



THE GEORGE
WASHINGTON
UNIVERSITY
WASHINGTON DC

The Long-Term Care Partnership Program: Issues and Options

Alexis Ahlstrom
Emily Clements
Anne Tumlinson

The Health Strategies Consultancy LLC

Jeanne Lambrew

George Washington University School of Public Health and Health Services

This is one in a series of papers in the Retirement Security Project supported by a grant from The Pew Charitable Trusts.¹ The Retirement Security Project is intended to bolster financial security for America's aging population by raising retirement savings and improving long-term care insurance products. It brings together pension researchers and health care experts to undertake non-partisan research and outreach in areas such as using home equity to purchase long-term care insurance; reforming the existing saver's credit to strengthen its incentives for moderate-income households to save; and removing the disincentive for pension saving implicit in the existing asset tests under various means-tested government programs.

¹ The opinions expressed in this report are those of the authors and do not necessarily reflect the views of The Pew Charitable Trusts, George Washington University, The Brookings Institution, or any other institution with which the authors are associated. The authors would like to thank Judy Feder, Dean of the Public Policy Institute Georgetown University for reviewing earlier drafts of this paper.

The Long-Term Care Partnership Program: Issues and Options

Introduction

There is an ever-present tension in the financing of long-term care (LTC) in America over what share of the burden private or public sources should bear. A significant proportion of LTC is provided on an informal basis by family and friends, or paid for out-of-pocket. However, as family structures change, the Baby Boomer generation retires, and the intensity and cost of care have increased, demand has grown for insurance coverage of such services, especially for seniors.² Medicare does not pay for most LTC services and access to Medicaid is restricted to low-income individuals.³ Yet, because the cost of LTC impoverishes many seniors, Medicaid pays for a majority of formal LTC services.⁴ Budget constraints at the state and federal level, however, make it unlikely that government will assume additional financing responsibility in the short run. Policy makers are instead turning toward private-sector solutions, such as increasing the number of people buying LTC insurance through incentives like tax-credits.⁵

In this context, one idea being promoted is the expansion of the LTC Partnership Program. Started as a demonstration and limited to four states, the Partnership combines private LTC insurance with special access to Medicaid for those exhausting their insurance benefits. The idea is to encourage citizens to purchase a limited, and therefore more affordable, amount of LTC insurance coverage, with the assurance that they could receive additional LTC services through the Medicaid program as needed after their insurance coverage is exhausted. In addition, participants can access Medicaid without having to spend down all of their assets (although income must be devoted to LTC) to levels typically required in order to meet Medicaid eligibility requirements. Bipartisan support in Congress and among governors has emerged to allow all states to create such partnerships. Yet, concerns about the program's effectiveness and implications remain.

This issue brief examines the LTC Partnership Program, reviewing its design, implementation, and outcomes to date and identifying questions that should be considered in expanding the Partnership.

² This paper focuses on long-term care needs and coverage of people ages 65 and older.

³ Congressional Budget Office (CBO). (2004, April). *Financing Long-Term Care for the Elderly*. Washington, D.C.

⁴ Levit, K, Smith, C., Cowan, C., Sensenig, A., Catlin, A., & the Health Accounts Team. (2004). Health Spending Rebound Continues in 2002. *Health Affairs*, 23(1):, 147-159. The authors estimate that Medicaid (federal and state) spending on nursing home and home health care was \$59.3 billion in 2002.

⁵ Most tax credit proposals have relatively low budgetary costs.

