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# LONG-TERM CARE INSURANCE

Partnership Programs  
Include Benefits That  
Protect Policyholders  
and Are Unlikely to  
Result in Medicaid  
Savings





Highlights of [GAO-07-231](#), a report to congressional requesters

## Why GAO Did This Study

Partnership programs allow individuals who purchase Partnership long-term care insurance policies to exempt at least some of their personal assets from Medicaid eligibility requirements. In response to a congressional request, GAO examined (1) the benefits and premium requirements of Partnership policies as compared with those of traditional long-term care insurance policies; (2) the demographics of Partnership policyholders, traditional long-term care insurance policyholders, and people without long-term care insurance; and (3) whether the Partnership programs are likely to result in savings for Medicaid.

To examine benefits, premiums, and demographics, GAO used 2002 through 2005 data from the four states with Partnership programs—California, Connecticut, Indiana, and New York—and other data sources. To assess the likely impact on Medicaid savings, GAO (1) used data from surveys of Partnership policyholders to estimate how they would have financed their long-term care without the Partnership program, (2) constructed three scenarios illustrative of the options for financing long-term care to compare how long it would take for an individual to spend his or her assets on long-term care and become eligible for Medicaid, and (3) estimated the likelihood that Partnership policyholders would become eligible for Medicaid based on their wealth and insurance benefits.

[www.gao.gov/cgi-bin/getrpt?GAO-07-231](http://www.gao.gov/cgi-bin/getrpt?GAO-07-231).

To view the full product, including the scope and methodology, click on the link above. For more information, contact John E. Dicken at (202) 512-7119 or [dickenj@gao.gov](mailto:dickenj@gao.gov).

## LONG-TERM CARE INSURANCE

### Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings

#### What GAO Found

California, Connecticut, Indiana, and New York require Partnership programs to include certain benefits, such as inflation protection and minimum daily benefit amounts. Traditional long-term care insurance policies are generally not required to include these benefits. From 2002 through 2005, Partnership policyholders purchased policies with more extensive coverage than traditional policyholders. According to state officials, insurance companies must charge traditional and Partnership policyholders the same premiums for comparable benefits, and they are not permitted to charge policyholders higher premiums for asset protection.

Partnership and traditional long-term care insurance policyholders tend to have higher incomes and more assets at the time they purchase their insurance, compared with those without insurance. In two of the four states, more than half of Partnership policyholders over 55 have a monthly income of at least \$5,000 and more than half of all households have assets of at least \$350,000 at the time they purchase a Partnership policy.

Available survey data and illustrative financing scenarios suggest that the Partnership programs are unlikely to result in savings for Medicaid, and may increase spending. The impact, however, is likely to be small. About 80 percent of surveyed Partnership policyholders would have purchased traditional long-term care insurance policies if Partnership policies were not available, representing a potential cost to Medicaid. About 20 percent of surveyed Partnership policyholders indicate they would have self-financed their care in the absence of the Partnership program, and data are not yet available to directly measure when or if those individuals will access Medicaid had they not purchased a Partnership policy. However, illustrative financing scenarios suggest that an individual could self-finance care—delaying Medicaid eligibility—for about the same amount of time as he or she would have using a Partnership policy, although GAO identified some circumstances that could delay or accelerate Medicaid eligibility. While the majority of policyholders have the potential to increase spending, the impact on Medicaid is likely to be small because few policyholders are likely to exhaust their benefits and become eligible for Medicaid due to their wealth and having policies that will cover most of their long-term care needs.

Information from the four states may prove useful to other states considering Partnership programs. States may want to consider the benefits to policyholders, the likely impact on Medicaid expenditures, and the income and assets of those likely to afford long-term care insurance.

HHS commented on a draft of the report that our study results should not be considered conclusive because they do not adequately account for the effect of estate planning efforts such as asset transfers. While some Medicaid savings could result from people who purchase Partnership policies instead of transferring assets, they are unlikely to offset the costs associated with those who would have otherwise purchased traditional policies.

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## Abbreviations

ADL	activities of daily living
ACS	American Community Survey
CBO	Congressional Budget Office
CMS	Centers for Medicare & Medicaid Services
DOI	Department of Insurance
DRA	Deficit Reduction Act of 2005
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HRS	Health and Retirement Study
IADL	instrumental activities of daily living
NAIC	National Association of Insurance Commissioners
OBRA '93	Omnibus Budget Reconciliation Act of 1993
UDS	Uniform Data Set

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United States Government Accountability Office  
Washington, DC 20548

May 11, 2007

The Honorable Max Baucus  
Chairman  
The Honorable Charles E. Grassley  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable John D. Rockefeller, IV  
United States Senate

In 2004, national spending on long-term care, which includes care provided in nursing facilities, totaled \$193 billion and nearly half of that was paid for by Medicaid, the joint federal-state program that finances medical services for certain low-income adults and children. In contrast, private insurance paid for about \$14 billion worth of long-term care—about 7 percent of the total cost. The demand for this type of care is likely to increase as the proportion of those in the population age 65 and older—those most likely to need long-term care—increases. With Medicaid financing nearly half of the long-term care costs nationwide, policymakers are concerned that, without changes in how long-term care is financed, the growing demand for this type of care will continue to strain the resources of federal and state governments.

In the late 1980s the Robert Wood Johnson Foundation provided start-up funds for programs in eight states—California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin—aimed at helping to shift some of the responsibility for financing long-term care from Medicaid to private long-term care insurance. Four of the states that received funds—California, Connecticut, Indiana, and New York—established the programs. These four state-run long-term care programs, which are known as Partnership programs, encourage individuals to purchase long-term care insurance by providing an incentive—specifically, allowing those who purchase long-term care insurance policies through the program to exempt some or all of their personal assets from Medicaid eligibility requirements should the policyholders exhaust their long-term care insurance benefits and need to continue financing their long-term care. Without the exemption, before individuals could receive Medicaid benefits they would typically have to spend their assets on their long-term care until the assets met or fell below certain Medicaid thresholds.

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Medicaid does not allow for asset protection for long-term care insurance policies purchased outside of Partnership programs.<sup>1</sup> In order to implement their Partnership programs, the four states with Partnership programs had to obtain approval from the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, and amend their state Medicaid plans to allow them to exempt the assets of Partnership program participants from Medicaid eligibility requirements.<sup>2,3</sup>

Since the early 1990s, the treatment of Partnership programs under federal law has changed. Although a number of states established, or were authorized to establish, programs prior to the enactment of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), OBRA '93 prohibited additional states from establishing similar programs. The legislation was enacted, in part, because of concerns about potential costs to Medicaid, but allowed California, Connecticut, Indiana, and New York to maintain their programs.<sup>4,5</sup> More recently, the Deficit Reduction Act of 2005 (DRA) authorized all states to establish Partnership programs that meet certain criteria and required the original 4 participating states to maintain the existing consumer protections in their Medicaid plans. DRA provisions are intended, in part, to allow states to provide an incentive for individuals to take responsibility for their own long-term care needs rather than relying

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<sup>1</sup>For the purposes of this report, we use the term “Partnership policies” to refer to long-term care insurance policies purchased through Partnership programs and the term “traditional long-term care insurance” to refer to long-term care insurance policies that are not purchased through these programs. To refer to both Partnership and traditional long-term care insurance policies, we use the term “long-term care insurance.”

<sup>2</sup>A state plan describes the state’s Medicaid program and establishes guidelines for how the state’s Medicaid program will function.

<sup>3</sup>For our purposes we use the Partnership program’s definition of “assets,” that is, when we refer to assets, we mean savings and investments, while excluding income. For eligibility purposes, the Medicaid program considers both income—which is anything received during a calendar month that is used or could be used to meet food or shelter needs—and resources, which are cash or anything owned, such as savings accounts, stocks, or property that can be converted to cash.

<sup>4</sup>Another objective of OBRA '93, as expressed in the accompanying House of Representatives Budget Committee report, was to close a loophole permitting wealthy individuals to qualify for Medicaid. H.R. Rep. No. 103-111, at 536.

<sup>5</sup>Prior to the enactment of OBRA '93, California, Connecticut, Indiana, and New York established Partnership programs. Iowa and Massachusetts also received permission from the Health Care Financing Administration (now CMS) to establish a Partnership program, but had not implemented one as of October 2006.

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on Medicaid. According to the National Association of Health Underwriters, prior to the enactment of DRA, there was legislative activity in 19 additional states to begin development of a Partnership program. As of October 2006, the only states with active Partnership programs were the original 4 states: California, Connecticut, Indiana, and New York.<sup>6</sup> However, HHS indicated that as of February 2007, CMS had approved Partnership program state plan amendments in 6 states: Florida, Georgia, Idaho, Minnesota, Nebraska, and Virginia. Although the program appears to be expanding beyond the original 4 states, concerns about the potential cost to Medicaid of expanding the program remain an issue. In 2005, the Congressional Budget Office (CBO) estimated that repealing the moratorium on new Partnership programs could increase Medicaid spending by \$86 million between 2006 and 2015.<sup>7</sup>

States are responsible for overseeing Partnership programs and regulating the Partnership programs as well as the traditional long-term care insurance policies sold in their states. As more states consider establishing Partnership programs, there is interest, on the part of Congress and others, in understanding how the four states with Partnership programs designed and regulate their Partnership programs, who purchases Partnership policies, and how these programs will impact Medicaid financially.

You asked us to analyze the experience of the four states with Partnership programs. In August 2005, we provided you with a briefing, which summarized aspects of the design of these Partnership programs and included demographic information on Partnership policyholders.<sup>8</sup> In this report, we updated our briefing information and provided a more detailed analysis of the Partnership programs. Specifically, we examined (1) the benefits and premium requirements of Partnership policies as compared with those of traditional long-term care insurance policies, including information on benefits purchased by policyholders; (2) the extent to which states oversee Partnership policies as compared with their

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<sup>6</sup>When we refer to the four states with Partnership programs or the four states, we are referring to California, Connecticut, Indiana, and New York. According to CMS officials, as of October 2006, no other states had active Partnership programs; that is, no insurance companies were issuing Partnership policies in any other states.

<sup>7</sup>Congressional Budget Office Cost Estimate: S. 1932 Deficit Reduction Act of 2005, at 36-39, January 27, 2006.

<sup>8</sup>GAO, *Overview of the Long-Term Care Partnership Program*, [GAO-05-1021R](#) (Washington, D.C.: Sept. 9, 2005).



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oversight of traditional long-term care insurance policies; (3) the demographics, including asset and income levels, of Partnership policyholders, traditional long-term care insurance policyholders, and people without long-term care insurance; and (4) whether the Partnership programs are likely to result in savings for Medicaid.

To compare the benefits and premium requirements of Partnership and traditional long-term care insurance policies, we reviewed state regulations, and interviewed Partnership program officials and department of insurance (DOI) officials in each of the four states with Partnership programs—California, Connecticut, Indiana, and New York. To compare the benefits purchased by Partnership policyholders and traditional long-term care insurance policyholders, we obtained data from 2002 through 2005 from two sources. Our data source for benefits purchased by Partnership policyholders was the Uniform Data Set (UDS)—a data set with information on Partnership policyholders compiled by officials in each of the four states with Partnership programs from data provided by participating insurers.<sup>9</sup> Our data source for benefits purchased by traditional long-term care insurance policyholders was from a survey we conducted of five of the largest long-term care insurance companies in the individual long-term care insurance market.<sup>10</sup>

To examine the extent to which states oversaw Partnership policies compared with state oversight of traditional long-term care insurance policies, we reviewed state regulations and Partnership program documents, and interviewed officials from Partnership programs, long-term care insurance companies, and each Partnership state's DOI, the entities that are responsible for regulating insurance policies, including long-term care insurance policies, that are sold in the states. We reviewed state regulations, Partnership program documents, and conducted interviews about how training requirements for insurance agents who sell Partnership policies compared with training requirements for agents who sell traditional long-term care insurance policies.

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<sup>9</sup>The UDS is a data set developed by the four states with Partnership programs; participating insurers; the National Program Office at the Center on Aging, University of Maryland; and the Program Evaluator, Laguna Research Associates. Data in the UDS are submitted by insurers to the Partnership program in the state in which they are participating and contain information on Partnership policyholders.

<sup>10</sup>We selected the five insurance companies on the basis of the total number of policies and amount of annualized premiums in effect in the individual market as of December 31, 2004.

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To examine the demographics, including income and assets levels, of Partnership policyholders, traditional long-term care insurance policyholders, and individuals without long-term care insurance, we used data from three sources. First, to calculate the household income and assets of Partnership policyholders, we used available survey data from a sample of Partnership policyholders in California and Connecticut. We restricted our analysis to the income and asset data from these two states because Indiana's data were not sufficiently detailed to include in our analysis, and New York was not able to provide us with data from recent years. We combined multiple years of these data in order to increase the sample size.<sup>11</sup> To estimate the household income of individuals without insurance in California and Connecticut, we used data from the American Community Survey (ACS) for 2004 published by the U.S. Census Bureau. Finally, we used national data from the Health and Retirement Study (HRS) for 2004, to compare household income and household assets for those individuals with traditional long-term care insurance and those without long-term care insurance.<sup>12</sup> The HRS is a national survey sponsored by the National Institute on Aging and conducted by the University of Michigan of individuals over the age of 50.<sup>13</sup> The HRS collected information about retirement, health insurance, savings, and other issues confronting the elderly. To examine the age, marital status, and gender of Partnership policyholders, traditional long-term care insurance policyholders, and individuals without long-term care insurance, we used data from the UDS and the HRS.

To examine whether the Partnership programs in the four states are likely to result in savings for Medicaid, we assessed (1) available state survey data of Partnership policyholders and (2) the options an individual has for financing long-term care and the time it would take for the individual to become eligible for Medicaid under three illustrative scenarios. We used the illustrative scenarios because the Partnership programs in the four states have only been operating since the early 1990s, and as yet there are

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<sup>11</sup>For income and asset data in California we combined data for 2003 and 2004, and for Connecticut, we combined data for 2002 through 2005.

<sup>12</sup>To make our income analysis consistent across the different data sources, we restricted our calculations of household income to individuals aged 55 and over.

<sup>13</sup>The Health and Retirement Study (HRS) is a longitudinal national panel survey that collects information over time on individuals over age 50. The first survey was conducted in 1992, and subsequent surveys were conducted every 2 years. The most recent survey for which data were available was 2004.

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no available data describing when or if Partnership policyholders would have accessed Medicaid. As a result, there are insufficient data available to directly measure whether the Partnership programs are associated with increased or decreased Medicaid spending. We used available survey data in California, Connecticut, and Indiana to determine what Partnership policyholders report they would have done to finance their long-term care needs if there had not been a Partnership program in their state.<sup>14</sup> In addition, we assessed three scenarios that represent the three main options an individual has for financing long-term care: financing using a Partnership policy, financing using a traditional long-term care policy, and self-financing without any long-term care insurance. The latter two scenarios describe the financing options that a Partnership policyholder could use if the Partnership programs did not exist. We used the three scenarios to explore how long it would likely take before the individual depicted in our scenarios would become eligible for Medicaid with a Partnership policy and—in the scenarios in which Partnership programs did not exist—with the other two financing options. In the scenarios, if, in the absence of a Partnership program, an individual using a traditional long-term care insurance policy or relying on self-financing is likely to become eligible for Medicaid sooner than the same individual would have using a Partnership policy, we consider the Partnership programs to be a potential source of savings for Medicaid. In contrast, if the same individual delays Medicaid eligibility using a traditional long-term care insurance policy or self-financing, when compared with the time it would take the individual to become eligible for Medicaid using a Partnership policy, we consider the Partnership program to be a potential source of increased spending for Medicaid. To develop our scenarios, we made several simplifying assumptions. These include the following:

- The individual depicted in the scenarios has \$300,000 in assets, and in two of our scenarios a long-term care insurance policy worth \$210,000—assets and benefits that are typical of many individuals with long-term care insurance—and the individual receives long-term care in a nursing facility with costs for a year of care of \$70,000, about equal to average nursing facility costs nationwide in 2004.
- The individual has assets that are no less than the value of the individual's Partnership policy—that is, the individual does not overinsure his or her assets.

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<sup>14</sup>New York State survey data were unavailable.

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- The individual is unmarried. While most Partnership policyholders are married at the time they purchase a Partnership policy, they are unlikely to require long-term care for many years, and their marital status can change. Most individuals who are admitted to a nursing facility are unmarried.

Where possible, we use data from surveys of Partnership policyholders to support our assumptions. We also explored whether adjusting the assumptions changed the conclusions we could draw. Although our scenarios represent the choices facing a single individual, the results of this analysis are applicable beyond this individual. For example, the relative impact on Medicaid spending across the scenarios is independent of the amount of assets owned by the individual or the level of the individual's insurance coverage.

As part of our efforts to examine whether the Partnership programs are likely to result in savings for Medicaid, we also examined the likelihood that the population of Partnership policyholders will ever become eligible for Medicaid. To assess this likelihood, we examined the long-term care insurance benefits and income of Partnership policyholders. We also assessed the number of people with Partnership policies who accessed Medicaid as of October 2006.

Based on discussions with state officials and reviewing documentation on uniformly collected insurer data and surveys of policyholders, we determined that the information we used was sufficiently reliable for our purposes. We also examined reports on the Partnership program from the CBO, the Congressional Research Service, and other research organizations. Appendix I provides information on the data and methods used for our analyses of long-term care insurance benefits, policyholder income, assets, age, gender, and marital status. Appendix II provides more information about the illustrative scenarios, the simplifying assumptions underlying the scenarios, and the effect on our analysis of adjusting these assumptions. We conducted our work from September 2005 through May 2007 in accordance with generally accepted government auditing standards.

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## Results in Brief

In the four states with Partnership programs, Partnership policies must include certain benefits not generally required of traditional long-term care insurance policies, and insurance companies cannot charge higher premiums for asset protection in Partnership policies. Partnership policies must include certain benefits, such as inflation protection and minimum daily benefit amounts, while traditional long-term care insurance policies

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may include these benefits but are generally not required to do so. Partnership policies include these benefits in order to increase the likelihood that Partnership policyholders will have sufficient long-term care insurance coverage to pay for a significant portion of their long-term care. For example, Partnership policies must include inflation protection, which increases the amount a policy pays over time to account for increases in the cost of care, and minimum daily benefit amounts, which are set at levels designed to cover a significant portion of the costs of an average day in a nursing facility. Though traditional long-term care insurance policyholders are able to purchase most of the same benefits as Partnership policyholders, in comparing these two groups we found that a higher percentage of Partnership policyholders purchased policies from 2002 through 2005 with more extensive coverage—for example, higher levels of inflation protection and coverage for care in both nursing facility and home and community-based care settings. Officials in states with Partnership programs told us that companies selling long-term care insurance are not permitted to charge Partnership policyholders higher premiums for the asset protection benefit—Partnership and traditional long-term care insurance policies with otherwise comparable benefits must have equivalent premiums. However, Partnership policies are likely to have higher premiums because they are required to have inflation protection and other benefits that are not required for traditional long-term care insurance policies.

