
*INNOVATION WITHIN ESTABLISHED
FEDERAL-STATE PROGRAMS*

Partnership Insurance:
An Innovation to Meet Long-Term Care
Financing Needs in an Era
of Federal Minimalism

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SUMMARY. In the case of long-term care financing, federal minimalism is not new news. Long-term care has long played a weak “third fiddle” to national health reform concerns about the uninsured and catastrophic expenditures on prescription drugs. The states have been left to struggle with the issue of long-term financing as part of their responsibilities in

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funding and administering the means-tested Medicaid program. Recently, the environment has become even more challenging. Much of what is on the national agenda for health and welfare reform has been delegated to the states. This “devolution” of responsibilities has created many competing priorities for both the attention and resources of states.

This context of evolving federal minimalism calls for creative solutions that balance competing points of view. In this article, we provide some background and insights from one such effort: a collaboration between state governments and private insurers to put into operation an insurance-based approach to long-term care financing that uses Medicaid as an incentive to encourage potential purchasers. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2002 by The Haworth Press, Inc. All rights reserved.]*

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THE PROBLEM

Long-term care involves a broad array of supportive medical, personal, and social services needed by people unable to meet basic living needs due to illness or disability. Much of it is provided informally by family and friends. When care is purchased, the location typically involves various non-medical settings, including the home as well as community-based facilities. As a result, private insurers were very hesitant to sell coverage for long-term care, and the costs for such care became a significant cause of catastrophic expenses for seniors.

By the mid-1980s, the lack of adequate insurance funding for long-term care in the United States was beginning to receive national attention, and the fact that Medicare does not cover long-term care was beginning to be recognized. The major role of Medicaid in paying those bills once people became impoverished was alarming state governments. During that time, a private long-term care insurance market began to develop, but it was still in its infancy. First-generation private policies were being criticized for their numerous limitations and shortcomings (prior hospitalization requirements, lack of meaningful home- and community-based care benefits, eligibility based on medical neces-

sity); consumer group reaction to private insurance was often negative. Nonetheless, states were becoming interested in this new source of financing for its potential to reduce the fiscal pressure on their Medicaid programs. Through task forces and study commissions, states began to look for ways to encourage improved products and support broader market development.

THE PARTNERSHIP FOR LONG-TERM CARE

The interests of the states in exploring ways to make private long-term care insurance more appealing and affordable to the public encouraged the Robert Wood Johnson Foundation (RWJF) to launch an initiative that provided planning grants to selected states that demonstrated a commitment to these goals (Merrill & Somers, 1989; Somers & Merrill, 1991). California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin received support to define and develop a public-private insurance partnership to pay for long-term care. With the help of the National Program Office, based at the University of Maryland Center on Aging, the states participating in the planning phase developed strategies to encourage the purchase of private insurance (Meiners, 1988; Meiners & McKay, 1989). The states recognized that to broaden the market for long-term care insurance it was important both to decrease the cost of the policies and to increase their quality. This is a special challenge, since increasing the quality of insurance policies generally increases the premium, which cuts down on the market.

Solving this cost-quality dilemma was at the heart of the strategies used by the four states that ultimately implemented their public-private partnerships (California-1994, Connecticut-1992, Indiana-1993, and New York-1993) (Meiners, 1993). The key incentive is a unique approach that allows people who purchase a state-certified long-term care insurance "Partnership" policy to get help from Medicaid without having to exhaust their assets.

Broadening the Market by Reducing the Financial Risk

While the states explored a variety of ideas on how to encourage the use of long-term care insurance to help their citizens avoid impoverishment, the basic approach was the same: Buy a state qualified insurance policy and get special asset protection (McCall, Knickman, & Bower, 1991). The quality/cost trade-off was handled by assuring that purchas-

ers with less than comprehensive coverage could still be protected from impoverishment.

Normally, when a long-term care insurance policy runs out, policyholders risk having to spend virtually all their savings before qualifying for Medicaid. In contrast, when a Partnership policy is exhausted, the policyholder is eligible for coverage under Medicaid without having to deplete previous savings. The details of the models differed from state to state. The most interesting difference was between New York and the three other states.

