

The Partnership for Long-Term Care: A Public-Private Partnership to Finance Long-Term Care



Robert Wood Johnson
Foundation

JOSEPH ALPER

Chapter Five,
excerpted from *The Robert
Wood Johnson Foundation
Anthology*:

**To Improve Health
and Health Care
Volume X**



Edited by
Stephen L. Isaacs and
James R. Knickman
Published 10/2006

Editors' Introduction

For many Americans over 65, gaining access to high-quality long-term care has proven to be a formidable challenge. The Robert Wood Johnson Foundation's efforts to improve access to and quality of long-term care includes programs to improve nursing homes;¹ to expand home care, adult day care, and assisted living;² to give elderly people more choice in the type of care they receive;³ to encourage volunteerism,⁴ and to better integrate the delivery of medical care and long-term care⁵ among other initiatives.⁶

Then there is the problem of paying for long-term care. The cost of nursing home care routinely impoverishes older Americans, who are then forced to rely on Medicaid (or to spend down in order to qualify for Medicaid). Long-term care insurance, a way of protecting people against going broke in old age, is expensive and has appealed primarily to a narrow band of upper middle-class or wealthy individuals. To increase the appeal of long-term care insurance, the Robert Wood Johnson Foundation, in 1987, initiated an experimental program called the Program to Promote Long-Term Care Insurance for the Elderly. This program fostered a new and controversial type of long-term care insurance product that allowed nursing home patients with state-approved private long-term care insurance policies to be eligible for Medicaid with substantially higher levels of assets than are normally allowed. This would permit them to receive nursing care and still have enough to live on and to bequeath to their children.

Joseph Alper, a freelance journalist and frequent contributor to *The Robert Wood Johnson Foundation Anthology*, describes the logic of the program and the hurdles that had to be overcome to field the demonstrations, including federal legislation limiting the program to the four states. The result of nearly 20 years' effort is mixed. The product has proven viable, but the number of policies sold to date—especially those sold to middle-class and lower middle-class individuals—is far smaller than was expected. The story ends on an upbeat note, however, with the passage of legislation in 2006 that will allow all 50 states to market the private-public policies.

1. Bronner E. "The Teaching Nursing Home Program." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care, Vol. VII*. San Francisco: Jossey-Bass, 2004.

2. Henry RS, Cox NJ, Reifler BV, et al. "Adult Day Centers." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care 2000*. San Francisco: Jossey-Bass, 1999.

3. Benjamin AE and Snyder RE. "Consumer Choice in Long-Term Care." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care, Vol. V*. San Francisco: Jossey-Bass, 2002.

4. Dentzer S. "Service Credit Banking." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care, Vol. V*. San Francisco: Jossey-Bass, 2002; and Jellinek P, Appel TG and Keenan T. "Faith in Action." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care 1998-1999*. San Francisco: Jossey-Bass, 1998.

5. Alper J and Gibson R. "Integrating Acute and Long-Term Care for the Elderly." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care 2001*. San Francisco: Jossey-Bass, 2001; and Begley S. "The Covering Kids Communications Campaign." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care, Vol. VI*. San Francisco: Jossey-Bass, 2003.

6. Mockenhaupt RE, Lowe JI and Magan GG. "Improving Health in an Aging Society." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care, Vol. IX*. San Francisco: Jossey-Bass, 2006.

One of the great economic changes that has occurred over the past 25 years is that the United States has become a nation of investors. Over two-thirds of Americans now own their homes, and for many of us our home is our biggest investment. Just over half of all households own stock, thanks to the availability of mutual funds and tax-favored retirement vehicles such as 401(K) plans. The median net worth of the average American household now stands at just over \$100,000, and is just under \$200,000 for Americans age 65 and older.¹

But looming on the horizon is something that could not only strip those assets from a great many American households but also draw significant financial resources from both the federal treasury and state government coffers. That "something" is the need for services to help individuals suffering from a chronic physical ailment or deteriorating mental capacity—a broken hip, signs of dementia, a car accident, any medical condition that requires long-term care.

"Every American is at risk of needing long-term care, and for most middle-class Americans that means that all of the assets that they've worked a lifetime to accumulate are at risk," says David Guttchen, director of the Connecticut Partnership for Long-Term Care. "At the same time, as the baby boomers age, the growing need for long-term care that will occur has the potential to overwhelm the Medicaid system and place a huge burden on state budgets." Joyce Ruddock, a vice president at MetLife in Connecticut, adds, "This is a problem that we as a nation are going to have to face, and the sooner we do it, the better individuals will be and the better our government's finances will be."

