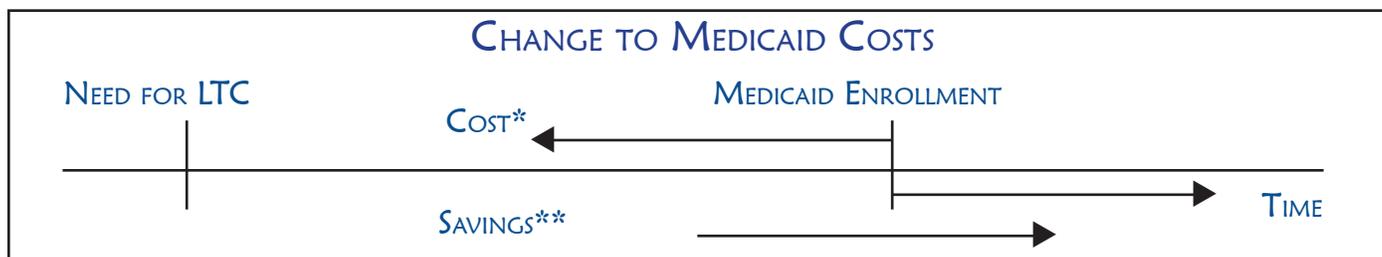
BASIC ASSUMPTIONS

At some point, the need for LTC services arises, and some individuals become eligible for



Medicaid payment of their LTC services. Conceptually, the Partnership would save, cost or be budget neutral to Medicaid depending on how the Partnership affects the timing of Medicaid eligibility for LTC, other things being equal.

- ★ MEDICAID COSTS WOULD ACCRUE because of the Partnership if enrollee’s use of Medicaid were higher (assume longer time on Medicaid or that people access Medicaid earlier) than in the absence of the Partnership plan. Shifting Medicaid eligibility closer to the date when LTC was needed, other things being equal, would result in Medicaid program cost increases under the program.*



- ★ MEDICAID SAVINGS WOULD ACCRUE because of the Partnership if enrollee use of Medicaid is lower (assume shorter or later) than what otherwise would have been the case without the Partnership plan. Lengthening the time between need for LTC and Medicaid payment for LTC, other things being equal, would result in program savings.**
- ★ MEDICAID EXPENDITURES WOULD BE COST NEUTRAL if, under the Partnership, there was no significant change to the time during which Medicaid covered LTC.

The Connecticut model identifies whether LTC Partnership purchasers are likely to be cost-neutral, produce savings, or cost Medicaid, and uses survey data to categorize purchasers and estimate program savings or costs.

Conceptually, using two basic criteria, all purchasers are put in one of four categories. Before the Partnership, individuals:

- ★ either would or would not have purchased other LTC insurance; and they
- ★ either would or would not have planned to transfer assets. *(Connecticut includes additional criteria such as whether or not decisions regarding which LTCi benefit to purchase was affected by the Partnership program. This information is excluded here in an effort to lay out the basic conceptual model.)*

The model then conceptualizes whether the four resulting groups would be cost-neutral, or

	WOULD NOT TRANSFER ASSETS	WOULD TRANSFER ASSETS
WOULD PURCHASE LTC INSURANCE	CATEGORY 1 POTENTIAL COST	CATEGORY 2 COST NEUTRAL
WOULD NOT PURCHASE LTC INSURANCE	CATEGORY 3 COST NEUTRAL	CATEGORY 4 POTENTIAL SAVINGS

generate additional costs or savings for the Medicaid program. The following four categories compare behavior “before” and “after” the Partnership is in place.

CATEGORY 1 - NO ASSET TRANSFER, WOULD HAVE PURCHASED LTCI

Potential COST to Medicaid: These individuals would have had LTCi and would not have transferred assets without Partnership.

BEFORE _____ LTCi Covers _____ \ _____ Assets Used _____
AFTER _____ LTC Pi Covers _____ \ _____ Assets Exempt-On Medicaid

Result: These individuals substitute Partnership and asset protection for LTCi they would have purchased without asset protection. Without the Partnership, these individuals would not have accessed Medicaid until they used their insurance benefits AND would have used their existing assets (because they would not have transferred assets). By using the Partnership, they may use Medicaid sooner than they otherwise would have because under the Partnership, they use their insurance benefit then qualify for Medicaid without using assets. Actual costs would depend on whether or not their LTC needs exceed the Partnership benefit, and they access Medicaid payment.