In New York, Partnership policies are required to pay three years of nursing home care, six years of home care, or some combination, after which all remaining assets are protected. A high priority of the New York approach is to offer middle- and upper-class seniors a viable alternative to giving away their assets and impoverishing themselves in order to qualify for Medicaid (Holubinka, 1992).

The underlying logic of this “total-assets” model is that the period of insurance is equal to or exceeds the time during which a person would be penalized by having to pay for long-term care if he or she had transferred assets in order to become eligible for Medicaid. When the program in New York began, this period was 30 months. Securing a three-year commitment to pay nursing home costs with private insurance would save the state money as compared to when someone is divested of his or her assets to receive Medicaid’s assistance.

California, Connecticut, and Indiana adopted a “dollar-for-dollar” model. In addition to serving as an alternative to transferring, it allows people to buy a policy that protects a specified amount of their assets. An individual with \$50,000 in assets might buy \$50,000 in insurance protection while another individual with \$150,000 in assets might buy \$150,000 in insurance protection. Payments for long-term care by the insurance company are considered the equivalent of spending assets for the purpose of establishing Medicaid eligibility (Mahoney, 1992). Thus, a person who purchased a \$75,000 policy would be able to keep \$75,000 when he or she became eligible for Medicaid.

Though it would be simpler if all states used the same approach, both models have unique strengths. The total-assets approach provides the maximum incentive to purchase long-term care insurance (total-asset protection) and is arguably easier to understand because of its one-size-fits-all approach. It also fits better with existing long-term care insurance in that it requires at least three years of nursing home coverage. This had been the industry standard throughout much of the early market development. As such, the average commission per sale tends to be higher.

For insurers and agents, then, the total-assets model is often viewed as preferable to the dollar-for-dollar approach. They see it as the most reasonable compromise sale for those who cannot afford lifetime coverage, which is becoming the new industry standard sale.

The special strength of the “dollar-for-dollar” asset-protection model is that it makes purchases of insurance covering the equivalent of one to three years of benefits (e.g., anywhere from about \$50,000 to \$300,000, depending on the location) more meaningful by those in the middle to modest income group. Without the special asset protection, shorter, more affordable, coverage can still leave the purchaser at risk of impoverishment from catastrophic expenses. Faced with this possibility, people too often go without long-term care insurance, even though they need and could afford some protection.

In an interesting twist, Indiana revised its program to include a hybrid approach intended to get the best of both asset-protection strategies. Up to a set amount of coverage (the dollar equivalent of four years in the average Indiana nursing home) the purchaser is eligible for dollar-for-dollar asset protection while getting Medicaid benefits. But those who buy a policy covering more than this amount will receive total-asset protection along with help from Medicaid once they use up their insurance.

Quality Emphasis

The basic message of the Partnership emphasizes product quality—everyone should have some coverage, if necessary, trading lifetime less comprehensive coverage for shorter high-quality benefits—and then be able to access Medicaid’s benefits without being impoverished if those benefits are not enough.

Each state’s Partnership staff actively worked with Insurance Department analysts in reviewing and approving Partnership policies. In developing their approach to product quality, the states learned from and built on each other’s experience. Connecticut was the first state to wrestle with the issue of standards (Mahoney & Wetle, 1992). Areas of agreement that emerged included the development of objective measures of functional and cognitive disability—rather than professional judgments regarding medical necessity—to determine when insurance coverage would be triggered; measuring cognitive impairment using observable behaviors; utilizing state-licensed independent care management agencies to develop care plans; and a commitment to create a uniform database documenting the use of service in an insured environ-

ment and preserving a record of the asset protection that each individual had accumulated (Spector, 1991; Mahoney, 1997).