Long-term care expenditures represent one of the largest medical and financial risks facing elderly Americans today. While we all want to believe that we will remain healthy and active until dying peacefully in our sleep at night, the harsh reality is that nearly half of all Americans turning 65 years of age will spend time in a nursing facility at some point in the remaining days of their lives. Given that the average cost of a year of long-term care was \$72,240 in 2004 and that the average length of long-term care is two and a half years, it is easy to see that an economic train wreck awaits many unprepared Americans. A few Americans, mostly members of the upper-middle class, have purchased long-term care insurance—relatively expensive coverage that under specified conditions provides skilled nursing or custodial care in a nursing facility or at home following an injury or an illness. Most Americans, however, either cannot afford or choose not to buy long-term care insurance and are at risk of suffering catastrophic expenses if they need long-term care.

But individuals are not alone, because state and federal Medicaid budgets are on that same train, heading for the same financial disaster. Today, long-term care accounts for a third of Medicaid funding. From 1990 to 2003, Medicaid spending on long-term care increased from \$30 billion to \$87 billion, costs shared by state and federal governments.² With Medicaid already accounting for more than 20 percent of state spending, state budgets could be as overwhelmed by long-term care costs as the typical American's pocketbook would be.

Charles and Gloria Dougherty are manifestly not in the ranks of the unprepared. Charles, 65, and Gloria, his wife, 59, have each purchased a long-term care insurance policy that enables them to protect \$182,000 in assets and pay for five years of nursing home and home care benefits. If either Charles or Gloria requires more than five years of care, Medicaid would then assume the ongoing costs, even though the couple would still have their nest egg. "This is the best way to protect ourselves," Dougherty says.

Before the Doughertys bought long-term care insurance, their plan, like that of many middle-class Americans, had been to transfer their assets to a relative if either husband or wife needed long-term care, and then apply for Medicaid assistance. An individual with more than \$2,000 in nonhousing assets is normally ineligible for Medicaid services, and anecdotal evidence suggests that a growing number of Americans are planning to essentially bankrupt themselves and then apply for Medicaid if they should need long-term care. Congress has, however, made it increasingly difficult for middle-class families to spend-down, qualify for Medicaid, and have the government pay for their long-term care. Medicare, to the surprise of most people, covers little in the way of long-term care expenses.

The Doughertys, though, are among the 225,000-plus Americans who have taken advantage of a unique program to insure themselves against having to hide their assets if they do require long-term care. This program, the *Program to Promote Long-Term Care Insurance for the Elderly*—also known as the Partnership for Long-Term Care—was initiated in 1987 with funding from the Robert Wood Johnson Foundation and has been offering asset-protecting long-term care insurance policies in California, Connecticut, Indiana, and New York. Since the early 1990s, private insurance companies have been selling special Partnership policies that have protected approximately \$30 million dollars in assets while saving the states an unquantified amount of money—but an amount that state officials nonetheless say is significant.

Since 1992, fewer than 150 policyholders out of more than 250,000 have exhausted their benefits and applied for Medicaid. "It doesn't take much of a leap to see that these policies are protecting the states from a much bigger number of Medicaid claims," says Sam Morgante, vice president of government relations at Genworth Financial in Washington, D.C. Genworth, the successor to GE Financial's insurance business and AMEX Life Assurance Company, is the country's leading seller of long-term care insurance.

Connecticut's Guttchen, along with his colleagues in California, Indiana, and New York, agrees wholeheartedly. "Can I tell you exactly how much money Connecticut has saved? No. But has the state saved money? Absolutely," Guttchen says. Michael Staresnick, who heads Indiana's Partnership

program, estimates his state's savings at \$2.2 million over 12 years. "Is that a huge savings? No, but it is a savings nonetheless, and given the challenges we've faced in getting people interested in long-term care period, let alone in buying Partnership policies, we're encouraged that this program will save us substantial dollars over the coming decades."

