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# Public-Private Partnerships in Medicaid Long-Term Care

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**A**lthough managed care is fairly common for Medicaid acute services, using managed care to provide long-term care services is rare. Only 3% of Medicaid long-term care beneficiaries receive care in a managed care setting. Six states, including Wisconsin, have managed care programs for certain populations in the state. Of the managed care organizations providing care across the country, 70% are nonprofits and 15% are local government agencies (e.g., counties). Another public-private venture for states involves long-term care insurance. Four states (California, Connecticut, Indiana and New York) currently participate in the Long-Term Care Partnership Program. Nearly 212,000 people have purchased policies, but only 1.3% have received insurance benefits. The program cannot be expanded nationwide unless Congress changes the federal estate recovery statutes.

Long-term care accounts for approximately one-third of Medicaid spending nationwide. In 2003, nursing home expenditures represented the largest category of Medicaid spending. While the growth of long-term care has slowed in recent years, states are anticipating an increased demand for long-term care services, especially as the population ages.<sup>1</sup>

States increasingly are turning to the private sector for assistance in delivering Medicaid services and in managing the growth of Medicaid expenditures. Several states have reported success in providing Medicaid-funded acute health care benefits through private entities. Building on that success, many states are considering additional partnerships with the private sector to address Medicaid long-term care service delivery.

This chapter will review two avenues for public-private partnerships in the delivery and financing of Medicaid long-term care services: a) contracting with private entities for long-term care service delivery, and b) shifting financial responsibility for long-term care services to the private sector through the Long-Term Care Insurance Partnership Program.

## How Common is Managed Care Delivery of Long-Term Care Services?

Over the past 15 years, state Medicaid programs increasingly have implemented managed care programs to provide acute care benefits to their Medicaid enrollees. In 2002, 58% of Medicaid beneficiaries received some portion of their Medicaid benefits through a managed care program.<sup>2</sup> Most Medicaid managed

care programs, however, exclude long-term care benefits and/or populations who use most of the long-term care benefits, such as Medicare/Medicaid dual eligibles. In 2004, less than 3% of the population receiving publicly-funded long-term care services received those services through managed care programs.<sup>3</sup>

### **What do Existing Managed Long-Term Care Programs Look Like?**

The characteristics of managed long-term care programs vary considerably across the country. Arizona has over 23,000 managed long-term care enrollees in its mandatory statewide program—the only statewide program in the country. Six states operate programs targeted at specific populations within certain counties or groups of counties. Enrollments in these programs range from less than 100 to over 10,000. The third, and most prevalent, model is the Program for All-Inclusive Care for the Elderly (PACE). It operates much like a staff-model HMO and generally serves the patients of a specific provider organization. Close to 8,500 people were served by 40 PACE sites around the country in 2004.<sup>4</sup>

**Most (70%) of the entities in the managed long-term care market are non-profit organizations.**

As shown in Figure 1, most of the entities that have entered the managed long-term care market are non-profit organizations. This group is dominated by provider organizations that manage care through PACE programs. It also includes the four plans in the Wisconsin Partnership Program and those participating in Minnesota’s Medicaid managed long-term care program.<sup>5</sup> Sixteen percent of managed long-term care entities are publicly owned, including the county-based plans in Wisconsin’s Family Care program. Public plans also provide services in many of the rural counties in Arizona. The number of for-profit entities participating in managed long-term care is relatively small. Currently two major commercial health plans lead this group: EverCare and Amerigroup.<sup>6</sup>

**Figure 1. Who Owns Managed Long-Term Care Entities?**

Type of Organization	Number of Entities	Percent
For-profit	9	13%
Not-for-profit	47	70%
Local Government Agency	10	15%
State Government Agency	1	1%

*Data Source: Saucier, P., Burwell, B., and Gerst, K. (2005, April). The Past, Present and Future of Managed Long Term Care. Washington DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.*

Of the existing managed long-term care programs, only two have mandatory enrollment: the Arizona Long Term Care System (ALTCS) and Texas Star Plus. The remaining programs are voluntary.

## Why Partner with Private Health Plans?

The passage of the Medicare Modernization Act in 2003 created an opportunity for expansion of the Medicaid managed long-term care market. The legislation established Medicare Advantage Special Needs Plans as a class of managed care entities that may limit their enrollment to certain populations, such as Medicare/Medicaid dual eligibles, and Medicare beneficiaries residing in nursing facilities. As a result, the private entities that participate in Medicare managed care are poised to better understand the needs of nursing facility residents and enter the market in states that develop Medicaid managed long-term care programs to target the dually eligible population.

Partnering with private entities in the development of a managed long-term care program has several benefits. First, plans that have considerable experience managing commercial health insurance benefits will have well-developed provider networks that likely will include providers who do not typically serve Medicaid populations. Partnering with private plans, therefore, may provide states the opportunity to leverage access to a larger provider network for Medicaid recipients.