The states that followed the dollar-for-dollar approach to asset protection built on one another's work in other respects as well. Indiana took Connecticut's approach to regulations and adapted them—mainly by standardizing benefit eligibility rules to assure greater continuity of coverage with Medicaid, if it was still needed after the insurance ran out. California, in turn, took Indiana's regulations and augmented them, insisting on numerous regulations for its participating insurers, all aimed at the special needs of consumers who had middle or modest incomes (Mahoney & Connolly, 1995; Mahoney et al., 1997). For example, California requires insurers to offer a one-year policy as a prerequisite to participation and has pioneered approaches (such as requiring state approval of initial premiums as well as rate increases) to prevent or mitigate premium increases and to prevent policy lapses.

New York took a different approach when it came to quality assurance. Rather than put new and higher standards into its regulations, the state put the special terms and conditions for the Partnership into contracts between the state and the insurers, a more flexible and less time-consuming approach (Nussbaum, 1992). New York relies on an "Evolution Board" that allows insurers and the state to share equal authority over major policy decisions. This arrangement cemented insurer support for the Partnership in New York and helped the state win special recognition for its efforts, including a 1995 Innovations Award in State and Local Government from the Ford Foundation and Harvard University's Kennedy School of Government.

Inflation protection—whereby the value of the policy rises by a specified percentage every year—is perhaps the best single example of the state's push for quality products. Lifetime coverage only assures avoidance of impoverishment if the product is inflation-protected and covers nursing home and home care. The states were especially concerned that without inflation protection a purchaser could end up impoverished from the deductible and co-payment responsibilities of a "lifetime" policy. For this reason, mandatory inflation protection is among the certification standards that insurers participating in the Partnerships must meet to help ensure that long-term care policies are of high quality.

Development of a Uniform Data System

One of the best examples of the partnership that emerged in this program is the uniform data system developed through the cooperative ef-

fort of the states, the insurers, the University of Maryland Center on Aging, and the program evaluator (Laguna Research Associates). Because of the interest and controversy surrounding the partnership concept, the participating states knew it was essential to require information from insurers with which they could monitor the program and the state's potential liability.

The states decided to capture detailed information at the individually insured level so that characteristics of persons purchasing insurance and utilizing benefits could be tracked. Person-level data help assure that information about asset protection will be available to insured persons and to the state if and when Medicaid contributed to a person's long-term care expenses.

During the implementation process, insurers realized that each of the four Partnership Programs intended to promulgate a unique set of requirements. The Health Insurance Association of America arranged a meeting at which it was strongly suggested that making the reporting requirements uniform would get more insurers to participate. Shortly after the meeting, the state Partnership Programs agreed that following through on the suggestion made by the insurers was important to the success of the partnership. This set in motion the creation of the uniform data set (UDS).

The development and maintenance of the UDS has been a challenge. Among the areas in which there were great differences were the fundamental purpose of the file, the willingness and ability of insurers to provide specific information, and state laws dealing with the release of individual-level data for research purposes. In spite of these differences in perspective, agreement was reached on a set of reporting requirements.

The data set has proven useful to the states and the Program Evaluator, providing information on the purchase and use of long-term care insurance benefits that is traditionally not available to the public. The following list shows some of the ways in which these data are currently being used:

- **Transition Planning**—When a Partnership policy holder is about to exhaust benefits, partnership staff can ensure that that beneficiary is aware of how the partnership works and, thus, gets the asset protection he or she is entitled to under the rules of the program.
- **Product Sales**—States are also using the UDS to ensure that the products being sold under the partnership license in fact do meet partnership standards. One of the states discovered a participating

insurer whose policy initially met the partnership licenser standards, but over time did not. The data set allows the states to identify and correct such problems.

- **Research**—The data set is used extensively by the Program Evaluator for research purposes. It provides data on the many aspects of the products that are sold under the partnership. Researchers thus have a common data set for four different states and can then supplement the baseline data with additional special studies.
- **Policy Features**—The Registry Files allow partnership staff to monitor the appeal of specific optional benefits, such as non-forfeiture, and provide information on its sale. States also have the option of monitoring how initial purchasers change their policies over time. This will allow for a calculation of lapse rates and of rate increases.