A Novel Partnership is Born

State governments have been eager to head off the impending avalanche of long-term care claims against their Medicaid programs. Indeed, the states woke up to the magnitude of the problem in the mid-1980s, and it was their explorations into how long-term care insurance could help both their treasuries and their citizens that helped lead the Robert Wood Johnson Foundation to launch its Partnership for Long-Term Care initiative in 1987. The idea of the program was to work from concepts that several national and state commissions, as well as social policy experts, had developed through meetings and studies:

- Delaying the moment at which patients qualify for Medicaid—which occurs when patients exhaust their assets or spend them down 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.
- An overwhelming majority of Americans believe it is wrong to transfer assets and want to take personal responsibility for funding their long-term care.
- 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.

Though the Foundation's formal role in this program ended a decade ago, the experiences of California, Connecticut, Indiana, and New York have finally gotten the attention of Congress. In February of 2006, President George W. Bush signed into law a bill that will allow the remaining 46 states and the District of Columbia to create their own Partnership programs. This will enable Americans to share the responsibility of paying for long-term care with state and federal governments while making it harder for them to shield their assets before turning to Medicaid to fund a part of their long-term care.

"Congress has finally recognized the successes of the Partnership programs and has taken the necessary steps to open these plans to all Americans, not just those lucky enough to live in the four states with existing programs," says Stephen Somers, a former associate vice president and program officer at the Robert Wood Johnson Foundation, who founded and heads the Center for Health Care Strategies, in Hamilton, New Jersey. "The result will be a win-win-win-win situation because individuals, insurers, and both state and federal treasuries will all come out ahead thanks to the expansion of this program."

This is exactly the outcome that the Foundation had hoped for when it started the Partnership program, says Mark Meiners, director of the Center for Health Policy Research and Ethics at George Mason University in Fairfax, Virginia. Meiners headed the national program office that oversaw the program when it was based at the University of Maryland, and he still holds monthly conference calls with state officials administering the current Partnership programs.

According to Meiners, the goal of the Partnership program was to fund the efforts of interested states to develop strategies that would encourage middle-class Americans to buy private long-term care insurance, and to provide an incentive to do so by including some form of asset protection. These policies would then enable individuals to shoulder a significant part of the burden of providing for long-term care while shielding the states from a majority of the cost of paying for long-term care for a growing number of people.

“Private long-term care insurance was certainly available when we started the Partnership program, but the plans were expensive, often confusing, didn’t always protect assets, and were usually deficient in terms of consumer protections,” Meiners says. “These policies were somewhat successful with the wealthiest Americans, but wealthy people don’t usually think about Medicaid, and so these early long-term care policies weren’t addressing the issue of how to finance long-term care for the majority of our citizens in a fiscally responsible manner.

“Our intention with the Partnership program was to work with interested states and insurance companies in true partnerships to explore different avenues for making private long-term care insurance more appealing and affordable to the middle-class public. The idea was that if we could design high-quality insurance products and get the insurance industry to sell those policies at a reasonable cost, significant numbers of middle-class Americans would take advantage of this opportunity. The result, at least in theory, would be that individuals would take more responsibility for their own care while enabling the states’ Medicaid programs to act as the safety nets they were designed to be and not a *de facto* long-term care program.”

In response to the Foundation’s initiative, eight states—California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin—received planning grants to define and develop a public-private insurance partnership to pay for long-term care. These states explored a variety of ideas on how to encourage the use of long-term care insurance to help their citizens avoid impoverishment, but the basic approach of the four states that eventually created long-term care insurance programs—California, Connecticut, Indiana, and New York—was the same, and that approach involved giving consumers a new choice: buy a state-qualified insurance policy and get special asset protection in exchange for shouldering some of the responsibility for their long-term care.

Normally, when a conventional long-term care insurance policy runs out, policyholders risk having to spend virtually all their savings before qualifying for Medicaid. But by buying a Partnership policy, a person qualifies for Medicaid benefits under special rules that each of the four states established with the approval of the federal Medicaid agency and that the remaining 46 states will now be able to duplicate. As a result, when a Partnership policy is exhausted, the policyholder is permitted to retain predefined levels of assets that depend on the specific policy purchased, which in turn depend on the state in which the individual lives. The person thus becomes eligible for coverage under Medicaid without having to be impoverished.