Another benefit of partnering with private entities is the ability to avoid problems of cost-shifting. Consider the possible tension created when a dual eligible joins a private Medicare Advantage plan for Medicare-funded services and a different (e.g., county-based) health plan for Medicaid-funded services. There is not always a clear delineation of responsibility between Medicare and Medicaid for certain services [e.g., home health, durable medical equipment (DME), and skilled nursing]. The Medicare plan may make utilization review decisions that shift responsibility for the services to Medicaid. A capitated reimbursement system creates an incentive to shift costs to other entities where feasible. This incentive not only reduces coordination and efficiency, but may also compromise care for the beneficiary, particularly if decisions about which plan is responsible for care are delayed. Privatizing delivery of the Medicaid-funded services allows the beneficiary to enroll in a single plan for both Medicare- and Medicaid-funded services, eliminating the incentive to shift costs to other plans.

***Allowing beneficiaries to enroll in a single plan for Medicaid and Medicare services eliminates the incentive for cost shifting.***

## What are the Possible Disadvantages of Partnering with Private Health Plans?

There are disadvantages to implementing a managed long-term care program that relies on private entities for managing service delivery. When partnering with privately-owned health plans, whether for-profit or not-for-profit, a state should recognize that the operation must remain profitable for plans to stay in the market. With for-profit plans, excess funds become profits to be distributed to shareholders or used to support additional business ventures, often out-of-state. Plans that are not able to generate net operating gains are likely to leave the market. This may cause disruptions in care during enrollees' transitions to other plans. Additionally, the state will need to monitor whether the remaining plans have the capacity to absorb additional enrollment if some plans exit the market.

Partnering with private plans may also negatively impact the existing infrastructure of long-term care service delivery. Private health plans may interrupt long-standing relationships between service providers if they are not all included in the plan's provider network. There is also a risk that traditional safety-net providers, including county-based programs, will lose business if health plans offer enrollees a broader network of service providers.

## What is the Long-Term Care Insurance Partnership Program?

The Long-Term Care Insurance Partnership Program (LTC Insurance Partnership) is a specific type of public-private partnership designed to decrease Medicaid expenditures for long-term care services by increasing the purchase of private long-term care insurance. Individuals who purchase approved long-term care policies, exhaust their benefits, and apply for Medicaid benefits may protect a portion of their assets from being counted during the Medicaid eligibility determination process. Applicants must continue to meet the income eligibility guidelines while receiving Medicaid benefits. The program also protects the insured's assets from later estate recovery by the state Medicaid program. By creating an incentive for individuals to purchase private insurance coverage, states hope to prevent, or at least delay, their reliance on Medicaid to support their long-term care needs.

At present, only four states are authorized to operate LTC Insurance Partnership programs. Congress is considering whether to extend this authority to other states; many states are interested in implementing these programs. The four states that currently operate the program, California, Connecticut, Indiana, and New York, use three different program models.

- **Dollar-for-dollar:** Individuals may protect \$1 of assets for every \$1 of private insurance coverage purchased. In other words, purchasing a \$200,000 policy would allow the individual to protect \$200,000 in assets. California and Connecticut have implemented the dollar-for-dollar model.
- **Total asset protection:** Under this model, all of the individual's assets are protected when a state-defined minimum benefit package is purchased. New York's program offers total asset protection.
- **Hybrid Model:** Indiana has implemented a hybrid of the above two models. Dollar-for-dollar protection is provided for policies under a threshold limit and total asset protection is offered for policies that meet a minimum threshold.

The dollar-for-dollar model allows access to the program for lower-income individuals who may not be able to afford a policy that meets the minimum requirements under the total asset protection model. For this reason, New York is reportedly considering a hybrid model.<sup>7</sup> By way of contrast, Indiana introduced the total asset protection option in 1998 and discovered that it provided a strong incentive to individuals to increase the amount of coverage purchased. Prior to 1998, 29 percent of policies met the minimum threshold to qualify for total asset protection. In the first quarter of 2005, 87 percent of the policies purchased met the threshold.<sup>8</sup>

*By creating an incentive for individuals to purchase private insurance coverage, states hope to prevent or delay their reliance on Medicaid for their long-term care needs.*

## Have the Insurance Partnership Programs Been Successful?

While all four programs have been in place for more than ten years, the data available to evaluate their success are limited. A September 2005 Government Accountability Office (GAO) report indicates that 211,972 policies have been sold and 172,477 remain currently active (see Figure 2).<sup>9</sup>

**Figure 2. Long-Term Care Insurance Partnership Program Experience**

Number of policies ever purchased	211,972
Number of policyholders who have ever received long-term care insurance benefits	2,761 (1.3%)
Number of policyholders who died while receiving benefits	899
Cumulative value of assets protected of policyholders who died while receiving benefits	\$10,869,369†
Number of active policyholders who have exhausted long-term care insurance benefits	251
Have accessed Medicaid	119 (47%)
Have not accessed Medicaid	132 (53%)
Cumulative value of assets protected of policyholders who have exhausted long-term care insurance benefits	\$11,319,409†
Have accessed Medicaid	\$4,162,812†
Have not accessed Medicaid	\$7,156,597†

