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and Katherine Swartz**

**Assessing Long-Term Care Partnerships:
An Old Concept to Redefine?**

Assessing Long-Term Care Partnerships: An Old Concept to Redefine?

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Abstract

Sluggish insurance uptake for long-term care supports and services (LTSS) in the United States coexists with an unrelenting growth in Medicaid expenditures, increased need for LTSS and lack of financial wherewithal for paying for LTSS, especially among middle-class Americans. Long-term care partnerships (LTCP) programs were designed in a number of states. Under the LTCP programs, assets protected by long-term care insurance (LTCI) would be disregarded when determining a person's eligibility for Medicaid coverage (mostly on a 'dollar-for-dollar' format). This paper examines the design and implementation of LTCP and how they explain some of the major trends in slow insurance uptake and limited decline in Medicaid expenditure and claims. We offer four explanations for such evidence including: saliency of Medicaid eligibility, potential for insurance substitution and poor targeting, significant role of underwriting, and common problems of long-term care insurance, namely late purchase and denial. Policy implications include the need for further targeting populations alongside program redefinition.

Keywords: long-term care insurance, long-term care partnerships, long-term care

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1. Introduction

Demand for long-term care services and supports (LTSS) is expected to rise sharply with the aging of the population and the ensuing pressures on the supply of informal caregiving within the household. But as the latest Health and Retirement Survey (HRS, 2013) data from 2010 show (Figure 1), barely 14 percent of Americans over the age of 50 purchase some form of long-term care insurance (LTCI). When we distinguish by age group, it becomes clear that there are important differences between individuals 50-64 and those over 64, who exhibit slightly higher take up rates between 15-16 percent. The latter contrast with evidence that among Americans reaching age 65 in 2005, 16 percent would have LTC expenses greater than \$100,000 (in 2005 dollars) during their remaining years of life (Kemper, Komisar, and Alecxih 2005).

1.1 Why Do So Few Americans Have Long-Term Care Insurance?

There are many explanations for why only small numbers of Americans have private long-term care insurance (LTCI) (Frank 2013; Brown and Finkelstein 2011). Chief among these are that purchasing LTCI is not straightforward – people have to think through how much of their own savings and assets they will be able to spend on LTSS many years in the future, which is a cognitively costly exercise if taken seriously. Ultimately, provided the exercise took place, it is unclear whether LTCI is affordable for a middle-income family. Indeed, they also have to assess trade-offs between the amount of their annual premium and the amount they will pay out-of-pocket for LTSS in the future, especially when companies can increase their insurance premiums¹. Nonetheless, premiums are lower both when people choose to pay a higher fraction of LTSS costs and if they start purchasing a policy in their younger middle-age years – long before they may be most likely to need LTSS.²

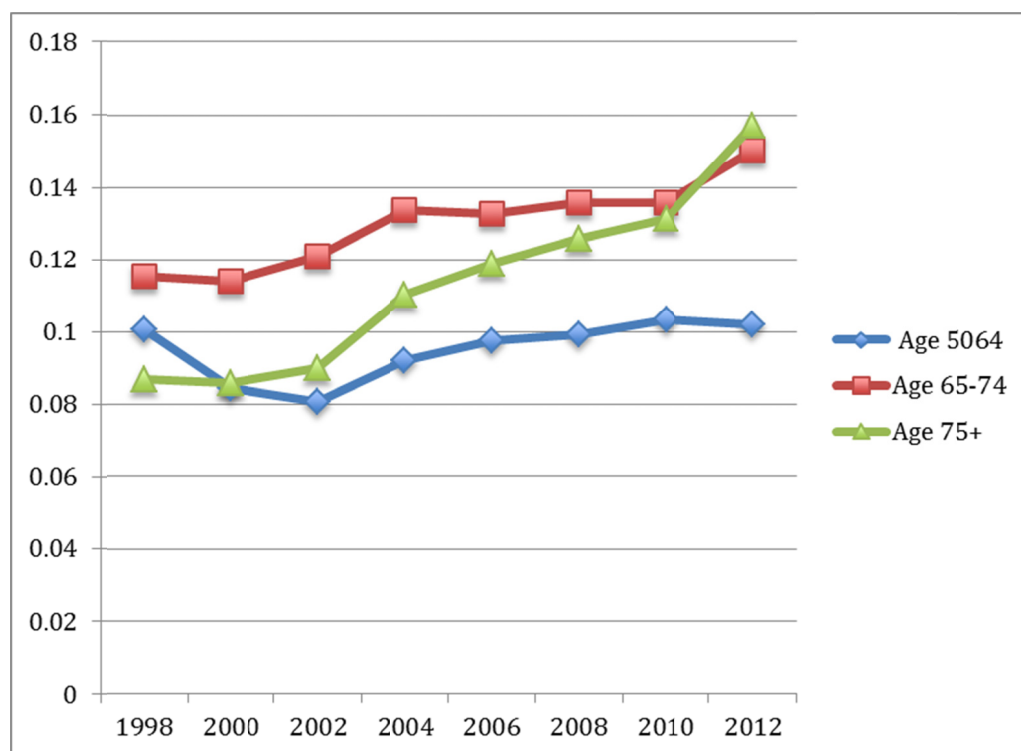
Insurance companies also have become more skittish about selling LTCI. The number of insurers selling substantial numbers of LTCI policies has declined from around 100 to about half-a-dozen

¹ This is critically important in undermining consumer faith in long-term care insurance companies, since policies are sold with the expectation of level premiums.

² Low levels of LTCI uptake allow premiums to exhibit higher loading factors than of other insurance products (Brown and Finkelstein 2011), and the age profile of buyers is older than what would be optimal (Meier 1999).

between 2000 and 2010 – causing most interested buyers of LTCI significant uncertainty as to whether an insurer they choose will still be around several decades into the future (Cohen, Kaur, and Darnell 2013). Moreover, because long-term care insurers can charge higher premiums for people who are perhaps more likely to need LTSS (e.g., men who occasionally smoke cigars or people who are mildly overweight) or reject applications altogether, some agents discourage people from even applying for LTCI because the agents want to protect their own reputations with the insurers (Frank 2013).

Figure 1. Percentage of Americans 65 or older with Private Long-term Care Insurance



Source: Health and Retirement Study, 2012

A second explanation is that most Americans believe – erroneously – that Medicare, and/or private health insurance cover expenses for LTSS. A third explanation is that people assume they will qualify for Medicaid if and when they exhaust their savings and assets, which is

refereed referred to as “Medicaid crowd-out” of LTCI (Brown et al. 2007; Brown and Finkelstein 2004; Pauly 1991). However, evidence on the role of Medicaid crowding out is limited. Wiener et al (2013) estimates that about 10 percent of the previously non-Medicaid population age 50 and over spent down to Medicaid eligibility, they are disproportionately lower income and community residents using personal care services.