“By including asset protection in the Partnership policies, we’ve created a product that for a relatively small price becomes an important financial tool that an individual can use to protect all that he or she has saved over a lifetime,” says Adrianna Takada, director of New York State’s long-term care insurance program. “Middle-class Americans today purchase all kinds of insurance to protect themselves and their savings.” She adds, somewhat wistfully, “Now if only we could get more people to think about long-term care insurance in the same way.”

A Long and Winding Road

In 1987, when the Robert Wood Johnson Foundation initiated the planning phase of its Partnership initiative, long-term care insurance was a rather new and expensive product, and most consumers took the attitude that this was something that they either couldn’t afford or didn’t understand and therefore weren’t interested in buying. “In the early days, long-term care insurance was something we sold largely to upper-middle-class and wealthy individuals, with little emphasis on the middle class,” says John Greene, senior director of federal affairs for the National Association of Health Underwriters, or NAHU, a professional organization that represents insurance agents. “Partnership plans have changed the situation dramatically.”

The idea that the Foundation would play a role in redesigning long-term care policies so that they would appeal to the middle class—and therefore get the middle class to shoulder part of the responsibility for providing for their long-term care if they should need it—began in 1986, when James Knickman, who was then a professor of public policy at New York University’s Wagner Graduate School of Public Service, and Nelda McCall, who was then at SRI International, an independent think tank in Palo Alto, California, convened a meeting that brought together leading thinkers in the health care financing field and social policy experts to discuss ideas on how to head off the looming long-term care crisis. Through a series of meetings held in the fall of 1986 and the spring of 1987, Knickman, McCall, and others refined their ideas and attempted to overcome some fundamental disagreements between those who believed that government should shoulder all of the burden for long-term care through a new entitlement program or an add-on to Medicare and those who favored a hybrid model requiring American citizens to take on some of the responsibility for their long-term care needs. In 1987, Knickman and McCall met with Jeffrey Merrill, who was then a Foundation vice president, and Somers, who was a Foundation senior program officer at the time. “Jeff and Steve ended up being the real driving forces that got the Partnership program funded and running,” Knickman says.

The process of designing the Partnership program fell to Meiners and his deputy, Hunter McKay, who has since moved to the Department of Health and Human Services. They began their efforts by getting in touch with officials in eight states that had demonstrated a commitment to reforming long-term care financing. As part of the planning phase, the eight states collected data from nursing homes, the elderly population, state Medicaid files, and insurers to help them design and price their products and to assess the products’ impact on costs. The data confirmed the idea that a hybrid approach would best balance the needs of the nation and middle-class Americans. “We realized that there was a compromise position, one in which the insurance industry and state governments would

share the risk of paying for long-term care protection, and by doing so insurance companies would be able to offer policies that were far more affordable to the average American, and to increase the market for their products,” Meiners says.

The three guiding principles that came from reaching this conclusion were that:

- Insurance companies would offer policies with comprehensive coverage but for a limited time and with a limited maximum payout that would be equal to the dollar value of assets that a consumer wanted to protect.
- The states would then provide Medicaid coverage for all policyholders once they had exhausted their benefits.
- The policies would contain consumer protection provisions assuring worthwhile coverage.

For example, an insurance company might sell an individual a policy that paid out a maximum of \$200,000 over a three-year period; such a policy would protect the assets held by the average American age 65 or older and cover the average two-and-a-half-year length of long-term care. The insurance company would assume the risk inherent in providing that amount of coverage, with the state assuming the risk that the policyholder would require lengthy long-term care. By sharing this risk, the insurance company could sell its policy for a reduced premium, making such policies more attractive to Americans of average means. The states, in return, would assume the responsibility and associated risk of paying for care beyond three years while being shielded from the risk that large numbers of their citizens would divest assets and apply for Medicaid benefits immediately. Part and parcel of this partnership was the notion that consumers would take personal responsibility for a significant part of their long-term care, with the reward of being able to legally protect the assets that they had worked hard to acquire.

Unfortunately, the whole concept of asset protection was not allowed under Medicaid rules, and it appeared that Congress would have to pass legislation that would allow states to approve such policies. “Given that there were certain powerful legislators who were totally against anything but a federally funded program [to pay for long-term care], it appeared that the Partnership program was dead in the water,” Somers says. “That was when the Connecticut team came up with what in retrospect was a brilliant solution, and then the Partnership program was off and running.”