According to state officials, compared with traditional long-term care insurance policies, Partnership policies in two Partnership states are subject to additional review, and in all four Partnership states, insurance agents who sell Partnership policies are subject to additional state training requirements compared with agents who sell only traditional long-term care policies. While all long-term care insurance policies are reviewed by the DOI in each state, Partnership policies in California and Connecticut are also reviewed by Partnership program offices. This additional review is designed by these states to ensure that the Partnership policies that are issued meet all specific Partnership regulatory requirements, and the insurance companies issuing these policies meet the data reporting and other administrative requirements. Before they can sell Partnership policies, long-term care insurance agents are required by each of the four Partnership states to undergo training specific to the state's Partnership program, in addition to the training that is required for those who sell traditional long-term care insurance. This specialized training typically provides information on long-term care planning, Medicaid, Medicare, the specific benefits required by the state's Partnership program, and how

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policies sold through the program differ from traditional long-term care insurance policies.

Partnership and traditional long-term care insurance policyholders tend to be relatively wealthy with higher incomes and more assets, compared with those without insurance. At the time they purchased their Partnership policies, more than half of Partnership policyholders over 55 in California and Connecticut had monthly household incomes of \$5,000 or greater, and more than half of all households had assets of \$350,000 or greater. Partnership policyholders in the four states with Partnership programs are also younger on average than traditional long-term care insurance policyholders. In addition, a higher percentage of Partnership and traditional long-term care insurance policyholders are married rather than unmarried, and female rather than male.

Available survey data from three states with Partnership programs and our three illustrative financing scenarios together suggest that the Partnership programs are unlikely to result in savings for Medicaid and may result in increased Medicaid spending. Based on surveys of Partnership policyholders in California, Connecticut, and Indiana, we estimate that, in the absence of a Partnership program in their state, 80 percent of Partnership policyholders would have purchased a traditional long-term care insurance policy. Our long-term care financing scenarios suggest that it takes longer for an individual with a traditional long-term care insurance policy to become eligible for Medicaid than it would take the same individual to become eligible for Medicaid if he or she owned a Partnership policy. Therefore, the 80 percent of surveyed Partnership policyholders may represent a potential source of increased spending for Medicaid, as Medicaid is likely to begin paying for the long-term care of these policyholders sooner than if they had held traditional long-term care insurance policies instead. The survey data also indicate that the remaining 20 percent of surveyed policyholders would not have purchased any long-term care insurance if Partnership programs did not exist. Data are not yet available to directly measure when or if these individuals will access Medicaid had they not purchased a Partnership policy. However, our scenarios suggest that an individual who self-finances his or her long-term care without any long-term care insurance is likely to become eligible for Medicaid at about the same time as the individual would using a Partnership policy, though there were some circumstances that could accelerate or delay the individual's time to Medicaid eligibility. While the majority of Partnership policyholders have the potential to increase spending, we also anticipate that the impact of these programs is likely to be small because few policyholders will become eligible. Partnership

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policyholders tend to have incomes that exceed Medicaid eligibility thresholds and insurance benefits that cover most of their long-term care needs.

With DRA authorizing all states to implement Partnership programs, information on the Partnership policies and policyholders from the four states with Partnership programs may prove useful to other states considering implementing such programs. States may want to consider the benefits to Partnership policyholders, the likely impact on Medicaid expenditures, and the incomes and assets of those likely to be able to afford long-term care insurance.

We received comments on a draft of this report from HHS and state officials from California, Connecticut, Indiana, and New York. HHS commented that our study results should not be considered conclusive and the simplified scenarios were flawed because they did not adequately account for the effect of asset transfers. HHS also noted that our data sources were unlikely to yield accurate data on asset transfers and criticized the report for not incorporating a review of the literature on this issue and the analyses conducted by the four states with Partnership programs. The four states disagreed with our conclusion that the Partnership programs are unlikely to result in Medicaid savings, and like HHS, commented that our scenarios did not adequately account for the impact of asset transfers. California, Connecticut, and New York objected to our methodology for estimating the financial impact of the program on Medicaid. California and Connecticut suggested that our analysis should have included results from two Partnership policyholder survey questions that they consider in their own analysis of the Partnership program.

We maintain that the evidence suggests that the Partnership program is unlikely to result in savings for Medicaid, despite limited data and program experience. As discussed in our draft report, some savings to Medicaid could be associated with individuals who would have transferred their assets and become eligible for Medicaid sooner in the absence of the Partnership program. However, we noted that these savings are unlikely to offset the potential costs associated with policyholders who would have purchased traditional long-term care insurance in the absence of the Partnership programs. We did not provide a review of the literature on asset transfers because—as we previously noted in our March 2007 report on the subject—the evidence on the transfer of assets to become eligible

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for Medicaid coverage for long-term care is generally limited.<sup>15</sup> However, in response to HHS' comments, we have amended our draft report to make the discussion of asset transfers more prominent in the body of our report and to include reference to the 2007 GAO study. We also maintain that our methodology for estimating the financial impact of the program on Medicaid is sound and disagree with California and Connecticut regarding the appropriateness of using the two survey questions. Specifically, by relying on the responses from these questions, the method California, Connecticut, and Indiana use to evaluate Medicaid costs underestimates the percentage of people who would have purchased traditional policies in the absence of the Partnership program, while their method of evaluating Medicaid savings overestimates the percentage of people who would transfer assets.

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## Background

Long-term care comprises services provided to individuals who, because of illness or disability, are generally unable to perform activities of daily living (ADL)—such as bathing, dressing, and getting around the house—for an extended period of time.<sup>16</sup> These services can be provided in various settings, such as nursing facilities, an individual's own home, or the community.<sup>17</sup> The typical 65-year-old has about a 70 percent chance of needing long-term care services in his or her life.<sup>18</sup> Long-term care can be

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<sup>15</sup>GAO, *Medicaid Long-Term Care: Few Transferred Assets before Applying for Nursing Home Coverage; Impact of Deficit Reduction Act on Eligibility Is Uncertain*, GAO-07-280 (Washington, D.C.: Mar. 26, 2007).

<sup>16</sup>As people age, they typically experience a decline in their ability to perform basic physical functions, increasing the likelihood that they will need long-term care services. Individuals qualify for Medicaid coverage for long-term care services if they meet certain functional criteria that in general involve a degree of impairment measured by the level of assistance an individual needs to perform six activities of daily living (ADL): eating, bathing, dressing, using the toilet, getting in and out of bed, and getting around the house, as well as the instrumental activities of daily living (IADL), which include preparing meals, shopping for groceries, and venturing outside of a home or facility.

<sup>17</sup>Long-term care services, such as personal care, homemaker services, and respite care, are known as home care. Home care can also include services provided outside of policyholders' homes, such as services provided in adult day care centers. Long-term care services provided in community-based facilities are generally designed to help people receive long-term care and remain living in their own homes. Known as community-based services, these long-term care services can be supplied in settings such as policyholders' homes, adult day care facilities, or during visits to a physician's office.

<sup>18</sup>P. Kemper, H.L. Komisar, and L. Alecxih, *Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?* Inquiry, vol. 42, no. 4 (Winter 2005/2006) pp. 335-350.



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expensive, especially when provided in nursing facilities. In 2005, the average cost of a year of nursing facility care was about \$70,000.<sup>19</sup> In 1999, the most recent year for which data were available, the average length of stay in a nursing facility was between 2 and 3 years.<sup>20</sup>

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## Long-Term Care Insurance

Long-term care insurance is used to help cover the cost associated with long-term care. Individuals can purchase long-term care insurance policies directly from insurance companies, or through employers or other groups. The number of long-term care insurance policies sold has been small—about 9 million as of 2002, the most recent year for which data were available. About 80 percent of these policies were sold through the individual insurance market and the remaining 20 percent were sold through the group market.

Long-term care insurance companies generally structure their long-term care insurance policies around certain types of benefits and related options.

- A policy with comprehensive coverage pays for long-term care in nursing facilities as well as for care in home and community settings, while a policy with coverage for home and community-based settings pays for care only in these settings.
- A daily benefit amount specifies the amount a policy will pay on a daily basis toward the cost of care, while a benefit period specifies the overall length of time a policy will pay for care. Data from 2002 through 2005 show that the maximum daily benefit amounts can range from less than \$100 to several hundred dollars per day, while benefit periods can range from 1 year to lifetime coverage.<sup>21</sup>

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<sup>19</sup>MetLife Mature Market Institute, *The MetLife Market Survey of Nursing Home & Home Care Costs* (September 2005).

<sup>20</sup>Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *The National Nursing Home Survey: 1999 Summary*, Series 13, No. 152 (June 2002).

<sup>21</sup>GAO analysis of data provided by five insurance companies selling traditional long-term care insurance: see GAO, *Long-Term Care Insurance: Federal Program Compared Favorably with Other Products, and Analysis of Claims Trend Could Inform Future Decisions*, [GAO-06-401](#) (Washington, D.C.: March 2006).

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- A policy's elimination period establishes the length of time a policyholder who has begun to receive long-term care has to wait before his or her insurance will begin making payments towards the cost of care. According to data from 2002 through 2005, elimination periods can range from 0 to at least 730 days.<sup>22</sup>
  - Inflation protection increases the maximum daily benefit amount covered by a policy, and helps ensure that over time the daily benefit remains commensurate with the costs of care.

There can be a substantial gap between the time a long-term care insurance policy is purchased and the time when policyholders begin using their benefits, and the costs associated with long-term care can increase significantly during this time. A typical gap between the time of purchase and the use of benefits is 15 to 20 years: the average age of all long-term care insurance policyholders at the time of purchase is 63, and in general policyholders begin using their benefits when they are in their mid-70s to mid-80s. Usually, automatic inflation protection increases the benefit amount by 5 percent annually on a compounded basis. A policy with automatic 5 percent compound inflation protection and a \$150 per day maximum daily benefit in 2006 would be worth approximately \$400 per day 20 years later. Another means to protect against inflation is a future purchase option. This option allows the consumer to increase the dollar amount of coverage every few years at an extra cost. Some future purchase options do not allow consumers to purchase extra coverage once they begin receiving their insurance benefit and the opportunity to purchase extra coverage may be withdrawn should the consumer decline a predetermined number of premium increases. A policy with a future purchase option may be less expensive initially than a policy with compound inflation protection. However, over time the policy with a future purchase option may become more expensive than a policy with compound inflation.

Without inflation protection, policyholders might purchase a policy that covers the current cost of long-term care but find, many years later, when they are most likely to need long-term care services, that the purchasing power of their coverage has been reduced by inflation and that their coverage is less than the cost of their care. For example, if the cost of a day in a nursing facility increases by 5 percent every year for 20 years, a

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<sup>22</sup>See [GAO-06-401](#).

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nursing facility that costs \$150 per day in 2006 would cost about \$400 per day 20 years later in 2026. A policy purchased in 2006 with a daily benefit of \$150 without inflation protection would pay \$150 per day—or 38 percent—of the daily cost of about \$400 in 2026. The remaining \$250 of the daily cost of the nursing facility care would have to be paid by the policyholder.

Long-term care insurance policies may also include other benefits or options. For example, policies can offer coverage for home care at varying percentages of the maximum daily benefit amount. Some policies include features in which the policy returns a portion of the premium payments to a designated third party if the policyholder dies. Some policies provide coverage for long-term care provided outside of the United States or offer care-coordination services that, among other things, provide information about long-term care services to the policyholder and monitor the delivery of long-term care services.

Many factors impact the premiums individuals pay for long-term care insurance. Notably, long-term care insurance companies typically charge higher premiums for policies with more extensive benefits. In general, policies with comprehensive coverage have higher premiums than policies without such coverage, and policyholders pay higher premiums the higher their maximum daily benefit amounts, the longer their benefit periods, the greater their inflation protection, and the shorter their elimination periods. For example, in Connecticut, if a 55-year-old man decided to buy a 1-year, \$200 per day comprehensive coverage policy, in 2005 it would have cost him about \$1,000 less per year than a comparable 3-year policy. Similarly, the age of an applicant also impacts the premium, as premiums typically are more expensive the older the policyholder at the time of purchase. For example, in Connecticut, a 55-year-old purchasing a 3-year, \$200 per day comprehensive coverage policy in 2005 would pay about \$2,500 per year, whereas a 70-year-old purchasing the same policy would pay about \$5,900 per year. Health status may also affect premiums. Insurance companies take into account the health status of an applicant to evaluate the risk that he or she will access long-term care services. If an applicant has a medical condition that increases the likelihood of the applicant using long-term care services, but does not automatically disqualify the applicant from

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purchasing insurance, the applicant may receive a substandard rating from an insurance company, which may result in a higher premium.<sup>23</sup>

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## Long-Term Care Insurance Regulation

Regulation of the insurance industry, including those companies selling long-term care insurance, is a state function. Those who sell long-term care insurance must be licensed by each state in which they sell policies, and the policies sold must be in compliance with state insurance laws and regulations. These laws and regulations can vary but their fundamental purpose is to establish consumer protections that are designed to ensure that the policies' provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specified conditions under which long-term care insurance benefits and premiums would receive favorable federal income tax treatment.<sup>24</sup> Individuals who purchase policies that comply with HIPAA requirements, which are therefore "tax-qualified," can itemize their long-term care insurance premiums as deductions from their taxable income along with other medical expenses, and can exclude from gross income insurance company proceeds used to pay for long-term care expenses. Under HIPAA, tax-qualified plans must begin coverage when a person is certified as: needing substantial assistance with at least two of the six ADLs for at least 90 days due to a loss of functional capacity, having a similar level of disability, or requiring substantial supervision because of a severe cognitive impairment. HIPAA also requires that a policy comply with certain provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Insurance Model Act and Regulation adopted in January 1993. This model act and regulation established certain consumer protections that are designed to prevent insurance companies from (1) not renewing a long-term care insurance policy because of a policyholder's age or deteriorating health, and

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<sup>23</sup>The process of reviewing medical and health-related information furnished by an applicant to determine if the applicant presents an acceptable level of risk and is insurable is known as underwriting. Examples of medical conditions that may not disqualify an individual from obtaining insurance but that can result in a substandard rating during the underwriting process include osteoporosis, emphysema, and diabetes. However, the severity and the ability to control and treat the medical condition are all factors that can also impact how a nondisqualifying medical condition impacts an underwriting rating.

<sup>24</sup>Pub. L. No. 104-191, §§ 321-327, 110 Stat. 1936, 2054-2067.

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(2) increasing the premium of an existing policy because of a policyholder's age or claims history. In addition, in order for a long-term care insurance policy to be tax-qualified, HIPAA requires that a policy offer inflation protection. The NAIC, which represents insurance regulators from all states, reported in 2005 that 41 states based their long-term care insurance regulations on the NAIC model, 7 based their regulations partially on the model, and 3 did not follow the model.

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## Medicaid

Medicaid is the primary source of financing for long-term care services in the United States. In 2004, almost one-third of the total \$296 billion in Medicaid spending was for long-term care. Some health care services, such as nursing facility care, must be covered in any state that participates in Medicaid. States may choose to offer other optional services in their Medicaid plans, such as personal care.<sup>25</sup>

Medicaid coverage for long-term care services is most often provided to individuals who are aged or disabled. To qualify for Medicaid coverage for long-term care, these individuals must meet both functional and financial eligibility criteria. Functional eligibility criteria are established by each state and are generally based on an individual's degree of impairment, which is measured in terms of the level of difficulty in performing the ADLs and IADLs. To meet the financial eligibility criteria, an individual cannot have assets or income that exceed thresholds established by the states and that are within standards set by the federal government. Generally, the value of an individual's primary residence and car, as well as a few other personal items, are not considered assets for the purpose of determining Medicaid eligibility.<sup>26</sup> Individuals with high medical costs and whose income exceeds state thresholds can "spend down" their income on their long-term care, which may bring their income below the state-determined income eligibility limit. In all four states with Partnership programs, for the purpose of obtaining Medicaid eligibility, individuals are

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<sup>25</sup>Personal care includes long-term care services that help people meet personal needs such as assistance with personal hygiene, nutritional or support functions, and health-related tasks.

<sup>26</sup>Under DRA, certain individuals with an equity interest in their home of greater than \$500,000 are not eligible for Medicaid coverage for nursing facility services or other long-term care services. However, states have the option to increase the home equity interest level to an amount that does not exceed \$750,000. This home equity limitation does not apply to individuals if they have a spouse, a child under age 21, or a child who is blind or disabled living in the home.

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allowed to deduct medical expenses, including those for long-term care, in order to bring their incomes below the state-determined thresholds.

In order to meet Medicaid’s eligibility requirements, some individuals may choose to divest themselves of their assets—for example, by transferring assets to their spouses or other family members.<sup>27</sup> However, those who transfer assets for less than fair market value during a specified “look-back” period—a period of time before an individual applies for Medicaid during which the program reviews asset transfers—may incur a penalty, that is, a period during which they are ineligible for Medicaid coverage for long-term care services. Evidence of the extent to which individuals transfer assets for less than fair market value to become financially eligible for Medicaid coverage for long-term care is generally limited and often based on anecdote. However, our March 2007 report on asset transfers suggests that the incidence of asset transfers is low among nursing home residents covered by Medicaid.<sup>28</sup> Nationwide, about 12 percent of Medicaid-covered elderly nursing home residents reported transferring cash during the 4 years prior to nursing home entry, and the median amount transferred was very small (\$1,239). The percentage of nursing home residents not covered by Medicaid who transferred cash was about twice that of Medicaid-covered nursing home residents. However, the median amount of cash transferred as reported by non-Medicaid covered residents and Medicaid-covered residents did not vary greatly.<sup>29</sup> In addition to the nationwide analysis, our report summarized an analysis of a sample of approved Medicaid nursing home applicants in three states who generally applied to Medicaid in 2005 or before, and found that about 10 percent of applicants had transferred assets for less than the fair market value during the 3-year look-back period before Medicaid eligibility began. The median amount transferred was about \$15,000. DRA tightened the requirements on Medicaid applicants transferring assets by extending the look-back period for all asset transfers from 3 to 5 years. In addition, DRA changed the beginning date of the penalty period. Prior to enactment of DRA, the penalty period started on

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<sup>27</sup>For asset transfer purposes, Medicaid defines the term “assets” to include income and resources, such as bank accounts.

<sup>28</sup>See [GAO-07-280](#).

<sup>29</sup>The median amount of cash transferred by non-Medicaid-covered residents during the 4 years prior to nursing home entry was \$1,859. During the 2 years prior to nursing home entry, the median amount transferred for both non-Medicaid-covered residents and Medicaid-covered residents was \$2,194.

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the first day of the month during or after which assets were transferred. DRA changed this so that the penalty period now begins on the first day of the month when the asset transfer occurred, or the date on which the individual is eligible for medical assistance under the state plan, and is receiving institutional care services that would be covered by Medicaid were it not for the imposition of the penalty period, whichever is later. The extension of the look-back period and the redefinition of the penalty period may reduce transfers of assets.