History

In the early 1980's, with the costs of LTC escalating in Medicaid, states began exploring, among other ideas, whether increasing private LTC insurance ownership would reduce or slow Medicaid expenditures for LTC. At that time, the LTC insurance market was relatively new but seen as having great potential. In this environment, the Robert Wood Johnson Foundation (RWJF) sponsored an initiative to examine whether combining public and private resources would help balance the financing of LTC.⁶ The result of the RWJF initiative was the creation of the LTC Partnership Program, which combines a specially-designed private insurance product with Medicaid coverage. The creators of the Partnership aimed at promoting private insurance for LTC, which could improve access to care and limit the financial exposure to high costs. They also were hoping that, by increasing the number of people financing at least part of their care through private insurance, they could reduce Medicaid expenditures. Not only would the insurance limit people's "spend down" to qualify for Medicaid, it would, in theory, also reduce the incentive for individuals to undertake asset transfers in order to appear to be eligible for Medicaid.⁷

As the states began implementing their RWJF Partnership demonstrations, several criticisms were leveled at the program which prevented further expansion. First, policy makers were troubled that a public program like Medicaid would endorse private insurance products, which they believed to be beyond the mission of the program and which could inappropriately promote products with limited value.⁸ Others were concerned that the Partnership would increase Medicaid spending rather than reduce it. This could occur if wealthy individuals who would buy insurance anyway participate in the Partnership, keep their assets, and have new-found access to Medicaid services, which were intended for low-income Americans. As a result of these concerns, Congress included a provision in the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) that effectively prevented new states from developing Partnership programs.⁹ This law remains in effect today.

⁶ Meiners, M. R., McKay, H., & Goss, S. (2001). National Program Office. In N. McCall (Ed.) *Who Will Pay for Long Term Care: Insights from the Partnership Programs*. (pp. 49-64) Chicago: Health Administration Press.

⁷ While some asset transfers are legal (e.g., those that occur outside of a state's look back threshold), most states are concerned that incentives do exist for people to transfer assets in order to become Medicaid-eligible.

⁸ Meiners, M.R. (2001). Reflections of a Partnership Insider on Long Term Care Financing. In N. McCall (Ed.) *Who Will Pay for Long Term Care: Insights from the Partnership Programs*. (pp. 289-299) Chicago: Health Administration Press.

⁹ OBRA 1993 amended section 1917(b)(1)(C) of the Social Security Act; it requires states to perform estate recovery actions against Medicaid beneficiaries upon their death. Beneficiaries participating in established or approved Partnership programs as of that date were exempted from this requirement. This provision would not allow any new programs to offer asset protection, without which there is little incentive to participate (i.e., upon death, the Partnership program participants' assets would have to be taken by the state, even though they were protected when they were alive). Iowa has an approved plan amendment that beat the 1993 deadline, but has yet to implement a Partnership program.

The Partnership Program Models

Four states (California, Connecticut, Indiana, and New York) of the original eight with RWJF planning grants implemented Partnership Programs in the early 1990s.¹⁰ Before the states were able to implement the Partnership, they needed approval from the Center for Medicare and Medicaid Services (CMS)¹¹ to allow participants to qualify for Medicaid without meeting the state's asset test. The states applied to CMS for plan amendments using existing statutory authority in §1902(r)(2), which gives states the authority to regulate eligibility criteria. Two different Partnership model designs emerged from the development phase of the program – the dollar-for-dollar and total asset models. The two model designs have attracted different types of consumers, and could have different effects on Medicaid expenditures.

The dollar-for-dollar model, implemented by California and Connecticut, allows people to buy LTC insurance policies that protect a specific amount of their assets. For example, someone who purchases a LTC insurance policy with maximum benefit coverage equaling \$50,000 would have protection for \$50,000 worth of assets if ever in need of Medicaid coverage. The rationale behind the dollar-for-dollar model is that the dollar amount the LTC insurance pays out is analogous to the beneficiary spending down private assets before qualifying for Medicaid. Once the benefits of the policy have been exhausted, the beneficiary must use any remaining assets above the protected amount (i.e., any assets above the \$50,000 threshold) and income to pay for LTC services. After such sources have been exhausted, the beneficiary qualifies for Medicaid benefits. Even with asset protection, those on Medicaid must use most of their income (some part may be kept for personal use) to pay for LTC services.