CATEGORY 4 - ASSET TRANSFER, WOULD NOT HAVE PURCHASED LTCI

POTENTIAL SAVINGS to Medicaid: These individuals would not have had LTCi and would have transferred assets without Partnership.

BEFORE _____ Medicaid Pays (no insurance; no assets) _____
AFTER _____ LTC Pi Covers _____ \ _____ Assets Exempt-on Medicaid

Result: Those who would not have bought LTCi and would have protected their assets would have gone onto Medicaid without using their assets or a private benefit. By having the Partnership insurance, they delay their use of Medicaid for the length of time that their insurance benefits pay for care and have potential Medicaid savings.

CATEGORY 2 - ASSET TRANSFER; WOULD HAVE PURCHASED LTCI

COST NEUTRAL to Medicaid: These individuals would have had LTCi and would have transferred assets.

BEFORE _____ LTCi Covers _____ \ _____ Medicaid Pays (no assets) _____
AFTER _____ LTC Pi Covers _____ \ _____ Medicaid Pays (assets protected) _____

Result: Partnership replaces other LTCi; and asset protection replaces asset transfer. No change in Medicaid payment but assets protected.

CATEGORY 3 - NO ASSET TRANSFER, NO LTCI

COST NEUTRAL to Medicaid: These individuals would not have had LTCi and would not transfer assets.

BEFORE _____ Assets Used _____ \ _____ Medicaid Pays _____
AFTER _____ LTC Pi Covers _____ \ _____ Medicaid Pays (assets protected) _____

Result: Partnership replaces asset use. No change in Medicaid payment but assets protected.

POPULATING THE MODEL WITH SURVEY DATA

Connecticut conducts a survey of Partnership enrollees to see which of the four categories the enrollees were in prior to purchasing Partnership plans. By applying survey data to the categories, and adjusting the data to take into account program factors (such as Medicaid paying less than private insurance), the analysis provides information about program cost-effectiveness. Use of this data assumes that the results based on those surveyed are generalizable to all Partnership Purchasers.

The Connecticut Partnership for LTC publishes an annual evaluation report. The report for July 2004 - June 2005 was published in June 2006. It includes data from a summary of individuals who purchased, dropped or were denied a Partnership policy during that year, and compares information to previous years' data. In 2006, the survey was sent to a random sample of individuals, and 48 percent (379 individuals) of those to whom surveys were sent, responded. The survey information is used for basic demographic information as well as to produce cost-effectiveness estimates.

For its analysis, Connecticut identifies total cumulative Partnership completed claims paid out to date. This includes the total Partnership claims of those who used Partnership benefits and died; and those who used Partnership claims and then used Medicaid. The sum of all Partnership claims for these individuals is the total Connecticut Partnership LTC claims payout. In 2005, this amount was \$23,531,394. This amount is also averaged to produce an average Partnership claims payout per participant.

In the most recent available report, survey data identified 24 percent of respondents in a savings category; i.e., in a group that would have transferred assets in absence of a Partnership Program, and if they needed LTC, would have gone directly to Medicaid for payment of LTC services. For individuals in these circumstances, purchase of a Partnership program avoids Medicaid expenditures. Connecticut assumes that 24 percent is a conservative number based on the survey respondent dynamics of reporting to the Connecticut Medicaid program. Connecticut believes it is reasonable to expect an under-reporting of individuals to the state regarding whether or not they would have intentionally transferred assets to be eligible for Medicaid LTC.

Connecticut applies 24 percent of those in the savings category to the total claims payout for an estimated amount that the Partnership insurance paid, that, in the absence of the Partnership, Medicaid would have paid. In 2005, that amount was \$5,647,535. In Connecticut, Medicaid pays less than private insurance for LTC services. On average, Medicaid pays 53 percent of what private insurance would pay, so the potential savings number is adjusted down; 53 percent of the potential savings yields a potential savings to Medicaid of \$2,993,194.