The crowd-out hypothesis has had a political impact: the 2005 Deficit Reduction Act extended from three to five years the look-back period for checking for transfers of assets prior to an individual being able to qualify for Medicaid.

In 2010, 41 percent of long-term care expenditures in the United States were funded by Medicaid (Kaiser 2013). About half of Medicaid’s expenditures for LTSS are for non-elderly, but the growth in the elderly population who are expected to need LTSS within the next two decades has policy makers concerned about their ability to pay for an expansion of Medicaid due to increased need for LTSS.

1.2 Partnership for Long-Term Care Program

One proposal for reducing pressure on Medicaid to pay for LTSS has been the Partnership for Long-Term Care Program (LTCP). The program was originally established in the early 1990s in California, Connecticut, Indiana, and New York through grants from the Robert Wood Johnson Foundation (RWJF), which had fostered the idea through a demonstration program.³ The Partnership program concept is based on the assumption that middle-class people will be more likely to purchase a LTCI policy if they could protect a significant share of their assets in the event that their LTC expenses exceeded some threshold. Most LTCI policies limit the amount of

³ James Knickman and Nelda McCall are credited with pushing the concept of the Partnership Program and interesting the RWJF in funding a demonstration of the concept (Alper 2007). Knickman credits Jeffrey Merrill (then a foundation vice-president) and Stephen Somers (a foundation program officer at the time) with getting the demonstration program funded by the foundation in 1987. Mark Meiners (then at the University of Maryland) was in charge of the national program office that designed and ran the demonstration program (Alper 2007). In the planning phase of the RWJF initiative, eight states received planning grants: the four that established the LTCP programs plus Massachusetts, New Jersey, Oregon and Wisconsin.

long-term care expenses they cover. Thus, when a person's insurance benefits are exhausted, the person has to pay all of the costs of LTSS. For many people, this means they must draw down their savings and assets to afford LTSS. If they then exhaust their assets (except for their equity in a home and a car), they probably are eligible for Medicaid to pay for their LTSS either at home or in a nursing home. In contrast, the Partnership program protects a person's assets up to the value of the Partnership LTCI policy if they exhaust the LTCI benefits and then need Medicaid. It aims to provide an incentive for middle-class people to purchase LTCI by protecting some of their assets if they have LTSS expenditures greater than what a qualifying private policy covers (Meiners 2009). The LTCI policies sold through the Partnership programs generally provide comprehensive coverage for one to three years. In contrast, LTCI policies sold in the private market generally provide more limited benefits for three to five years.

The Partnership program is designed to offer two advantages for policyholders: the protection of more of the policyholder's assets, and lower premiums than traditional LTCI because the policyholder is usually covered for a shorter amount of time than under traditional policies. In addition, income earned on protected assets can be applied to the cost of care, providing yet further resources for paying for LTSS (Meiners 2009). The advantage for states is that people who purchase such LTCI policies may not need Medicaid to help pay for LTSS as early as they would otherwise. If more people's initial three years of LTSS expenses are covered by private insurance, the growth in states' expenditures for Medicaid might be slowed. This is especially important with larger numbers of elderly expected to need help in financing LTSS in the next two decades. Thus, advocates of the Partnership program anticipate that middle-class people who in the past have not been interested in purchasing LTCI will be enticed to do because of anticipated lower premiums and they can protect more of their assets.

Given that by mid-2012, 37 more states had implemented several versions of Partnership programs, this paper does not aim at providing a full quantitative analysis of the LTCP, but to provide a policy analysis on its design and expectations on uptake and expenditures alongside the trends in insurance purchases and Medicaid expenditures, and other evidence available. More specifically, we first examine the Partnership program design in the wider context of limited take-up of private insurance for LTC. Second, we exploit unique data from the National

Association of Insurance Commissioners (NAIC) and other sources to assess the extent to which the original four states' Partnership programs impacted the take-up of private LTCI contracts between 2000 and 2008. Finally, we provide some evidence of the patterns of expenditure on long-term care of those LTCP states compared to the rest of the United States.

We begin by discussing the background for the Partnership programs. We describe the empirical evidence to then analyze. We finally conclude with a discussion of the implications of our results for the future direction of Partnership programs and LTCI more broadly.

2. Long-Term Care Insurance and the Partnership Program

The Partnership program attempts to promote the purchase of private long-term care insurance by offering access to Medicaid under special eligibility rules regarding asset levels if policyholders purchase a state approved Partnership qualified plan (Meiners et al. 2002). The Partnership program also aims to reduce Medicaid spending by having individuals assume responsibility for at least the initial phase of their long-term care through private insurance (Rothstein 2007).

When the Partnership program was envisioned and designed, the long-term care insurance market was seen as having great promise in spite of the very low percentage of people 50 and older who were buying policies (Ahlstrom et al. 2004). The RWJF Partnership initiative was launched in 1987, and resulted in four states implementing public-private LTCI partnerships: California (1994), Connecticut (1992), Indiana (1993), and New York (1993) (Alper 2007). These state programs are referred to as the RWJF Partnership programs; details about the four states' programs are shown in **Table 1**.

Shortly after California, Connecticut, Indiana, and New York passed legislation enabling the establishment of their Partnership programs, Congress expressed concern about the appropriateness of using Medicaid funds for the Partnership program (Rothstein 2007). The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) required any states implementing Partnership programs after May 14, 1993 to recover assets from the estates of all persons

receiving services under Medicaid. This meant that asset protection would be in effect only if the insured were alive, and after death the promised asset protection would disappear (Meiners et al. 2002).⁴ OBRA '93 effectively put a moratorium on the Partnership program in all states but California, Connecticut, Indiana, and New York.

Table 1. Description of the partnership models

| State | First Year Operational | Program Model | Stated Goals | Reciprocity | Total Policies Purchased | Total Policies Dropped | Total Policies Denied |
|-------------|------------------------|---|---|--|--------------------------|------------------------|-----------------------|
| California | 1994 | Dollar for Dollar | Educate consumers, improve quality, availability and affordability | No | 142,474 as of 2011 Q1 | 20,571 as of 2011 Q1 | 27,178 as of 2011 Q1 |
| Connecticut | 1992 | Dollar for Dollar | Constrain Medicaid expenditures, educate consumers quality, affordable insurance | Yes, with Indiana in 2001; National Reciprocity Compact 2009 | 54,969 as of 2011 Q3 | Unavailable | 8,809 as of 2011 Q3 |
| Indiana | 1993 | Dollar for Dollar; hybrid model with Total Asset 1998 | Incentives for insurance; educate consumers; contain Medicaid expenditures; raise awareness | Yes, reciprocity with CT in 2001; National Reciprocity Compact in 2009 | 52,070 as of 2011 Q4 | 6,461 as of 2011 Q4 | 9,826 as of 2011 Q4 |
| New York | 1993 | Total Asset; Dollar for Dollar 2006 Q1 | Financial planning | Yes, 2012 | 95,702 as of 2011 Q2 | 23,292 as of 2011 Q2 | 22,531 as of 2011 Q2 |

⁴ Illinois received approval as a Partnership state after 1993, but the program was unable to overcome the asset recovery requirement (CT OPM 2011).