New York's total assets model requires a participant's insurance to cover three years of nursing home care, six years of home care or a combination of the two in order to qualify as a Partnership policy.¹² This minimum coverage is more generous than most products sold today and thus its premiums are higher. While this model requires greater premium commitment from enrollees than the dollar-for-dollar model, it provides protection of 100 percent of assets if participants exhaust their policies and require Medicaid services.

Indiana has developed a hybrid model, which provides participants with total asset protection if they purchase a policy whose benefits value meets the threshold, or dollar-for-dollar asset protection if they purchase a minimum of a one-year LTC insurance

¹⁰ Meiners, M.R., McKay, H.L., & Mahoney, K.J. 2002. Partnership Insurance: An Innovation to Meet Long-Term Care Financing Needs in an Era of Federal Minimalism. *Journal of Aging & Social Policy*, 14, 75-93.

¹¹ CMS was, until 2001, called the Health Care Financing Administration (HCFA). Throughout this paper, the agency will be referred to as CMS.

¹² Meiners et al., 2002.

policy.¹³ With the goal of attracting lower income participants, New York is developing a hybrid model to be offered in early 2005.¹⁴

Evaluating the Partnership Programs

The empirical effect of the Partnership has been a topic of much interest among both advocates, who would like to see the Partnership expanded, and critics, who wonder if the program is costing Medicaid money. Because LTC insurance is generally bought years in advance of needing benefits, many Partnership purchasers have yet to use their insurance policies. As such, evaluating the effects of the Partnership on the Medicaid budgets of the four participating states is difficult at this time.¹⁵ What can be determined thus far is that the Partnership has not attracted large numbers of LTC insurance purchasers, and those participating have not used Medicaid services to any great degree. As more policyholders use and exhaust their insurance benefits, more data will be available to evaluate whether the Partnership is meeting its goals (increasing insurance coverage rates, decreasing Medicaid expenditures or slowing their growth, and reducing the incentive to transfer assets in order to become Medicaid-eligible). In addition to these explicit goals, other aspects of the programs should be assessed to determine how the Partnership has influenced the financing or provision of LTC.¹⁶

As of December 31, 2003, a total of 180,531 Partnership policies had been purchased and 148,405 of them were still in force (see Table 1 for more detailed data).¹⁷ To put this into context, the Partnership policies in force represent 1.5 to 5.7 percent of the elderly populations in these states. This is less than the nationwide rate of purchasing LTC insurance; according to a Health Insurance Association of America report, about 5.8 million LTC insurance policies were in force in 2000, representing 16.6 percent of the nation's elderly population.¹⁸

Of the Partnership policyholders, 2,057 have received benefits from their LTC policies and 89 policyholders have exhausted their benefits and accessed Medicaid (or have Medicaid applications pending).¹⁹ The Partnership literature does not contain information on whether the 89 people using Medicaid would have likely spent down to

¹³ Purchasers receive total asset protection if their policy benefit value is at least \$187,613 in 2004. The threshold increases each year with inflation for new purchasers.

¹⁴ Information provided during a phone interview with Robert Borrelli, director of the New York Partnership for LTC.

¹⁵ The Robert Wood Johnson Foundation. (2001). *National Program Report: Program to Promote Long-Term Care Insurance for the Elderly*.

¹⁶ An evaluation of program implementation, insurer participation, and consumer participation can be found in: McCall, N. & Korb, J. 2001. What Have We Learned from the Partnership for Long Term Care? In N. McCall (Ed.), *Who Will Pay for Long Term Care? Insights from the Partnership Programs* (pp. 149-184). Chicago: Health Administration Press.

¹⁷ National Association of Health Underwriters (NAHU). (2004, June). *LTC Partnership Statistics*.

¹⁸ For insurance numbers: Health Insurers' Association of America, (2003). Long-Term Care Insurance in 2000-2001. For census data: Census Bureau. (2004). Table ST-EST2003-01res - Annual Estimates of the Resident Population by Selected Age Groups for the United States and States: July 1, 2003 and April 1, 2000. Calculation of the insurance rate among the elderly was done by the authors.