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## Long-Term Care Partnership Programs

The Partnership programs are public-private partnerships between states and private long-term care insurance companies. Established in 1987 as programs funded through the Robert Wood Johnson Foundation, the programs are designed to encourage individuals, especially moderate income individuals, to purchase private long-term care insurance in an effort to reduce future reliance on Medicaid for the financing of long-term care. As of October 2006, the original four Partnership programs in California, Connecticut, Indiana, and New York remained the only active Partnership programs.<sup>30</sup>

Partnership programs attempt to encourage individuals to purchase private long-term care insurance by offering them the option to exempt some or all of their assets from Medicaid spend-down requirements. However, Partnership policyholders are still required to meet Medicaid income eligibility thresholds before they may receive Medicaid benefits. In the four states with Partnership programs, those who purchase long-term care insurance Partnership policies generally must first use those benefits to cover the costs of their long-term care before they begin accessing Medicaid.<sup>31</sup> In 2006, there were about 190,000 active Partnership policies, out of the approximately 218,000 Partnership policies that had been sold

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<sup>30</sup>Iowa and Massachusetts received approval from the Health Care Financing Administration (now CMS) to establish Partnership programs, but programs were not functioning in these states as of October 2006. Since enactment of DRA, a Partnership program in Idaho was approved by CMS, though the program was not functioning as of October 2006. Also, as of that date, amendments to state Medicaid plans allowing Partnership programs in Florida, Georgia, Minnesota, and Nebraska were under review at CMS.

<sup>31</sup>For the purposes of this report, we use the term “accessing Medicaid” to describe the point at which long-term care policyholders first begin receiving Medicaid payments for their long-term care.

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since the inception of the Partnership programs.<sup>32,33</sup> Between September 2005 when we last reported on the Partnership programs, and August 2006, the number of Partnership policies in the four states combined increased by about 10 percent.<sup>34</sup>

The four states with Partnership programs vary in how they protect policyholders' assets. The Partnership programs in California, Connecticut, Indiana, and New York have dollar-for-dollar models, in which the dollar amount of protected assets is equivalent to the dollar value of the benefits paid by the long-term care insurance policy. For example, a person purchasing a long-term care dollar-for-dollar insurance policy with \$300,000 in coverage would have \$300,000 of assets protected if he or she were to exhaust the long-term care insurance benefits and apply for Medicaid. However, New York's program also offers total protection. That is, those who purchase a comprehensive long-term care insurance policy, covering a minimum of 3 years of nursing facility care or 6 years of home care, or some combination of the two, can protect all their assets at the time of Medicaid eligibility determination. In Indiana, in addition to the dollar-for-dollar models, the Partnership program offers a hybrid model that allows purchasers to obtain dollar-for-dollar protection up to a certain benefit level as defined by the state; all policies with benefits above that threshold provide total asset protection for the purchaser.

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<sup>32</sup>Partnership program offices reported that about 235,000 Partnership policies had been sold since the four Partnership programs began, but that number included people who subsequently dropped their policies within 30 days of purchasing the product. The four states with Partnership programs give Partnership policy purchasers a 30-day "free look" period during which they can decide whether to keep their policy or drop it and receive a full refund.

<sup>33</sup>By state, the number of Partnership policies, excluding those that were dropped, was 73,811 in California and 33,040 in Connecticut, through March 2006; 31,750 in Indiana through June 2006; and 51,262 in New York through December 2005.

<sup>34</sup>This rate of increase varied across the states: the sales of Partnership policies in California increased by 14 percent—the largest percentage increase among the Partnership states—compared with increases of 7, 9, and 8 percent in Connecticut, Indiana, and New York, respectively.



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Under DRA, any state that implements a Partnership program must ensure that the policies sold through that program contain certain benefits, such as inflation protection.<sup>35,36</sup> DRA also requires that Partnership policies provide dollar-for-dollar asset protection. Insurers are not allowed to offer Partnership policies that provide the total asset protection feature found in Partnership policies in New York and Indiana.<sup>37</sup> DRA also requires Partnership policies to include consumer protections contained in the NAIC Long-Term Care Insurance Model Act and Regulation as updated in October 2000. DRA established specific requirements for Partnership policies that do not apply to traditional long-term care insurance policies sold in the Partnership states, such as inflation protection and dollar-for-dollar asset protection. DRA prohibits states from creating other requirements for Partnership policies that do not also apply to traditional long-term care insurance policies in the four states with Partnership policies. The Partnership programs in California, Connecticut, Indiana, and New York, which were implemented before DRA, are not subject to these specific requirements, but in order for those programs to continue, they must maintain consumer protection standards that are no less stringent than those that applied as of December 31, 2005.

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<sup>35</sup>DRA requires Partnership policies to provide compound inflation protection for individuals younger than 61. For individuals younger than 76, Partnership policies must provide policyholders with some level of inflation protection, although not necessarily compound inflation protection, while inflation protection is an optional feature for Partnership policyholders aged 76 or older. Pub. L. No. 109-171, § 6021(a)(1), 120 Stat. 68 (codified at 42 U.S.C. § 1396 p(b)(1)(c)(iii)(IV)).

<sup>36</sup>Some of the states that passed legislation prior to the passage of DRA to enable the creation of a Partnership program may need to make additional changes to meet DRA requirements.

<sup>37</sup>According to CMS officials, policies in New York and Indiana may continue to provide this type of coverage.

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## Partnership Policies Must Include Certain Benefits Not Required of Traditional Policies, and Insurance Companies Cannot Charge Higher Premiums for Asset Protection in Partnership Policies

The four states with Partnership programs require that Partnership policies include certain benefits—such as inflation protection and minimum daily benefit amounts—while traditional long-term care insurance policies may include these benefits but are not generally required to do so. Compared with policyholders of traditional long-term care insurance policies, a higher percentage of Partnership policyholders purchased policies with more extensive coverage. In the four states, insurance companies are not allowed to charge policyholders higher premiums for policies with asset protection, and Partnership and traditional long-term care insurance policies with comparable benefits are required to have equivalent premiums.

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## The Four States Require Partnership Policies to Include Certain Benefits Not Required for Traditional Long-Term Care Insurance Policies

In general, the four states with Partnership programs require that Partnership policies sold in their states include certain benefits that are not required for those states' traditional long-term care insurance policies. A state DOI official told us that they have these benefit requirements for Partnership policies in order to protect policyholders by helping to ensure that benefits are sufficient to cover a significant portion of their anticipated long-term care costs and to protect the Medicaid program by reducing the likelihood that policyholders will exhaust their benefits and become eligible for Medicaid.

In addition to asset protection, which by definition Partnership policies include, all four states require Partnership policies to include inflation protection.<sup>38</sup> Three of the four Partnership states—California, Connecticut, and New York—require that Partnership policies include inflation protection that automatically increases benefit amounts by 5 percent annually on a compounded basis.<sup>39</sup> The four states do not require traditional long-term care insurance policies to include inflation protection, though insurance companies in these states are required to

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<sup>38</sup>There are some exceptions to the inflation protection requirement. For example, in New York, insurance companies are allowed to sell Partnership policies to policyholders 80 years of age or older without inflation protection.

<sup>39</sup>In Indiana, Partnership policies are required to include either automatic compound inflation protection at 5 percent annually or in accordance with the consumer price index, or an inflation protection option that covers at least 75 percent of the average daily private pay rate.

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offer inflation protection as an optional benefit. While policies with inflation protection may include coverage that is more commensurate with expected future costs of care, these policies can be two or three times as expensive as policies without inflation protection. For example, in 2005 a long-term care insurance policy with a \$200 daily benefit, a 3-year benefit period, and inflation protection cost about \$3,000 per year for a 60-year-old male; the same policy cost about \$1,350 per year without inflation protection. An insurance company official told us that the additional cost of inflation protection is the primary reason individuals do not buy a Partnership policy.

The four states with Partnership programs also require minimum daily benefit amounts for all Partnership policies, while in three of the Partnership states, traditional long-term care insurance policies are not subject to this requirement.<sup>40</sup> According to Partnership and DOI officials in California and Connecticut, minimum daily benefit amounts are required for Partnership policies in order to prevent consumers from purchasing coverage that would be insufficient to cover a substantial portion of the cost of their care. According to Partnership program materials from New York, for example, the average daily cost of long-term care in a nursing facility in New York was about \$263 per day in 2004. Anything less than New York's 2004 minimum daily benefit amount of \$171 for nursing facility care would therefore have required out-of-pocket payments for policyholders of more than one-third of the cost of their nursing facility care. In 2006, the required minimum daily benefit amounts for nursing facility care in Partnership policies ranged from \$110 per day in Indiana to \$189 per day in New York.

In the four states with Partnership programs, Partnership policies are subject to minimum nursing facility benefit period requirements established by the states, but some traditional long-term care insurance policies are not subject to these same requirements. In California and Indiana, Partnership policies are required to have dollar coverage that provides for at least 1 year of care in a nursing facility, while traditional long-term care insurance policies are not subject to a minimum benefit period requirement.<sup>41</sup> In New York, Partnership policies are required to

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<sup>40</sup>New York requires minimum daily benefit amounts for traditional long-term care insurance policies.

<sup>41</sup>The minimum amount paid under a Partnership policy for this dollar coverage can be no less than 70 and 75 percent of the average daily private pay rate for nursing facilities in California and Indiana, respectively.

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have minimum nursing facility benefit periods ranging from 18 months to 4 years, depending on the type of coverage an individual purchases, while certain traditional long-term care insurance policies are required to have 1-year minimum nursing facility benefit periods. In Connecticut, Partnership and traditional long-term care insurance policies are both required to have 1-year minimum benefit periods for care provided in nursing facilities.

Partnership and traditional long-term care insurance policies both typically include elimination periods, which establish the length of time a policyholder who has begun to receive long-term care has to wait before receiving long-term care insurance benefits. The four states with Partnership programs limit the length of the elimination periods that can be included in Partnership policies. Two of the four states, Connecticut and New York, also generally limit the elimination period included in traditional long-term care insurance policies. In 2006, the elimination period for Partnership policies in California was no more than 90 days, while New York had a 100-day limit<sup>42</sup> and Indiana had a 180-day limit. In Connecticut, the elimination period limit for both Partnership and traditional long-term care insurance policies was 100 days. According to a New York Partnership program staff member, in New York the elimination period for traditional policies was generally no more than 180 days. The effect of increasing the elimination period is to increase the out-of-pocket costs policyholders incur in paying for their long-term care. One official from an insurance company that sells long-term care insurance policies told us that having long elimination periods could quickly deplete an individual's assets, which might make the asset protection under the Partnership program less valuable.

Unlike traditional long-term care insurance policies, Partnership policies in the four states must cover or offer case management services.<sup>43</sup> Case management services can include providing individual assessments of policyholders' long-term care needs, approving the beginning of an episode of long-term care, developing plans of care, and monitoring policyholders' medical needs. According to a Partnership program official, by helping policyholders assess their medical needs and develop a plan of

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<sup>42</sup>This was for New York's total asset protection policies. The maximum elimination period for New York's dollar-for-dollar policies was 60 days.

<sup>43</sup>In Connecticut and Indiana, the case management provision for Partnership policies is specific to home and community-based services.

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care, case management services can help policyholders use their benefit dollars efficiently. Partnership program officials in California, Connecticut, and Indiana explained that their states require that Partnership policies cover case management services provided through state-approved intermediaries that are independent of insurance company control. Partnership program officials in New York told us that Partnership policyholders have the option to seek case management services from independent case management service providers, but they can also elect to receive case management services from their own insurance company. Traditional long-term care insurance policies are not required to cover case management services, though some may offer them as an optional benefit. In addition, some insurance companies that sell traditional long-term care insurance policies may directly provide case management services.

Insurance companies in the four states with Partnership programs are subject to restrictions on the types of coverage they can offer in Partnership policies, while they are allowed to offer traditional long-term care insurance policies with more coverage options. In California, Connecticut, and Indiana, insurance companies can only offer Partnership policies with two types of coverage: an option that covers only nursing facility care, and a comprehensive option that covers nursing facility care as well as care provided in the home and in community-based facilities.<sup>44</sup> In New York, insurance companies may only offer Partnership policies that cover comprehensive care. The four states do not allow insurance companies to offer Partnership policies in their state that exclusively cover care provided in the home and in community-based facilities. However, in the four states, insurance companies can offer traditional long-term care insurance policies with nursing facility care only, home and community-based facility only, and comprehensive coverage options.

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<sup>44</sup>In California, Indiana, and New York, nursing facility coverage also includes other settings that are similar to nursing facilities.

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## Partnership Policyholders Purchased Policies with Benefits That Were More Extensive Than Those Purchased by Traditional Policyholders Nationwide

In the four states with Partnership programs, traditional long-term care insurance policies can include—and individuals can therefore choose to purchase—generally the same benefits found in Partnership policies.<sup>45</sup> However, Partnership policyholders tended to purchase benefits that are more extensive than those purchased by traditional long-term care insurance policyholders. We found that from 2002 through 2005, a higher percentage of Partnership policyholders purchased policies with more extensive coverage compared with policyholders who purchased traditional long-term care insurance nationally. Specifically, more Partnership policyholders purchased policies with higher levels of inflation protection and coverage that includes care in both nursing facility and home and community-based care settings. See table 1 for a summary of the benefits purchased by Partnership and traditional long-term care insurance policyholders. For example, while all Partnership policyholders had policies from 2002 through 2005 with the required inflation protection that generally increases daily benefit amounts by 5 percent annually, about 76 percent of traditional long-term care insurance policyholders had policies with some form of inflation protection. Similarly, during this period, 64 percent of all Partnership policyholders had policies that included daily benefit amounts of \$150 or greater, while 36 percent of traditional long-term care insurance policyholders nationwide had policies that provided daily benefit amounts at this level or greater. While these differences may reflect the benefit requirements found in Partnership policies, they may also reflect the incentive offered by the asset protection benefit of Partnership policies, which may influence consumers deciding whether to buy a Partnership or traditional long-term care insurance policy. The differences may also reflect the demographic and financial characteristics of the people living in the four states with Partnership programs relative to other states.

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<sup>45</sup>Traditional long-term care insurance policyholders cannot obtain asset protection through their policies.

**Table 1: Percentage of Partnership and Traditional Long-Term Care Insurance Policyholders Purchasing Benefits from 2002 through 2005**

	Partnership <sup>a</sup>	Traditional long-term care insurance policyholders <sup>b</sup>
<b>Inflation protection</b>		
Yes	100%	76%
No	0	16
Other <sup>c</sup>	0	8
<b>Daily benefit amount</b>		
Less than \$100	0	11
\$100 to \$149	35	53
\$150 to \$199	40	25
\$200 and greater	24	11
<b>Benefit period</b>		
1 year	3	3
More than 1 and less than 3 years	13	11
3 years	37	23
More than 3 years but not unlimited	30	37
Lifetime/unlimited benefit	19	26
<b>Elimination period</b>		
Less than 30 days	3	8
30 days to 89 days	23	21
90 days	47	60
More than 90 days	27	11
<b>Coverage type</b>		
Comprehensive <sup>d</sup>	99	91
Nursing facility-only	1	3
Other <sup>e</sup>	0	6

Sources: GAO analysis of the four states' UDS Partnership data and data provided by five insurance companies selling traditional long-term care insurance.

Note: Percentages may not add to 100 due to rounding.

<sup>a</sup>Reported values for daily benefit amount, benefit period, and elimination period include nursing facility data, but not home care data.

<sup>b</sup>Approximately 2 percent of people nationwide with long-term care policies have Partnership policies. Thus, although the data may include a number of Partnership policyholders, about 98 percent of these people are likely to have traditional long-term care insurance. Because this is only 2 percent, we consider this as a reasonable proxy for traditional long-term care policyholders.

<sup>c</sup>Includes policies with a future purchase option (7 percent) and policies with a deferred inflation option (1 percent). Enrollees who select a deferred inflation option may increase benefits at a later date that they choose.

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<sup>d</sup>Comprehensive coverage insurance policies provide benefits for both nursing facility-only and home care services.

<sup>e</sup>Includes home care coverage.

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**Insurance Companies Cannot Charge Partnership Policyholders Higher Premiums for Asset Protection, and Premiums for Partnership Policies Must Be Equivalent to Premiums of Traditional Policies That Have Comparable Benefits**

According to state officials, the four states with Partnership programs require Partnership and traditional long-term care insurance policies to have equivalent premiums if the benefits offered—except for asset protection—are otherwise comparable. According to information from one state’s Partnership program, one reason for this requirement is that, unlike other insurance company benefits, insurance companies do not provide asset protection to Partnership policyholders. Instead, the four states with Partnership programs provide the asset protection benefit by allowing Partnership policyholders to protect some or all of their assets from Medicaid spend-down requirements. However, because Partnership policies are required to have inflation protection and other benefits that traditional long-term care insurance policies are not required to have, Partnership policies are likely to have higher premiums. According to a Connecticut state official, in 1996, before the state required that Partnership and traditional long-term care insurance policies have equivalent premiums for the same benefits, Partnership policies were 25 to 30 percent more expensive than traditional long-term care insurance policies with comparable benefits. The official further explained that after the requirement was established, sales of Partnership policies in Connecticut more than tripled.



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## Compared with Traditional Long-Term Care Insurance Policies, Two of Four States Subject Partnership Policies to Additional Review, and All Four States Require Additional Agent Training

State officials told us that, while both Partnership and traditional long-term care insurance policies undergo reviews by the DOI in each of the four states with Partnership programs, Partnership policies in California and Connecticut also undergo another review by state Partnership program officials.<sup>46,47</sup> California and Connecticut Partnership program staff review Partnership policies to determine whether the policies include the benefits mandated by Partnership regulations, and whether the insurance companies can meet additional data reporting and other administrative requirements. The programs' staff also try to ensure that the policies can be easily understood and contain all of the required language. The Partnership program offices in California and Connecticut perform their review of policies first, and then pass the application on to the DOI for further review.

DOI officials in California and Connecticut told us that the Partnership office review of Partnership policies tends to be lengthier for insurance companies than the DOI review. A DOI official explained that when insurance companies add new benefit options to policies, the Partnership review can take longer. Other factors that may slow the Partnership review process include the time spent coordinating between the Partnership program and the state DOI, and the time it takes for insurance companies to learn how to complete the Partnership review process for the first time. State officials in Indiana and New York—where reviews of new Partnership policies are conducted by the DOI and not a separate Partnership program office—told us that it generally takes the same amount of time for Partnership and traditional long-term care insurance policies to pass through the review process.

Before they can sell Partnership policies, insurance agents are subject to additional state training requirements compared with agents who sell only traditional long-term care insurance policies. Although each of the four states with Partnership programs has somewhat different requirements, in general the states require Partnership agents to undergo about a day of

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<sup>46</sup>The New York Partnership program does not conduct a review of Partnership policies. The New York DOI reviews all Partnership and traditional long-term care insurance policies.

<sup>47</sup>Until recently, the Indiana Partnership program was housed in the Medicaid office and conducted an initial review of Partnership policies prior to the DOI review. As of September 2006, the Indiana Partnership program was housed in, and administered by, the DOI and there was only one review of Partnership policies, which was conducted by the DOI.

