



The California Partnership for Long Term Care

Recollections of an Advocate: A Brief Overview

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The California Partnership program has been in decline for several years. Insurance companies have left the program in frustration because they haven't been able to add or change products within the structure or administration of the program, and agents have complained about the lack of new products to sell. In 2016 Governor Brown signed SB 1384 (Liu) that among other things charges the Partnership program with establishing a task force of industry, consumer groups, and agency stakeholders to review and make recommendations on necessary changes to the program. The goal is to encourage greater industry participation and provide high quality benefits for consumers. A background issue is whether the program is meeting the goal of protecting those consumers most in danger of spending down to Medi-Cal with a long term care expense, and whether the program is saving any Medi-Cal funds that would otherwise pay for care.

Partnership Background

In the early 1990's, by then Assemblyman Lloyd Connelly created the Partnership through legislation, which was then funded by a Robert Wood Johnson 4 year demonstration program grant. The legislative intent was to develop an insurance program tailored specifically to the needs of the middle class who were the most likely population to spend down to Medicaid if they needed long-term care. This program would test the potential for savings to California's Medi-Cal program with privately purchased insurance benefits paying for care first, backed up by Medi-Cal paying for care after those privately paid benefits had been exhausted. The Partnership was to report to the legislature periodically on how the program was meeting that intention. The report would help the legislature understand if the program was producing savings to the state and reducing reliance on the Medi-Cal program.¹

California was one of four state grants² to test financing long-term care with private insurance at the front end and public benefits at the back end. Three of the states designed a dollar for dollar asset protection³ with Medicaid, while New York chose to require a specified term of coverage and total Medicaid asset protection after exhaustion of Partnership insurance benefits.

NOTE: At the time, or perhaps somewhat later, the ability of states to allow asset protection was limited under federal law to the four participating states.

¹ DHCS appears to only report to the legislature changes that occur to the program or legislation that requires changes. There doesn't appear to be any report to the legislature about whether the program is accomplishing its intended purpose.

² Connecticut, Indiana, New York.

³ One dollar of long-term care insurance benefits paid exempts one dollar of countable assets from consideration for Medicaid eligibility.

In 2005 that limitation was removed from federal law for insurance policies that complied with selected provisions of the NAIC Model Act and Regulation specified in federal law. Those standards became the threshold standard that allowed states to provide Medicaid asset protection in long-term care insurance Partnership policies.

California organized an Advisory Committee of stakeholders to design the program as required by the Partnership legislation. Stakeholders included the state Medicaid agency and various other state agencies, insurance companies, agents, and consumer representatives. The advisory committee was staffed from Senate research (Dail Phillips, on loan), and a director (Kevin Mahoney) was hired.⁴ The advisory committee met for nine months to design the benefit package and standards for operation, and receive approval from the state Medicaid agency for the asset protection feature. Regulations were developed and have been amended a few times since the beginning of the program.

Insurance companies were and continue to be charged an administrative fee to participate. Policies were then and are now submitted for approval to the Department of Insurance to ensure that all of the current state requirements for long-term care insurance are met. Policies are separately approved by the Partnership after approval by the insurance department to ensure that those policies and benefits also comply with Partnership requirements and qualify for asset protection. The Partnership began offering products for sale in 1994 with 3 or 4 participating insurance companies and CalPERS.

Early Partnership Policies

These policies were almost identical to the same benefit design being offered in the private market at that time, with a few mandatory differences related to the asset protection feature. In general, Partnership policies were required to include:

- 5% compounded inflation protection
- Minimum daily benefit based on 70% of the current cost of nursing home care in the year the policy was sold
- Minimum 1 year duration of benefits, with a maximum of 5 years
- Initial care assessment and connection to all available services charged as an administrative cost to the insurer, ongoing care management can be paid by the insured
- Each dollar of benefits paid protects one dollar of otherwise countable assets

Note: Later, following complaints from agents and companies, Partnership regulations were changed to allow lifetime coverage to be sold because agents complained that Partnership policies were not competitive with non-Partnership policies offering lifetime benefits. Lifetime coverage disappeared from the marketplace in later years due to adverse experience and pricing problems. Simple 5% interest was added in an attempt to offer a lower premium rate. It should be noted that lifetime benefits in a Partnership program are meaningless if the intent of the program is to protect middle-income people who would otherwise become eligible for Medi-Cal. Someone with lifetime benefits is unlikely to ever qualify for Medi-Cal benefits.