¹⁹ Ibid.

Medicaid absent participation in the program.²⁰ However, the data indicate that those participants who have needed Medicaid have made substantial contributions to their own care prior to accessing Medicaid.²¹ They have bought policies worth over \$2.8 million, and spent down the rest of their assets before they were eligible for Medicaid services. Additional participants have purchased policies worth over \$7 million (thus protecting at least the same amount of assets), and never accessed Medicaid (e.g., because they died before qualifying).²²

Table 1. State LTC Partnership Statistics²³

| Partnership States | Policies Purchased | Policies in Force | Policies in Force as Percent of Elderly ²⁴ | Policyholders who received benefits | Policyholders who accessed/applied for Medicaid |
|--------------------|--------------------|-------------------|---|-------------------------------------|---|
| California | 63,984 | 54,632 | 1.5% | 743 | 21 |
| Connecticut | 33,068 | 26,938 | 5.7% | 244 | 16 |
| Indiana | 29,950 | 25,103 | 3.3% | 174 | 11 |
| New York | 53,529 | 41,732 | 1.7% | 896 | 38 |
| Total | 180,531 | 148,405 | | 2,057 | 89 |

The studies do not answer key questions such as whether the policies were purchased by people who otherwise would not have bought insurance, whether the Partnership policies are a substitute for other LTC insurance policies, and if participants would have used Medicaid regardless. Data from the Partnership states do indicate that the program attracts upper middle-class individuals, which is similar to LTC insurance market. For example, about half of Partnership purchasers in California, Connecticut, and Indiana have assets greater than \$350,000 (excluding the home), while the average person over age 55 has saved less than \$50,000 for retirement (excluding the home).²⁵⁻²⁶ Because of both its higher protection and higher cost to participants, the New York Partnership has mainly attracted higher-income participants. Because the Partnership policies have been more attractive to higher-income people, they may not be reaching those most likely to

²⁰ There is limited evidence that LTC insurance protection can delay or prevent spend down to Medicaid eligibility. See for example: Health Insurance Association of America. (2002, September). *Benefits of Long-Term Care Insurance*.

²¹ NAHU, 2004. Data on protected assets are available from California, Connecticut, and Indiana only because in those states, the value of the insurance product equals the value of the protected assets; the New York total assets model does not require disclosure of total assets protected.

²² Stone-Axelrad, J. (2004). *Long-Term Care Insurance Partnership Program*. Washington DC: Congressional Research Service. These values do not include participants from New York, as the total value of their protected assets is not collected.

²³ Data from California, Connecticut, and Indiana are current as of December, 2003; data from New York are current as of September, 2003. NAHU, 2004.

²⁴ 2003 state estimates of people age 65 and older from the U.S. Census Bureau. Note: the age group targeted for purchasing LTC insurance also includes those under age 65.

²⁵ Stone-Axelrad, 2004.

²⁶ Employment Benefit Research Institute, American Savings Education Council, & Mathew Greenwald & Associates (2004). *2004 RCS Fact Sheet: Savings and Retiring in America*. Washington DC: Retirement Confidence Survey. Approximately half of the people who answered the question reported less than \$50,000 in assets.

spend down to Medicaid. In a recent report by the Congressional Budget Office, researchers found a “drawback to partnership policies is that they might increase Medicaid’s spending for long-term care.”²⁷ However, other research suggests that the Partnership could produce savings to both Medicaid and consumers.²⁸

The Partnership states are adapting their programs to meet their goals. In the late 1990’s Connecticut and California made changes to the Partnership insurance policies in response to lower-than-expected sales. Non-Partnership policies were cheaper because they did not have to meet the stricter product requirements the states mandated for the Partnership policies. The states worked with insurers to redesign the Partnership policies to make them competitive in the marketplace, and required non-Partnership policies to have similar consumer protections. As a result of the changes, both California and Connecticut experienced an immediate and significant increase in participation.²⁹