An assumption is made that the assets individuals protect when using Partnership insurance coverage also generate interest of 3 percent. It is assumed that the amount (\$91,918 in 2005) is available for LTC expenditures and further delays use of Medicaid. The potential savings is the sum of \$2,993,194 and the interest of \$91,918 or \$3,085,112.

Based on survey information, another 11 percent of individuals fall into a cost category that

they would have purchased LTCi in the absence of the Partnership program. However, from a Medicaid cost-effectiveness perspective, the only individuals who are a concern are those who would have used the Partnership benefit and then use Medicaid. Simply substituting Partnership insurance for other LTCi is cost neutral to Medicaid. It is only a cost to Medicaid if individuals in this category use all their Partnership benefits and then use Medicaid. To estimate this, Connecticut identifies the number of individuals in the category of potential cost-drivers, who used more benefits than were covered by the policies. In 2005, there were two individuals with total claims greater than the average claim amount for all benefits paid out. Two purchasers represent 0.18 percent of all purchasers. This percent is applied to the total claims payout of \$23.5 million to yield a net cost to Medicaid of \$42,357 for these individuals.

Total program savings are estimated to equal potential savings less the cost component, or \$3,042,755 as of 2005. These costs do not include costs to administer the Partnership programs. Other relevant considerations are that for each additional LTCi policy sold, the state receives additional revenue to its general revenue fund by premium taxes raised from the new policies. Connecticut generates \$1 million annually from Partnership insurance premium taxes. With an assumption that some of these policies, in the absence of the Partnership, would have been purchased through other tax-generating LTCi policies, Connecticut believes, nevertheless, there is a net revenue gain from Partnership programs.

Connecticut also points out that there is an uncalculated benefit to having qualified Partnership insurance instead of other LTCi without the same protections, (i.e., inflation protection). Better protections and coverages under Partnership programs reduce out of pocket costs, which further delays beneficiaries' use of Medicaid.

Connecticut is aware that predicting the outcome of a hypothetical situation is a challenge dependent on a number of unknowns that are difficult to predict. However, in the absence of knowing all the variables and factors, this model does include a basic conceptual approach to analyzing cost-effectiveness using actual survey data to conclude that the Partnership program in Connecticut does provide program savings.

CALIFORNIA

A 2003 California LTC Partnership document summarizes an analysis of individuals who purchased Partnership insurance and then accessed Medicaid as the initial basis of its cost-savings analysis. The state conducted a detailed assessment of 9 of the 19 people who, at that time, had accessed Medicaid. The study compared when, based on the specifics in each case, individuals would have accessed Medicaid funding for LTC in the absence of the Partnership, and when they actually did access Medicaid. The analysis also included associated Medicaid costs.

The study concludes that based on assessment of these nine individuals, California Medicaid saved \$437,085 for LTC facility costs alone. California estimates that including the entire 19 individuals would likely double the estimated savings. This number excludes savings from Medicaid acute care expenditures for these individuals, such as physician visits, hospital care, and prescription drugs. Inclusion of these savings, California believes, would increase overall Medicaid savings further.

California concludes that the Partnership model has benefited the taxpayers as well as

consumers, because of Medicaid savings and LTCi market improvements. Prior to the Partnership, California LTCi tended to be provided for longer duration and was therefore more expensive and practical only for wealthier individuals. With more moderately priced, shorter duration benefits available, California has found that the purchasers are “more interested in protecting their independence and assuring access to a facility of their choice than protecting assets from Medi-Cal spend down.”⁴⁰ Having shorter-term policies available with coverages for one-to-two years makes them more affordable for middle class individuals.

California believes that availability of Partnership Programs has increased the purchase of LTCi in California and has improved the quality of the policies offered. Program data show that while LTCi purchases have increased, overall Partnership Programs represent an increasing percentage of all LTCi policies purchased (2.3 percent of the 10,242 LTC policies sold in 1994 to 47 percent of the 21,878 LTC policies sold in 2005).⁴¹

INDIANA

Indiana also reports program savings from the Partnership program. Over 37,960 policies have been sold to date, with 114 policyholders exhausting their benefits. Of those who exhausted benefits, 22 have subsequently accessed Medicaid assistance.

