



Program to Promote Long-Term Care Insurance for the Elderly

An RWJF national program

SUMMARY

Authorized in 1987, the *Program to Promote Long-Term Care Insurance for the Elderly* (LTCI), a national program of the Robert Wood Johnson Foundation (RWJF), was charged with providing states with resources to plan and implement private/public partnerships (Partnership programs). The Partnership programs joined private, long-term care insurance with Medicaid to offer high-quality insurance protection against impoverishment from the costs of long-term care—including both nursing home care and/or home care.

Consumers who purchase such policies are insured for long-term care up to a pre-set dollar level through the private insurer. Once the private insurance is exhausted, they can continue their long-term care under Medicaid without spending their assets, as is usually required to meet the criteria for Medicaid eligibility.

Key Results

- By 2000, a total of 104,000 applications had been taken and more than 95,000 had been sold in the four program states—California, Connecticut, Indiana and New York.
- More than 25,000 new applications were received for Partnership policies in 1999.
- Program redesigns in Connecticut, Indiana and California have produced increases in applications received ranging from 324 percent to 540 percent, compared to similar time periods prior to those adjustments.
- In New York, where total sales have been the largest in number, updates to its program model are being explored to further program goals. This progress was accomplished despite restrictive language embedded in the [Omnibus Budget Reconciliation Act \(OBRA\)](#) of 1993 effectively curtailed one of the program's goals: replicating the partnerships in other states.

Evaluation Findings

Laguna Research Associates, Inc. of San Francisco conducted an evaluation of the program. Nelda McCall was the principal investigator.

- The evaluators found that the state regulations that had been developed for partnership products represented a more rigorous regulatory model—specifying higher quality policies—than previously existed in the states for long-term care insurance policies.
- More than 30 percent of those who purchased policies said they would not have purchased long-term care insurance without the partnership program.

Essential Features of the Policies

- Suitability for a broad income and age group among the elderly.
- Protection of beneficiaries' assets and income against catastrophic chronic care costs (with different levels of asset protection in each state).
- Coverage of a broad range of services, including home and community-based services and nursing home services.
- Case management and preadmission screening.

Program Management

The program operated under the leadership of a national program office at the University of Maryland Center on Aging.

Funding

RWJF's Board of Trustees originally authorized the program in December 1987 for \$3.2 million. Implementation grants were authorized on an individual basis from 1989 to 1996 for \$9.2 million.

THE PROBLEM

Health policy analysts first recognized long-term care as an insurable event in the early 1980s—about the same time that policymakers began seeking new ways to pay for such care. By the mid-1980s, major insurance companies were marketing private long-term-care policies as a way to guard against the catastrophic costs associated with long-term care.

At the same time, many states became interested in long-term-care insurance as a way to stem increasing middle-class dependence on Medicaid as families' assets became

exhausted paying for long-term care and the individual in need of care became poor enough to be eligible for Medicaid.

Financing Long-Term Care

Concern about the financing of long-term care is based on a set of grim predictions: The population of chronically ill elderly will inevitably increase with the population growth of those older than age 80 and with medical advances that enable those with chronic diseases to survive longer.

According to a study published in the *New England Journal of Medicine*, 43 percent of all Americans will enter a nursing home at some time before they die. Of these, 55 percent will stay at least a year and 21 percent will stay at least 5 years, with the average stay lasting 2.5 years. Currently, the average cost of a year in a nursing home, nationwide, is about \$40,000. By 2010 the cost is expected to rise to more than \$83,000 per year.

Many people mistakenly think Medicare pays much of the bill for nursing home care. However, Medicare has paid less than 9.4 percent of long-term-care costs.

In 1997, 68 percent of nursing home residents were dependent on Medicaid to finance at least some of their care. From 1993 to 2018, Medicaid long-term-care expenditures for the elderly are projected to more than double in inflation-adjusted dollars because of the aging of the population and because of nursing home price increases in excess of general inflation.

Medicaid is already one of the largest items in state budgets, accounting for an average of 13 percent of outlays in 1993; Medicaid's proportion of state budgets exceeded 20 percent in 2000. Although the elderly and disabled represent less than one-third of the total Medicaid caseload, more than two-thirds of total program funding goes for support of their nursing home care.