Collateral Effects of the Partnership

The effectiveness of the Partnership in reducing the burden of the Medicaid programs in the financing of LTC remains unclear. However, the Partnership has had some effects in areas other than Medicaid budgets. A notable outcome of the Partnership has been its impact on consumer insurance protections. During its development phase, the states realized that the existing LTC insurance policies available in the market were inadequate to meet the minimum program standards for high-quality, low-cost policies and lacked certain consumer protections they wanted to offer.³⁰ As such, they improved insurance regulation for all LTC products.

Similarly, at that time, many policies were sold limiting coverage to the nursing home setting and without an inflation rider (that is, without protection against inflation in the cost of care). States believed Partnership policies should provide coverage in both nursing homes and in the home and contain an inflation protection component.³¹⁻³² The states also worked with insurers to create and price policies that would contribute to the stabilization of the market. The Partnership states have targeted potential purchasers at the best age to purchase insurance through effective marketing strategies. Typical Partnership participants are in their late 50’s or early 60’s, while the average age for all LTC insurance purchasers is 67 years old.³³⁻³⁴ Thus, the Partnership has spawned new

²⁷ CBO, 2004.

²⁸ Meiners et al. 2001. In addition to savings estimates produced by the Partnership National Program Office, Partnership states have developed models to estimate the cost-effectiveness of their program.

²⁹ LTC insurance policy sales data can be found on the websites for California and Connecticut’s Partnership programs. <http://www.dhs.ca.gov/cpltc/> and <http://www.opm.state.ct.us/pdpd4/ltc/home.htm> respectively.

³⁰ Meiners et al., 2002.

³¹ Meiners et al., 2001.

³² Inflation riders increase the value of the total benefit each year. Without inflation protection, by the time an enrollee needs LTC services, the policy might only cover a fraction of the cost of the care.

³³ Stone-Axelrad, 2004.

³⁴ Cohen, M. A. (2003). Private Long-Term Care Insurance: A Look Ahead. *Journal of Aging and Health*, 15(3), 74-98.

and improved insurance policies for consumers, and influenced how the market developed.

Partnership Program Expansion: Issues and Prospects

In 2004, the idea of expanding the LTC Partnership Program re-emerged. Bills pending in both the House and the Senate would remove the statutory barrier to more states adopting private-public LTC insurance partnerships, and a similar policy has been included in the 2004 President's Budget. Sixteen states have passed legislation to implement a Partnership when the OBRA 1993 restrictions are withdrawn or waived for the Partnership.³⁵ If Congress acts to lift the ban on new Partnerships, these states could move forward immediately. In addition, Partnership and non-Partnership states are in the process of designing a national Partnership Program, with reciprocity agreements among all participating states.³⁶ This is intended to increase the portability of the Partnership. The National Governors Association has also made expanding the Partnership a priority.

To inform this debate, we address three major questions regarding the expansion of the LTC Partnership Program. First, beyond simply lifting the restriction on expansion, what can be done to improve consumer protections and confidence in the Partnership? Second, how can the Partnership design be changed to attract more middle-income participants likely to spend down to Medicaid while keeping wealthy people who otherwise would never qualify for Medicaid out of the programs? And, third, what are the prospects that the Partnership can make a significant inroad into the LTC financing challenge? The ideas prompted by these questions could be addressed either at the Federal level, through the legislation authorizing the Program expansion, or at the state level, through implementation of the expansion.

Improving Consumer Protections and Confidence

Maintaining and Expanding Consumer Protections. During the past decade, the four Partnership states have worked with insurers to incorporate specific consumer protections into LTC insurance policies. One of the more important consumer protections that the Partnership states required was an inflation protection rider.³⁷ Because states have been targeting citizens in their 50s and 60s, inflation protection is important to maintaining the value of the policy until the policyholder needs the insurance, which could be decades later. Because an inflation-protected policy pays for more care over time than one without it, this option can postpone spend down, which occurs more quickly if the policyholder has to pay for a substantial portion of care while in benefit. Within the existing Partnership, there does not appear to be a uniform standard for who needs to purchase an inflation protection rider. Policy makers should develop standards for

³⁵ Corcoran, K. Testimony before the United States Senate Special Committee on Aging, June 22, 2004.