Based on insurers asset protection reports, Indiana calculated that the program has saved \$10 - \$12 million in Medicaid assistance not used that, in the absence of the Partnership, likely would have been accessed.⁴²

CONGRESSIONAL BUDGET OFFICE

While the early program modeling and more current state assessments indicate long term Medicaid cost savings potential, the Congressional Budget Office (CBO) scored LTC Partnership legislation with overall net costs to the program. CBO expressed concern that under the programs, individuals would buy Partnership LTC insurance (and Medicaid asset protection) in lieu of existing private LTC insurance, and that individuals may spend down insurance benefits at a faster pace than if they were spending their own savings (assets).⁴³ Either of these outcomes would increase Medicaid LTC expenditures.

In the context of estimating the fiscal impact of earlier federal legislation allowing Partnership program expansion, the CBO initially suggested that over a 10-year period the program could increase federal Medicaid expenditures nationwide by \$100 million. No formal analysis of this number is available from CBO.⁴⁴ However, this estimate is thought to have slowed forward movement of federal legislation to allow Partnership programs.

CBO's 2004 LTC financing report also indicated partnership policies might increase Medicaid LTC expenditures if it crowded out other private LTCi policies, however no financial estimates are available for this finding. CBO indicated that for those who would not have otherwise purchased LTCi, policyholders might use the benefits quicker than they would their own assets, qualifying for Medicaid more quickly. On the other hand, compared to those with a Partnership policy, those without insurance might be more likely to spend down assets quicker to access to Medicaid benefits. Therefore CBO's report was neutral regarding the potential fiscal impact.⁴⁵

In its analysis of the Deficit Reduction Act, the LTC Partnerships Programs item is shown as costing the federal Medicaid program \$3-4 million a year in 2006-2007; \$26 million nationally for the five-year period of 2006–2011, and \$86 million for 2006–2015.⁴⁶⁻⁴⁸ It is not clear, however, what CBO’s methodology is, and whether the CBO included considerations such as the cost to Medicaid even in a crowd out situation (e.g., when Partnership insurance replaces other private insurance) only accrues if individuals’ service needs in private insurance exceed the benefit purchased.

ADMINISTRATIVE COSTS

The states with existing Partnership programs benefited from initial grant funding from RWJ. New York for example used about \$2 million of grant funds to support the majority of its administrative costs over 10 years. Historical administrative cost estimates vary by state.

The information below is based on telephone and email exchange with the current Partnership states. Startup costs were based on costs at that time (typically 1992) and have not been adjusted to current dollars. Also, while the existing states benefited from the RWJ grants, states now pursuing Partnership programs will have advantages such as existing forms, state plan amendments, basic policy benefits, existing outreach and marketing strategies and materials, and other work products as guides.

New York estimated its costs were about \$350,000 per year over 10 years, \$200,000 of which per year was funded by the grant. Current administration and staffing includes 12 full time equivalents (FTEs), and associated outreach and related costs.

Connecticut estimated initial costs of over \$500,000 per year for staff, research, media and outreach. It had eight FTEs dedicated to the project. Current administration costs and staffing levels are estimated at \$300,000 per year largely allocated to salaries, 1.5 dedicated FTEs and an additional partial staffing by four other FTEs with other non-Partnership duties.

Indiana indicated its start up began with three FTEs, which gradually increased to five FTEs, but has no available cost information. Current administrative costs and staffing include two FTEs and about \$180,000 for salaries and related operational costs.

California estimated its start up and current administrative costs at a total of about \$1.1 million per year, with about half of that funding for staff and half for operational costs.

COST-EFFECTIVENESS SUMMARY

A definitive determination of state-specific projected Medicaid costs or savings through cost-avoidance is difficult due to a number of reasons. First, it is difficult to analyze the hypothetical situation of what costs would be under circumstances that do not exist. Second, there are a significant number of variables and behaviors affecting the outcome. These include factors as varied as the required LTCi benefits package and cost, consumer decisions about the value of LTCi, service utilization patterns, beneficiary lapse rates (the rate at which individuals stop coverage once started), and the difficulty of predicting future rates of disability and future claims that may not occur until 5 – 40 years out (the “time warp”).⁴⁹ Ultimately, if the program causes a delay and reduction in use of Medicaid payments for LTC, it will save the program money. If it accelerates use of Medicaid LTC, there will be additional costs.