By 2003, however, Medicaid spending for long-term care had grown from \$33.5 billion in 1993⁵ to \$75.3 billion in 2001 (both in 2001 dollars), and policymakers became more interested in Partnership programs (Summer 2003). As noted earlier, concerns also had been raised that Medicaid spending for LTSS was increasing because people were thought to be transferring their assets to relatives so they could qualify for Medicaid. In February 2006, Congress passed the Deficit Reduction Act (DRA) of 2005, which contains several provisions directly affecting the Partnership program. Chief among these is the repeal of the requirement that states recover assets from anyone covered by Medicaid who also had a Partnership LTCI policy, and expansion of the Partnership program to all states was approved. Another provision lengthened the look-back period for transfer of assets from three to five years – so anyone who transferred assets within five years of applying for Medicaid could not qualify, thereby increasing the attractiveness of the Partnership LTCI policies for middle-class people. The DRA permits states to increase this amount to \$750,000 with state option to expanding the limit. The goal of this change was to encourage the use of home equity to pay for long-term care since asset protection cannot be used to increase protected home value (e.g., \$100,000 of asset protection cannot be used to boost protected home equity from \$500,000 to \$600,000) (Meiners 2008). By July 2012, 37 states had established Partnership programs in addition to the four original RWJF programs.

2.1 Program Designs for Protecting Assets

As described in Table 1, the original four states do not have identical programs – there are several variations of the Partnership program. The primary difference involves the extent of asset protection provided by a state's program. The total asset protection model began in New York and expanded to Indiana in 1998 (ILTCIP 2011). The New York policies pay for three years of nursing home care, six years of home care, or some combination of the two, after which all remaining policyholder assets are protected. This model provides maximum incentive to purchase long-term care insurance. It is targeted more to middle to higher middle-class income groups as an alternative to transferring assets or spending down to become Medicaid eligible (Meiners et al. 2002; Rothstein 2007). Total asset protection aims to save Medicaid money

⁵ Burwell and Crown (1994) show that Medicaid paid \$23.5 billion for nursing home care and \$3.8 billion for home health services for the elderly in 1993 (both figures in 1993 dollars).

because instead of immediately divesting assets to qualify for Medicaid, there is a period of time in which care is privately financed (Meiners et al. 2002). It is important to note that Medicaid nursing home beneficiaries in the Partnership program must still contribute all of their income towards their cost of care, except for a small personal needs allowance. However, Partnership beneficiaries draw on their assets to supplement their small personal needs allowance.

An alternative model is the dollar-for-dollar model. The dollar-for-dollar model originated in California, Connecticut, and Indiana, and expanded to New York in 2006 (Meiners et al. 2002; NYSPLTC 2011). The dollar-for-dollar approach allows people to buy a policy that protects a specified amount of their assets and hence can be adjusted to the amount of an individual's assets that he or she wishes to protect. Payments for long-term care are considered the equivalent of spending down to establish Medicaid eligibility. For example: if a policy pays out \$75,000 in benefits, then the individual may keep \$75,000 of assets (plus the \$2,000 in assets normally allowed under Medicaid eligibility criteria) and still qualify for Medicaid after the policy benefits are exhausted so long as the person meets the remaining Medicaid income and need requirements (Meiners et al. 2002).

2.2 Partnership Program Expansion

Since 2006, states that wish to implement long-term care Partnership programs are required to include certain consumer protections, including provisions of the National Association of Insurance Commissioners (NAIC)'s Model Long-Term Care regulations and inflation protection when the purchaser is under age 76 (Rothstein 2007). All new programs must operate the dollar-for-dollar model of asset protection; this was required in an effort to target middle and lower-income individuals (Rothstein 2007).

The DRA also set out several requirements to educate consumers and insurers, and established a National Reciprocity Compact (Rothstein 2007; Meiners 2008). All Partnership states have reciprocity for their dollar-for-dollar programs as of July 2012 with the exception of California, which has unique a Medi-Cal asset disregard that is not recognized outside California (Truven Health Analytics 2012a; CPLTC 2012).

2.3 Earlier Evaluations

There is an ongoing debate about whether or not sufficient time has passed for an assessment of the four original Partnership programs. Program redesigns in the late 1990s – particularly in California and Connecticut – contributed to a belief that the programs’ effects in the years before 2000 could not be evaluated well (Ahlstrom et al. 2004; Meiners et al. 2002).

Previous assessments of the Partnership programs focused largely on the numbers of policies sold and their impact on state Medicaid expenditures for LTSS. (See Appendix Table 1 for a list of such studies). The U.S. Department of Health and Human Services (HHS) has assumed that the programs are at least budget neutral with opportunities for savings because they provide people with an alternative to transferring their assets and becoming Medicaid beneficiaries. A Government Accountability Office (GAO) study in 2007 found that Medicaid savings were not likely, but that costs to Medicaid would be minimal because it assumed that many participants would still be too wealthy to qualify for Medicaid. The GAO study also assumed that policyholders do not over-insure their assets, which is a major source of potential savings, and it assumed that people do not often transfer their assets to qualify for Medicaid (GAO 2007; Meiners 2009). Finally, Sun and Webb’s (2013) numerical optimization shows that the programs only increased insurance coverage among single individuals (4-5%), and that Partnership policies have been purchased mostly by people who, absent the availability of the Partnership programs, would have purchased traditional LTCI.

3. Evidence and Trends from Partnership Programs

Our analyses of the data trends from the states are organized as follows. First, we examine the trend in sales of traditional LTCI across the country. Then we focus on the sales of Partnership plans in the RWJF Partnership states between 2000 and 2008 and compare the trends in sales of Partnership plans to the trends in sales of traditional LTCI in each state. We also examine trends in applications for Partnership plans and rejections of such applications by state; whether the availability of the Partnership plans might be increasing overall sales of LTCI and trends in Medicaid expenditures and compare these trends to that of the rest of the country.