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training specific to the Partnership program in addition to the training that the states require for those who sell traditional long-term care insurance.<sup>48,49</sup> Partnership program training typically includes information on topics such as long-term care planning, Medicaid, Medicare, the specific benefits required by the Partnership program, and how Partnership policies differ from traditional long-term care insurance policies. According to some state officials, agents need training on the Partnership program and Medicaid in order to understand the program and provide appropriate advice to their clients. In 2006, in three of the four states all Partnership program training was conducted in person, rather than via correspondence or on the internet; however, in New York agents completed an online internet-based course as well as classroom training as part of the Partnership program training. According to state officials, all four Partnership states require that the provider of this specialized Partnership training be approved by the state DOI, and in Connecticut, the training is provided exclusively by Partnership program staff.

Despite the complexity of long-term care insurance products, DOI officials in three states with Partnership programs reported that long-term care insurance policies, including Partnership policies, garner few complaints from policyholders. For example, from 1998 to 2005 the New York Insurance Department received an average of two to three complaints about Partnership policies each year (there were 51,262 active Partnership policies in the fourth quarter of 2005 in New York). During this time period, according to data from the New York state DOI, complaints about all long-term care insurance policies in New York related to issues such as the interpretation of policy provisions, premium amounts, and refusals to issue policies.

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<sup>48</sup>In order to continue to sell long-term care insurance in the four Partnership states, insurance agents must receive several hours of continuing education every 2 years. The required hours ranged from 5 hours every 2 years in Indiana to 24 hours every 2 years in Connecticut.

<sup>49</sup>In New York, the continuing education credits from the required Partnership policy training can be used to meet the DOI requirements for agent recertification for traditional long-term care policies.

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## Long-Term Care Insurance Policyholders Are Generally Wealthier than Those Without Such Insurance, and Partnership Policyholders Are Typically Younger than Traditional Long-Term Care Insurance Policyholders

Long-term care insurance policyholders—that is, both Partnership policyholders and traditional long-term care insurance policyholders—are more likely to have higher incomes and more assets than people without long-term care insurance. On average, Partnership policyholders are younger than traditional long-term care insurance policyholders. Those with long-term care insurance policies are also more likely to be female rather than male, and married than unmarried.

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## Long-Term Care Insurance Policyholders Generally Have Higher Incomes and More Assets than Those Without Long-Term Care Insurance

In examining Partnership policyholders in two states, traditional long-term care insurance policyholders nationwide, and those without long-term care insurance nationwide, we found that Partnership and traditional long-term care policyholders are more likely to have higher incomes than those without such insurance.<sup>50</sup> In California and Connecticut—the two states with Partnership programs for which we had data—at the time they purchased a policy, 55 percent of Partnership policyholders over age 55 had monthly household incomes of \$5,000 or greater. In comparison, 43 percent of all households with people over age 55 in these states had monthly household incomes at this level at the time they were surveyed.<sup>51,52</sup>

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<sup>50</sup>Data from Indiana and New York are excluded from our income and asset comparisons. New York did not collect income or asset data for its Partnership program, while Indiana income and asset data were not detailed enough to make comparisons with other states.

<sup>51</sup>Income data for Partnership policyholders in Connecticut were from 2002 through 2005. Income data for Partnership policyholders in California were from 2003 to 2004. Data for all households in those two states were from 2004. We combined multiple years of these data in order to increase the sample size.

<sup>52</sup>Because we did not have a direct measure of the population without long-term care insurance, we used the general population of all households as a proxy. Nationally, about 12 percent of the population over age 55 has long-term care insurance. Therefore we assume that the income information from all households in two states with Partnership programs—California and Connecticut—largely reflects the income and asset patterns of people without long-term care insurance.

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Similarly, at the national level, when surveyed, 46 percent of traditional long-term care policyholders over age 55 had monthly household income of \$5000 or greater, whereas 29 percent of those individuals over age 55 without long-term care insurance had such incomes.<sup>53</sup> We also found that more than half (53 percent) of Partnership policyholders had household assets of \$350,000 or more in California and Connecticut. Data on the asset levels of all households in those states were not available for our comparison. Nationwide, 36 percent of traditional long-term care insurance policyholders and 17 percent of people without long-term care insurance had household assets exceeding \$350,000 (see table 2).

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<sup>53</sup>The national-level data are from 2004.

**Table 2: Household Income and Household Asset Distribution among Partnership Policyholders and Comparison Populations in Partnership States and Nationally**

	Partnership states: CA and CT <sup>a</sup>		All states <sup>b</sup>	
	Partnership policyholders <sup>c,d</sup>	All households <sup>e,f</sup>	Traditional long-term care insurance policyholders <sup>g</sup>	Those without long-term care insurance
<b>Monthly household income ranges<sup>h</sup></b>				
<\$1000	1%	8%	4%	15%
\$1000-\$4999	45	49	50	56
\$5000 or greater	55	43	46	29
<b>Household asset ranges<sup>i,j</sup></b>				
<\$100,000	16%	Not Available	36%	62%
\$100,000-\$199,999	14	Not Available	14	12
\$200,000-\$349,999	17	Not Available	14	9
\$350,000 or greater	53	Not Available	36	17

Sources: GAO analysis of Partnership program purchaser surveys, American Community Survey (ACS), and the HRS.

Note: Percentages may not add to 100 due to rounding.

<sup>a</sup>Does not include data from New York and Indiana.

<sup>b</sup>Data for all states are from the HRS, 2004.

<sup>c</sup>Connecticut values are based on survey data from 2002 through 2005.

<sup>d</sup>California values are based on survey data from 2003 and 2004.

<sup>e</sup>Data are from the ACS, 2004.

<sup>f</sup>We use the All Households category as a proxy for those without long-term care insurance in California and Connecticut. Approximately 12 percent of people nationwide over 55 have long-term care insurance so our measure is likely to contain approximately 88 percent without long-term care insurance.

<sup>g</sup>Approximately 2 percent of people nationwide with long-term care policies have Partnership policies. Thus, although the HRS data may include a small number of Partnership policyholders, about 98 percent of these people likely have traditional long-term care insurance.

<sup>h</sup>Data for monthly income ranges are for survey respondents aged 55 and over.

<sup>i</sup>Data for asset ranges are for all survey respondents regardless of age.

<sup>j</sup>In the policyholder surveys, California and Connecticut instructed policyholders to exclude the value of homes and cars when reporting their assets. The HRS data for assets also exclude homes and vehicles.

Partnership Policyholders Are Younger on Average than Traditional Long-Term Care Insurance Policyholders and People Without Long-Term Care Insurance

In our analyses, we found that Partnership policyholders in California, Connecticut, Indiana, and New York are younger on average than traditional long-term care insurance policyholders nationally and those without long-term care insurance nationally (see table 3). We also found that those who purchase long-term insurance policies—both traditional and Partnership—are more likely to be women than men, and married than unmarried.<sup>54</sup>

**Table 3: Demographic Characteristics of Partnership Policyholders and Comparison Populations in Partnership States and Nationally**

	All partnership policyholders <sup>c,e</sup>	Traditional long-term care insurance policyholders <sup>a,d</sup>	People without long-term care insurance <sup>d</sup>
<b>Average age</b>	59	63 <sup>c</sup>	64 <sup>b</sup>
Age range	18-104	30-95 <sup>c</sup>	24-107 <sup>b</sup>
Age categories			
Under 55 years	28%	20%	21%
55-64 years	49	37	36
65-74 years	19	30	22
75 years & over	3	13	20
<b>Sex</b>			
Female	58%	56%	54%
Male	42	44	46
<b>Marital status</b>			
Married	75%	72%	62%
Not married	24	28	38
Unknown	1	0	0

Source: GAO analysis of the UDS and the HRS.

Note: Percentages may not add to 100 due to rounding.

<sup>a</sup>Approximately 2 percent of people nationwide with long-term care policies have Partnership policies. Thus, although the HRS data may include a small number of Partnership policyholders, about 98 percent of these people are likely to have traditional long-term care insurance.

<sup>b</sup>Denotes average age at time of survey.

<sup>c</sup>Data are as of time of purchase.

<sup>d</sup>Data are from the 2004 HRS, which is a longitudinal national panel survey of individuals over age 50.

<sup>54</sup>To make this comparison, we used cumulative data from the 2002 through 2005 UDS data sets on Partnership policyholders and data from the 2004 HRS survey.

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\*Data are from the UDS for 2002 through 2005.

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## Partnership Programs Unlikely to Result in Savings for Medicaid Largely Because of the Asset Protection Benefit of Partnership Policies

Surveys conducted in some states with Partnership programs and our illustrative financing scenarios together suggest that in the four states with Partnership programs, the programs are unlikely to result in Medicaid savings and could result in increased Medicaid spending. Survey data show that in the absence of a Partnership program in their state, 80 percent of Partnership policyholders would have purchased a traditional long-term care insurance policy and may represent a potential source of increased spending for Medicaid. Data are not yet available to determine the extent to which the 20 percent of individuals who would have self-financed their care will access Medicaid in the absence of a Partnership program. However, our scenarios suggest that an individual could self-finance care and delay Medicaid eligibility for about the same amount of time as he or she would have with a Partnership policy, although we identify some circumstances that could delay or accelerate the time to Medicaid eligibility. Because of the amount of insurance Partnership policyholders generally purchase and their typical income and assets, few Partnership policyholders are likely to ever become eligible for Medicaid, which suggests that the Partnership programs are likely to have a small impact on Medicaid spending.

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## Most Partnership Policyholders Would Have Purchased Traditional Long-Term Care Insurance in Absence of Partnership Program, Suggesting an Increase in Medicaid Spending

The four Partnership programs are unlikely to result in savings for their state Medicaid programs and may result in increased Medicaid spending.<sup>55</sup> Based on surveys of Partnership policyholders conducted by state Partnership programs in California, Connecticut, and Indiana, we estimate that, in the absence of a Partnership program in their state, 80 percent of Partnership policyholders would have purchased traditional long-term care insurance policies instead, while the other 20 percent would have self-financed their care.<sup>56</sup> To assess the impact Partnership programs may have on Medicaid savings in the four states with Partnership programs, we explored, under three different illustrative financing scenarios and using certain assumptions, how long it would take before an individual using a Partnership policy would become eligible for Medicaid and how long—in

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<sup>55</sup>This is consistent with CBO's estimate that repealing the moratorium on new Partnership programs could increase Medicaid spending.

<sup>56</sup>The results for the individual states were 84 percent, 76 percent, and 57 percent for California, Connecticut, and Indiana, respectively. Using the number of respondents in each state to weight the calculation, the average for the three states combined was approximately 80 percent.

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the absence of a Partnership program—it would take for the same individual to become eligible for Medicaid using the other two financing options depicted in the scenarios. Our financing scenarios indicate that with a Partnership policy, an individual with assets and benefits typical of many policyholders becomes eligible for Medicaid sooner than if the individual financed his or her long-term care with a traditional long-term care policy. Because a Partnership policy, unlike a traditional long-term care insurance policy, exempts the individual in the scenario from spending his or her protected assets on long-term care before the individual becomes eligible for Medicaid, the individual with a Partnership policy becomes eligible for Medicaid sooner than if the individual had a traditional policy, which is likely to increase the amount of time Medicaid finances the individual’s long-term care. The scenarios also suggest that if the individual would have self-financed his or her long-term care in the absence of the Partnership program, the individual would become eligible for Medicaid at about the same time as he or she would have with a Partnership policy.

The three financing scenarios we compared were

- financing using a Partnership policy,
- financing using a traditional long-term care insurance policy, and
- self-financing without any long-term care insurance.

For illustrative purposes, our scenarios are based on an individual with assets that are typical of many of those who have long-term care insurance—that is, an individual who holds assets of \$300,000.<sup>57</sup> In two of our scenarios, the individual holds long-term care insurance benefits of \$210,000, which will cover a nursing facility stay of about 3 years—the average nursing facility stay is between 2 and 3 years. We also make several simplifying assumptions, such as that the individual is not overinsured (i.e., does not have insurance that exceeds the value of the individual’s assets) and is unmarried at the time long-term care is required.

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<sup>57</sup>For example, 53 percent of Partnership policyholders in California and Connecticut had household assets of \$350,000 or more. Approximately 37 percent of Partnership policyholders purchased policies with a 3-year benefit period.



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Specifically, scenario A (see fig. 1) depicts a Partnership policyholder with \$300,000 in assets who purchases a policy valued at \$210,000 (worth about 3 years of nursing facility coverage), automatically receiving \$210,000 in asset protection. When the individual requires long-term care, the Partnership policy will pay for the first \$210,000 worth of care—the total amount of his or her insurance benefits. After these Partnership benefits have been exhausted, the individual will have to spend down the \$90,000 of unprotected assets on long-term care and then, assuming the individual meets state Medicaid income eligibility requirements, Medicaid will begin to finance the individual’s long-term care. As depicted by scenario B, if this same individual purchases a traditional long-term care insurance policy worth \$210,000 instead of the Partnership policy, insurance will pay for the first \$210,000, and the individual will then have to spend down the unprotected assets—all \$300,000—before he or she is eligible for Medicaid.<sup>58,59</sup> Scenario C describes how this same individual would finance his or her long-term care without any long-term care insurance. As scenario C shows, if the individual had \$300,000 in assets, these would have to be spent before the individual would be eligible for Medicaid.<sup>60</sup> In both this scenario and in the scenario in which the individual owns a Partnership policy, Medicaid begins paying for the individual’s long-term care at about the same time, with the difference being whether long-term care costs prior to Medicaid eligibility are paid by long-term care insurance or by the individual.

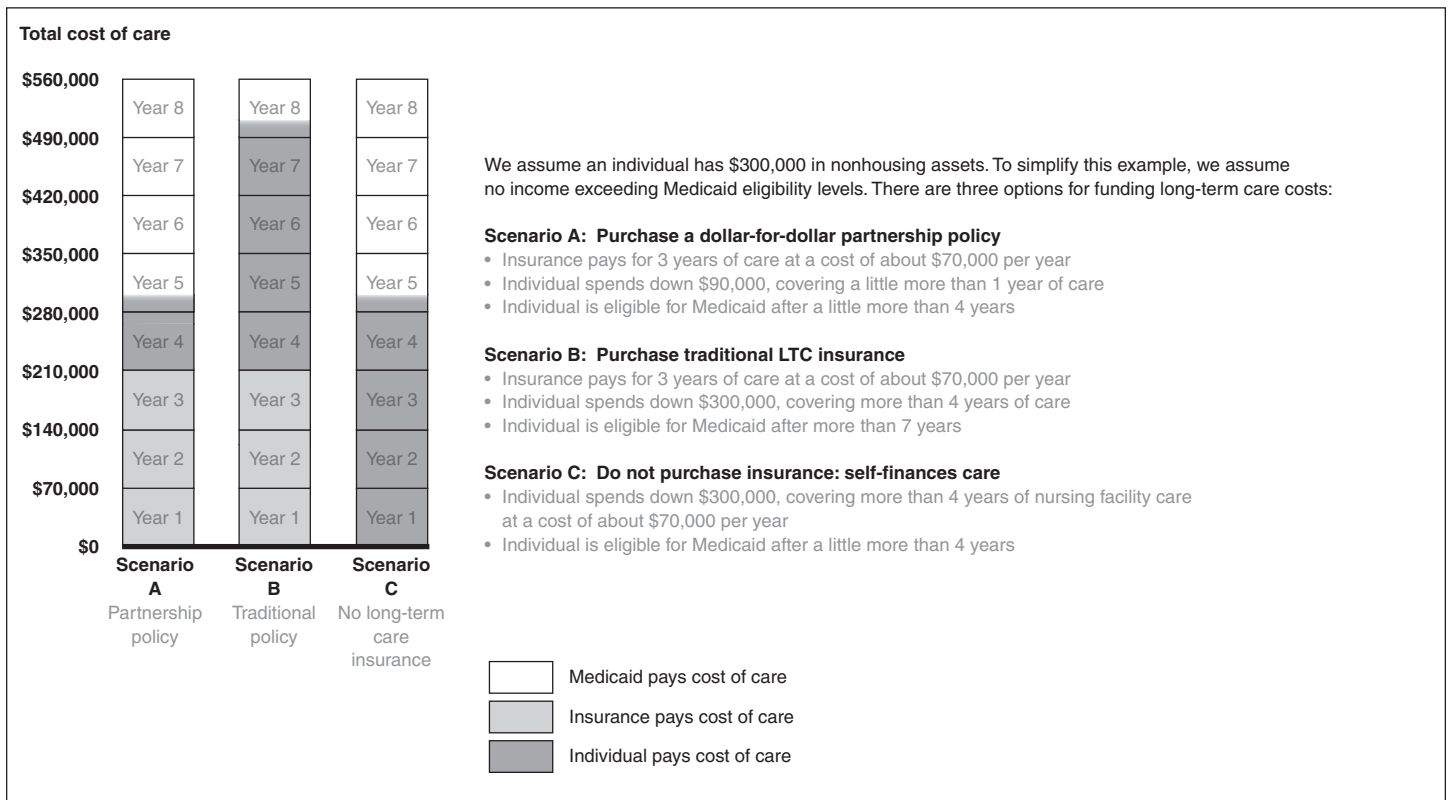
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<sup>58</sup>To qualify for Medicaid, individuals must meet a number of requirements, including their state’s allowable asset limitation, excluding the amount of protected assets due to the Partnership policy. For 2006, these were \$2,000 in California, \$1,600 in Connecticut, \$1,500 in Indiana, and \$4,150 in New York. The situation is more complicated when the person has a spouse. For instance, regarding assets, when someone in an institution applies for Medicaid and they are married, Medicaid looks at all the assets of the couple, regardless of ownership (certain items such as the couple’s home, personal and household property, one vehicle, and a small amount set aside for burial, are excluded). One half of the remaining countable assets, up to a maximum of approximately \$100,000 in 2007, are then protected for the community spouse. Any remaining assets are then used to determine Medicaid eligibility for the spouse in the institution.

<sup>59</sup>Individuals may choose a different set of benefits, depending on whether they select a traditional or Partnership program policy. In order to simplify our comparison of scenarios A and B, we assume that the benefits of a Partnership policy and a program traditional long-term care policy are the same, except for the asset protection benefit of the Partnership policy.

<sup>60</sup>More than half of all Partnership policyholders in California and Connecticut combined reported assets of at least \$350,000, which is more than the national average of about \$210,000 that would be needed to pay for a 3-year stay in a nursing facility—the average stay being between 2 and 3 years.

**Figure 1: Financing of Long-Term Care Nursing Facility Stays Under Three Scenarios**



Source: GAO.

Note: To simplify our scenarios, we made some simplifying assumptions, such as, the individual depicted in the scenarios has assets and benefits that are typical of many individuals with long-term care insurance; the individual is unmarried; and the individual has assets that are greater than or equal to the value of the individual's Partnership policy. Our results do not depend on the level of assets or the amount of insurance dollars, provided the amount of insurance dollars does not exceed the amount of assets. Appendix II further discusses the effects of changing these assumptions.