The Need for Insurance

A number of commissions at the federal and state levels have defined the need for insurance for the growing number of elderly Americans who have or will develop chronic illnesses. Some commissions have also made some progress in developing conceptually appealing models for addressing the problem.

They have reached broad agreement that:

- Delaying the moment at which patients qualify for Medicaid—which occurs when patients exhaust, or **spend down**, their assets to the maximum level allowed for Medicaid eligibility—could avoid financial disaster among long-term-care patients and their families.

- Preventing such [spending down](#) could also save public funds.
- Elderly consumers would benefit if risk pooling—special programs created by state legislatures to provide a safety net for medically uninsurable populations—could be implemented. Yet in spite of these efforts and the emerging consensus, little real action has been taken by the public sector.

While private long-term-care insurance represents a \$160-million industry, the coverage offered is limited and the costs remain high. Thus, only a narrow spectrum of the elderly population is attracted to and can afford current long-term-care insurance policies.

Of the total cost of long-term-care services, far less than 1 percent is covered by private insurance. As a result, the public sector still bears the largest financial stake in this problem.

The problem is compounded by three other things:

- Elderly consumers either are not aware of or deny the need for long-term-care coverage.
- Elderly individuals often believe, mistakenly, that Medicare pays for long-term-care costs.
- The public sector, particularly the federal government, is reluctant to address any major new initiatives that could increase its budget.

The idea of financing long-term care through public-private partnerships between state governments and insurance companies grew out of meetings and discussions among health care policy experts in the mid-1980s.

The Robert Wood Johnson Foundation (RWJF) was attracted by its win-win-win potential: its potential to benefit consumers, Medicaid, and private insurers. RWJF authorized the national program in 1987.

PROGRAM DESIGN

RWJF staff set out the following goals in establishing the program:

- Avoidance of impoverishment among elderly families by guaranteeing asset protection.
- Ensuring access to quality long-term care.
- Coverage of a full range of home and community-based services.
- Development of a case management infrastructure in which the [gatekeeper](#) bears some financial risk in order to prevent excessive or inappropriate utilization.

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

THE PROGRAM

The national program office is located at University of Maryland Center on Aging. Mark R. Meiners, Ph.D., was the program director, and Hunter McKay was the deputy director. The national program office's primary responsibilities were to:

- Provide leadership and technical assistance for grantee institutions during the planning and implementation of their projects.
- Conduct site visits and monitor grantee institutions' progress.
- Offer information to other states interested in replicating the public-private partnership or in pursuing alternative financing mechanisms.
- Develop and implement a media relations strategy that would increase policy sales.
- Perform analyses and cross-site comparisons of data and assist in the data's dissemination.
- Conduct annual meetings of project directors at grantee institutions.

The Planning Phase

The planning phase of the program was authorized in the amount of \$3.2 million in 1987. The national program office contacted states that had demonstrated a commitment to reforming long-term-care financing.

Planning grants were awarded to:

- California.
- Connecticut.
- Indiana.
- Massachusetts.
- New Jersey.
- New York.
- Oregon.
- Wisconsin.

As part of the planning phase, the eight states collected and analyzed data from nursing homes, the elderly population, state Medicaid files, and insurers to help them design and price their products and to assess products' impact on costs.

Using the [Brookings/ICF long-term care-financing model \(BICF\)](#)—which simulates the utilization and financing of long-term-care services for elderly individuals through 2020—the national program office estimated that participation in partnerships by all 50 states could result in a 7 percent drop in Medicaid's share of the total long-term-care bill between 2016 and 2020.

Collectively, the eight states also designed (with input from insurance companies, the national program office, and the evaluator) a [uniform data set \(UDS\)](#)—a standardized data-reporting method intended to ease the reporting burden on insurers participating in more than one state, because states typically have different reporting requirements.

The states also considered possible educational, outreach, and promotional activities that would target both the public and insurance agents.