⁴ Lora Connelly, now director of the California Department of Aging, was staff support to Dail Phillips and Kevin Mahoney

Premiums for Partnership policies were close, if not identical, to a private market non-Partnership policy of the same design from the same company – if the non-Partnership policy included 5% compound inflation protection which it frequently didn't. Since inflation protection was sold as an optional rider at a significant increase in cost, agents often failed to include it in non-Partnership policies when comparing coverage with Partnership policies in which it was a mandatory benefit.

Agents

Every insurance product needs a distribution system to sell it, and Partnership policies were not being sold. Agents weren't selling Partnership policies because they were hostile to the program, and because their training and sales techniques had always focused on long-term care insurance as a strategy to avoid Medi-Cal. Suddenly they were being asked to sell long-term care insurance with a "benefit" for Medi-Cal called asset protection, which few people understood. In addition, Partnership policies were more expensive as a result of the mandatory inclusion of inflation protection.

The Partnership subsequently developed and required additional training before an agent could sell a Partnership policy. Agents needed to have a basic understanding of Medi-Cal eligibility and benefits in order to understand the concept of asset protection and any value it would have to their clients. It took years to entice small numbers of agents to sell Partnership products. Long term care insurance was and continues to be a complicated product to sell and the connection to Medi-Cal adds more complexity. Long-term care insurance is a product that people usually have to be convinced to buy, and at significant annual cost.

Companies

Companies participating in the Partnership have come and gone over the years. There has seldom been more than 6 companies participating at any one time plus CalPERS⁵, and those same companies continued to sell their non-Partnership policies alongside their Partnership policies, contributing to the confusion in the marketplace between the two types of policies. New companies have not joined the Partnership and many companies have withdrawn from it, citing the inability to introduce new product designs, the inflexibility of the program, and the onerous and lengthy process of participation. Sales in recent quarters have dwindled making it unprofitable for companies to continue participation and calling into question the ability of the program to survive.

The Partnership Experience With Long-Term Care Insurance

According to the latest figures available from the Partnership, 129,045 people own a California Partnership policy. Nationwide 7.2 million people own a long-term care insurance policy.⁶

While 6,726 people have used their Partnership policy benefits since the program began, 598 of those policyholders have exhausted their insurance benefits. But only 101 of those policyholders subsequently used Medi-Cal.

Spending Down: Cumulative Data

- ▶ 6,726 policyholders have used benefits since program began
 - 2,112 policyholders died while in benefit
- ▶ 598 policyholders exhausted benefits, but most did not sign up for Medi-Cal
 - 101 policyholders receiving Medicaid benefits had:
 - 1 year policy = 21 people ← Most likely to spend down
 - 2 year policy = 40 people ←
 - 3 year policy = 7
 - 4 year policy = 3

⁵ CalPERS includes 2 Partnership options, 1 year and 2 year benefit packages as part of their long term care insurance program.

⁶ NAIC Experience Exhibit Reports through 2014.

It's important to note that more than half of those who became eligible for Medi-Cal benefits had purchased minimum amounts of coverage; 1 or 2 years of benefits. In all likelihood the amounts of coverage purchased reflects both the amount of premium these policyholders could afford to pay and the amount of asset they would have otherwise spent. These policyholders were the intended target market for the Partnership because they were the purchasers who were most likely to spend down to Medi-Cal in the absence of insurance benefits.

However, there is little proof that having long term care insurance has reduced what Medi-Cal would have paid in the absence of those benefits. Without the benefits of these limited amounts of private coverage these policyholders would have been required to spend any assets they had before becoming eligible for Medi-Cal. A 2007 Government Accounting Office (GAO) report by the concluded that it was unlikely that Partnership programs would result in any savings to state Medicaid programs.⁷

Long-term Care Insurance and Premiums

Long-term care insurance experience has been tracked since about 1989. Experience refers to sales, claims, retention of coverage, and reserving. Almost all of the assumptions companies made in regards to these policies have been wrong. Companies seriously underestimated:

- How many would keep these policies leading to more claims than expected (lapse rates);
- How many would live to older ages leading to more claims at older ages than expected;
- The number of people who would need benefits due to dementia (half of claims) leading to higher cost and longer claims than expected; and
- The precipitous drop in interest rates and persistent of a low interest return on investments, leading to the need for more reserves than expected.

All of this resulted in massive premium increases, negative publicity, pressure on regulators to balance increases based on solvency concerns, and companies leaving the market in droves.