3.1 Key Trends in Sales of Traditional and Partnership LTCI Policies

New private long-term care insurance contracts of all types (traditional and Partnership) show low market penetration since 2000. **Figure 2** shows the total number of insured lives per 100 people by Partnership and traditional LTCI policies in the US from 2000 to 2008. To put Figure 2 in perspective, recent estimates indicate that sales to individuals of all LTCI policies were around 233,000 in 2012 (a decline of 37% since 2004), with close to 7 million people covered by LTCI (Greene and Scism 2013). There were substantial declines in insured lives in 2004 and 2007. Several factors contributed particularly to the decline in 2004: substantial rate increases for traditional LTCI went into effect in 2004, rate stability regulations were passed by states starting in 2004, and the exit of insurers CNA and AEGON from the market (Society of Actuaries 2005). The lower sales in 2007 and 2008 can be attributed to the financial crisis and the first years of the great recession, when interest rates fell dramatically and reduced insurers' investment returns.⁶

Figure 3 shows the Partnership sales in California, Connecticut, Indiana, and New York.⁷ Sales of Partnership policies per 100 people are lower than traditional LTCI policies during the years for our data; the four states' programs sold approximately 20,000 contracts per year in total during the 2000s. Given the small numbers of sales in each state, trends in state sales over the 2000-2008 time period provide a better indication of Partnership programs' success (or lack thereof) in attracting people than do the year-to-year sales numbers, which fluctuated. Notably, the Partnership sales numbers did not suffer a decline in 2004 like the traditional policies did.⁸ Sales in California and New York follow a similar trend line, despite selling different policy types until New York introduced dollar for dollar plans in 2006. Interestingly, there are not any real shifts in New York sales after 2006, although it is possible the new policy helped buffer sales during the financial crisis. In Connecticut, sales dropped after 2004 but picked up again in 2008. The Connecticut program holds public forums and gives private presentations to various

⁶ Since 2008, there have been further exits by big LTC insurers from the market; now there are only about a dozen companies selling policies compared to about 100 in the early 2000s.

⁷ There is no yearly data for Connecticut in 2000. The total sales in 2007 in New York are an estimation based on Q1 and Q2 figures.

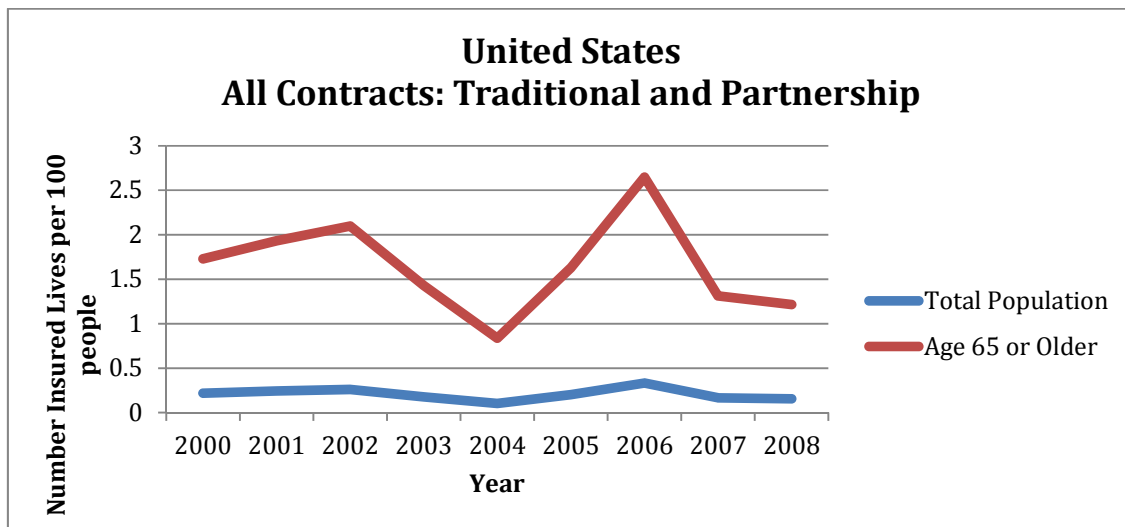
⁸ However, application denials increased in 2003-2004; we do not know why they increased during that time

organizations around the state; this proactive effort to educate consumers may account for comparatively higher sales numbers than the other RWJF Partnership states. Indiana is unique among the four RWJF Partnership states: the decline in its Partnership sales parallels the decline for traditional LTCI sales in the state.

For the most part, Partnership purchasing trends track with application trends in each state (Figure 3). Unfortunately, we cannot compare the purchasing and application trends of the Partnership program states with the same trends for traditional LTCI because data on rejection rates for traditional policies are not available. Nonetheless, the trends for applications and denials of Partnership policies suggest that between 2000 and 2008 the market stabilized in terms of fewer people being denied policies (Figure 4). In Indiana, the number of denied applications rose from 2001 to 2004, perhaps causing the decline in applications and purchases that started in 2003. In 2005, however, the number of policies purchased was greater than the number of applications received, indicating a backlog of applications had built up. Similarly, in Connecticut, the number of denied applications rose from 2001 to 2004, contributing to the decline in purchases during the same time period. Beginning in 2005, the trends for applications received, denied, and policies purchased match up closely, indicating more stable proportions of applicants and purchasers. The closer matching of trends after 2005 also suggests that brokers and consumers learned more about the Partnership program over time, and understood better who would be a good candidate for the Partnership policies. However, measuring underwriting is challenging as individuals can be turned away from particular insurers before an application has been completed, and policies can have premium “add-ons” if a person has been an occasional smoker or is overweight even though the person may not be hypertensive or diabetic.

In both Connecticut and Indiana, Partnership policies are a larger percentage of the LTCI market than in California and New York (Figure 5). The large increase in the Partnership share of the market in Connecticut and Indiana in 2004 is likely due to the decline in sales of traditional LTCI policies caused by the upsurge in premiums that year. But the decline in Partnership policies’ share of the LTCI market in 2005-2006 reflects a fall-off in Partnership sales while traditional policy sales rose again. By comparison, Partnership policies in California and New York maintained a relatively steady percentage of overall sales, between 10 and 20 percent.

Figure 2



Source: National Association of Insurance Commissioners (NAIC), 2012

Figure 3.