We found some circumstances when adjusting the assumptions underlying our scenarios resulted in delaying or accelerating Medicaid eligibility, but most did not change the outcomes related to Medicaid savings. For example, to construct our scenarios, we assumed an individual who had \$300,000 in assets, \$210,000 in insurance coverage, and who used this coverage for long-term care that cost about \$70,000 per year. When we changed these amounts—as long as the amount of insurance coverage did not exceed the amount of assets—the scenarios still showed that the individual became eligible for Medicaid sooner with a Partnership policy than with a traditional policy, and became eligible for Medicaid at the same time with a Partnership policy and self-financing.

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Our scenarios also assumed that the individual with a Partnership policy or a traditional long-term insurance policy was not overinsured—that is, had more insurance coverage than the value of his or her assets. When we modified this assumption, we found that one portion of our finding still held true—the individual in the scenarios using the Partnership policy still became eligible for Medicaid sooner than he or she did using a traditional long-term care insurance policy. However, the individual also became eligible for Medicaid later using the Partnership policy than when the individual self-financed his or her own long-term care. This suggests that if individuals overinsure their assets, those who finance their long-term care using Partnership policies could represent a source of savings for Medicaid when compared with those who self-finance their care. However, the number of policyholders that this applies to is unlikely to be large enough to offset the number of Partnership policyholders who represent a potential source of increased Medicaid spending. While we do not have information about the amount of assets that Partnership policyholders have at the time they use their benefits, survey data from California and Connecticut indicate that when Partnership policyholders purchased their policies, they tended to purchase policies that were equal to or lower than the value of their household assets. This suggests that most individuals are unlikely to overinsure their assets at the time of purchase, though their status could change over time.<sup>61</sup> In California and Connecticut combined, in 2004, 53 percent of Partnership policyholders had at least \$350,000 worth of household assets at the time of purchase, while only about 32 percent of these Partnership policyholders have more than 5 years of coverage equal to about \$350,000.

Our scenarios also depicted an unmarried individual. While most Partnership policyholders are married when they purchase a Partnership policy, by the time most individuals require long-term care services, they are unmarried. Our analysis of 2004 HRS data of individuals entering a nursing facility who are age 65 or older showed that about 66 percent are widowed, and more than 75 percent are not married. However, there are likely some individuals who will be married when they require long-term

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<sup>61</sup>Household assets may be jointly owned by a couple. In order for assets to be fully protected for the couple, both individuals need to have their own Partnership policies that insure all eligible assets because many individuals are no longer married by the time they require long-term care services, and the asset protection associated with a Partnership policy is not transferable. We do not consider a married couple to be overinsured when both individuals have long-term care insurance policies that are worth the value of their estate.

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care services. In general, after applying the Medicaid spousal exemption, if the individual's assets remain higher than the value of his or her insurance, being married does not change the result that compared with a Partnership policy, the individual's time to attain Medicaid eligibility is accelerated with a traditional policy and is the same as with self-financing.<sup>62</sup> However, if the amount of the Medicaid spousal exemption brings the individual's eligible assets below the value of the insurance policy, then the individual would fall into an overinsured category. Being overinsured means the individual would become a source of savings for Medicaid; however, this only applies to the 20 percent of individuals who would have self-financed their care in the absence of a Partnership program. The 80 percent of individuals who would have purchased a traditional policy still represent potential increased spending, whether they are overinsured or not.

We also explored what would occur if we modified our assumption that an individual is equally likely to transfer assets in all three of our scenarios. We found that if the individual who would have self-financed care transfers his or her assets, it would likely take less time for the individual to become eligible for Medicaid than it would with a Partnership policy. This could result in some savings to Medicaid for those individuals who purchase Partnership policies instead of transferring assets. We also found that for an individual who would have purchased traditional insurance, the amount of assets transferred would have to be at least as much as the value of the insurance policy purchased in order for the Partnership program to result in Medicaid savings. While we do not know how many individuals would have transferred assets in the absence of the Partnership program, one of our recent reports suggests that asset transfers may not be that prevalent. In March 2007, we reported that few applicants who were approved for Medicaid coverage ultimately transferred assets.<sup>63</sup> In addition, the asset transfer standards established under DRA increased the look-back period to 5 years, which reduces the

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<sup>62</sup>The Medicaid spousal exemption, also known as the community spouse resource allowance, permits the spouse remaining in the community to retain an amount equal to one-half of the couple's combined countable assets, up to a state-specified maximum level. In 2007, the federal maximum was \$101,640; that is, states were allowed to set their community spouse resource allowance equal to a value no greater than this amount. Medicaid eligibility of the institutionalized spouse is determined using the remaining assets.

<sup>63</sup>This finding was based on our review of the prevalence of asset transfers among 465 approved applicants in three states. See [GAO-07-280](#).

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opportunity for individuals to transfer assets to establish Medicaid eligibility.

Overall, our scenarios suggest that in the aggregate the savings potential from the Partnership programs of the 20 percent of individuals who would have self-financed their care is outweighed by the 80 percent of individuals who will likely result in increased Medicaid spending. For more information on our simplifying assumptions and the impact of adjusting these assumptions on our findings, see appendix II.

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### Few Partnership Policyholders Are Likely to Become Eligible for Medicaid, Limiting the Impact on Medicaid Expenditures

Although our survey data and scenarios show that about 80 percent of Partnership policyholders who become eligible for Medicaid are likely to do so sooner than they otherwise would have without a Partnership program, we also expect that few Partnership policyholders will actually become eligible for Medicaid and turn to the program to finance their long-term care. There are two reasons for this expectation. First, most Partnership policyholders purchase policies that are likely to cover all or most of their long-term care expenses during their lifetimes, thereby reducing the likelihood that the policyholders will require financing from Medicaid for their long-term care. We found that 86 percent of Partnership policyholders had benefits covering 3 or more years, while the average nursing facility stay lasts between 2 and 3 years. One study of traditional long-term care insurance policyholders with lifetime benefits found that only about 14 percent of policyholders used their benefits for more than 3 years, and fewer than 5 percent of all policyholders used their benefits for more than 5 years. These data suggest that if Partnership policyholders continue to purchase policies with benefit periods that cover their long-term care needs, the percentage of Partnership policyholders who exhaust their benefits and then become eligible for Medicaid is likely to be limited. While some experts have reported that there is a recent trend for traditional long-term care insurance policies to be sold with shorter benefit periods, the minimum benefit requirements that applied to Partnership policies could result in Partnership benefits remaining more stable over time.

The second reason we estimate that few Partnership policyholders are likely to turn to Medicaid for their long-term care financing is that, in general, Partnership policyholders have incomes that exceed Medicaid income eligibility thresholds. Although Partnership policyholders can purchase varying amounts of asset protection, they must still meet state Medicaid income thresholds in order to become eligible for Medicaid. In 2006, the monthly income eligibility thresholds for all states were required

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to be no higher than 300 percent of the Supplemental Security Income standard, which was \$1,809 in 2006.<sup>64</sup> However, only 1 percent of the Partnership policyholders in California and Connecticut had household incomes less than \$1,000 per month at the time they purchased their long-term care insurance policies. Our analysis of HRS data also indicates that wealthy individuals continue to have a high level of assets<sup>65</sup> at the time they are admitted to a nursing facility, which suggests that many Partnership policyholders will continue to be relatively wealthy and unlikely to meet Medicaid eligibility thresholds, even at the time they enter a nursing facility. For example, of all people who entered a nursing facility in 2004, the average asset value for the 25 percent of people with the highest assets was over \$334,000 in 1992, and by 2004, 12 years later, their assets had grown to almost \$430,000. Similarly, the average monthly income for the 25 percent of people with the highest incomes who were admitted to a nursing facility in 2004 was about \$5,600 in 1992, and about \$3,700 in 2004—more than double the threshold for Medicaid eligibility in any of the four states with Partnership programs.

The income levels of Partnership policyholders may reflect the fact that the cost of purchasing a long-term care insurance policy—including a Partnership policy—may exceed what most elderly households can afford. According to guidelines published by the NAIC, a person should spend no more than 7 percent of his or her income on long-term care insurance. A traditional long-term care insurance policy covering 3 years of care, with inflation protection, a \$200 daily benefit allowance, and comprehensive coverage, costs about \$3,000. In order to afford such a policy, an individual would need an annual income of about \$43,000. However, data from the 2004 HRS show that about half of elderly households nationwide had annual incomes below \$43,000. A survey of Connecticut Partnership policyholders suggested that cost was the most important factor in policyholders' decision to let their policies lapse. Sixty-two percent of

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<sup>64</sup>Specifically, the Medicaid eligibility thresholds in the four states with Partnership programs were \$600 in California, \$619 in Indiana, \$1,809 in Connecticut, and \$692 in New York in 2006. If individuals were in a nursing facility, they were permitted to keep a personal allowance amount to cover incidental purchases in the nursing facility. The personal allowances for individuals in nursing facilities in 2006 were \$35 in California, \$52 in Indiana, \$61 in Connecticut, and \$50 in New York.

<sup>65</sup>In this particular example, our criterion for being among the wealthiest people is those people whose assets are in the highest 25 percent.

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surveyed individuals in Connecticut who let their Partnership policy lapse said that they dropped their Partnership policy because it was too costly.<sup>66</sup>

As of 2006, few Partnership policyholders in the four states with Partnership programs had accessed Medicaid to finance their long-term care. Of the approximately 218,000 Partnership policies sold since the program was first introduced in the late 1980s, approximately 190,000 were still active as of August 2006. In addition, as of that same date, a total of 3,454 Partnership policyholders—less than 2 percent of all Partnership policyholders—have accessed long-term care benefits since the Partnership programs began. Of that group, 292 Partnership policyholders exhausted their long-term care insurance benefits, and 159 policyholders—approximately 54 percent of those who exhausted their benefits—subsequently went on to access Medicaid benefits. The number of Partnership policyholders who access benefits and also access Medicaid is likely to grow, because people typically use long-term care services 15 to 20 years after they purchase a policy, and the first Partnership policies were established less than 20 years ago. We do not know why some of the 292 individuals who exhausted their long-term care insurance benefits did not access Medicaid. It is possible that their income was higher than Medicaid eligibility thresholds, or they may have had unprotected assets that they had to spend down. Alternatively, they may have preferred to self-finance their care, they may have died, or they may have stopped using long-term care services.

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## Concluding Observations

With DRA authorizing all states to implement Partnership programs, information on the Partnership policies and policyholders from the four states with Partnership programs may prove useful to other states considering implementing such programs. In particular, states may want to consider the trade-offs that come with implementing a Partnership program. First, a Partnership program's potential impact on Medicaid expenditures should be considered. Based on our scenario comparison and survey data, we anticipate that Partnership programs in California, Connecticut, Indiana, and New York are unlikely to result in savings for their state Medicaid programs and could result in increased Medicaid

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<sup>66</sup>It is possible that Partnership policyholders with higher incomes could meet Medicaid income thresholds because the four states with Partnership programs allow individuals to deduct medical expenses from their income when determining Medicaid eligibility. However, the individuals would still need to contribute their income toward the cost of care. Therefore, this limits Medicaid's liability for individuals with higher incomes.

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expenditures. This is largely due to the modifications of state Medicaid eligibility requirements states have to make in order to offer asset protection to Partnership policyholders and survey data showing that the majority of Partnership policyholders would have purchased traditional long-term care insurance had the Partnership program not existed. However, given the amount of long-term care insurance benefits and income and asset levels of current Partnership policyholders, we also anticipate that relatively few policyholders will access Medicaid in the four states with Partnership programs. Therefore, the impact of Partnership programs on state Medicaid programs will likely be small.

While Partnership programs are not likely to reduce states' Medicaid expenditures, the programs do offer some benefits to some consumers. The asset protection feature, which states require Partnership policies to offer at no additional premium cost, can benefit policyholders who exhaust their Partnership benefits and who access Medicaid. Even if individuals do not end up using their Partnership insurance or Medicaid, the availability of asset protection may provide peace of mind for those who fear the risk of having to spend their assets on their long-term care. However, states that implement Partnership programs should recognize that, because of their cost, Partnership policies generally do not benefit all consumers. The cost of annual premiums for long-term care insurance may not be affordable to individuals with moderate incomes, and as a result long-term care insurance policyholders, including Partnership policyholders, tend to be wealthier than those without such insurance.

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## Agency and State Comments and Our Evaluation

We received written comments on a draft of this report from HHS (see appendix III) and from the four states with Partnership programs, California, Connecticut, Indiana, and New York (see appendix IV).

HHS commented that the results of our study should not be considered conclusive because the results do not adequately account for the effect of estate planning efforts such as asset transfers. Specifically, HHS was concerned that the simplified scenarios were flawed in that they did not account for individuals who engage in estate planning activities prior to expending all of their own funds on long-term care costs. HHS further noted that the data sources used in our report would not likely yield accurate data on asset transfers and criticized the report for not incorporating a review of the literature on this issue and reporting on analyses of the experience of the four states with Partnership programs. The four states with Partnership programs disagreed with our conclusion that the Partnership programs are unlikely to result in Medicaid savings



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and, like HHS, commented that our scenarios did not adequately account for the impact of asset transfers. California, Connecticut, and New York raised concerns about our methodology for estimating the financial impact of the Partnership program on Medicaid. California and Connecticut noted that we had excluded two Partnership policyholder survey questions from our analysis that they consider in their own analysis of the Partnership program.

We maintain that the evidence suggests that the Partnership program is unlikely to result in savings for Medicaid, despite limited data and program experience. We agree with HHS and the four states with Partnership programs that Medicaid savings could result from those individuals who would have transferred assets in the absence of the Partnership program. However, our scenarios suggest that the savings associated with asset transfers are likely to offset the potential costs associated with policyholders who would have purchased traditional long-term care insurance in the absence of the Partnership programs. Further, the assumptions used by California, Connecticut, and Indiana to predict savings could underestimate the percentage of Partnership policyholders that represent a cost to Medicaid and overestimate the percentage that represent savings to Medicaid. We did not provide an overview of the literature on asset transfers in our draft report because, as we noted in our March 2007 report, the evidence on the extent to which individuals transfer assets to become financially eligible for Medicaid coverage for long-term care is generally limited and often based on anecdote.<sup>67</sup> We did not comment on states' analyses of their experience with the Partnership programs because, according to our analysis, their methodology overstates potential savings and understates potential costs.

## Impact of Asset Transfers on Medicaid

In appendix II of our draft report we acknowledged that some savings could result for Medicaid if, in the absence of a Partnership program, an individual would have self-financed his or her long-term care and transferred assets. We also acknowledged how a Partnership program can result in Medicaid savings if, in the absence of the Partnership program, an individual would have purchased a traditional long-term care insurance policy and transferred assets that were at least equal to the value of the traditional long-term care insurance policy. However, our analysis suggests that these savings would be limited to those individuals who, prior to requiring long-term care, would have transferred assets to become

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<sup>67</sup>See [GAO-07-280](#).

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eligible for Medicaid in the absence of the Partnership program. Further, the larger percentage of policyholders who represent a potential cost to Medicaid are likely to offset savings attributable to asset transfers.

While the literature on the extent of asset transfers is generally limited and anecdotal, in March 2007, we published a report that included an analysis of asset transfers by nursing home residents using HRS data. We complemented that analysis by examining a sample of Medicaid applications in three states to identify the extent of asset transfer activity.<sup>68</sup> Both of these analyses suggested that about 10 to 12 percent of individuals transferred assets before applying for Medicaid, and the median amount transferred based on analysis of the HRS data and state Medicaid applications was \$1,239 and \$15,152, respectively.<sup>69</sup> The relatively low incidence of asset transfers and the small amounts transferred relative to the costs associated with long-term care suggest that the impact of asset transfers on Medicaid may be limited. While the results of this study are not specific to Partnership policyholders, we found no other credible evidence suggesting that Partnership policyholders would transfer sufficient assets to offset the costs to Medicaid associated with the large number of individuals who would have purchased traditional long-term care insurance in the absence of the Partnership program. Also, although the overall impact of DRA on Medicaid eligibility is uncertain, DRA reduces the opportunity for people to transfer assets in order to become Medicaid eligible by increasing the period Medicaid programs can “look-back” at an individual’s assets to 5 years. In response to HHS’ comments about asset transfers, we have amended our draft report to make the discussion of asset transfers more prominent in the body of our report and to include reference to our March 2007 study.

## Methodology for Assessing Medicaid Savings

California, Connecticut, and New York raised concerns about our methodology for estimating the financial impact of the Partnership program on Medicaid. California and Connecticut noted that we had excluded two Partnership policyholder survey questions from our analysis that they consider in their own analysis of the Partnership program. These questions asked Partnership policyholders whether they would have

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<sup>68</sup>See [GAO-07-280](#).

<sup>69</sup>The HRS analysis was based on transfers during the 4 years prior to nursing home entry by elderly nursing home residents who were Medicaid-covered. The analysis of a sample of Medicaid applications in three states was based on transfers during the 3-year look-back period by approved Medicaid applicants.

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transferred assets to become eligible for Medicaid in the absence of the program and whether the Partnership program influenced their decision to buy long-term care insurance.<sup>70</sup>

We maintain that our methodology is sound and that the methodology California, Connecticut, and Indiana use underestimates the potential for Medicaid costs and overestimates the potential for Medicaid savings. We relied on a question that asked Partnership policyholders whether they would have purchased traditional long-term care insurance in the absence of the Partnership program.<sup>71</sup> We disagree with California, Connecticut, and Indiana regarding the appropriateness of including additional survey information because of concerns about ambiguous wording and these states' assumption that policyholders' responses can be used to predict the likelihood of future asset transfers. We did not present the states' analyses for evaluating Medicaid spending in our draft report because we believe the states' analyses overstate potential savings and understate potential costs.

In our analysis, we estimated that about 80 percent of policyholders would have purchased traditional long-term care insurance in the absence of the program, and we estimated that these individuals generally represented a potential cost to Medicaid. Our 80 percent estimate was based on analysis of the survey question about how Partnership policyholders would have financed their long-term care in the absence of the Partnership program. The methodology that California, Connecticut, and Indiana use to estimate potential costs is based on a policyholders' response to the following criteria, obtained from three survey questions:

1. The policyholder would have purchased traditional insurance in the absence of the Partnership program;
2. the Partnership program had no influence on the policyholders' decision to purchase insurance; and

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<sup>70</sup>One survey question asks: "Did the [partnership program] influence your decision to purchase long-term care insurance? (yes or no)." The other asks: "Why did you decide to purchase long-term care insurance?" Eight response options are provided, one being "As an alternative to transferring assets to qualify for Medicaid."

<sup>71</sup>The California, Connecticut, and Indiana surveys asked: "Would you have purchased long-term care insurance in the absence of the Partnership?" (yes or no).

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3. the policyholder would not have transferred assets in the absence of the Partnership program.