With the exception of the CBO, in general, recent analyses and information tend to indicate that Partnership programs would either be cost-neutral or may have some long-term savings for Medicaid LTC.

DEFICIT REDUCTION ACT (DRA) IMPACTS

In addition to making Partnership Programs an option for states to pursue, the DRA also includes asset transfer reform and Medicaid LTC eligibility changes to reduce overall Medicaid spending for LTC.

The net effect of the asset changes are anticipated to result in individuals who have transferred assets at less than fair market values, being more likely to have a penalty period of ineligibility for Medicaid LTC when they apply for Medicaid LTC services. For individuals who are familiar with, or work with consultants, lawyers or financial planners familiar with this information, there may be an incentive to purchase LTCi to pay for the care that would not be paid for under Medicaid as a result of the penalty applications. The DRA changes may also encourage individuals to transfer assets earlier than they otherwise would. The ultimate and net impacts on Partnership programs and on cost-effectiveness are unknown (DRA was passed in February 2006) and are not factors in the dynamics of the existing Partnership program analysis.

IMPLEMENTING A LTC PARTNERSHIP PROGRAM IN TEXAS

Because of changes in the Deficit Reduction Act, Texas now has the option of pursuing a LTC Partnership program. If Texas does decide to pursue the program, considerations would include program design and compliance with DRA requirements. A 2004 analysis of Partnership program performance recommended specific program design features states should consider. These features would improve consumer protections and confidence as well as target the program to lower and middle-income individuals. Recommendations include:

- ★ Working with state insurance regulators to develop LTCi standards including compound inflation protection (to assure benefit value keeps pace with inflation) and non-forfeiture clauses (to equitably protect investments in benefit premiums even if an individual lapses on premium payments in the future);
- ★ Allowing beneficiaries to access Medicaid home and community-based waiver programs;
- ★ Providing effective education targeted to those who could benefit from it and encouraging them to purchase insurance;
- ★ Limiting the eligibility of higher-income individuals (to protect against increases to the Medicaid budget);
- ★ Redesigning asset protection to make it more attractive to lower-income individuals; and
- ★ Creating policies for community care coverage only.⁴⁹

Any new state Partnership initiative would need to carefully develop the program design, and include coordination with insurance regulators to craft a program as part of an overall approach to LTC policy and financing. The DRA includes specific requirements with which states would need to comply.

In order to pursue a LTC Partnership Program in Texas, HHSC and the Texas Department of Insurance (TDI) would have to take action including the following:

- ✪ State Plan Amendment (SPA)-HHSC would need to allow for dollar-for-dollar asset protection in determining eligibility for Medicaid and a waiver of asset recovery for qualified Partnership policy purchasers. CMS provided states with information and guidance for pursuing Partnership SPA in July 2006, including a SPA template that provides for the disregard of any assets or resources in a “dollar-for-dollar” model. The following requirements must be met:
 - ★ The insured was a resident of the state when coverage became effective;
 - ★ The policy is tax-qualified;
 - ★ The policy meets certain specified consumer protection requirements of the NAIC LTCi Model Act and Regulation;
 - ★ The policy contains specified inflation protection if sold to an individual under age 76;
 - ★ The state Medicaid agency provides information and technical assistance to the State Insurance Department and their role of assuring producers of partnership policies are trained;
 - ★ The issuer provides regular reports to the DHHS Secretary (set by the Secretary in; and
 - ★ The state does not impose any requirements on a Partnership policy that it does not impose on other LTC policies.⁵¹
- ✪ Texas Administrative Code
 - ★ HHSC would need to revise the eligibility rules under Title 1, Part 15, Chapter 358 to include the provisions for asset protection in the Partnership Program.
 - ★ TDI may need to revise rules to incorporate the model language and adjust to existing TDI LTC insurance rules.