It Pays to Read the Regulations

“It was 1990, and the Robert Wood Johnson Foundation gave us an ultimatum,” Connecticut’s David Guttchen recalls. “Either we figured out an alternative to Congress’s changing the Medicaid rules or the program would end.”

The House of Representatives had just voted down a bill that would have allowed the states with planning grants to proceed with Partnership program demonstrations, and the Foundation was set to change course and spend its money on more fruitful endeavors. Kevin Mahoney, who was then Guttchen’s boss in Connecticut, pored over the regulations and found a provision that would allow for asset protection with a simple amendment to the state’s Medicaid plan. Amendments to state plans are common, and require only signoff from the lawyers at what was then called the Health

Care Financing Administration and is now the Centers for Medicare & Medicaid Services. The Foundation hired a Washington, D.C. law firm to write an opinion on Connecticut's plan amendment, and with that legal blessing Mahoney asked the state's newly elected governor, Lowell Weicker, to sign a letter requesting HCFA approval for the necessary Medicaid plan amendment.

"To his credit, the governor-elect signed the letter, and in January 2001, we received formal approval to go ahead with the Partnership demonstration," Guttchen says. Within months, New York, California, and Indiana received official approval to amend their state Medicaid plans, and the Partnership programs were off and running, with California, Connecticut, and Indiana trying one approach to asset protection and New York taking a slightly different tack.

The Partnerships in California, Connecticut, and Indiana were based on what is known as the dollar-for-dollar model. Under the dollar-for-dollar model, for every dollar of long-term-care coverage that the consumer buys from a private insurer participating in the Partnership, a dollar of assets is protected from the spend-down requirements for Medicaid eligibility. The individual buys a policy that stipulates the amount of coverage. 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 paid out by the policy is equal to the amount of the policyholder's assets, Medicaid can assume coverage, following application for Medicaid eligibility. However, the policyholder must contribute any income to pay for the coverage. With non-Partnership 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.

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 permitted 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 New York Partnership was based on a different model, known as the total-assets protection model. In this type of plan, certified policies must cover three years in a nursing home or six years of home health care, or a combination of the two (with two days of home care equal to one day of nursing home 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.

Partnership policies in each of the four states also included significant consumer protection features, including 5 percent compound inflation protection and required agent training. “One of the issues with long-term care insurance is that you’re buying coverage that you may not use for 20 to 30 years, and without inflation protection, that \$100,000 in benefits you purchased when you were 60 may get you very little when you’re 80 and actually need nursing home care,” says Raul Moreno, a research specialist with the California Partnership for Long-Term 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 Robert Wood Johnson Foundation communications contracts with public relations firms. The states also collected and analyzed sales and marketing data, and have used the information to evaluate the Partnership programs and make changes as needed and allowed.

For example, Indiana has now added a total assets protection option to its policies, while New York revamped its program to add a dollar-for-dollar provision. New York has also added a tax credit for Partnership policy premiums. “Our initial product was bad,” Brenda Bufford, chief of California’s Partnership for Long-Term Care, acknowledges. “But we redesigned the policies in terms of adding some consumer protection provisions and getting rid of benefit caps and other provisions that experience showed us weren’t working, and now Partnership policies are solid products that [insurance] agents want to sell to middle-class Californians.”

Grinding to a Halt

It wasn’t long before officials at the four states with demonstration projects came to the conclusion that the Partnership program offered real opportunities to get consumers to take responsibility for their eventual long-term care needs. “Once individuals heard about the Partnership policies, either from one of the informational meetings we were holding or from an insurance agent, they were far more likely to actually buy a policy,” Guttchen says. And agents, according to both NAHU’s Greene and Genworth’s Morgante, loved selling the policies. “The Partnership policies quickly became a favorite with agents, because they came with a sort of state seal of approval and because they opened up an entire new market for long-term care policies—the middle class,” said Greene.

Soon other states were making plans to establish their own Partnership programs. “While each of the four demonstration projects had its own limitations, the general feeling was that we were definitely on the right track,” Meiners recalls. “Certainly, we were getting lots of calls from the states looking for information and help in the days after the first four states were up and running.”

Not everyone was happy with the end run that the Partnership programs had made around the Congress, however. “At the time, there were certain powerful members of the House who really felt that Partnership policies would primarily benefit the rich,” said Katherine Hayes, a senior staff member in Senator Evan Bayh’s office. Bayh was supportive of Indiana’s Partnership program when he was the state’s governor, as was Robert Orr, who was governor when the state received its first grant in 1988.