By adding the two additional criteria to determine whether an individual represents a potential cost to Medicaid, the states' estimate of the percentage of policyholders who fell into this category was more restrictive than ours. We have several concerns with the wording of the survey questions used to define the additional two criteria. In addition, according to our analysis, the criteria that define costs are not correctly specified because there are some circumstances when the second criterion would represent a cost to Medicaid whether or not the Partnership program had an influence on the policyholder's decision to purchase insurance.

The wording of the survey question about whether the Partnership program influenced the policyholder's decision to purchase insurance was not specific with regard to how the decision was influenced. In particular, the Partnership programs' influence could have been to influence the policyholder to purchase a different benefit package, to change the timing of the policyholder's purchase, or to change the policyholder's decision to purchase at all. Given the ambiguity of the question, it is not clear how a response should be interpreted. Moreover, how this question is interpreted could influence the outcome of an analysis of the likely impact of the Partnership program on Medicaid spending. Our analysis suggests that even if the Partnership program influenced policyholders to purchase enhanced benefits, the Partnership program still represented a potential cost, just a smaller cost. Adding this criterion incorrectly narrows the number of policyholders who represent potential costs to Medicaid.

We also disagree with the states' assumption that policyholders' responses to the asset transfer question can be used to approximate the extent to which individuals would or would not transfer all of their assets in the future and—in the absence of the program—become eligible for Medicaid. The respondents were asked about events that are unlikely to occur for 15 to 20 years, and to speculate on what their actions would be in the future if there was no Partnership program. California, Connecticut, and New York reported that about 25 percent of respondents said they would have transferred assets to become eligible for Medicaid. All of these individuals are excluded from the pool of policyholders who represent a potential cost to the program in the state cost estimates. The assumption that all of these individuals would have transferred all of their assets is inconsistent with our March 2007 report regarding the incidence of asset transfers and amount of assets transferred for the purposes of becoming eligible for

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Medicaid. We agree that some individuals would have transferred assets in the absence of the program, but do not agree that this question provides an adequate measure of the extent to which it occurs. Therefore, we believe using the responses to this question may overstate the extent to which respondents would actually transfer all of their assets.

We have similar concerns with the methodology California, Connecticut, and Indiana used to estimate savings, because it is based on the same three questions, two of which we view as inadequate. We assumed in our scenarios that individuals who would have self-funded their long-term care without insurance were likely to be budget neutral, but acknowledged there were several circumstances that would cause these individuals to become a potential source of savings. However, we did not attempt to quantify the percentage who would become a source of savings because of data limitations and because the savings were likely to be outweighed by the larger percentage of policyholders who likely represented a cost to the program. In contrast, California, Connecticut, and Indiana consider a policyholder to represent savings if:

1. the policyholder would have purchased a Partnership policy as an alternative to transferring assets; and
2. (a) the Partnership program influenced their decision to purchase insurance, or  
(b) the policyholder would not have purchased long-term care insurance in the absence of the Partnership program.

As we noted in the discussion above regarding the states' methodology for estimating Medicaid costs, we disagree with the reliance on the asset transfer question as a measure of the extent to which individuals would have transferred assets. We also believe it was incorrect to predict Medicaid savings for those respondents who said the Partnership program influenced their decision to purchase a policy. Even if the Partnership program influenced the policyholder's decision to purchase enhanced benefits, our analysis suggests the Partnership program would not result in savings but would rather result in a reduction of costs to Medicaid.

New York commented that our analysis was not applicable to their state. They cited preliminary results of a 2006 survey that estimated the number of recent Partnership policyholders who would have financed their care with a traditional policy in the absence of the Partnership program. Their estimates were considerably lower than the 80 percent we estimated based on our results from California, Connecticut, and Indiana. New York used

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Impact on Medicaid Savings of  
Purchasing Different Levels of  
Benefits by Partnership and  
Traditional Policyholders

different questions in their survey than California, Connecticut, and Indiana.<sup>72</sup> As such, their results were not comparable to those of the other states. We believe New York's question was less direct for the purposes of our analysis than the question used by California, Connecticut, and Indiana in their survey of Partnership policyholders. New York's question asked policyholders—using a multiple choice format—how they would pay for long-term care in the future, if they had not purchased a Partnership policy. One of the possible responses was that they would purchase traditional insurance. This required policyholders to speculate about future behavior, and to respond to a more complex question and answer format. California, Connecticut, and Indiana asked directly about decisions made in the past—whether the Partnership policyholder would have purchased long-term care insurance in the absence of the Partnership program, with a simple yes or no response.

California, Connecticut, and New York also commented that our finding that Partnership policyholders tended to have more extensive benefits than traditional policyholders was inconsistent with our scenarios that assumed that the policyholder would have purchased comparable benefits in the absence of the Partnership program. Assuming comparable benefits in our scenarios allowed us to assess the impact of the Partnership program on Medicaid savings in a simpler framework. As we explain in appendix II, some Partnership policyholders may have more coverage than if they had purchased a traditional policy. We show that if the value of the insurance policy is less than the amount of assets owned by the policyholder, the person will still take longer to become Medicaid eligible with a traditional long-term care insurance policy with a lesser value than with a Partnership policy. However, the amount of additional time it would take for the individual with a traditional policy to become eligible for Medicaid would be less than if the two policies had the same amount of benefits.

HHS, the Indiana Partnership program, and the New York Department of Insurance provided us with technical comments and clarifications, which we incorporated as appropriate.

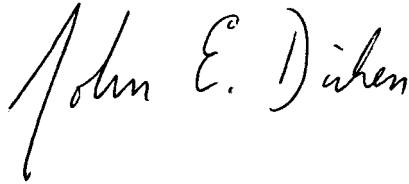
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<sup>72</sup>Whereas California, Connecticut, and Indiana surveys asked: "Would you have purchased long-term care insurance in the absence of the Partnership?" (yes or no), New York's survey asked: "Had you not purchased Partnership insurance, what would be your plan to pay for LTC you may need?" Seven response options were provided, one being "I would purchase non-Partnership long-term care insurance."

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As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Secretary of Health and Human Services, congressional committees, and other interested parties. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have questions about this report, please contact me at (202) 512-7119 or [dickenj@gao.gov](mailto:dickenj@gao.gov). Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in Appendix IV.

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive style with a large, sweeping initial "J".

John E. Dicken  
Director, Health Care

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# Appendix I: Data and Methods for Analysis of Long-Term Care Insurance Benefits and Demographics

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In this appendix we describe the data and methods that we used to examine the benefits of Partnership and traditional long-term care insurance policyholders. We also describe the data and methods we used to assess income, assets, age, gender, and the marital status of Partnership program long-term care insurance policyholders, traditional long-term care insurance policyholders, and people without long-term care insurance.

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## Examining Long-Term Care Insurance Benefits Purchased by Partnership Policyholders and Traditional Long-Term Care Insurance Policyholders

We examined the benefits purchased by Partnership long-term care policyholders and the benefits purchased by traditional long-term care policyholders, using 2002 through 2005 data from two sources. Our data source for the benefits purchased by Partnership policyholders was the Uniform Data Set (UDS)—a data set supplied to us by each of the four states with Partnership programs that contained information on all Partnership policyholders who had purchased long-term care Partnership policies. The UDS was developed collaboratively among the four states with Partnership programs, insurers, the National Program Office at the Center on Aging, University of Maryland, and the Program Evaluator, Laguna Research Associates. The UDS contains information submitted by insurers with Partnership policyholders and summarized by each of the states on a quarterly basis. Insurers are required to submit data to the state Partnership program on: (1) newly insured people,<sup>1</sup> (2) people who dropped their policies, (3) applicants for insurance who were assessed for long-term care insurance eligibility, and (4) the amount of payments for services and utilization. We used the data set for newly insured people to analyze the benefits purchased by Partnership policyholders. These data contain information on daily benefit amounts, the length of the benefit period, the length of the elimination period, and the type of coverage, including whether the coverage is comprehensive coverage or for facilities only. To obtain data about the benefit characteristics of insurance policies purchased by traditional long-term care policyholders, we surveyed five large insurance companies selling long-term care insurance. We selected these five insurance companies on the basis of the total number of policies and amount of annualized premiums in effect in the individual market, as of December 31, 2004. The five insurance companies were AEGON USA,<sup>2</sup> Bankers Life and Casualty Company, Genworth Financial, John Hancock

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<sup>1</sup>This part of UDS data contains information on each person who applied for a Partnership policy and who passed the underwriting process.

<sup>2</sup>AEGON USA left the long-term care insurance market on March 31, 2005.



Life Insurance Company, and Metropolitan Life Insurance Company. All five insurance companies sold policies in the individual market, and two of the five carriers—John Hancock Life Insurance Company and Metropolitan Life Insurance Company—were also among the five largest carriers that sold products in the group market. We requested data on the number of enrollees in the individual market who chose selected benefit options for new long-term care insurance policies sold from July 1, 2002, to March 31, 2005. We collected data on coverage types, daily benefit amounts, elimination periods, benefit periods, inflation protection options, and optional benefits offered.

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### Examining Income and Asset Distributions Among Partnership Policyholders and Comparison Populations in Two Partnership States and Nationally

We used three data sources to examine the income and assets of Partnership policyholders, traditional long-term care insurance policyholders, and people without long-term care insurance: Partnership program surveys of Partnership policyholders; the 2004 American Community Survey (ACS); and the 2004 Health and Retirement Study (HRS).

To examine the household income and household assets of Partnership policyholders, we used data from Partnership program surveys of a sample of Partnership policyholders at the time they first purchased insurance coverage. We restricted our analysis of the income and assets of Partnership policyholders to surveys conducted by the California and Connecticut Partnership programs because the Indiana Partnership program's data were not sufficiently detailed to include in our analysis, and the New York Partnership program was not able to provide us with data from recent years. In addition, because the surveys were of a sample of Partnership policyholders—40 percent of Partnership policyholders in California and 50 percent of Partnership policyholders in Connecticut—we increased the number of observations by analyzing more than 1 year of data. We included data from 2003 and 2004 for California, and data from 2002 through 2005 for Connecticut.

To approximate the household income of individuals without long-term care insurance in California and Connecticut, we used the 2004 ACS. Household asset information was not available in these states. The ACS is conducted by the Census Bureau, as a part of the Decennial Census Program, and provides information about the characteristics of local communities. The ACS publishes social, housing, and economic characteristics for demographic groups, including household income and assets, covering a broad spectrum of geographic areas in the United States and Puerto Rico. It is the largest household survey in the United States,

with an annual sample size of about 3 million. In order to make appropriate comparisons between the income data from the California and Connecticut Partnership program surveys and the ACS, we restricted our calculations in the income analysis to respondents who were aged 55 and over, when we calculated our household income ranges.<sup>3</sup> In our analysis, we used the ACS state population data as a proxy for people without any long-term care insurance. Approximately 12 percent of people over age 55 have long-term care insurance, so our measure is likely to contain approximately 88 percent of people without long-term care insurance.

To examine national-level data on household income and assets of individuals with and without long-term care insurance, we used information from the 2004 HRS, the most recent year available for that survey data set. The HRS is a longitudinal national panel survey of individuals over age 50, and is sponsored by the National Institute on Aging and conducted by the University of Michigan. The HRS includes individuals who were not institutionalized at the time of the initial interview and tracks these individuals over time, regardless of whether they enter an institution. Researchers conducted the initial interviews in 1992 in respondents' homes and conducted follow-up interviews over the telephone every second year thereafter. HRS questions pertain to physical and mental health status, insurance coverage, financial status (including household income and assets), family support systems, employment status, and retirement planning. We used data from the HRS to calculate the household income distribution nationally for people with long-term care insurance and for people without long-term care insurance. To make our income analysis of HRS data consistent with the income analysis of Partnership policyholders and individuals without long-term care insurance in California and Connecticut, we restricted the HRS income analysis to individuals age 55 and over. The HRS data for people with insurance do not differentiate between Partnership and traditional insurance policyholders and approximately 2 percent of people with long-term care insurance nationwide have Partnership policies. Therefore, although the HRS data may contain a small number of Partnership policyholders, about 98 percent of all long-term care policyholders are likely to have traditional long-term care insurance.

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<sup>3</sup>We restricted our analysis of income to people age 55 and older because long-term care policies tend to be purchased by people in their late 50s or early 60s, and people in this age group may have a different level of income compared to the average for the population as a whole.

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**Examining Demographic  
Characteristics—Age,  
Gender, and Marital  
Status—of Partnership  
Policyholders and Other  
Populations in Partnership  
States and Nationally**

To compare the age, gender, and marital status of Partnership policyholders and other populations in Partnership states and nationally, we used data from the UDS from 2002 through 2005 and the HRS data from 2004. The UDS data contain information on Partnership policyholders, while the HRS was used to calculate estimates for traditional policyholders and for those people without long-term care insurance.

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**Data Reliability**

We took several measures to ensure the reliability of the data used in this report. For the UDS and Partnership policyholder surveys conducted by the states with Partnership programs, we interviewed the officials at the state offices familiar with these data in order to establish whether the data were reliable and suitable for the purposes of our report. For the GAO survey of traditional long-term care insurance carriers, we interviewed each of the carriers about their data to ensure the accuracy and reliability of the data provided. For the ACS and HRS data sets, we collected and examined the data documentation and sought information from the providers of the data. In addition, we took steps to ensure that the data were valid and within reasonable ranges. To do this, where appropriate, we examined the distribution of our key variables, calculating estimates of central tendency, ranges, and frequencies, missing values, and sample size. We determined that these data sets were sufficiently reliable for the purposes of this report.

We performed our work from September 2005 through May 2007 in accordance with generally accepted government auditing standards.

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# Appendix II: Explanation of the Simplifying Assumptions Used in the Illustrative Scenarios

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To analyze the impact of the Partnership programs on Medicaid, we used scenarios that are illustrative of the options individuals have to finance their care. This appendix provides additional information on the construction of the three scenarios and how adjusting the simplifying assumptions affects the length of time it takes for the individual to become eligible for Medicaid in the scenarios.

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## Illustrative Scenarios for Time Taken to Become Eligible for Medicaid

We developed three illustrative scenarios based on the three basic options that are available to an individual for financing his or her long-term care: (1) self-financing without any long-term care insurance, (2) financing using traditional long-term care insurance, and (3) financing using Partnership long-term care insurance. For illustrative purposes, our scenarios are based on an individual who owns assets worth \$300,000. If the individual has a long-term care insurance policy, this policy covers 3 years of nursing facility care at a cost of \$70,000 per year: that is, the policy covers \$210,000 of nursing facility care costs. We then used the scenarios to compare the time it would take for the individual to become eligible for Medicaid using each of the three financing options.<sup>1</sup>

- **Self-financing Without Any Long-term Care Insurance (Scenario C):** The calculations underlying the self-financing scenario are the simplest. If the individual self-finances in the absence of the Partnership program, the individual pays for his or her own care, essentially spending his or her assets down to Medicaid eligibility thresholds before becoming eligible for Medicaid. In this case, the number of years it takes for the individual to become eligible for Medicaid equals the total assets<sup>2</sup> divided by the cost of a year of nursing facility care. In our example, this is \$300,000 in assets divided by \$70,000 in nursing facility costs per year, or about 4.3 years until the individual is eligible for Medicaid. The equation for this calculation can be expressed as

Equation 1: Self-financing time to Medicaid

= Assets / cost per year

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<sup>1</sup>We used constant dollars in our scenarios. This means that the purchasing power of dollars in our scenarios is constant over time. We also hold the individual's assets at a fixed dollar amount over time.

<sup>2</sup>In our illustrative scenarios, we assume the individual spends his or her assets to zero. In other words, we disregard the effect of Medicaid allowing beneficiaries to retain some assets. We address the effect of adjusting this assumption in this appendix.

- **Traditional Long-term Care Insurance (Scenario B):** Next we calculated the time it would take to become Medicaid eligible if the same individual has a traditional long-term care insurance policy. In this scenario, the insurance policy pays for care up to the limits of the policy. After the insurance policy is exhausted, the individual spends his or her own assets to pay for long-term care. Once the assets are exhausted, the individual is eligible for Medicaid. In our example, the individual has a traditional long-term care insurance policy worth 3 years of care in a nursing facility or \$210,000. The time to Medicaid in this example is \$210,000 in insurance coverage plus \$300,000 in assets, all divided by \$70,000 in nursing facility costs per year, or about 7.3 years. The equation for this calculation can be expressed as

Equation 2: Traditional insurance time to Medicaid

$$= (\text{Insurance policy value} + \text{assets}) / \text{cost per year}$$

- **Partnership Long-term Care Insurance (Scenario A):** Finally, we calculated the time it would take to become Medicaid eligible if the same individual has a Partnership policy. In this scenario, the insurance pays for care up to the limits of the policy, and then the individual has to self-finance using unprotected assets. Once those assets are exhausted, the individual is eligible for Medicaid because protected assets do not have to be spent on care. In a dollar-for-dollar model, the protected assets are equivalent to the value of the insurance policy. The time to become eligible for Medicaid in this example is \$210,000 in insurance coverage plus \$90,000 in unprotected assets, all divided by \$70,000 in nursing facility costs per year or 4.3 years. The equation for this calculation can be expressed as

Equation 3: Partnership insurance time to Medicaid

$$= (\text{Insurance policy value} + \text{unprotected assets}) / \text{cost per year}$$

Under the assumptions of our illustrative scenarios, with a dollar-for-dollar policy, the sum of the insurance policy and the unprotected assets is equal to total assets: the same as for the self-financing scenario. Therefore, the time to Medicaid is the same for the individual in both the Partnership and self-financing scenarios, and it is greater if the individual purchases a traditional policy than if he or she purchases a Partnership policy. These relationships are shown graphically in the report in figure 1.

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## Evaluating the Effects of Adjusting the Assumptions Underlying the Illustrative Scenarios

Underlying our illustrative scenarios were several simplifying assumptions. When we adjusted these simplifying assumptions, we found that some resulted in no change, some resulted in accelerated Medicaid eligibility, and some resulted in delayed Medicaid eligibility. Overall, we believe that the survey data showing that 80 percent of Partnership policyholders would have purchased a traditional long-term care insurance policy in the absence of the Partnership program represent compelling evidence that, as currently structured, the Partnership programs are unlikely to result in Medicaid savings.