The Need for Federal Approval

Medicaid is a joint federal-state program that is financed, on average, 57 percent by the federal government and 43 percent by the states. It is administered by the individual states according to their Medicaid state plans, which are set up within broad federal guidelines and which dictate when an individual becomes financially eligible to receive Medicaid benefits.

When a state makes changes or innovations in its Medicaid program that involve features that go beyond the current parameters—which was the case with the *Long-term-care Insurance for the Elderly* initiatives in the eight participating states—the federal government requires the state to seek permission to have those federal parameters (or requirements) changed.

One approach is to use waivers of federal requirements. A [waiver](#) of Medicaid requirements can be obtained in several ways:

- *Federal legislation.* A federal legislative waiver is essentially a congressional mandate that gets written into public law.
- *Administrative approval.* The [Health Care Financing Administration \(HCFA\)](#) of the U.S. Department of Health and Human Services administers Medicaid and can grant an administrative waiver of Medicaid requirements. Administrative waivers are of three types:
 - Freedom-of-choice waivers.
 - Home- and community-based-services waivers.

- Research waivers. Research waivers are typically used to test innovative ideas on a subpopulation of people eligible for Medicaid.

All types of waivers are often used to allow exemption of the statewide requirement for services and to allow the state to aim experimental services at a specific group. All administrative waivers are generally time limited and have special reporting requirements.

The other approach—used in this program—is through a state amendment to its Medicaid state plan. A state plan amendment may be used in lieu of waivers. States can submit state plan amendments to HCFA to alter their Medicaid programs.

The federal role in this case is not to waive compliance with the law, but, rather, to approve modifications within the existing federal statutory authority. If an amendment is approved, the changes become part of the state plan until either the state makes another amendment or until the statutory requirements are changed. Unlike administrative waivers, the state plan amendment is not time limited and does not necessarily have special reporting requirements.

While initial partnership models required waivers, later models did not. Models were amended to minimize the need for federal waivers.

Efforts to Obtain a Federal Waiver

In early 1988, some of the states participating in the program began to investigate how to obtain federal approval for their initiatives. Due to the time limit on the duration of administrative waivers and the length of time administrative approvals often take, attention soon focused on federal legislative waivers.

Legislative activity on the waiver included introducing bills specifically addressing the partnerships, along with attempts to include waiver language in various budget reconciliation bills.

Those efforts never reached the floor of Congress for a vote because to undo a logjam of the 1989 budget reconciliation process, a congressional conference eliminated from consideration all budget-neutral items, including the partnerships.

Subsequent efforts to revive waiver legislation met with strong opposition led by Democratic Congressmen Henry Waxman of California, Chair of the House Subcommittee on Health and the Environment, which controls legislation involving the Medicaid program, and John Dingell of Michigan, chair of the House Energy and Environment Committee.

Concerns raised by partnership opponents were based primarily on perceptions that:

- The standards implicit in the waiver request were too lenient.

- Private insurers needed to improve consumer protections substantially before playing a major role in a public-private partnerships.
- Medicaid dollars should go to help only the poor and near poor.
- The direct link between the public and private sectors should be made only with great caution, since direct links might imply extensive public responsibility to ensure the fairness, viability, and quality of the private insurance product.

After political opposition blocked those attempts in the late 1980s, the state partnership program teams shifted to a Medicaid state plan amendment strategy to obtain the necessary approvals.

This occasioned a number of delays for the following reasons:

- Insurance regulations governing partnerships in several of the states had to be modified to reflect the Medicaid state plan amendments.
- State legislatures usually had to approve the regulation changes, and HCFA, in turn, had to approve the state plan amendments.

In the end, the four states that implemented their partnerships received HCFA approval of their Medicaid state plan amendments.

The Implementation Phase

Because of the delays caused by the Medicaid state plan amendment process and HCFA's separate process to approve the amendments, RWJF awarded implementation grants to the states one at a time, from August 1987 to December 1988. This contrasts with the more typical RWJF national program procedure of authorizing all project sites at once.

Four states—California, Connecticut, Indiana, and New York—implemented their partnerships.

The states that did not move beyond the planning phase cited political opposition, fiscal constraints, and regulatory barriers as the chief obstacles to implementation.