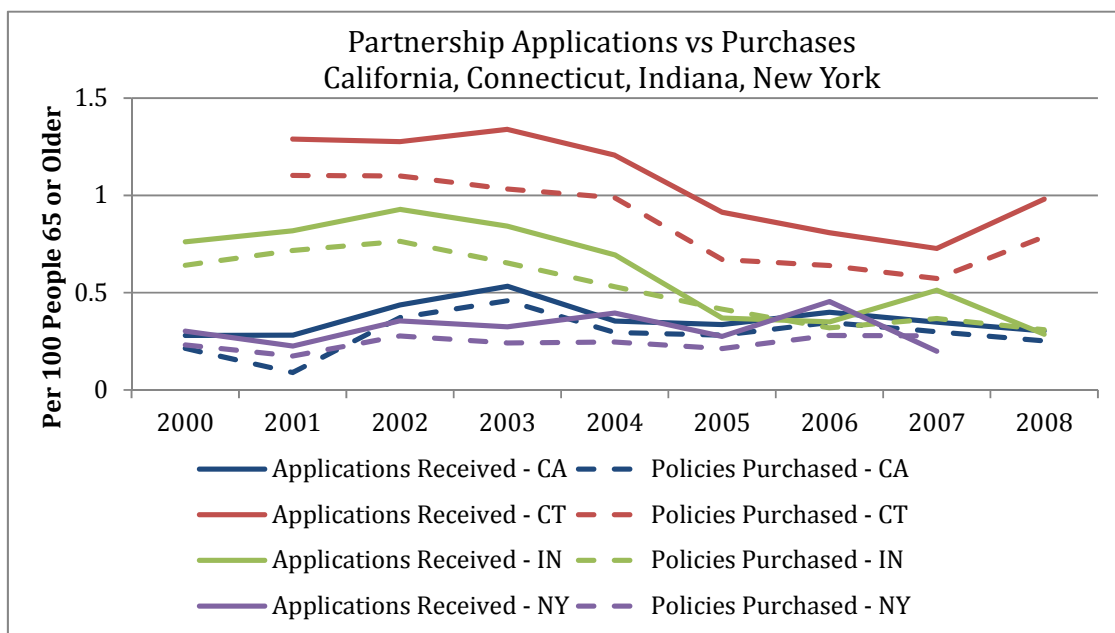
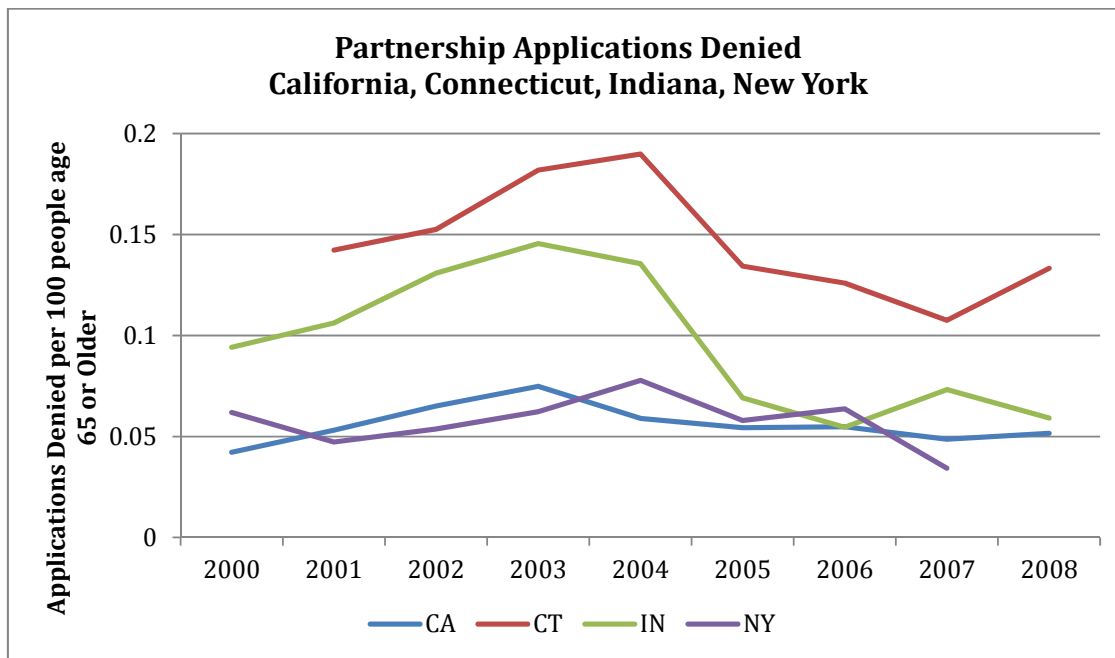


Figure 4.