While some of the 20 percent of Partnership policyholders who would have self-financed their care and become eligible for Medicaid may represent a source of savings, others may represent a source of increased spending and still others will result in neither savings nor spending. We believe that in the aggregate the savings potential from the Partnership programs of these 20 percent of individuals is outweighed by the 80 percent of individuals who will likely result in increased Medicaid spending. Specifically, we made the following simplifying assumptions in our scenarios and discuss the effect on our results of adjusting these assumptions:

- **The individual depicted in the scenarios has assets and benefits that are typical of many individuals with long-term care insurance.** The individual depicted in the scenarios has \$300,000 in assets and 3 years of long-term care insurance—assets and benefits that are typical of many individuals with long-term care insurance. The individual also receives long-term care in a nursing facility with costs for a year of care of \$70,000 that are roughly equivalent to average nursing facility costs nationwide in 2004. In our example, the individual has assets of \$300,000 and, in two of our scenarios, a long-term care policy worth \$210,000. The cost of a year of nursing facility care is \$70,000. As long as the individual has assets that are greater than the value of the insurance policy, we can insert any numbers into equations (1), (2), and (3), and the individual becomes eligible for Medicaid at the same time as with a Partnership policy and if he or she self-finances, but it takes longer if the individual has traditional insurance.
- **The individual spends eligible assets to zero as a condition for Medicaid eligibility.** While states allow individuals to keep a small amount of assets, these assets are in addition to anything that needs to be spent to become eligible for Medicaid. Including these assets has little impact on the scenarios since the individual can keep the same assets in all three scenarios, and these assets are outside of any spend-down requirement. Using our examples above, we decrease the assets in

equations 1 and 2, and decrease the unprotected assets in equation 3 by the amount of assets the individual is allowed to keep. We find that having a traditional policy will still result in more years to Medicaid eligibility than having a Partnership policy or self-financing, and the Partnership and self-financing scenarios still result in the same time to Medicaid eligibility.

- **The individual purchases the same amount of insurance benefits under the Partnership and traditional long-term care insurance scenarios.** While this is our simplifying assumption, we recognize that the Partnership policyholder might have more coverage than if he or she had purchased a traditional policy because of the extra benefit requirements of Partnership policies, such as inflation protection, that are not required of traditional policies. Provided the individual has assets that are no less than the value of the insurance policies, the Partnership policyholder will still not take as long to reach Medicaid eligibility as he or she will with a traditional policy, although the difference is narrower than if the benefits are the same. For example, if we change the value of the benefits in the traditional policy to \$150,000 (and keep the value of the Partnership policy at \$210,000 and the value of assets at \$300,000) the equation for the traditional policy becomes  $(\$150,000 + \$300,000)/\$70,000$ , which is about 6.4 years and is still longer than the approximate 4.3 years with the Partnership policy but less than the approximate 7.3 years expected if the policies in the traditional and Partnership scenarios were the same.
- **The individual has income below Medicaid eligibility thresholds.** We made this assumption because Medicaid income eligibility thresholds vary across states. However, increasing the individual's income up to Medicaid eligibility thresholds has no impact on the scenarios since the individual can keep the same income in all three scenarios. If the income exceeds Medicaid eligibility thresholds, the individual is ineligible for Medicaid in all three scenarios.
- **The individual's assets are greater than the value of the insurance policy.** We assumed that most individuals would have assets that are worth more than the value of the insurance policy. Individuals have a disincentive to purchase long-term care insurance with a value exceeding their assets because it might increase their premium unnecessarily. While we do not have information about the amount of assets that Partnership policyholders have at the time they use their benefits, available evidence suggests that most individuals do not overinsure the value of their assets at the time of purchase, though their status could change over time. Survey data from California and Connecticut show that while 53 percent of Partnership policyholders have more than \$350,000 worth of household

assets at the time of purchase, only about 32 percent of these Partnership policyholders have more than 5 years of coverage equal to \$350,000.<sup>3</sup>

However, it is possible that some policyholders will spend some or all of their assets by the time they require long-term care and will have more insurance than assets. If we modify our example above, and assume the individual's insurance policy has greater value than the assets in our scenarios, we see that with a Partnership policy, the individual will still become eligible for Medicaid sooner than with a traditional policy, but later than if he or she self-financed. Therefore, for the 20 percent of individuals who would have self-financed their care in the absence of a Partnership program, and who have more insurance than assets, the Partnership program results in savings to Medicaid. Specifically, if we assume the insurance policy is worth \$210,000, and the individual has assets equal to \$150,000, we obtain the following results from our scenarios:

Self-finance:  $\text{assets} / \text{cost per year} = \$150,000 / \$70,000 = 2.1 \text{ years}$

Traditional insurance:  $(\text{insurance} + \text{assets}) / \text{cost per year} = (\$210,000 + \$150,000) / \$70,000 = 5.1 \text{ years}$

Partnership insurance:  $(\text{insurance} + \text{unprotected assets}) / \text{cost per year} = (\$210,000 + 0) / \$70,000 = 3 \text{ years}$

- **The individual is unmarried.** In our illustrative scenarios, we assume the individual is unmarried—the most likely marital status of policyholders at the time nursing home care is required. On the other hand, if the individual is married, Medicaid allows spouses to keep a certain amount of jointly owned assets (i.e., half of the value of the assets up to a maximum amount that was approximately \$100,000 in 2007). In general, the spousal exemption that is deducted from assets would be the same across all three scenarios and would not affect the basic relationships among the three scenarios unless the net assets after the spousal exemption are of less value than the insurance policy. If the

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<sup>3</sup>Some of these individuals may be married and the household assets may be shared. In order for the assets to be fully protected for married individuals, both individuals need to have a Partnership policy. Partnership policies are not transferable, and if a surviving spouse of a Partnership policyholder requires long-term care and does not have a Partnership policy, the assets would not be protected.



amount of insurance exceeds the value of assets net of the spousal exemption, there is a potential for Medicaid savings for a Partnership policyholder who would have self-financed. If that individual would have purchased a traditional policy, Medicaid spending would increase. Our scenarios illustrate this point. If we assume the individual is married and the spouse has already taken the spousal exemption such that the individual's assets are \$300,000, the results do not change and our original formulas remain intact. Alternatively, if we assume the individual's spouse is entitled to half of the household assets of \$300,000, up to the maximum of \$100,000, then our results do change and the policyholder becomes overinsured. In this instance, if the individual self-finances, the spousal exemption would be \$100,000, leaving the individual with \$200,000 in assets. If the individual has traditional insurance, the spouse is also entitled to \$100,000. However, if the individual has a Partnership policy, \$210,000 of the assets are protected, leaving \$90,000 in unprotected assets. The spouse would be entitled to half of the \$90,000, or \$45,000. The formulas are presented below.

Self-finance:  $\text{assets} / \text{cost per year} = \$200,000 / \$70,000 = 2.9 \text{ years}$

Traditional insurance:  $(\text{insurance} + \text{assets}) / \text{cost per year} = (\$210,000 + \$200,000) / \$70,000 = 5.9 \text{ years}$

Partnership insurance:  $(\text{insurance} + \text{unprotected assets}) / \text{cost per year} = (\$210,000 + \$45,000) / \$70,000 = 3.6 \text{ years}$

- **The individual uses the same long-term care services in all three scenarios.** An individual who self-finances might have an incentive to use fewer or less expensive services than if he or she were insured by either a Partnership or traditional policy because the individual would be paying for services. If the individual uses fewer services when self-financing, the assets last longer, enabling the individual to pay for care longer and postponing Medicaid eligibility. In this situation, the cost per year of self-financing would be smaller than if he or she had either Partnership or traditional insurance. This would result in an increase in the time it takes to become Medicaid eligible for a person who self-finances relative to what it would have taken if he or she had purchased either a Partnership or traditional insurance policy.

- **The individual does not save premiums paid if he or she would have self-financed their care such that assets are equal in all three scenarios.** We made this assumption to make our scenarios easier to understand. Premium payments may be substantial—potentially as much as \$3,000 per year—so it is possible that if the individual would have saved their premium payments by instead self-financing his or her long-term care, the individual would have more assets than either Partnership or traditional policyholders would when they begin to use their benefits. If this is the case, by self-financing, the individual would have more assets to pay for long-term care before becoming eligible for Medicaid, which would delay the time to Medicaid. Therefore, individuals who purchase Partnership policies would have saved their premium dollars and not purchased long-term care insurance represent a potential cost to the Medicaid program. Using our examples above and assuming 15 years of payments saved at \$3,000 per year, by self-financing, the individual would save \$45,000 in additional assets that would otherwise have been spent on Partnership premiums. Therefore, the self-financing individual has assets of \$345,000. Using our equation we see that the time to Medicaid is delayed ( $\$345,000 / \$70,000 = 4.9$  years) if the individual self-finances, while relative to this option a Partnership policy would accelerate the individual's time to Medicaid by 0.6 years. In this case, the Partnership and traditional policy scenarios would not change because premiums are required to be identical for the Partnership and traditional policies.
- **The individual is equally likely to transfer assets in all three scenarios.** An individual who self-finances or uses traditional insurance might be more likely to transfer assets to a spouse or other family members than he or she would with a Partnership policy, because assets are protected under Partnership policies. If the individual self-finances and transfers assets, he or she would likely take less time to become eligible for Medicaid than with a Partnership policy (and assuming no transfers with the Partnership policy), resulting in Medicaid savings. If the individual would have purchased traditional insurance, the amount of assets transferred would have to be equal to at least the value of the insurance policy purchased in order for the Partnership program to result in Medicaid savings. If the amount of asset transfer is less than the value of the insurance policy, the increase in Medicaid spending attributable to the Partnership program would be less than without the asset transfer, but would still be an increase.

# Appendix III: Comments from the Department of Health & Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary  
for Legislation

Washington, D.C. 20201

MAR 22 2007

Mr. John Dicken  
Director, Health Care  
U.S. Government Accountability Office  
Washington, DC 20548

Dear Mr. Dicken:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "Long-Term Care Insurance: Partnership Programs Include Benefits That protect Policyholders and Are Unlikely to Result in Medicaid Savings" (GAO-07-231), before its publication.

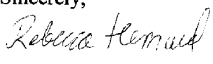
We acknowledge the complexity of an analysis of this nature, and appreciate GAO's decision to base their findings on simplified assumptions, however we do not believe the results of this methodology should be considered conclusive. We believe that the simplified scenarios are flawed in their lack of accounting for individuals who do engage in estate planning prior to expending all of their own funds on long-term care costs. Even if addressed, it is unlikely that the data sources used in this report would have yielded accurate data on this factor. Over the past 15 years a number of studies have been conducted and published which used sound research methods, and States themselves have analyzed actual data based on more than a decade of experience. We believe a balanced report should include a review of this literature and State experience. Consequently, we believe that the report's *Concluding Observations* should acknowledge the limitations of the study methodology and reference the findings of other researchers and States' experience to be considered along with GAO conclusions.

We also believe the report gives insufficient attention to the possibility that the availability of Partnership policies will result in a reduction of efforts to transfer assets for less than fair market value in order to become eligible for Medicaid.

The Department has provided several technical comments directly to your staff.

The Department appreciates the opportunity to review and comment on this report.

Sincerely,

  
for Vincent J. Ventimiglia  
Assistant Secretary for Legislation

# Appendix IV: Comments from the Four States with Partnership Programs, California, Connecticut, Indiana, and New York



MAR 26 2007

John E. Dicken  
Director, Health Care  
United States Government Accountability Office  
Washington, DC 20548

RE: Comments on Proposed Report Entitled *LONG-TERM CARE INSURANCE: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings* (GAO-07-231)

Dear Mr. Dicken:

Thank you for the opportunity to comment on the draft copy of the proposed "Long-Term Care Insurance, Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings".

The Department of Health Services, California Partnership for Long-Term Care commends the U.S. Government Accountability Office for its efforts in determining program efficacy, particularly as it pertains to the Partnership long-term care programs. California also shares the GAO's desire to ascertain program efficacy. In fact, the California Partnership for Long-Term Care conducts yearly evaluations of the Program to determine to what extent it is meeting its program goals and is also committed to finding ways to lessen Medicaid's fiscal exposure.

We appreciate the GAO's analysis of the Partnership program's impact on Medicaid, but have reservations about the underlying assumptions used in developing the scenarios designed to determine the potential costs or savings to Medicaid, particularly the assumptions made about the scope, duration and economic value of benefits under a Non-Partnership policy. We believe the GAO did not give adequate consideration to critical differences in elimination periods, benefit payment levels, inflation protection, and asset shielding versus asset transfers. These reservations give us reason to believe the report, in its present iteration, is flawed in its analysis. We will expand on these reservations in Attachment A. Based on our own Program evaluations and analyses, we are confident that the Partnership program results in short-term as well as long-term cost savings to Medicaid.

[www.dhs.ca.gov](http://www.dhs.ca.gov)

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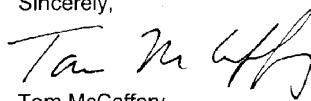
**Appendix IV: Comments from the four  
states with Partnership programs, California,  
Connecticut, Indiana, and New York**

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John E. Dicken  
Page 2

Thank you again for the opportunity to comment on your report. Please feel free to contact Mr. Mark S. Helmar, Chief, Office of Long-Term Care at (916) 440-7534 if you should have any questions.

Sincerely,



Tom McCaffery  
Chief Deputy Director

cc: Stan Rosenstein  
Deputy Director  
Medical Care Services

Mark S. Helmar, Chief  
Office of Long-Term Care

MH/eh/G:/OLTC/CPLTC/GAO Report Response Message

**Attachment A**  
**California Partnership for Long-Term Care Comments on Draft GAO Report (GAO-07-231)**

**A. OMISSION OF KEY ASSUMPTIONS FROM THE FINANCING SCENARIOS**

The GAO developed three scenarios as the basis for determining which of the three was more protective of Medicaid fiscal exposure. These scenarios are:

- A. Financing long-term care using a Partnership policy.
- B. Financing long-term care using a traditional/Non-Partnership policy.
- C. Self-financing.

The GAO financing scenarios presume that an individual purchasing a Non-Partnership long-term care insurance (ltci) policy would purchase the same level of benefits as a person purchasing a Partnership policy. This runs counter to the GAO's own conclusions that Partnership requirements such as yearly compounded inflation protection and minimum daily benefits make for more extensive/richer policies under the Partnership. It is not accurate to assume that a Non-Partnership policy would have the same minimum daily benefit or the same level of inflation protection (if any at all) as a Partnership policy. In fact, California's most recent Non-Partnership policy sales experience<sup>1</sup> (year 2005) shows that only 57% of policy sales contain yearly compounded inflation protection and 49% of sales contained a daily benefit below the minimum required in a Partnership policy in the year 2005. Failure to factor in that Non-Partnership policies have lesser benefits, particularly as related to inflation protection, significantly skews the analysis in favor of the Non-Partnership scenario.

We also believe it is imperative to factor the impact of yearly compounded inflation protection coupled with a minimum daily benefit since long-term care insurance is generally utilized many years after purchase. California's experience in this area reveals that over the past 28 years (1980 – 2007), the statewide average daily private pay rate for nursing facility care has risen at an average annual rate of 5.9%<sup>2</sup>. This effectively doubles the cost of care every 14 years.

We agree with GAO's approach to simplifying the financing scenarios by ignoring the marital status variable. However, we believe that GAO has omitted other important factors pertaining to elimination periods, policyholder payments for LTC costs above the benefit amounts in their policies, and asset transfers. Each of these factors has a direct impact on the amount of policyholder assets available to continue paying for LTC after exhaustion of policy benefits. The differences in these factors between Partnership and Non-Partnership policies materially affect the length of time after ltci benefits are exhausted before a policyholder qualifies for Medicaid.

For example, both Partnership and Non-Partnership policyholders will be spending personal assets to pay for their LTC during the elimination period. Since Partnership policies (based on Table 1 of your report) have an average elimination period longer than Non-Partnership policies, Partnership policyholders will spend more of their assets during the elimination period than Non-Partnership policyholders. However, Partnership policies provide a higher level of daily benefits than Non-Partnership policies, resulting in more ongoing costs to Non-Partnership policyholders during their active benefit period. These higher costs reduce Non-Partnership assets faster, resulting in a much shorter time period before they qualify for Medicaid benefits. Additionally, the shortened time period for which Non-Partnership policyholders qualify for Medicaid is additionally truncated by the lack of inflation protection in nearly a quarter of Non-Partnership Itci policies. Over time, these policies will pay a lesser percent of the daily costs of LTC services, requiring policyholders to use more of their assets during the time they are drawing Itci benefits, thereby qualifying for Medicaid LTC services even more quickly.

We believe GAO's analyses should have included these factors to arrive at a more realistic comparison of Partnership and Non-Partnership policies and their potential for creating or avoiding costs to Medicaid programs. We would be happy to work jointly with the GAO to incorporate these factors into a revised analysis of the financial scenarios covered by the study.

***B. ASSET TRANSFER BEHAVIOR IMPACTS COMPARISON***

It is difficult to measure the degree to which individuals have used asset transfer techniques as a means to achieve artificial impoverishment so they can use Medicaid as inheritance insurance. But the fact remains that these asset transfer techniques exist even though the Deficit Reduction Act makes the asset transfer rules tougher. California's most recent survey data (year 2005) shows that 24% of respondents indicated they purchased a Partnership policy as an alternative to transferring assets in order to qualify for Medicaid. We infer that at least this level of asset transfer behavior exists among Non-Partnership policyholders. This would significantly narrow the difference in the fiscal impact Partnership and Non-Partnership policies have on Medicaid costs.

***C. CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE PURCHASER SURVEY DATA***

The California Partnership for Long-Term Care uses the same cost effectiveness measure developed by the Connecticut Partnership. This measure is based on Partnership purchaser survey data used in conjunction with actual Partnership claims data. We shared our survey information with the GAO as part of this study.

As we understand it, GAO based the development of Scenario B on a single survey question, that being, "Would you have purchased long-term care insurance in the absence of the Partnership?" While this question is important, an equally important question is, "Did the California Partnership for Long-Term Care influence your decision

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**Appendix IV: Comments from the four states with Partnership programs, California, Connecticut, Indiana, and New York**

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to purchase long-term care insurance?" We believe in-depth analysis of Medicaid costs or savings cannot be based on a single question. Such an analysis must be made on a combination of questions that will yield a more accurate understanding about the motivations and purchasing decisions of Itci consumers.

California's most recent survey (year 2005)<sup>3</sup> shows that 82% of survey respondents (CPLTC policyholders) indicated they would have purchased long-term care insurance in the absence of the Partnership. 24% of these respondents stated they would have transferred assets in the absence of the Partnership. This leads us to believe that many Partnership policyholders purchase these policies to protect assets, whereas many Non-Partnership policyholders still contemplate (and often effect) the transfer of assets to become eligible for Medicaid, on the chance they will outlive their Itci policy benefits.

Survey data also reveals that 44% of those who indicated that they would have purchased Itci in the absence of the Partnership also indicated that the Partnership influenced their purchasing decisions. In fact the purchase of Itci, whether the policies are Partnership or Non-Partnership, result in cost avoidance/savings to Medicaid programs. Policyholders who die before exhausting Itci benefits represent direct cost avoidance to Medicaid. The majority of those who exhaust their policy benefits still have a significant amount of assets to continue financing their LTC without ever qualifying for Medicaid. Those that do qualify for Medicaid have delayed their reliance on publicly funded LTC services for several years, because of their Itci coverage.

<sup>1</sup> California Department of Health Services, California Partnership for Long-Term Care, "Year 2005 Partnership vs. Non-Partnership Comparison of Insurance Policy Sales", Raul Moreno, July 2006.

<sup>2</sup> California Department of Health Services, California Partnership for Long-Term Care, Issuers Bulletin 2007, November 2006.

<sup>3</sup> California Department of Health Services, California Partnership for Long-Term Care, Purchaser Survey 2005, Annual Report, September 2006.