The partnerships in California, Connecticut, and Indiana were based on a [dollar-for-dollar model](#) (Indiana changed its model in 1998). Under the [dollar-for-dollar model](#), for every dollar of long-term-care coverage that the consumer purchases from a private insurer participating in the partnership, a dollar of assets is protected from the [spend-down](#) requirements for Medicaid eligibility.

The purchaser buys a policy that stipulates the amount of coverage that the purchaser wants to purchase. That figure is also the amount that the insurer will pay out in benefits under long-term-care coverage when the policyholder is admitted to a nursing home or is receiving long-term care at home or through community-based services.

At the point at which that amount is fully paid out by the insurer, Medicaid can assume coverage, following application for Medicaid eligibility. However, the policyholder must contribute any income to pay for the coverage.

With nonpartnership policies, Medicaid coverage would begin only when the insured had spent down nonhousing assets to approximately \$2,000. However, with partnership policies, special Medicaid eligibility regulations allow the policyholder to keep assets up to the level of insurance paid benefits.

(Note: If the partnership policy expires at a point when the policyholder has more assets than were originally insured—either because the policyholder insured for less than was owned or because the policyholder had accumulated assets in the meantime—partnership regulations require that the policyholder **spend down** those assets to the insured amount before Medicaid assumes coverage.)

For instance, assume that a purchaser wants to protect \$100,000 in nonhousing assets. The purchaser would buy from a partnership insurer a policy to cover that amount.

When the policyholder becomes eligible for benefits either by being admitted to a nursing home or by receiving long-term care at home or through community-based services, the insurer will cover those expenses up to \$100,000—or up to the total of the policyholder's remaining nonhousing assets, if those assets happen to fall below \$100,000.

After that sum is paid out by the insurer, the policyholder must **spend down** remaining assets to \$100,000, at which point Medicaid coverage can begin, pending application to Medicaid and a determination of eligibility.

The policyholder is allowed to keep the \$100,000 in nonhousing assets—in addition to the approximately \$2,000 everyone is allow to keep—though any income received—such as Social Security, pension, or income from nonhousing assets—must be contributed to the policyholder's care.

The following chart shows the theoretical amounts that an individual needing long-term care must **spend down** to become eligible for Medicaid in California, Connecticut, and Indiana, according to the amount the person insured for and the amount of assets the person has when the policy expires—and the scenario when there is no policy in place.

AMOUNT POLICY INSURES FOR	POLICYHOLDER ASSETS UPON APPLICATION FOR MEDICAID	REQUIRED ASSET SPEND-DOWN BEFORE POLICYHOLDER IS ELIGIBLE FOR MEDICAID
\$100,000	\$100,000	\$0
\$50,000	\$100,000	\$50,000
No partnership policy	\$100,000	\$100,000

The New York partnership was based on a different model: the [total-assets protection model](#). According to this model, certified policies must cover three years in a nursing home or six years of home health care.

Once the benefits are exhausted, the Medicaid eligibility process will not consider assets at all. Protection would be granted for all assets, though an individual's income must be devoted to the cost of care.

Each of the implementation states conducted extensive promotional and educational campaigns designed both to inform the public about the partnerships' policies and to increase sales.

Assistance for some of these campaigns was funded by RWJF communications contracts with public relations firms. The states have also collected and analyzed sales and marketing data and are using the information to evaluate the partnership programs and make changes as needed and allowed.

EVALUATION

In March 1989 RWJF commissioned Laguna Research Associates, Inc., of San Francisco, Calif., to conduct an evaluation of the national program. The purpose of the evaluation was fourfold:

- To understand the administrative and political process of planning and implementing the partnerships
- To learn the characteristics and motivations of partnership policy purchasers
- To learn what types of policies the insurance companies developed
- To learn about possible ways to expand health care financing without costing Medicaid more money

The evaluation was divided into two phases.

The first phase, which began in March 1989 and continued for four years, examined the planning of the partnerships. The second phase, which began in March 1992 and continued for a little more than six years, examined their implementation.