³⁶ Connecticut and Indiana programs implemented a reciprocity agreement in 2000 that allows participants moving to the other state to qualify for Medicaid with asset protection. The agreement only recognizes LTC benefits paid in the nursing home setting.

³⁷ The inflation protection requirement is waived for policyholders who purchase LTC after a certain age. Stone-Axelrad, 2004.

Partnership policies to delineate at what age purchasers should have compound inflation protection and at which age simple inflation protection is adequate.³⁸

Another important consumer protection included in some Partnership policies is a nonforfeiture clause which protects peoples' investment in their LTC insurance policy if they can no longer afford the premiums. Because people pay their insurance premiums for years in advance of needing LTC services, it is important that they are able to maintain some portion of their policy benefits if they cannot continue to pay premiums. California requires all policies to contain a nonforfeiture clause, and policies with this option are common in New York as well.³⁹ While a nonforfeiture clause increases the cost of a policy, it also increases the value of the policy. Policy makers should consider making this a required protection for Program policies.

Enhancing the Medicaid Component. Partnerships can do more to make themselves more attractive and to protect the interests of people who have made a commitment to the program. For example, Partnership states have endorsed private insurance policies that allow policyholders to access care in a variety of settings, including in their home and in the community. This suggests that the states respect an individual's desire to receive care in those settings, rather than solely in a nursing home. Partnership states and states interested in implementing their own Partnership should allow participants to access Medicaid services through the state's home- and community-based waiver program.

States should also consider whether it is feasible to allow participants who have purchased nonforfeiture protection to remain eligible for Medicaid in the event they need services beyond the policy's paid-up benefit. Currently, the Partnership does not offer participants any asset protection under Medicaid if the participant has stopped paying premiums. Because these states encourage participants to purchase insurance policies with a nonforfeiture option (California requires it), they should also grant partial asset protection to the participants. This option should only apply to participants who have chosen a paid-up benefit, and not to those who have chosen to have their premiums returned to them (since such individuals have no LTC insurance which protects Medicaid from exposure). The asset protection should be equal to the value of the paid-up benefit. For example, someone whose original policy value was \$100,000 but whose paid up value is \$70,000 would be eligible for \$70,000 worth of asset protection if every needing Medicaid LTC services.

Education. An effective education campaign is an important component in reaching the goals of the Partnership. A recent study demonstrates that strengthening consumer counseling and providing clear and consistent information is a key factor in targeting people who would benefit from long-term care insurance and encouraging them to

³⁸ The standard inflation rate used in both compound and simple inflation protection policy riders is 5 percent. Typical health care inflation rates exceed that amount, so even with inflation protection the value of a policy can erode over time.

³⁹ Stone-Axelrad, 2004.

purchase it.⁴⁰ For example, it is important that counseling include not only education about the risk of needing LTC and the cost of services and insurance, but also that the education be provided in a systematic and clear way, since LTC insurance is a complicated product. Since the Partnership states have neither met their enrollment expectations nor attracted the type of participants targeted, improving educational efforts could be one way to better meet program goals.

Improving Targeting

Absent evaluation results showing that the existing Partnerships are attracting its target population -- people who would not have bought LTC insurance -- and are producing savings to Medicaid, policy makers pursuing a Partnership may want to refocus the program to more effectively enroll these people.

Limit Eligibility of High-Income People. The clearest way to avoid enrolling people who might inappropriately access Medicaid coverage is to apply limits on program participation for people with assets and income above a certain amount. Currently, none of the Partnership states restricts enrollment by income, and they have found that mostly upper-income people have enrolled in their programs. To be sure, the greater a person's assets, the less likely he or she is to spend down and qualify for Medicaid – even with dollar-for-dollar Partnership protection. Nonetheless, excluding such individuals from participation minimizes concerns about inappropriate use of tax payer dollars.