Unexpected Barriers to Program Implementation

The idea of the Partnership was hatched at a time when there was relatively little talk of universal health insurance. Participating states felt that the Partnership was an approach that would allow them to deal with long-term care in a helpful, budget-neutral way that could easily be supported. By linking the Partnership incentive to Medicaid, the constituency for the means-tested program could be enhanced rather than eroded (Meiners & McKay, 1990; Mahoney & Meiners, 1994; Meiners & Goss, 1994).

However, for advocacy groups such as AARP and Families USA, the means tested Medicaid was viewed as part of the problem that required a social insurance solution. The linking of long-term care insurance with Medicaid as a way to address financing problems of long-term care was philosophically unacceptable, if not damaging, to the case for a social insurance approach to long-term care.

Advocacy group opposition to the Partnership approach was far from unanimous. As the states worked to gain a consensus on key issues, it was not unusual for the local consumer representatives from groups such as AARP to end up in support of the Partnership in spite of the opposition from the national office. Local advocates liked the consciousness raising that went with the process of gaining acceptance of the enhanced standards of the Partnership.

While every RWJF Partnership was enacted as a result of unanimous votes in the state legislatures, the opposition at the federal level resulted in legislation that grandfathered the four RWJF State Partnerships but put restrictions on further replication. The Omnibus Budget Reconcilia-

tion Act of 1993 (OBRA '93) requires that any states implementing Partnership Programs after May 14, 1993, must recover assets from the estates of all persons receiving services under Medicaid. The result of this language is that, for replication states, the asset-protection component of the Partnership is still in effect but only while the insured is alive. After the policyholder dies, those states must recover what Medicaid spent from the estate, including protected assets.

OBRA '93 has had the effect of stifling interest in replicating the Partnership. Prior to passage of this legislation, interest in the Partnership had grown well beyond the four states funded by the Robert Wood Johnson Foundation. As many as 12 states had passed enabling legislation to create programs modeled on the Partnership. In recognition of the desire of states to deal with the long-term care financing problem, a bill (H. R. 1041) was recently offered that would eliminate the wording requiring estate recovery of protected assets and would remove the May 13, 1993, deadline for states to obtain an approved state plan amendment.

While the OBRA '93 restrictions were originally offered by a few key Democratic legislators who had reservations about private long-term care insurance, the reasons for not removing them today are more difficult to understand. There has been bipartisan support for long-term care insurance as a piece of the financing puzzle that culminated in the tax clarifications of HIPAA, and there has been serious talk of new premium credits as part of tax reform. One theory is that the political environment has changed so much since the Partnership Program began that the insurance industry is reluctant to support a compromise idea with the features of the Partnership Program.

Insurers and Agents as Key Partners

The program has represented a major change in the traditional relationship between state governments and insurers. Usually, contact is through the Department of Insurance, and then it has been mostly about issues related to product approvals and company solvency. The Partnership has involved a whole new layer of oversight. But when the program began, there was a strong sense on the part of key insurers that the market for long-term care insurance could benefit from the visibility and credibility brought about by working closely with state governments. Insurers and states were in agreement on the importance of private responsibility in paying for long-term care and the need to avoid dependence on Medicaid.

Initially, 22 insurers, accounting for the sale of three-quarters of the long-term care insurance policies sold nationwide, sought and received approval to market Partnership policies (McCall, Bauer, & Korb, 1996). Currently, the number of insurers participating is 30, with California being the most selective with 6 and Indiana being the most inclusive with 15. The insurers tend to participate in more than one state, but few are partners in all states. Nearly all insurers participating in the Partnership maintained their regular product offerings.

In all Partnership states, at least some insurers actively participated in the planning and implementation of product design, consumer education, and marketing. In-kind contributions toward printing and distribution of materials are common in the participating states, and several states have collected contributions toward general education and marketing activities.