The goals of the first phase were to:

- Document the context and process of the efforts to establish public-private partnerships for long-term-care insurance in the eight states funded under the program.

- Develop collaboratively with the national program office and with the sites certain management information systems that could be used to evaluate demonstrations that may be funded under the program.
- Develop a range of design options that would be available for a full-scale-evaluation report on the lessons the participating states learned when the planning stage has been concluded.
- Develop consensus on the information to be collected by the demonstrations.
- Develop an implementation plan for the evaluation design.
- Document accomplishments and plans regarding long-term care in two states—Massachusetts and Wisconsin—not continuing in the program. This was done in phase 1.

The goal of the second phase was to:

- Conduct an evaluation of the four partnerships (phase 2).

The major activities undertaken in the course of the phase 2 evaluation were:

- Site visits with planning and implementation sites.
- Coding of the detailed features of the policies approved for sale under the partnerships and other long-term-care insurance policies in the market—in order to facilitate analyses.
- Surveys—in partnership states—of the purchasers of partnership and nonpartnership policies for long-term care.
- Surveys of partnership and nonpartnership insurers.
- The development of a [uniform data set](#) containing administrative and evaluation data Participation in the national meetings of partnership participants.
- The creation of reports and papers summarizing the evaluation.

The evaluation effort focused on the study of eight issues:

- **Demonstration activities**, including the processes used to implement the programs, the problems each state initiative faced, and the successes and failures in overcoming those problems.
- **Insurer participation**, including the effectiveness of the partnerships in encouraging insurer participation and the perceptions of insurers as to whether the partnerships were an effective means in the promotion of long-term -care insurance.

- **Insurance policies developed**, including the types of instruments and arrangements (service coverage, eligibility, reimbursement practices, etc.) offered to consumers as part of each demonstration.
- **Purchasers of policies**, including comparisons and analysis of characteristics of purchasers and nonpurchasers, and understanding purchaser motivations.
- **Consumer satisfaction**, including an analysis focused on satisfaction at the time of purchase.
- **Insurer performance**, including a comparison across all insurers of their reported [loss-ratio](#) experience and administrative costs (recognizing that most of the policyholders are not expected to receive benefits until a much later date).
- **Use and cost experience**, focusing on the kinds of services used and the amounts paid for each of these services.
- **Medicaid cost experience**, focusing currently on monitoring the methods planned and under way to measure cost savings in partnership states, since any effect the partnerships will have on Medicaid spending will not occur until a much later date.

Communications

National program office staff published one report based on the project, one book chapter, and nine journal articles over the term of the program.

In 1998, RWJF issued an additional grant (ID# 031572) to Laguna Research Associates to coordinate the writing of a book on the implementation and future prospects of the Partnerships for Long-Term Care. In addition, the national program office convened yearly meetings for partnership states.

The results of the evaluation were published in 5 journal articles (with one more forthcoming), 10 discussion papers, and 2 data reports.

The evaluation director also worked on a book that would serve as a reference about partnerships for long-term care—their implementation, operation, and prospects for the future in the financing of long-term care.

See the [Evaluation Bibliography](#) for details and the [National Program Office Bibliography](#) for its bibliographic listings for since 1995. Similarly, site bibliographies cover communications activities from 1995 onward.

OVERALL PROGRAM RESULTS

Overall Results

- By 2000, a total of 104,000 applications had been taken and more than 95,000 had been sold in the four program states—California, Connecticut, Indiana and New York.
- Program redesigns in Connecticut, Indiana and California produced increases in applications received ranging from 324 percent to 540 percent, compared to similar time periods prior to those adjustments.
- In New York, which had the largest total sales, updates to its program model were being explored to further program goals. This progress was accomplished despite restrictive language embedded in the [Omnibus Budget Reconciliation Act \(OBRA\)](#) of 1993 effectively curtailed one of the program's goals: replicating the partnerships in other states.

Although [OBRA](#) grandfathered the four RWJF program states, it also required states obtaining a state plan amendment after May 14, 1993, to recover assets from the estates of all persons receiving services under Medicaid. The result of that language is that the asset protection component of the partnership is in effect only while the insured is alive.