Redesign Asset Protection. Changing the nature of the asset protection could increase participation among lower-income populations. For example, some evidence suggests that the dollar-for-dollar model attracts more lower-income individuals than does the total assets model. This probably stems from the lower prices of such policies. For this reason, the four state Partnership directors recommend all future Partnership states adopt the dollar-for-dollar model.⁴¹

Create Home-Based LTC Policies. One way to encourage participation of middle-income people is to lower the premiums of LTC policies. Rather than doing so by reducing consumer protections, this could be accomplished by focusing the benefit on home and community-based services, with a lower lifetime limit. Under this approach, the same dollar-for-dollar model would apply, but the policy would insure only non-institutional costs and thus would have a significantly lower lifetime limit. By lowering this limit, premiums and thus asset protection would be limited, making it more attractive to people who less able to afford the premiums and have fewer assets to protect in the first place. It would keep Medicaid as the primary payer of institutional care and simultaneously encourage greater insurance protection for services in the community that people generally prefer. However, this approach may disadvantage people who have

⁴⁰ Friedland, R.B. & Lewis, S.E. (2004). *Choosing a Long-Term Care Insurance Policy: Understanding and Improving the Process*. Washington DC: Center on an Aging Society, Health Policy Institute, Georgetown University.

⁴¹ Phone interview with Mary Anne Hack, director of the Indiana Partnership for LTC.

sudden and intense LTC needs that require institutionalization, and overlooks the fact that LTC insurance was created to protect against the catastrophic cost of nursing home use.

Prospects of the Partnership Programs

With uncertainty about the current and future success of the Partnership, expanding them may not necessarily lead to increased insurance coverage and a shift in the financing burden of state Medicaid programs. At the time when the Partnership was envisioned and designed, the LTC insurance market was seen as having great promise. Although its market has expanded in recent years, LTC insurance continues to experience problems on both the supply and demand sides. There have been criticisms of these policies' limits on their financial protection, small range of services covered, and high provider payment rates. LTC insurers have not been active in negotiating with nursing homes and others to lower the cost of care received by policyholders.⁴² The market is unstable, with some insurers quitting the market, and others raising premiums significantly in order to remain solvent. Perhaps because of these problems, demand for LTC insurance has remained weak; a majority of Baby Boomers still do not have any protection against the risk of needing LTC.⁴³ Quality issues with LTC insurance products and lack of consumer understanding of and desire to purchase LTC insurance persist.⁴⁴ The success of the Partnership relies to a large extent on the success of the LTC insurance market. Policy makers can rightly be troubled by the obstacles this reliance presents.

It is certainly possible that policy changes and new states implementing a Partnership will lead to greater success. Options exist to use the Partnership to leverage greater consumer protections and benefits and thus consumer confidence and possibly participation. Policy makers could also refine the policy parameters to better target people who can afford insurance and would likely spend down to Medicaid. However, as the few existing Partnership programs have matured over the past decade, researchers and consumer advocates have questioned whether the Partnership will ever be effective in altering the payer mix in LTC financing. With no evidence to the contrary, they could worsen rather than ameliorate Medicaid's long-run financing problems. As such, the LTC Partnership Program should be considered as one, relatively small policy option among many to prepare the nation for the large and inevitable long-term care financing challenge.

⁴² Cohen, 2003.

⁴³ CBO, 2004.

⁴⁴ Gale, W.G., Iwry, J.M., Orzag, P., Ahlstrom, A., Clements, E., Lambrew, J., & Tumlinson, A. (2004). *Retirement Savings and Long-Term Care Needs: An Overview*. Washington DC: The Brookings Institution. Also see Cohen, 2003 and CBO, 2004.