**Appendix IV: Comments from the four  
states with Partnership programs, California,  
Connecticut, Indiana, and New York**



**STATE OF CONNECTICUT**  
*OFFICE OF POLICY AND MANAGEMENT*  
POLICY DEVELOPMENT AND PLANNING DIVISION



March 8, 2007

John E. Dicken  
Director, Health Care  
United States Government Accountability Office  
Washington, DC 20548

RE: Comments on Proposed Report Entitled *LONG-TERM CARE INSURANCE:  
Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to  
Result in Medicaid Savings (GAO-07-231)*

Dear Mr. Dicken:

Thank you for the opportunity to comment on the GAO proposed report on the  
Partnership for Long-Term Care programs (GAO-07-231).

While we appreciate the GAO analysis of the impact of the Partnership for Long-Term  
Care programs, we must raise several objections to the underlying assumptions used in  
the financial scenarios devised for the purpose of determining potential Medicaid savings  
or costs due to the presence of a Partnership for Long-Term Care program.

[www.CTpartnership.org](http://www.CTpartnership.org)  
Phone: (860) 418-6318 Fax: (860) 418-6495  
450 Capitol Avenue MS#52LTC • Hartford, Connecticut 06106-1308

**1. Narrow usage of Connecticut survey data:**

The most troubling aspect of the GAO financing assumptions is the narrow application of data available from the Connecticut survey of purchasers of Partnership policies. The report relies exclusively on the answer to a single survey question: “Would you have purchased long-term care insurance in the absence of the Partnership?”, while completely ignoring the equally relevant survey question “Did the Connecticut Partnership for Long-Term Care influence your decision to buy long-term care insurance?”. While 68% of all survey respondents indicated that they would have purchased a long-term care insurance policy in the absence of the Partnership, 67% of respondents also indicated that the Partnership influenced their decision to purchase and, more importantly, **54% of those who indicated they would have purchased in the absence of the Partnership also reported that the Partnership influenced their decision.**<sup>1</sup> Therefore, it is not absolutely clear, as your analysis assumes, that the 68% who indicated they would have purchased in the absence of the Partnership would actually have done so, nor can it be assumed that, if they did purchase, they would have purchased benefits identical to those included in their Partnership policy.

Also of significance is the fact that, of the 68% of respondents who reported they would have purchased long-term care insurance in the absence of the Partnership, **31% reported that they would have transferred assets in the absence of the Partnership.** As intended, the responses to this series of survey questions provide a clearer understanding about purchaser motivation and intention and underscores the weakness inherent in relying on the responses to a single survey question as the basis for an entire analysis of potential savings or costs to Medicaid.

The Connecticut Partnership for Long-Term Care has developed its own cost-effectiveness measure based on Partnership purchaser survey data and actual Partnership claims data. Rather than just utilizing the one question related to buying long-term care insurance in the absence of the Partnership, we examine all three questions as noted above. Individuals who 1) indicate they would have bought in the absence of the Partnership; 2) indicate the Partnership had no influence on their purchase decision; and 3) did not indicate they would have transferred assets in order to access Medicaid in the absence of the Partnership are considered potential costs to Medicaid. However, their potential cost to Medicaid must be viewed in light of the benefits they have purchased and the average amount of benefits used by actual Partnership claimants who have died after using their benefits (or, in other words, their claims are closed). Individuals meeting these three criteria who have purchased benefits that exceed the average actual claim do not pose any potential cost to Medicaid. Individuals in this category who purchase benefits that are less than the average claim under a Partnership policy are potential costs. However, this group only represents one half of one percent of purchasers.

<sup>1</sup> These figures are based on all available Connecticut purchaser survey data and may differ slightly from data used in the GAO report which was based on Connecticut purchaser survey data for a selected time period.

Individuals who indicate that 1) they purchased a Partnership policy as an alternative to transferring assets and 2) indicated the Partnership influenced their decision or noted they would not have purchased long-term care in the absence of the Partnership are included in the group that could generate potential savings to the Medicaid program. All other purchasers are considered budget neutral.

Our analysis has determined that, to date, Connecticut's Medicaid program has saved close to \$4 million due to the presence of the Partnership program and that those savings will only grow over time assuming the survey responses and claim data remain consistent.

This type of in-depth analysis is necessary to begin to answer the complex question of what impact the Partnership programs will have on Medicaid costs. Given the fact that the impact of the Partnership on Medicaid is based on the determination of behavior in the absence of the Partnership, an obviously hypothetical situation, it is vital that such an analysis not be narrowly focused on one isolated variable.

**2. Lack of recognition of asset transfers and establishment of trusts:**

The report only outlines three possible long-term care financing scenarios: 1) purchase a Partnership long-term care insurance policy; 2) purchase a non-Partnership long-term care insurance policy; and 3) pay out-of-pocket.

While it is difficult to accurately measure the extent to which individuals transfer and shelter assets in order to access Medicaid, we know with a certainty that the practice exists. Even with the passage of tougher asset transfer rules under the Deficit Reduction Act (DRA), this type of behavior will continue to be marketed and utilized as a means of accessing Medicaid and preserving assets. More importantly, the very same Connecticut survey data that was used in the GAO analysis reports that **27% of respondents indicated that one of the reasons they purchased a Partnership policy was as an alternative to transferring assets in order to access Medicaid.** This data, which was not even mentioned in the GAO report, should be factored into any responsible analysis of what purchaser behavior might be in the absence of a Partnership program. Another relevant consideration is that the Connecticut survey data is voluntary in nature and is reported directly to State government, which means that 27% of respondents have voluntarily revealed to the State of Connecticut that they would engage in an improper transfer of assets in order to qualify for Medicaid benefits. Logic would lead one to believe that many more individuals might be inclined to engage in the same behavior without being quite so candid about their intentions.

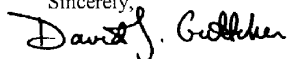
**3. Contradictory assumptions regarding benefits under non-Partnership policies:**

The GAO financing scenarios assume that an individual purchasing a non-Partnership long-term care insurance policy would purchase the same level of benefits if purchasing a Partnership policy. This seems to contradict GAO's own conclusions that, due to the requirements under the Partnership, such as minimum daily benefits and compound inflation protection, individuals will have richer benefits under their Partnership plans. It is not fair or accurate to assume that a non-Partnership policy would have the same daily benefit and the same level of inflation protection, if any at all, that would be included in a Partnership policy. Assuming the non-Partnership policy had lesser benefits, especially related to inflation protection, would have a dramatic impact on the analysis of the GAO financial scenarios. While the GAO report uses constant benefit levels for analysis purposes, in reality the impact of compound inflation protection must be taken into account since long-term care insurance is typically coverage that is utilized many years after initial purchase.

For the reasons noted above, we believe the GAO report is flawed in its analysis of the potential impact of Partnership for Long-Term Care programs on Medicaid expenditures. Based on our own analyses, we are confident that the presence of a Partnership program will result in short- and long-term cost savings to Medicaid.

Thank you again for the opportunity to comment on your report. Please feel free to contact me at 860-418-6286 or by email at [david.guttchen@po.state.ct.us](mailto:david.guttchen@po.state.ct.us) if you have any questions.

Sincerely,



David J. Guttchen  
Director  
Connecticut Partnership for Long-Term Care

**Appendix IV: Comments from the four states with Partnership programs, California, Connecticut, Indiana, and New York**



Taking care of tomorrow  
is just good policy

March 8, 2007

Mr. John E. Dicken  
Director, Health Care  
United States Government Accountability Office  
Washington, DC 20548

Re: *Report: Long Term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings (GAO-07-231)*

Dear Mr. Dicken:

On behalf of Carol Cutter, Health Deputy, Indiana Department of Insurance, we appreciate the opportunity to review and comment on the proposed report on Partnership for Long Term Care Programs.

I want to clarify a few features of the Indiana partnership program:

- 1) Two types of coverage are offered – Comprehensive and Facility Only; The facility only policy may cover nursing facility and assisted living facility care (not just nursing facility care as stated).
- 2) Indiana also requires the use of 5% compound inflation protection.
- 3) Both traditional long term care and Partnership policies are reviewed by the Indiana Partnership Program office which is part of the Indiana Dept. of Insurance.

The impact of buyer motivation for long term care policies must be factored into the savings equation. Even though this factor in purchase decisions could be difficult to quantify from surveys, I believe it will be a significant component in the future. As the report states, the demand for long term care services will be increasing and it will be from the baby boomers. The Partnership policies give the buyer more control and choice over their care – the desire for independence and financial control characteristic of this population group. The asset protection component plus the other policy features makes the Partnership policy even more valuable and attractive over a traditional policy.

Indiana Long Term Care Insurance Program  
Indiana Department of Insurance  
311 West Washington Street, Suite 300 • Indianapolis, IN 46204-2787  
317-233-1470 • 317-232-5251 fax

Page 2

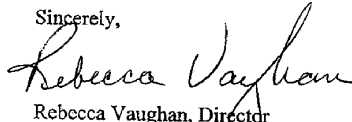
Also as the demand increases, the significance of the Partnership program features for consumers has to be weighted. As more consumers become aware, understand, and purchase long term care policies both traditional and Partnership, the projected number of claimants needing services and immediately accessing Medicaid dollars would decrease.

The awareness campaign, agent training, and state oversight are essential components of the program. Consumer education and awareness will be critical to addressing the looming crisis for services and funding of long term care.

An additional scenario should be considered in long term care financing options. Savings in Medicaid dollars could be realized from individuals purchasing Partnership policies instead of seeking out Medicaid planning attorneys to shelter assets.

We appreciate the opportunity to provide comment and additional insight on Partnership Programs. We believe the existence of the Partnership Program will result in savings to Medicaid and is a critical part of addressing the baby boomer crisis.

Sincerely,



Rebecca Vaughan, Director  
Indiana Long Term Care Partnership Program  
IDOI, 311 W. Washington St., Ste. 300  
Indianapolis, IN 46204-2787

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**Appendix IV: Comments from the four  
states with Partnership programs, California,  
Connecticut, Indiana, and New York**

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**STATE OF NEW YORK  
DEPARTMENT OF HEALTH**

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

March 20, 2007

John E. Dicken  
Director, Health Care  
United States Government Accountability Office  
Washington, DC 20548

Re: Comments on Draft Report Entitled *LONG-TERM CARE INSURANCE: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings (GAO-07-231)*

Dear Mr. Dicken:

Thank you for the opportunity to comment on the above-referenced draft report.

While the report correctly highlights the positive benefits included in Long-Term Care (LTC) Partnership programs that protect consumers, we wish to express our concern about the report's operational assumptions used to evaluate Partnership cost-savings, and its limited scope of analysis. We found the assumptions do not correctly portray the New York State (NYS) Partnership experience with its Medicaid program. In fact, the estimate resulting from our own analysis on NYS Medicaid cost-savings is quite different from what the GAO report concluded.

Therefore, the report's main conclusion that the Partnership programs overall are unlikely to produce savings to the Medicaid program, in our opinion, does not reflect the NYS Partnership experience. Further, we think that releasing the report in its present form would not provide accurate information to policymakers about an innovative and effective, alternative method of financing LTC.

The NYS Partnership's specific comments relative to our issues with the report are structured into two parts on the following pages:

1. general comments; and
2. comments specific to the operational assumptions and fiscal analysis.

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**Appendix IV: Comments from the four states with Partnership programs, California, Connecticut, Indiana, and New York**

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In addition, Attachment 1 contains comments by the NYS Insurance Department, a key member of the NYS Partnership steering board. The Insurance Department's comments reflect their expertise in monitoring the integrity of the Partnership program in terms of consumer safeguards and Medicaid cost containment as these factors merge with NYS insurance environment through the Partnership program.

**1. General Comments**

With the aging of 76 million baby boomers, the need for LTC is anticipated to grow rapidly, placing a financial burden on both public (Medicaid) and private resources. Faced with this demographic imperative and a lack of financial preparedness among baby boomers, the NYS Partnership was implemented to provide New Yorkers with an alternative and viable financing option to Medicaid estate planning and/or spending down lifetime savings. Due to the high cost of LTC in NYS and the socioeconomic demographics of the population, the program encourages the purchase of Partnership insurance by the many New Yorkers who are healthy and can afford the cost of the insurance, but can not afford the cost LTC. Such people, absent the Partnership, are likely candidates for Medicaid estate planning in NYS to protect their assets.

Thus, the NYS Partnership goals are:

- to promote LTC insurance planning among New Yorkers who are financially and physically eligible for insurance;
- to encourage shared financial responsibility through affordable, comprehensive LTC insurance with the incentive of Medicaid asset protection; and
- to reduce Medicaid dependency among those who would qualify for Medicaid through estate planning and/or the spend-down process.

Three stakeholders participate in the Partnership: consumers, the insurance industry, and NY Medicaid. None of these stakeholders alone could achieve the Partnership goals. Absent the NYS Partnership, consumers have no reasonable LTC financial planning or payment alternative to Medicaid estate planning or the spend-down process, resulting in Medicaid dependency. Without helping New Yorkers increase personal financial responsibility for LTC, particularly among the baby boomers, Medicaid is certain to experience unsustainable growth in program costs. Absent consistent public education and agent training efforts, traditional LTC insurance is a challenging product to market since the insurance has "long-tail" financial implications and benefits. The Partnership, therefore, operates as a catalyst among the three stakeholders to achieve the program goals by implementing the program requirements and activities including, but not limited to:

- required 5% compounded inflation protection for those at purchase age lower than 80;
- a minimum daily benefit requirement, which is higher than the traditional LTC insurance minimum requirement;



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**Appendix IV: Comments from the four states with Partnership programs, California, Connecticut, Indiana, and New York**

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- a minimum time duration requirement; Partnership insurance must provide minimum benefit duration coverage periods to ensure avoidance of Medicaid for specific time durations as a cost-saving component;
- ongoing public education and information dissemination activities;
- mandatory agent training; and
- the consumer safeguard of a denied benefit authorization review process, independent from insurers, with binding arbitration as a final step.

In terms of NYS Partnership insurance benefits, there are no comparable, traditional LTC insurance products available in NYS. The GAO report correctly concludes that the NYS Partnership provides quality consumer protections. However, the GAO analysis on Medicaid cost savings used a set of operational assumptions which do not reflect the profile of NYS Partnership purchasers, the program experience, or the characteristics of the NYS Medicaid program.

**2. Comments Specific to the Operational Assumptions and Fiscal Analysis**

The fiscal analysis presented in the GAO report attempts to compare a Partnership fiscal scenario with two scenarios that would exist in the absence of the Partnership: the traditional LTC insurance scenario and the self-insuring LTC scenario. However, the report scenarios are based, in part, on the authors' interpretation of results of surveys administered in California and Connecticut. From these surveys, the report concludes that 80% of current Partnership insureds would have purchased traditional LTC insurance, whereas 20% would pay for their LTC out-of-pocket.

In 1995, the NYS Partnership conducted a mail survey of 5,215 Partnership purchasers (52% response rate). Responders to the question about how they would have paid for LTC in the absence of the Partnership indicated: 25% - "Medicaid Estate Planning", and 21% - "non-Partnership insurance." Similar results have been found in the December 2006 survey of 1,200 Partnership insureds (35% response rate); i.e., Medicaid Estate Planning (24%) and non-Partnership insurance (19%).

Thus, one-quarter of all Partnership purchasers who responded in each of the NYS surveys indicated they would have transferred their assets in order to qualify for Medicaid in the absence of the Partnership. Yet, this asset transfer group is ignored in the development of the GAO scenarios. This estate planning group represents cost savings of 100% to the Medicaid program under the Partnership programs since Medicaid would have paid for their care from the beginning of their LTC episodes. In addition, only about one-fifth of NYS purchasers who responded to the NYS surveys indicated they would have purchased non-Partnership insurance in contrast to the 80% stated in the GAO report.

The GAO report also indicates a lack of data to identify who would qualify for Medicaid among the self-insuring population. During the development phase of the NYS Partnership program, the NYS Partnership conducted a Nursing Home Discharge Survey to gain an understanding of the nursing home population in NYS. The survey

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**Appendix IV: Comments from the four states with Partnership programs, California, Connecticut, Indiana, and New York**

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results indicated that among NYS nursing home residents aged 65 and over, private-pay residents accounted for only 38% at admission, whereas Medicaid and Medicare clients represented 58% and 4%, respectively. One-third (33%) of those private-pay residents at admission eventually became Medicaid recipients with their average length of time to Medicaid being 9.8 months (median) or 15.8 months (mean). Since the time of this survey, the private pay nursing home cost has rapidly increased in NYS with the current statewide average cost approaching \$100,000. We, therefore, confidently expect that the nursing home spend-down period has shortened, and the prevalence rate of spend-down among private-pay residents has increased.

In order to understand the fiscal impact of the NYS Partnership on NYS Medicaid, both the profile of NYS Partnership purchasers and NYS Medicaid characteristics should be incorporated into any analysis of Medicaid cost-savings.

**NY Partnership Cost Savings Analysis**

Given the following New York Specific circumstances:

- current NYS Partnership enrollment statistics (45,000 enrollees aged 55 and over),
- a methodology which reflects NYS survey information,
- NYS Medicaid nursing home payment characteristics, and
- the assumption of no Medicaid cost incurred by traditional LTC insurance policyholders,

our own analysis indicates that the NYS Partnership currently will help NYS Medicaid avoid, on average, three nursing home months per policyholder, which would have otherwise been the responsibility of the Medicaid program in the absence of the NYS Partnership.

Another consideration for Medicaid cost-savings with the NYS Partnership is that the transfer penalty applies only to those seeking Medicaid for institutional care. In non-institutional settings, one could reasonably assume that many who may have no knowledge of this transfer rule would come to rely on Medicaid estate planning, absent the Partnership program, in order to finance their home care. Therefore, Medicaid savings under a home care scenario would be much higher than for the nursing home scenario in NYS.

In addition, the federal spousal refusal provision (Section 1924(c)(3) of the Social Security Act) allows the healthy spouse to retain resources that would otherwise be available to the Medicaid spouse's care. Without the Partnership option, one could also reasonably assume that more New Yorkers may use spousal refusals, creating further Medicaid expense.

These comments highlight NYS' issues and concerns regarding the modeling scenarios used in the GAO report, and the report's conclusion of minimal Medicaid cost-savings

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**Appendix IV: Comments from the four  
states with Partnership programs, California,  
Connecticut, Indiana, and New York**

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under the Partnership. Based on the NYS experience described in our comments, NYS has carefully planned and fully expects its Partnership program to contain Medicaid costs for LTC through the increasing enrollment of New Yorkers in the Partnership program.

Thank you again for the opportunity to review and comment on this report before its release. If you have any questions about these comments, please do not hesitate to contact Adrianna Takada, Director of the NYS Partnership program at 518-474-0662.

Sincerely,



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Enclosure

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# Appendix V: GAO Contact and Staff Acknowledgments

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## GAO Contact

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Christine Brudevold, Assistant Director; Krister Friday; Michael Kendix; Julian Klazkin; Elijah Wood; and Suzanne Worth made key contributions to this report.

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