Given that one of the attractions of partnership policies is the possibility of passing one's assets on to one's heirs, [OBRA](#) effectively stifled interest in designing and implementing new partnerships.

- To date, only four other states have implemented [long-term-care partnerships](#):
 - Illinois.
 - Iowa.
 - Massachusetts (a modified partnership that protects some assets from the state's estate recovery program but provides no up-front asset protection).
 - Washington.

Neither the Illinois nor the Washington partnerships can protect purchasers from estate recovery, since the programs were created after [OBRA's](#) May 14, 1993, deadline.

Eight other states—Colorado, Florida, Georgia, Michigan, Missouri, North Dakota, Ohio, and Rhode Island—passed legislation that would facilitate partnerships; however, implementation in these states is awaiting the overturn of the sections of [OBRA](#) pertaining to estate recovery.

In the meantime, two of the partnership states—Connecticut and Indiana—are turning their efforts toward arranging reciprocal agreements by which qualified holders of partnership policies in both states may be eligible for care in either state. Because of the nature of long-term-care insurance—particularly the span of time between the purchase of a policy and the exhaustion of benefits—the ultimate effectiveness of the partnerships may not be known for more than 10 years.

See the [Project List](#) for a description of the projects.

Evaluation Findings

The major findings of the evaluation focused on partnership and state-level issues, insurers, and purchasers as follows.

Findings Concerning Partnership and State-Level Issues

- Implementation, though slower than envisioned, was successfully completed in four states and has resulted in real collaboration between the states and the insurers.
- State regulations that were developed for partnership products represented a more restrictive regulatory model than previously existed in the states for long-term-care insurance policies. The regulations specify that policies are standardized and of high quality; however, the tighter regulations also restrict the options of insurers that want to innovate changes that might make their policies more competitive.

Findings Concerning Insurers

- Policies were of high quality, covering a broad range of services, including [case management](#) (e.g., Connecticut, later adopted by New York and Indiana), home care, nursing home care, and alternative housing.
- Almost all of the insurers that are participating in the partnerships are big players and seem committed to continued participation in the partnerships. However, several companies expressed dissatisfaction with the partnerships in regard to the small number of policies sold and what they perceived to be the partnerships' potential to stifle choice and innovation.
- An atmosphere has been created in the partnerships that makes the joint sharing of data possible. Of substantial importance is the cooperation of the insurers in providing data on policyholders, policy features, assessments of eligibility for coverage, and use and cost of services. This willingness to supply data stands in sharp contrast to the strong proprietary concerns of prior decades.

Findings Concerning Purchasers

- Purchasers of partnership policies were more highly educated, healthier, and more affluent than both nonpurchasers who were surveyed and the population at large.

More than 30 percent said they would not have purchased long-term-care insurance without the partnership.

- Variables related to knowledge and attitudes are significantly important in policy purchase. Thus, education and marketing to involve consumers are important components in a strategy for increasing the purchase of products.
- The analysis suggests that the partnerships have not expanded access to insurance for individuals who are more ill.
- Analyses of purchasers in California indicated that the partnerships seem to be meeting their goal of increasing the sale of long-term-care insurance to those in middle-income groups.

LESSONS LEARNED

1. **The success of the public-private long-term-care-insurance partnerships depended largely upon effective promotion and marketing efforts by the states and insurance companies.**
2. **Communicating with and training insurance agents was crucial to the success of the public-private long-term-care-insurance partnerships. Agents need to believe in the product in order to produce sales.**
3. **Public-private long-term-care-insurance partnerships may have a better chance of reaching implementation stage if their planning stage can be completed within a single gubernatorial term of office.** It usually takes a year to get initiatives moving within a state bureaucracy. If the timing is wrong, all of the work done previously needs to be repeated when a new administration takes office. In addition, difficulties can arise because new administrations are sometimes suspicious of activities in progress from a previous administration.
4. **The advancement of complex projects such as the public-private long-term-care insurance may be helped by a concise description that can serve as way of introducing the project to potential supporters.** One project director says it was a significant liability that the concept could not be explained in 25 words or less.
5. **In projects that involve the innovation of new insurance products, it is important to bear in mind the general reluctance of Americans to purchase insurance to cover future risk.** Policy sales among the long-term-care partnerships have not met expectations. The evaluation officer suggests that part of the reason for this is that the financial circumstances of most middle-class Americans, the chief target of this initiative, lead them to make purchases that cover immediate needs rather than unforeseeable risk. Marketing efforts for long-term care carry the extra burden of surmounting the denial factor among consumers.