Despite this support, the Partnerships found that their long-term care insurance package was not necessarily attractive to insurance agents. As the Partnership was implemented, insurers and agents voiced dissatisfaction with certain aspects of the program design:

- The program requirements deviated from some of the standard approaches used to market long-term care coverage and required extra attention. To get lifetime coverage within a limited budget often leads to dropping inflation protection. The Partnership strongly encourages shorter coverage that is inflation-protected as the preferred choice.
- Many insurance agents tend to avoid Medicaid, whose future they view as uncertain. Additionally, the Partnership model cannot be easily generalized because many state Medicaid programs do not offer comprehensive home and community benefits or systems of care management that characterize Partnership Programs. The participating states see Partnership insurance as both a public policy and market intervention that can help keep Medicaid viable for those who need it.
- The Partnership's policy development, approval process, data reporting, and other requirements have made some companies and agents reluctant to market Partnership policies because of the extra effort involved in participation. In contrast, the states see these efforts as a way to encourage high quality product sales of both Partnership and non-Partnership insurance. This gives policymakers the confidence to support educational campaigns that feature long-term care insurance as a reliable option to be seriously considered.

- The primary target audience for Partnership policies differs from the audience with which agents have customarily worked. Selling to the high end of the income and asset spectrum is easier than targeting sales to those of middle and modest means, who might benefit most from the Partnership product options. Moreover, agent commissions are directly related to the size of the premiums they sell. The states recognize this but see Partnership insurance as a way to broaden the market to include those more at risk of being impoverished from high long-term care costs. This group represents a much larger part of the market and is ripe for insurers and agents willing to go after those sales.
- The lack of portability of the Medicaid asset-protection feature if one moves to another state is yet another barrier to sales. While this has no effect on the value of the insurance benefit payment itself, it is a concern for those who might move and depend on the asset-protection feature as the primary motivation for choosing a Partnership policy. To address this concern, two Partnership states have recently accomplished a breakthrough remedy that can serve as an example for other states to follow. Indiana and Connecticut have passed legislation and received approval from the Center for Medicare and Medicaid Services (CMS, formerly known as HCFA) that allows for the portability of the Medicaid asset-protection benefit.

Assessment

Evaluating the Partnership is tricky business, fraught with technical challenges as well as various different perspectives of how to define success (Knickman, 2001). Much of what has been discussed so far in this article comes from the “continuous quality improvement” mindset that is associated with the kind of process evaluation done by program developers. From this perspective, problems are expected in the process of accomplishing success. As for the technical challenges of evaluating the Partnership Programs, issues of timing are especially noteworthy. The classic evaluation concern is whether the program had enough time for a mature assessment of its potential.

A case in point on the issue of evaluation timing is the recently published book on the Partnership (McCall, 2001). While very useful, a number of key analyses in the book were based on data that predated

program adjustments that have had a significant effect on the market. For example, using data through 1996, Cohen compared the Partnership purchasers to a sample of non-Partnership purchasers in those same states, as well as to a national sample of purchasers (Cohen, 2001). He concluded that the Partnership Programs had not attracted the middle-income buyers it was targeting. But this assessment was heavily influenced by the New York data, the state with the largest sales during this early phase of the program. As noted above, New York had a target market somewhat different from the markets of other states.

Total Partnership policy applications grew from 28,000 in 1996 to 120,000 by the end of 2000. This significant boost can be attributed to two key factors. Over time, standards espoused by the Partnership plans have been applied to all policies—leading to comparable premiums for comparable products. Building on this, program redesigns in Connecticut (4th quarter 1996), Indiana (3rd quarter 1998), and California (4th quarter 1998) were undertaken to keep the programs current with non-Partnership product developments (Mahoney et al., 2001; Meiners, 2001). In each of these states, sales increased dramatically (in the range of 300%-500%, comparing one-year periods before and after the program adjustments) and the higher levels of sales are being maintained. The net effect is that many more policies are now being sold to the middle and modest income target market, and the target population assessment should be updated.

Some findings will not change with new data. All Partnership insurance is required to have inflation protection. When comparisons to non-Partnership insurance are made, this and other quality features will always be important points to consider in a careful assessment. Lower quality products purchased by those with modest resources are not a good buy just because they have lower prices. Market data on older sales may simply reflect nursing-home-only policies that were not inflation-protected. Inflation protection raises prices, and this issue was often avoided by insurance agents during policy sales in the early years of marketing long-term care insurance.