As a result, Congress included language in the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) that specifically required states to recover assets from the estates of all persons who have received services under Medicaid. While OBRA 1993 did grandfather the four states that had already created their Partnership programs, for all intents and purposes the language spelled the end for any program not yet running. “While states obtaining a state plan amendment after that date are allowed to proceed with Partnership programs, they are also required to recover assets from the estates of all persons receiving services under Medicaid,” Meiners says. “The result of this language is that the asset protection component of the Partnership is in effect only while the insured is alive. After the insured person dies, states must recover what Medicaid spent from the estate, including protected assets.

“At the very least, this becomes a very complicated and convoluted message for consumers. It also removes one of the major incentives people have to plan for their long-term care needs. The effect has been to significantly stifle the growing interest in replicating the Partnership in other states. Promising efforts in Colorado, Illinois, Iowa, Maryland, Michigan, and Washington, to name a few, were sidetracked by the impression that Congress did not support this program.”

The proverbial silver lining in this congressional storm cloud was that California, Connecticut, Indiana, and New York were able to run their Partnership programs largely out of the public eye. “Once OBRA was passed, it gave the four [grandfathered] programs a chance to establish themselves, to tinker with the details of how each state tailored its program to meet the goals of increasing uptake of long-term care insurance among the middle class, and to actually gain some experience with what was certainly an experimental program,” said Melanie Bella, who helped get Indiana’s Partnership program started and has since joined the Center for Health Care Strategies.

The states learned, for example, that inflation protection was a critical feature, and all Partnership policies include five percent compound inflation protection. Indeed, this has proved so popular that many non-Partnership policies now include this provision. Partnership states also put a significant amount of effort into developing objective measures of disability in order to determine what would trigger policy benefits to begin. The four Partnership states also created mechanisms and actuarial standards with which to review initial premiums and any subsequent request for premium increases, which by and large participating insurers have not requested. “Because of the objective procedures we put in place with our Partnership program, it has become far more difficult for companies to justify premium increases, and that has created stability that we think has helped sell long-term care insurance overall,” Guttchen says.

Assessing the Effort

From more than a dozen interviews with state government officials, congressional staff members, insurance industry executives, and social policy financing experts, there seems to be little agreement as to whether the Partnership experiment has proven to be a success, even one with limited scope. On the one hand, there are those such as Nelda McCall, who evaluated the Partnership program for the Foundation. “Was the program perfect? No, but in retrospect I would say that it was a success as far as it went, given that it never got a chance to go beyond the four initial states,” McCall says. Meiners adds, “We’re at a point now where I think we can say that the four states have tweaked their

Partnership programs with experience and have worked out the kinks, and we can now safely say that the program saves costs.”

Those who question the program’s success raise several points. First, they say it is too early to claim that the program is saving the government money. “We don’t have enough experience yet to judge,” says Judy Feder, dean of the Georgetown Public Policy Institute. “And I think that when you look at the cost of these policies, they haven’t dropped enough to convince middle-class Americans that long-term care insurance makes sense for them.” Stephen Moses, president of the Center for Long-Term Care Reform in Seattle and an outspoken critic of involving the Medicaid program in long-term care, concludes, “After a decade of trial, the consensus of thoughtful analysts and critics is that the Partnership has failed to achieve its main objectives.”³ He says, “All this [program] does is perpetuate the idea that eventually Medicaid will bail individuals out of the financial crisis that results from needing long-term care. Medicaid is going broke—it’s not going to be here when the limited benefits available under the Partnership policies run out. The Partnership program would be far more successful if the link with Medicaid was severed.”

But the most glaring failure, critics say, is that contrary to the designs of the program, the majority of those who bought Partnership policies were in the upper rather than lower income groups. Data gathered in the mid-1990s found that in the states that offered the plans, Americans in the middle-income and lower-income groups bought more standard long-term care policies than Partnership policies.⁴ “I believe that this type of data, along with the fact that not many people actually bought Partnership policies, says that the program failed the market test,” says Joshua Weiner, an expert on long-term care and health economics at RTI International in Washington, D.C.

