

**LONG TERM CARE PARTNERSHIP PROGRAM**  
**FACT SHEET/TOOLKIT**  
**FOR STATE EXECUTIVES**

**Background:**

The Long Term Care Partnership Program is a public-private partnership between states and private insurance companies, designed to reduce Medicaid expenditures by delaying or eliminating the need for some people to rely on Medicaid to pay for long term care (LTC) services. Individuals needing LTC services, who previously purchased select private LTC insurance policies that are designated by a state as qualified partnership policies, first rely on benefits from their private insurance policy to cover LTC costs before they access Medicaid. After the LTC insurance benefits are exhausted and to qualify for Medicaid, applicants must meet certain eligibility requirements, including income and asset requirements. To encourage the purchase of private partnership policies, qualified LTC insurance policyholders are allowed to retain an amount of assets equal to the monetary value of the insurance policy from Medicaid spend-down requirements during the eligibility determination process. For example, if an individual purchases a \$100,000 LTC insurance policy that qualifies under the Partnership Program and exhausts that coverage after a stay in a nursing home, then this individual can protect \$100,000 in assets when applying for Medicaid.

Under the Deficit Reduction Act, previous restrictions on LTC Partnership Programs were lifted, allowing for expansion beyond the original four states that implemented programs under demonstrations. The first states to implement LTC Partnership Programs included California, Connecticut, Indiana, and New York. In order for a state to implement a LTC Partnership Program, the state must file a Medicaid state plan amendment (SPA) and get it approved by the Centers for Medicare and Medicaid Services (CMS). Currently, there are approximately 25 states that have either filed an SPA for a Partnership Program or are actively considering steps to implement this program.

**Purpose:**

- Propose recommendations that state affiliates can pursue as legislation or rulemaking
- With these recommendations, arm state executives with relevant information to put pressure on their respective state Medicaid agencies
- Instruct state affiliates on how to create a state plan amendment (SPA) and successfully submit it to CMS
- SPA should work in the issues of grandfathering, tax credits, and portability/reciprocity separately
- Educate consumers

**Tools:**

- Model SPA: should contain recommended policy provisions below
- AHCA Website: AHCA will develop a website for state executives that will serve as a resource of information on LTC Partnership Programs

**Implementation Steps:**

- File a SPA with CMS (NOTE: It is not necessary to go to the state legislature to propose a state law)
- Get an approved SPA
- Get buy-in from consumer and other groups (e.g., AARP)

### **Recommended Key Provisions for DRA Qualified LTC Insurance Policies:**

The following key provisions are recommended for a comprehensive LTC insurance policy that qualifies under the DRA and covers all care settings (i.e., nursing facility, assisted living, and home health). Note that consumers may purchase qualifying LTC insurance policies that go above and beyond these recommendations.

1. **Waiting Period:** AHCA recommends that a maximum 100-day waiting period be an option to consumers. Ultimately, the consumer should decide what they want to have and how much they want to pay (e.g., a policy with a longer waiting period would be more inexpensive). There is no specific waiting period discussed under the DRA.
2. **Duration of Coverage:** AHCA recommends that a floor of one-year should be the requirement. The average length of stay in an institutional setting is less than one year.
3. **5% Automatic Inflation Protection:** AHCA recommends using automatic 5% compounded inflation protection, which provides for a decent protection. Most insurance companies offer the 5% compounded, and the DRA requires some level of inflation protection but not a specific percentage. Specifically, the DRA requires compound inflation protection for individuals under age 61; some level of inflation protection for individuals between ages 61 and 75; and there is no requirement for inflation protection for individuals age 76 and older. Inflation protection is recommended regardless of age—even if purchaser is over the maximum age and not required under the DRA.
4. **Minimum Disability Requirements/Eligibility for Services:** AHCA recommends that minimum disability requirements be consistent with activities of daily living (ADL) requirements for nursing home eligibility (i.e., no less than 2 ADLs or be cognitively impaired).
5. **Daily Benefit Amount and What That Amount Will Cover:** AHCA recommends that the daily benefit amount be 75% of the state average for semi-private services. There should be no real requirement that it be a daily benefit amount. The benefit amount could be paid daily or monthly.
6. **Reciprocity/Interstate Applicability:** Until CMS issues guidance on reciprocity, states should recognize out-of-state plans, as long as such plans qualify under a state plan amendment approved by CMS. If a state does not have reciprocity with other states, this should not be a reason to not pursue a Partnership Program.
7. **Grandfathering:** The issue of grandfathering previously purchased LTC insurance policies is an issue that must be determined at the state level because CMS does not have any authority regarding grandfathering. AHCA supports any mechanism recognizing the value of previously purchased policies and allowing consumers to remedy defects in such previously purchased policies in order to participate in Partnership Programs.