The Partnership states feel they are successful in providing quality coverage to persons of middle and modest means. This view received a welcome boost when, in the most recent review of long-term care insurance policies by *Consumer Reports* magazine, the Partnership Program received very positive treatment in a special side-bar article (*Consumer Reports*, 1997).

The evaluation complaint of too little time has an even more challenging dimension upon which both the Partnership evaluators and pro-

gram developers agree. Only with policies in force for many years will we be able to make a reasonable assessment of savings to Medicaid because long-term care insurance involves substantial years of prefunding before claims are expected. In the meantime, the incremental effect of Partnership vs. non-Partnership insurance faces a constantly changing baseline with interactive influences that become difficult to sort out (Weiner, 2001).

Whereas it will be some time before significant numbers of clients have drawn on their benefits and an impartial evaluation of the cost-effectiveness of the Partnership approach can be undertaken, simulations have shown that this approach can be budget neutral (National Program Office, 1991). Also, two separate studies conducted by the outside evaluator have indicated that, overall, “The Partnership attracted beneficiaries who would not have purchased long-term care insurance if the Partnership did not exist” (McCall & Korb, 2001). Results from a more in-depth study in California show that, “Partnership policyholders had significantly smaller levels of income and assets than other purchasers of long-term care insurance during the time the Partnership policies were available. Even more surprising, their reported income and assets were smaller or about the same as the random sample (of potential California purchasers 55 to 75 years of age)” (McCall, 1997).

In some cases, the four state Partnerships seem to have started a movement toward industry-wide change; in other cases, the Partnerships seem to have been ahead of the times, or perhaps naive. And while the Partnerships can't claim full credit, they did play a key supportive role in developing several major innovations and qualitative improvements. These contributions include:

- *A new emphasis on inflation protection.* This feature clearly distinguishes Partnership from non-Partnership sales. But it also appears that the Partnerships may already be having an effect on non-Partnership sales as well. In California, when a long-term care insurance offering by the California Public Employees Retirement System copied the Partnership benefit structure and used Partnership-approved scenarios to describe the value of the compound inflation protection option, 65% of the buyers—nearly double the national average—bought this protection against inflation.
- *Catalyzing and augmenting efforts to improve private policies.* The Partnership movement stimulated and supported efforts to:

1. develop objective measures of functional and cognitive disability as determinants of the “insured event”;
2. implement an approach for removing artificial restrictions so that a policy’s full lifetime maximum benefit could be used in the community or the nursing home—wherever the consumer needed it to be used;
3. utilize and adapt care management approaches to tailor benefits to individual needs;
4. stabilize premiums by requiring state insurance department reviews of initial premiums and any requests for rate increases, mandating continuing actuarial review of reserves, and setting limits on future rate increases; and
5. prevent an unintentional lapse of coverage for those with cognitive impairments.

Focusing on the Future

The Partnership is now at the stage where revisions and refinements are being made to increase its market impact. State budgets are becoming the predominant source of financial support since grant funding from the Robert Wood Johnson Foundation has ended. In three of the four states, the Partnership has already been made a permanent part of the Medicaid program, with line-item budget support. California’s Partnership has been extended to 2005, when it is expecting to seek similar permanent status.

While the introduction of tax-qualified plans brought about by the Health Insurance Protection and Portability Act (HIPPA) of 1996 has prompted renewed interest in the long-term care insurance market on the part of consumers, insurers, and states, there is a need to go further. The insurance industry favors tax credits that can be taken by anyone without income restrictions. If such tax breaks are politically possible, they will give the market a boost, but there is still a need to reach the moderate income and asset market targeted by the Partnership Program (Freudenheim, 1996). The incentive strategy used in the Partnership Program and the lessons learned about private insurance will be valuable as we seek to accomplish both private market and public policy goals.