Source: National Association of Insurance Commissioners (NAIC), 2012

Figure 5

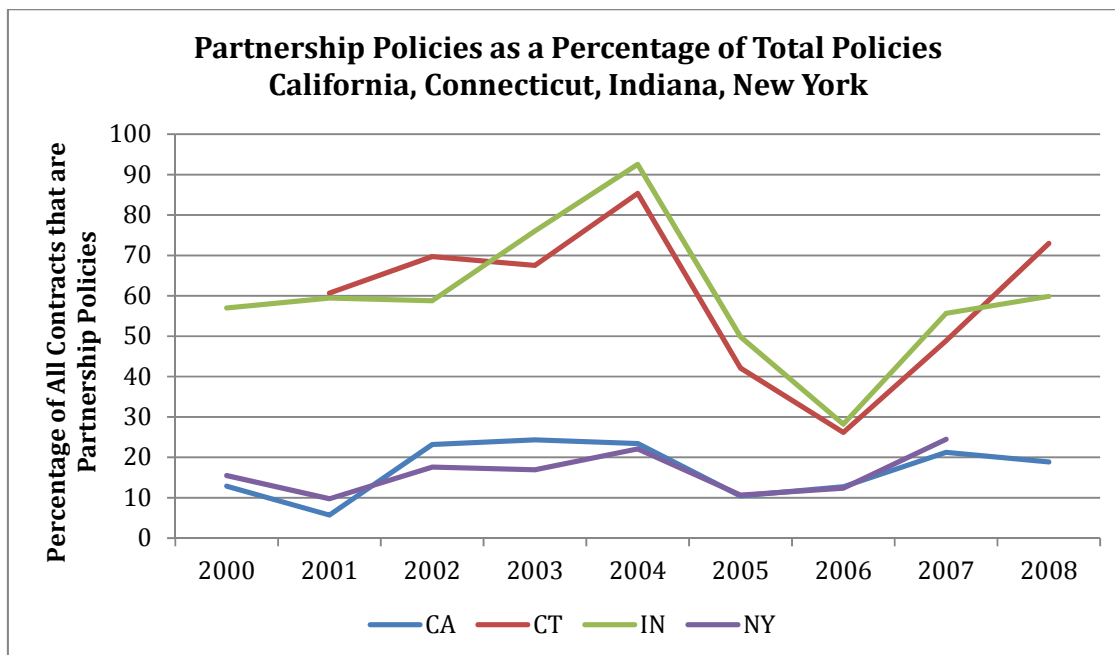


Figure 6. DRA Expansion Partnership Programs: Policies in Force

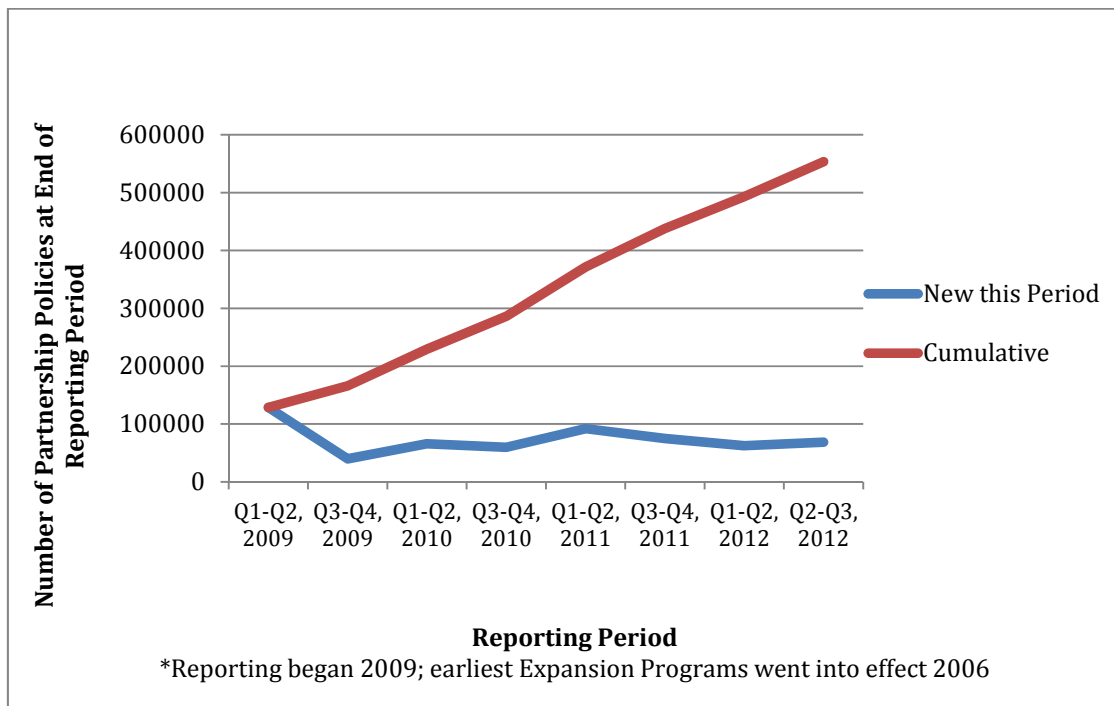
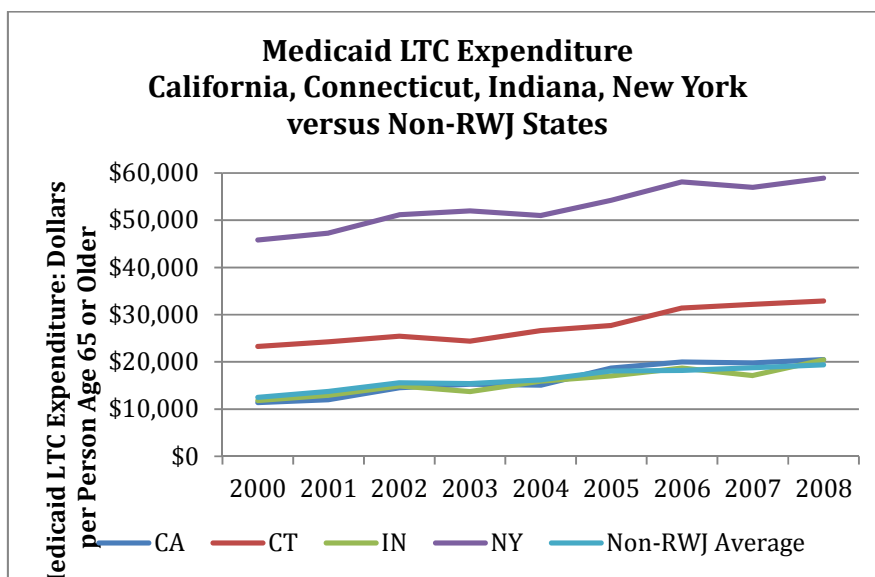


Figure 7. Medicaid Expenditure Patterns in Partnership and non-Partnership States



3.2 Expansion Partnership Programs

Most of the 37 new programs went into effect in 2008 or 2009; there are steady sales of less than 200,000 per year across all new programs (Figure 6). Given that the RWJF Partnership programs sold approximately 20,000 contracts per year in total during the 2000s, the expansion programs are generating similar sales numbers. Looking at trends in penetration of Partnership sales, from 2009 to 2012 the number of newly issued policies in force per 100 people age 65 and older has consistently stayed between 0.600 and 0.400. The rate appears to be highest in 2009, at 0.609, but because reporting began in 2009 the policies “newly” in force in the first reporting period (January-June 2009) are roughly triple those newly in force in the second reporting period (July-December 2009). In 2012, across all expansion states, approximately 0.433 newly issued policies were in force per 100 people age 65 and older. This rate is comparable to the penetration of Partnership sales in California and New York during the 2000-2008-time period. Overall, expansion state numbers could be suffering from the inclusion of states like West Virginia, where a low number of policies were sold and a relatively high percentage of the population is 65 and older. Removing West Virginia, which is an outlier in terms of policies newly in force, the new programs remain at 0.437 newly issued policies in force per 100 people age 65 and older. At the other end of the spectrum are Florida, Minnesota, Texas, and Wisconsin; their combined sales make up about a third of all new Partnership sales among the expansion states. In 2012, across these four states, approximately 0.652 newly issued policies were in force per 100 people age 65 and older, a rate that is well above the penetration rates seen in California and New York from 2000-2008, but below those seen in Connecticut.

Given the similarity in the expansion programs’ sales trends and program structure with the original Partnership states’ programs, our analysis of the Medicaid expenditure data from the original states may be generalizable to the expansion program states as well.

3.3 Medicaid Expenditures

Figure 7 shows Medicaid expenditures for long-term care per person age 65 and higher for each of the four RWJF Partnership program states and the average for all the other states between 2000 and 2008. The trends in Medicaid LTC spending per elderly person are very similar even

though the levels of spending differ across the states. Clearly, the sales of Partnership LTCI policies did not have an immediate effect on slowing Medicaid LTC spending per person in the four states.

4. Discussion

LTCP programs were developed to encourage middle-class Americans to buy private long-term care insurance – thereby reducing both their probability of becoming Medicaid beneficiaries and Medicaid expenditures for LTSS. The federal and state governments presumably benefit from such programs because Medicaid does not pay for the early years of LTC expenses.