6. **When programs require federal waivers, a strategy for securing those waivers should receive attention from the start of the program design.** Similarly, Congress and the staffs at HCFA should be asked to play a more central role earlier in the design process. Early involvement may provide clearer signals about how difficult legislative waivers would be to obtain, and might personalize the stake of Washington players in the initiative.

AFTERWARD

RWJF developed another national program—overseen by the same national program office—that built upon the long-term-care-insurance program. Entitled the *State Initiatives in Long-Term Care* program (1993–1998), it encouraged states to innovate delivery systems and financing arrangements that would cover a wide range of chronic care services for people of all ages—ranging from home and community care to institutional care.

OBRA 1993's Effect on the Model

The Omnibus Budget Reconciliation Act of 1993 contained language with direct impact on the expansion of partnerships for long-term care to other states. The Act recognized the four initial states that implemented the program—Connecticut, California, Indiana and New York—plus a future program in Iowa and a modified program in Massachusetts.

These six states were allowed to operate their partnerships as planned because their state plan amendments had been approved by the Department of Health and Human Services before OBRA 1993 went into effect. The remaining states were prohibited from doing so.

Four States Continue to Offer Long-Term-Care Insurance Policies

The four initial states continue to offer the specially tailored long-term insurance policies.

The partnership programs have saved the four states \$8 million to \$10 million in health care bills, plus it allows them to be more assertive in prodding people to get long-term-care insurance because the policies are more affordable, said Mark Meiners, the director for the [Center for Health Policy, Research and Ethics at George Mason University](#) and an architect of the partnership program.

New Federal Legislation Expands the Model

In the spring of 2006, President George W. Bush signed the Deficit Reduction Act of 2005 (DRA 2005) that allows the long-term-care insurance partnership model to be used in all 50 states. Besides increasing the incentives to purchase long-term-care insurance, the bill made it harder for seniors to give away money and property before asking Medicaid to pick up their nursing home tabs. Policies in these new programs must meet

specific criteria, including federal tax qualification, identified consumer protections and inflation protection provisions.

Mark Meiners said he hoped the nationwide clearance for the programs will help spur interest in consumers to buy coverage and in insurers to offer it.

Besides the four states with partnership programs in place, as of April 2006, according to a report by the AARP Public Policy Institute (Enid Kassner), another 21 have enacted authorizing legislation are: Arkansas, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, Virginia and Washington.

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APPENDIX

Glossary

ADL: Activities of Daily Living—eating, continence, transferring in and out of bed, toileting, dressing and bathing—that insurers use to analyze detailed observations of many basic activities of patients with chronic conditions. Long term care policies usually become activated when a person cannot perform two ADLs.

Assisted living benefits: coverage for a long term care for seniors who need more assistance than is available in a retirement community, but who do not require heavy medical and nursing care provided in a nursing facility.

BICF: Brookings/ICF Long Term Care Financing Model, which simulates the utilization and financing of long-term care services for elderly individuals through 2020.

Case management: The process by which all health-related matters of a case are managed by a physician or nurse or designated health professional.

CPI: Consumer Price Index, a measure of the average change over time in the prices paid by urban consumers for a fixed market basket of a range of consumer goods and services.

Dollar-for-dollar model: Once the benefits of a certified policy are exhausted, an application for Medicaid can be made using special eligibility rules. Every dollar paid out by an insurer through a certified policy will be deducted from the resource counted toward Medicaid eligibility. For example, if a person receives \$50,000 of insurance benefits and exhausts their policy, \$50,000 of assets will be disregarded and therefore protected in the Medicaid eligibility process.