Even supporters of the program agree with Weiner on that last point. “If there is one thing negative to say about the Partnership program, it’s that the number of policies sold isn’t that large, given the sizable populations of the four states that have Partnership programs,” Bella says. Joyce Ruddock, of MetLife, concurs: “You can list a lot of reasons why we haven’t sold as many Partnership policies as we would have liked to, but the bottom line is that we’ve come up short so far, though I expect that going forward we, and by we I mean both MetLife and the insurance industry, will be renewing our efforts to sell Partnership policies.”

What is the reason that so few Partnership policies have been sold to date? At the top of everyone’s list is a lack of sufficient marketing oomph. “We’ve lacked the resources to market this program as widely as we would have liked,” says Michael Staesnick, the head of Indiana’s program. “And because the Partnership program was limited to four states, I don’t think the insurance companies had the incentive to put significant resources into marketing these policies, either.” Connecticut’s Guttchen adds, “With long-term care insurance, you’re already in a hole, because the 50-year-olds that we want to reach aren’t interested in hearing about long-term care and the problems it can cause them financially, and if you don’t have the educational effort to really get that message out

constantly, in many venues, and from many sources, you're never going to get that many people to buy long-term care insurance of any kind."

Another reason may be cost. Marc Cohen, a vice president of LifePlans, Inc. and president of the Center for Health and Long-Term Care Research, wrote, "The average premium of Partnership policies selling in 1996 was 25 percent higher than the premiums of other long-term care insurance policies and 13 percent higher than other policies selling in Partnership states. Thus, that fewer moderate income individuals can afford the policies is not surprising."⁵ Moreover, it may be, as Weiner has written, that people do not really care about protecting their assets and want to avoid Medicaid, rather than have easier access to it.⁶

The states also underestimated the importance of getting the insurance agents excited about Partnership policies. New York's Takada says, "We needed to take charge of agent training and really explain to the agents the benefits of the Partnership policies compared with traditional long-term care policies."

John Greene of NAHU agrees that insurance agents haven't played as big a role as they could have in getting the word out about Partnership policies, but he expects that to change dramatically going forward. "The Partnership states have done a tremendous job creating a very good product over the past 10 years of running their programs, and what we're hearing from our members is that they are now chomping at the bit to sell these policies to their clients," he says. Morgante of Genworth, adds, "We have big plans now for making a major marketing push for Partnership policies."

Ironically, the impetus for this newfound excitement about Partnership policies comes from Congress, whose members have now been swayed by data compiled by the insurance industry, required as a condition of their ability to sell Partnership policies. For example, the sale of long-term care policies in Partnership states has grown an average of 7 percent over the past five years compared with no growth in non-Partnership states. But perhaps more important, of those individuals who bought long-term care insurance, those buying Partnership policies have a lower net worth than those buying non-Partnership policies. "We've found that most of the Partnership policies we've sold are to middle net worth individuals," Morgante says.

And according to Katherine Hayes, these data, combined with the fact that each of the four Partnership states believes it is saving Medicaid dollars, led former foes of the program to remain neutral during the past year's debate over legislation that will allow the remaining 46 states to offer Partnership policies. "There's also the realization that long-term care costs are rising rapidly and that here is a program aimed at the middle-class that protects both consumers and public funds that experience has shown can work," she says. "Is it a panacea? No, but the members of Congress now see it as program with no real downside." John Greene, who spent a great deal of time lobbying for congressional action on the Partnership program, adds, "This is now seen as an apple pie kind of program that hits all the right buttons—it encourages personal responsibility, it depends on a strong public-private partnership, and it doesn't cost the government a dime."

Notes

1. Bassett WF. "Medicaid's Nursing Home Coverage and Asset Transfers." *Federal Reserve System Report 2004-15*. Washington, D.C.: U.S. Federal Reserve, 2004.
2. Kaiser Commission on Medicaid and the Uninsured. *Medicaid and Long-Term Care*. Menlo Park, Calif.: Kaiser Family Foundation, 2004. (www.kff.org/medicaid/7089a.cfm)
3. Moses SA. "The Long Term Care Partnership: Why It Failed and How to Fix It." In *Who Will Pay for Long Term Care? Insights from the Partnership Programs*. Chicago: Health Administration Press, 2001.
4. Ibid.
5. Ibid.
6. Weiner JM. "The Limits of the Partnership for Long Term Care." In *Who Will Pay for Long Term Care? Insights from the Partnership Programs*. Chicago: Health Administration Press, 2001.