*Data Source: The above table summarizes data presented in the September 2005 GAO report, "Overview of the Long-Term Care Insurance Partnership Program."*

*† Data from California, Connecticut, and Indiana.*

Only 2,761, or less than 2 percent, of policyholders have accessed long-term care benefits. Of those, 251 have exhausted their benefits. It is interesting to note that of those who have exhausted their benefits, only 47 percent have accessed Medicaid benefits. What happened to the remaining 53 percent? States speculate that they are spending down income or unprotected assets, their health has improved, or their families are providing informal (unpaid) care.<sup>10</sup>

### Who purchases these policies?

- The average age of the purchaser ranges from 58-63 at time of purchase.<sup>11</sup>
- More women than men purchase policies.
- Most purchasers are married and in "excellent" or "good" health.
- Over 90% are purchasing long-term care insurance for the first time.
- A majority of purchasers reported assets greater than \$350,000 at time of purchase.<sup>12</sup>
- The percentage of purchasers with monthly income greater than \$5,000 ranged from 49% (Indiana) to 62% (Connecticut).<sup>13</sup>

**Asset protection does play a large role in encouraging participants to purchase long-term care insurance.**

Most policies are comprehensive, covering both nursing home care and community-based care, and are purchased individually, rather than through groups or organizations.<sup>14</sup>

#### **Are people buying more private insurance?**

A primary goal of the program is to encourage the purchase of long-term care insurance to reduce the dependence on Medicaid as a funder of long-term care services. A key program evaluation question, therefore, is whether the individuals participating in the program would have purchased long-term care insurance without the incentive for asset protection. There is limited survey data from all four states to answer that question. The benefits of asset protection did play a large role in encouraging participants to purchase policies, but it was just one of several considerations.<sup>15</sup>

#### **Does the program save Medicaid money?**

The fact that 899 policyholders died while they were accessing private insurance benefits might suggest the program is resulting in cost savings for Medicaid, but the data are insufficient to make that determination. The main reason is that it is unknown right now whether those individuals would have accessed Medicaid benefits had they not purchased private insurance.<sup>16</sup>

### **What is the Future for These Programs?**

LTC Insurance Partnership programs cannot expand to additional states without a change in federal statutes regarding estate recovery. In 1993, Congress passed legislation that requires states to seek recovery from the estates of individuals age 55 and older who received assistance from Medicaid. Recovery is mandatory for certain services, including nursing facility care, and optional for other services. The only exceptions are those states that had received approval before May 14, 1993 to disregard certain assets when making Medicaid eligibility determinations: Iowa and the four Long-Term Care Insurance Partnership Program states.<sup>17,18</sup>

### **What are Some Questions Policymakers can Ask to Assess Long-Term Care Insurance Legislation?**

The long-term care insurance market is relatively young and experience with the LTC Insurance Partnership programs is limited. As such, policymakers are concerned about a number of key issues, including market regulation, market stability, equity, and reciprocity.

**Market regulation.** Of particular concern is the current regulatory environment for the long-term care insurance market. Are consumer protections adequate?

- Long-term care insurance products are largely regulated by states. The lack of national standards may lead to considerable variation in the level of regulation across states. Officials from states with LTC Insurance Partnership programs, however, argue that the program has increased oversight in these states and improved the quality and regulation of the products offered.<sup>19</sup>

- Policymakers are also concerned about whether inappropriate products will be marketed to vulnerable individuals. For example, products may be sold to individuals who cannot afford to pay the premiums for the life of the policy. The carrier would collect payments and never risk a payout if the policy was cancelled. Another fear is that the coverage will be inadequate to cover the future costs of care—leaving a significant financial burden to the policyholder.

**Market stability.** Some policymakers are concerned about the stability of the market for long-term care insurance. There is a trend of consolidation in the market. One report estimates that nine companies will soon hold more than 90 percent of the market.<sup>20</sup> While this may improve administrative efficiencies and spread the risk across a larger population of policyholders, the insolvency of a single carrier could significantly impact policyholders and the market as a whole.

**Equity.** Another major issue for policymakers is whether the program violates equity standards. Medicaid is designed to assist people who are poor. Additionally, regulations exist to discourage people from transferring assets in order to qualify for Medicaid sooner than they otherwise would. Not everyone can afford to purchase long-term care insurance and in fact, some people are denied coverage. By allowing one group of individuals the opportunity to protect assets, does the program violate equity standards?

**Reciprocity.** Finally, those who purchase policies are concerned about the lack of reciprocity among states with LTC Insurance Partnership programs. While most states would likely support reciprocity, those with large retiree populations may be reluctant to participate for fear of assuming responsibility for long-term care costs for a greater number of individuals whose assets would be protected.<sup>21</sup>

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**Some policymakers are concerned about the stability of the market for long-term care insurance.**

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- <sup>11</sup> Data from Connecticut, Indiana, and New York.
- <sup>12</sup> Data from California, Connecticut, and Indiana.
- <sup>17</sup> Iowa had received approval, along with the four participating Long-Term Care Insurance Partnership states, but has not yet implemented a program.