Gatekeeper: a primary care physician responsible for overseeing and coordinating all aspects of a patient's medical care. In order for a patient to receive a specialty care referral or hospital admission, the gatekeeper must pre-authorize the visit, unless there is an emergency.

HCFA: Health Care Financing Administration, of the US Department of Health and Human Services, which administers the Medicare, Medicaid, and Child Health Insurance Programs.

Income contribution: a percentage of a policyholder's income that she would be required to pay toward coverage.

Inflation adjustment: the increase of the benefit amount to cover the effect of inflation.

Long-Term Care Partnership: a state program that joins private, long-term care insurance with Medicaid to provide high quality insurance protection against

impoverishment from the costs of long-term care. Consumers who purchase these policies are insured for long-term care for a certain amount of time through the private insurer. When the private insurance is exhausted, they can continue their long-term care under Medicaid without spending all of their assets, as is typically required to meet Medicaid eligibility criteria.

Loss ratio: the amount of revenues from insurance premiums that is spent to pay for the medical services covered by the plan. Usually referred to by a ratio, such as 0.96—which means that 96 percent of premiums were spent on purchasing medical services.

Medi-Cal: The California Medicaid program.

OBRA: Omnibus Budget Reconciliation Act of 1993. OBRA grandfathered (permitted pre-existing Partnerships to operate despite the changes effected by OBRA) the Partnerships in the four RWJF program states; however, it also required States obtaining a state plan amendment after May 14, 1993 to recover assets from the estates of all persons receiving services under Medicaid.

Preadmission screening: A required screening of anyone going to a nursing home, in order to identify the level of care required.

Reinsurance: A contract by which an insurer procures a third party to protect itself against part or all the losses incurred in the process of honoring the claims of policyholders. This is sometimes achieved through a pool of funds to which a number of insurance companies contribute.

Risk pooling: special programs created by state legislatures to provide a safety net for "medically uninsurable" populations.

Spending down: process by which a patient spends his non-housing assets on long-term care until they reach a level (approximately \$2,000) where he qualifies for Medicaid.

Total-assets protection model: This model requires long-term insurers to cover three years in a nursing home or six years of home health care. Once the benefits of a certified policy are exhausted, the Medicaid eligibility process does not consider assets at all. Protection is granted for all assets, but an individual's income must be devoted to the cost of care.

UDS: Uniform Data Set, a standardized data protocol intended to ease the reporting burden on insurers participating in more than one state, which typically have different reporting requirements.

Waiver: formal permission to have certain requirements disregarded. In the case of the Long-Term Care Partnerships, waivers from the federal government were necessary to

exempt the Partnerships from observing the financial eligibility requirements for Medicaid.

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Reports on the projects managed under this National Program are listed below. Click on a project's title to see the complete report, which typically includes a summary, description of the project's objectives, its results or findings, post grant activities and a list of key products.

California

- [Long-Term Care Insurance: CalPERS Policies Offer California Public Employees Asset Protection \(May 2006\)](#)

Connecticut

- [Long-Term Care Insurance: Connecticut's Public-Private Partnership Has Steady Growth \(January 2007\)](#)

Indiana

- [Long-Term Care Insurance: High Price, Lack of Understanding Hurt Sales in Indiana \(May 2006\)](#)

Massachusetts

- [Massachusetts Program to Promote Long-Term Care Insurance for the Elderly Sets Contribution Levels for Elders Based on Income and Assets \(May 2006\)](#)

New Jersey

- [Hiring Freeze and Lack of Medicaid Waiver Snarls N.J. Program to Promote Long-Term Care Insurance for the Elderly \(May 2006\)](#)

New York

- [New York Program to Promote Long-Term Care Insurance for the Elderly Offers Full Asset Protection in Exchange for Mandatory Insurance \(May 2006\)](#)

Oregon

- [Oregon Makes Plans for But Does Not Implement Lifetime Protection in Its Long-Term Care Insurance Program for the Elderly \(May 2006\)](#)

Wisconsin

- [Long-Term Care Insurance: Wisconsin Withdraws From Financing Partnership Program \(May 2006\)](#)