The fact that sales of LTCI policies did not increase and Medicaid expenditures did not slow in the original Partnership states compared to the other states is a puzzle as well as a disappointment for advocates of the program. As an idea, LTCP programs seem to be embraced in recent survey data.⁹ However, only one percent of the survey respondents state that they purchased their insurance policy now rather than later because LTCP was available (AHIP 2012). Although it is generally claimed that the Partnership program reduces incentives for people to strategically spend down or transfer their assets so they become eligible for Medicaid, the program might have the unintended effect of making Medicaid funding of LTSS more salient rather than causing people to purchase a Partnership insurance policy. This explanation is consistent with empirical evidence suggestive of slight Medicaid expenditure increases in the two states where LTCP was more popular.

Affordability of Partnership policies is almost certainly the primary obstacle to greater market penetration. State program data indicate that underwriting levels for the Partnership policies are as high as for traditional LTCI contracts. Moreover, a non-trivial share of applications is denied each year, likely contributing to consumer apprehensions that they may not be able to obtain LTCI. The extent of underwriting suggests that the original Partnership programs have so far

⁹ The latest wave of AHIP data from 2010-11 asks individuals who live in a state offering LTCP programs whether the Partnership policies were an important motivation for purchasing insurance. Sixty-five percent indicated they were (AHIP 2012).

failed to attract sufficient numbers of middle-income consumers who might reduce insurers' concerns about risk and thereby lower premiums.

Another explanation that has been offered for the low sales numbers for Partnership policies is the inadequate implementation and anemic marketing for Partnership plans (Meiners 2012; Alper 2007). This could account for why Partnership sales are not a higher percentage of overall sales, particularly in New York and California, which are less proactive about consumer education. Commission driven insurance agents may also be partially responsible for the Partnership program falling short: the shorter-term, comprehensive policies intended to appeal to the middle-income market have not been made a sales priority of insurance agents in comparison to high-end LTCI products that offer greater benefit amounts per policy sold (Meiners 2012).

Finally, the Partnership program has no real control over market stability or dynamic contracting issues connected to LTCI in general. Perhaps more concerted efforts to inform people about the risks of needing LTSS and their costs would increase sales of Partnership policies. However, even the outreach efforts of Connecticut's program have so far not produced increased sales results necessary to make this a viable national solution.¹⁰

5. Conclusion and Policy Implications

The most important empirical trends to highlight indicates that the RWJF Partnership programs did not significantly increase the total number of LTCI policies purchased and so far they have not substantially slowed the growth in Medicaid spending for LTSS in those states. These findings are discouraging for efforts to increase greater reliance on private LTCI.

Our analysis of the RWJF Partnership programs could not account for implementation issues encountered by each state. We do not know, for example, if the relatively anemic level of sales of Partnership policies was due to people being unaware of their availability or insurance agents

¹⁰ In this context, it is noteworthy that recent findings from a national survey show that 75 percent of the respondents were unaware that Partnerships exist and 45 percent indicated they would consider purchasing private insurance if their state offered a LTCP (AHIP 2012).

being reluctant to recommend them to clients. People may also have heard unfavorable reports about how the original Partnership policies changed or other people had difficulty obtaining such policies during the 1990s. We do not know if publicity about the exiting of insurers selling traditional LTCI policies caused people to assume that Partnership policies might be likely to disappear in the future, too. Debates about national health insurance reforms during the mid-2000s also could have deterred people from purchasing Partnership and traditional LTCI policies if they thought LTSS would be covered by reforms.

The ACA originally included the Community Living Assistance Services and Supports (Class) Act a major provision for financing and expanding LTSS coverage. However, it was put on hold in October 2011 for being financially insolvent (Greenlee 2011). The Class Act was stripped from the ACA during the fiscal cliff negotiations in October 2012, and replaced with the Commission on Long-Term Care (Section 643 of American Taxpayer Relief Act of 2012). The Commission was charged with developing plans for a comprehensive and coordinated system for ensuring long-term care. In September 2013, the Commission produced a report that featured recommendations on LTSS service delivery, workforce, and financing (Commission on Long-Term Care 2013).

However, the Commission failed to agree on a recommendation for financing – arguably the most important part of their task – and instead offered two opposing approaches. The first approach advocates for strengthening LTSS financing through private insurance options, and includes non-specific proposals for new market incentives, supporting the Partnership program, reducing insurance regulatory barriers, minimizing Medicaid crowd-out, and increasing awareness through an education campaign. The second approach proposes strengthening LTSS financing through social insurance. This proposal would increase the role of public financing, but maintain a place for private LTCI – essentially, redefining the nature of the public-private LTC partnership in the US. Members of the Commission have since expressed their discontentment at the Commission’s inability to address the issue of financing LTSS (Jaffe 2013).

The limited results of LTCP point to the need for identifying a proposal that would improve the wellbeing at old age of middle-income Americans who fail to insure LTC and run out of

resources when they are to pay out of pocket at the point of need. Alternatives that have been put in place include the tax subsidization of insurance. Some evidence for the latter is promising (Goda 2011). More generally, however, the limited results of LTCP suggest that Americans should be made more aware of the risks they are facing if they remain uninsured.

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Appendix

The data we analyze were obtained from different sources, which we describe by state and the set of new state Partnership programs (the expansion programs).

California: The quarterly reports issued by the California Partnership for Long-Term Care (CPLTC) program provided data for California from 2000 to 2008. The reports include information on participating insurers, quarterly and cumulative statistics, maximum benefit amounts, policyholder age, trends, policyholders and asset protection earned, and service utilization. The reports were obtained from the CPLTC website (CPLTC 2011).

Connecticut: Data for Connecticut was gathered from the Annual Progress Reports on the Connecticut Partnership for Long-Term Care from 2000 to 2008. These reports provide information on agent training and outreach, public forums, public relations activities, outreach to associations and employers, program reciprocity, outreach to nursing facilities, presentations and media coverage, and summary statistics. The reports were obtained courtesy of David Guttchen of the Connecticut Partnership for Long-Term Care, along with Annual Program Evaluations (CT OPM 2011).

Indiana: The quarterly reports issued by the Indiana Long-Term Care Program (ILTCP) provide the data on Indiana's program from 2000 to 2008. The reports include summary statistics, statistics on policyholders in benefits, claimant profiles, and age distributions. The reports were obtained from the ILTCP and Indiana Department of Insurance (ILTCP 2011).

New York: Quarterly reports issued by the NYSPLTC provide the main source of data on the New York program. The quarterly reports contain information on participating insurers, summary statistics, age distribution, and policy features. However, reports were only available covering the time period of Q1 2000 to Q2 2007. The data for the first half of 2007 is doubled to obtain full estimates for 2007 in P/PLTCI dataset (NYSPLTC 2007).