CONCLUSION

In coordination with a state effort that includes other important components such as insurance licensing standards, consumer outreach and education, etc., Partnership programs have the potential to help address LTC policy issues precipitated in part by the aging of the baby boomers. This includes the potential to support development of quality, privately funded LTC insurance benefits with increased participation and lower costs. With the exception of CBO’s informal fiscal impact assessment, Partnership programs are generally thought to be cost-neutral to Medicaid with some possibility they may offset some Medicaid costs and also support availability of a full range of services, including facility as well as home and community care. Even if these programs do not directly reduce Medicaid costs, their implementation may help achieve other important objectives and indirectly improve Medicaid LTC in the future. By addressing consumer incentives and insurance industry affordability, well-crafted and coordinated Partnership programs can help promote the following goals:⁵²

- ✪ Diversification of the LTC payer and provider base;
- ✪ Increased understanding and awareness of LTCi needs and options;
- ✪ Improved access to quality LTC services;
- ✪ Improved access to a full range of home and community-based services;
- ✪ Development of a more robust, quality, affordable private LTCi benefit; and
- ✪ Development of additional private market support for the LTC infrastructure and providers to help support the growing numbers of those who will need some type of LTC assistance.

2040 LONG-TERM CARE FORECAST ASSUMPTIONS

OBJECTIVE:

The intention is to examine short and long-term trends for the Long-Term Care (LTC) and Community Care programs. The trends cover the years 2004 through 2040. Since future policy and program changes cannot be anticipated, the forecasted trends are based on current program policy. The programs included are Medicaid-related entitlements or waivers.

MAIN ASSUMPTIONS:

The assumptions about future health and longevity of the population are implicitly incorporated into the forecast model based on trended program history and projected growth in key elderly population age cohorts. Any dramatic change in the general health of the elderly in the future will change those trends and therefore, can significantly change the client counts for the future.

The client forecasts are based on time-series models through 2010. As far as possible, they are based on the data and forecasts initially submitted in the September 2004 Legislative Appropriation Request (LAR). The 2008-2010 forecasts are an extended forecast of the LAR submittal. Program-relevant population yearly growth rates were used to forecast number of clients for the 2011-2040 periods.

The program-specific cost data applied to the client forecasts are based on state fiscal year 2004 average monthly costs per client. Therefore, future costs are expressed in SFY 2004 dollars.

The monthly average cost for nursing facility clients is the monthly rate minus the average Applied Income, which results in a net monthly cost.

APPLICATION OF POPULATION GROWTH FACTORS:

After 2010, the NF client forecasts are based on projected population growth rates specific to the 80 and older cohort, since over half of NF clients currently are from this age cohort. The projected population growth rates were derived from population projections developed by the Texas State Data Center (TXSDC).

Rider-28 allows medically qualified clients to transfer from a nursing facility to the Community Based Alternative (CBA) program. Rather than incorporate these Rider-28 clients into either NF or CBA data, thereby skewing either forecast, Rider-28 clients are forecasted separately. Therefore the NF and CBA forecasts are for base-line clients.

The other programs and services, except for Harris County's STAR+Plus and El Paso and Potter Counties' PACE programs, are forecasted, beyond 2010, using projected population growth rates for the 75 and older population cohort. Here again, the rationale is that this is the age group most likely to use the various services.

The STAR+Plus and PACE programs are forecasted, beyond 2010, using projected yearly growth rates for the 75 and older population cohort in the counties where these programs operate.

OTHER ASSUMPTIONS:

Implementation of a revised “functional assessment score” for DAHS recipients beginning in January 2005 was assumed. The projected impact is an estimated 4 percent decline in the DAHS case load during the 2005-2010 periods.

Many long-term care programs can be affected by changes in case load levels in the other LTC programs. For example, the “capping” of CBA baseline admissions has diverted clients to the Primary Home Care and Community Attendant Service programs. This inter-relationship between the programs is one of the factors that was taken into account in forecasting each of the aforementioned programs separately.

Program interrelationships can impact the cost forecast as well. For example, while Rider-28 transfer clients are originally NF clients, and are counted as such in the budget, their monthly costs are different when they become Rider-28 clients. These cost differentials were accounted for in the forecasting of program costs.

For the purposes of this analysis, the CBA admission “cap” is removed beginning in SFY 2008, allowing new CBA admissions into the baseline recipient count, which reduces the impact of client diversion to other LTC programs.

These estimates assume only the (1/05) STAR+Plus pilot site in Harris County.

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