Whether or not the Partnership Program is allowed to grow beyond the four states to further test what is possible remains to be seen. Insurance industry hesitance about pushing for repeal of the OBRA ’93 restrictions creates a classic “catch 22” situation. Without the repeal of the

OBRA '93 restrictions, it may be difficult to stimulate the multi-state interest necessary to justify the commitment of resources by insurers to help the Partnership expand to meet its potential. The Partnership is clearly designed to balance the public interest with the need for a strong private market. It will be necessary for organizations like the National Governor's Association (NGA) to act on their call for elimination of federal barriers to public/private insurance partnerships like those in the RWJF states and for the expansion of authority to all states to implement such programs (National Governors Association, 1997). The NGA understands that states need and want the opportunity to explore options like the Partnership because they are faced with significant budget concerns about their Medicaid long-term care responsibilities.

Building on the lessons learned in the Partnership, ideas for next steps can be examined (Meiners, 1998). One line of thinking is to work with selected insurers and agents implementing a marketing approach specifically for potential buyers who have middle or modest means. Revisions of the Partnership and non-Partnership policies to make them more compatible have already helped broaden the market. Continuing such efforts will be important as new generations of insurance products emerge on the market.

Because state-by-state development is costly, the idea of a uniform national partnership has also prompted discussions among the states and the insurers who have been most active in the current Partnership effort. However, dependence on state Medicaid programs as the basis for the asset protection does not easily allow for reciprocity agreements between states, and insurance agents often find it easiest to sell their policies as an alternative to Medicaid.

Developing an asset-protection incentive strategy that is not linked to Medicaid is worth consideration. Removing the asset-protection incentive from its direct link to Medicaid could eliminate concerns about variations across states and over time in what Medicaid will cover. It might also serve to allow for some combination of income and assets to be protected. One approach to removing the asset-protection incentive from its direct link to Medicaid would be to create a new optional benefit in which states could choose to contribute to a backup funding pool (perhaps with federal matching funds like Medicaid's). Under this approach, there could be uniform benefits once a Partnership policy ran out.

An even more ambitious federal version of this approach could dramatically reverse the trend toward devolution to the states. A new voluntary option under Medicare could be created that would require the

purchase of a certified private long-term care insurance policy in exchange for a commitment to protect some level of assets. An approach like this, modeled on the Partnership, was offered by Senators Kennedy and Wofford (1994) to supplement the long-term care proposals offered as part of the Clinton Health Reform plan (Kennedy & Wofford, 1994). This type of approach could be broadened to include the types of benefits covered by Medicare supplemental insurance, especially prescription drug costs, the other major source of catastrophic expenditures for senior and disabled citizens. It would provide dramatic relief to the states but would likely require some readjustments or trade-offs in responsibilities to balance the significant cost shift to the federal government.

CONCLUSION

With all the new responsibilities that have recently been devolved to states, one thing has not changed. There is a large untapped market of middle- and modest-income people who need help in preparing to pay for their long-term care. The Partnership for Long-Term Care offers a framework for a state-based strategy that builds incrementally on their current responsibilities. It offers real-world experience upon which to build an affordable way for states to offer this needed help.

The original goals of the Partnership Program center on giving consumers a viable way to pay for future long-term care costs by increasing the quality of long-term care insurance and making it affordable for middle-income individuals. The Partnership has a number of special features that should be viewed as appealing when all sides of the argument are considered. The program is fiscally conservative, helps middle-income people avoid impoverishment, serves as an alternative to Medicaid estate planning, promotes better quality insurance products, supports consumer protection efforts, enhances public awareness regarding long-term care needs and options, and helps maintain public support for the Medicaid program.

The Partnership has enjoyed persistent, patient support from states (Mahoney et al., 2001), insurers (Stucki, 2001), agents (Turner, Shelton, & Orr, 2001), consumers (Burns, 2001), and the Robert Wood Johnson Foundation (Somers, 2001)—the kind of support that comes when there is agreement that the problem needs to be solved, the program is promising, and everyone's collaboration is needed. The rationale that all participants could benefit from the Partnership has made it possible to go forward.

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