Expansion Partnership Programs: Insurers selling Partnership Qualified policies must file biennial reports on policies sold in each Expansion Partnership Program state. (Truven Health Analytics 2012b). The data from these reports are available online on a website operated by Truven Health Analytics on behalf of HHS. The data are aggregated by state and by insurance provider, in a format that includes the total number of records received, policy status, policies in claim, qualifying condition, and benefits paid. Depending upon the state, the time period covered in these reports dates from 2009 through 2012.

Tables

Appendix Table 1: Pre-existing Literature

| Subject | Author | Results |
|--|--------------------------|--|
| Partnership policyholder Income Level ¹ | Feder et al. (2007) | CA, CT, IN majority greater than \$350,000 in assets |
| | GAO (2007) | CA, CT majority monthly household incomes \$5,000+; 53% of households with assets \$350,000+; nationally only 36% of traditional LTC policyholders and only 17% without LTC insurance have assets \$350,000+ |
| | CT OPM (2011) | Cumulative, 44% policies sold to households with assets \$350,000+ (not including home and car) |
| Traditional policyholder age | HIAA (2000); AHIP (2012) | Average buyer age in 2000: 67; average buyer age in 2010: 59; non-buyer: 67 |
| Partnership policyholder age | CPLTC (2011) | Median age 59 |
| | CT OPM (2011) | Average age 58 |
| | ILTCP (2011) | Average age 61 |
| | NYSPLTC (2011) | Average age 60 |
| Market size | Stevenson et al. (2010) | Growth of 18% per year during 1987-2001; decline by 9% per year from 2000-2005 |

| | | |
|--|---------------------------|--|
| | | |
| | Stoltzfus and Feng (2011) | Significant sales declines in 2008 and 2009; sales increase 18% 2010 |

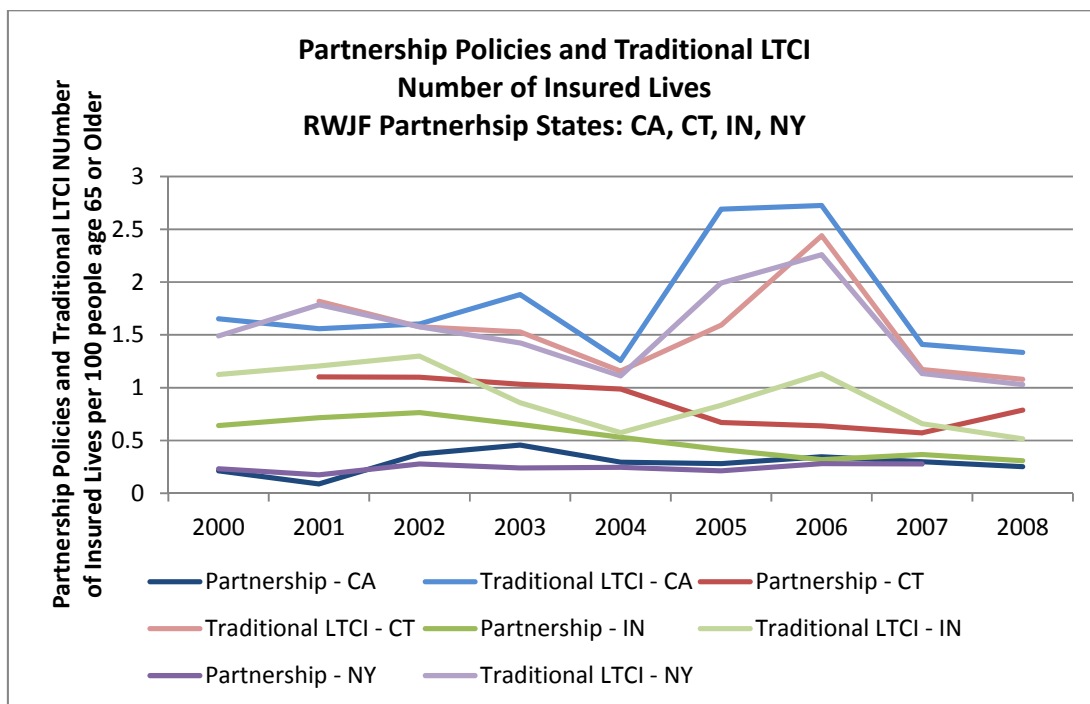
¹The NYSPLTC does not collect income or asset data

Appendix Table 2. Explanations for limited LTCI coverage

| Explanations | Description | Authors |
|--|---|---|
| Adverse selection | Self-evaluated probability of being in a nursing home within the next five years positively and significantly correlated with having private LTCI | Sloan and Norton (1997) |
| | Quantity rationing where consumers demand more comprehensive benefits at existing prices, but the policies do not exist | Brown and Finkelstein (2007) |
| Individual market | Most policies sold on the individual market, which contributes to higher administrative costs | Norton (2000); Stoltzfus and Feng (2011) |
| Extended time period between purchase and payout | Nondiversifiable intertemporal risk – indemnity benefits and higher rate of return reduce demand | Cutler (1996) |
| | Market stability – insurer’s ability to remain solvent; premium increases; policy changes; future relevancy of coverage choices | Stone-Axelrad (2005); Kaiser (2009a); Holm and Tergeson (2010); OR DCBS (2012); Frye (2012); CBO (2004); Brown and Finkelstein (2011) |
| Myopic decision making/consumer information | Lack of accurate perceptions regarding risk and survival | Finkelstein and McGarry (2006); Costa-Font and Font (2009) |
| Moral hazard | Insurers address traditional moral hazard through elimination periods | Norton (2000); ILTCP (2011) |
| | Intrafamilial bargaining where parents may purchase insurance to leave larger bequest, which may incentivize children to institutionalize their parents; conflicting evidence on role of bequests | Pauly (1990); Bernheim, Shleifer, and Summers (1985); Sloan and Norton (1997) |
| Substitutes | Medicaid is low-priced and imperfect substitute, but evidence of Medicaid crowd-out | Sloan and Norton (1997); Brown and Finkelstein (2004); Sloan and Norton |

| | | |
|-------|--|--|
| | | (2007) |
| | Home equity | Davidoff (2010) |
| | Combination annuity/insurance products | Freiman (2007); Stolfus and Feng (2011); Theroux *2012) |
| Price | Private LTCI median annual premiums for a 65 year old range from approx. \$2,200 to \$7,700; consumers discouraged from purchasing policies where premiums greater than 7 percent of their income or if they have less than \$35,000 in assets | Brown and Finkelstein (2011); Kaiser (2006); Feder et al. (2007) |

Figure A1



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