How The Market Has Changed

The market for long-term care insurance has changed considerably from the inception of the Partnership program to the present both in terms of people who buy this insurance and the claims companies pay. Premiums have become much more expensive as companies have adopted more realistic assumptions to reflect their experience. And companies have moved to life and annuity-linked products that will pay death benefit if the long-term care benefit is not used. These products are attractive to higher net worth buyers who can afford the higher premium.

The 2010 buyer is much different than the buyers in 1990. These buyers were younger with much higher incomes and assets, and likely to live in a household with someone who was still employed.⁸

The Market Has Changed

Who Buys Long-Term Care Insurance

Characteristic	2010	2005	2000	1995	1990
Average Age	59	61	65	69	68
% > 70	8%	16%	40%	49%	42%
% Married	69%	73%	70%	62%	68%
Median Income	\$87,500	\$62,500	\$42,500	\$30,000	\$27,000
% > \$50,000	77%	71%	42%	20%	21%
Median Assets	\$325,000	\$275,000	\$225,000	\$87,500	N.A.
% > \$75,000	82%	83%	77%	49%	53%
% College Educated	71%	61%	47%	36%	33%
% Employed household	69%	71%	35%	23%	N.A.

⁷ GAO-07-231

⁸ The survey of buyers is done about every 5 years, and the 2015 survey will soon be available.

Many middle class buyers have been priced out of the market in recent years as premiums have risen to unaffordable levels, both in the traditional products and in the newer combination products. And women in particular have been disadvantaged by gender-related premiums and much stricter underwriting.

What Went Wrong In The Partnership Program?

One by one, companies have dropped out of the program, frustrated with the lack of attention to their issues and changes that have occurred in private market products that can't be offered through the Partnership. Insurers cite the 5% compounded or simple interest inflation protection as too expensive, and offer lower percentages or different methods of inflation protection in their newer traditional non-Partnership policies. They also cite the mandatory minimum daily benefit of 70% of the current nursing home cost as being too high and seek a lower minimum daily benefit standard. Insurers cite both of these issues as being responsible for higher premium costs for Partnership policies that price many people out of Partnership products.

What Went Wrong?

Since 1994

- Administrative interest in the program faded
- Lack of interest in adding new companies or updating products or benefits
- Proposed regulations languish without action

2010 to present

- Companies begin dropping out
- Lengthy and inflexible review process
- Inability of program to adapt to changes
- New benefit structures, new products outside the Partnership

Agents have fewer products to sell, sales plummet

- 2nd qtr 2015 = 121 (applications received)
- 4th qtr 2010 = 2,175 (applications received)
- 4th qtr 2005 = 3,585 (applications received)



The process for participation in the Partnership, the lengthy process of policy approval, the higher premium costs for Partnership policies based on the inflexibility of the program all lead companies to the conclusion that they can't justify the cost of continued participation when so few policies are being sold. The program continues to struggle with insufficient staff and a turgid process for participation.

NOTE: In the private market, most companies have shifted from comprehensive long-term care policies to life and annuity-linked products. These products often require a single premium of \$50,000 or more and accelerate the underlying life or annuity benefit to pay for long-term care costs. Buyers are attracted to the notion that a death benefit will be paid if they never use the long-term care benefit. These high net worth buyers are unlikely to need Partnership protection, but none-the-less companies want to offer these types of policies in the Partnership.

Agents are frustrated with the cost of products and the defection of companies from the Partnership. Only 121 applications were submitted in the 2nd quarter of 2015, according to the latest data available on the Partnership website, compared with more than 3,500 in the 4th quarter of 2005. Agents trained to sell Partnership policies, say that only one insurance company is actively selling Partnership policies.⁹ There are rumors in the agent community that the last participating company may withdraw soon damping down the desire to sell that product.

How To Fix The Partnership By 2020

If legislation is needed to make changes to the Partnership it will take time and a process to introduce, pass, and implement any legislative changes. At a minimum it will take several years before new products can be introduced into the marketplace.

⁹ CalPERS continues to offer the 1 and 2 year Partnership option in their program.

- Year 1: Tasks:
 - Reconvene the Advisory Committee and charge it with redesigning the benefit packages,¹⁰ advise the legislature of what changes can be accomplished with emergency regulations, what changes will require legislation, and identify systemic changes that need to be made to the program within a 12-month term.
 - Redesign the approval process by creating a single process in a single agency that combines approval by CDI, Medi-Cal, and the Partnership.
- Year 2: Introduce and pass legislation, draft and submit regulatory changes.
- Year 3: CDI and the Partnership make necessary changes, companies design products that comply with required changes.
 - Recruit companies to participate based on anticipated changes.
- Year 4: Companies file revised products through a single simplified process, train agents and brokers, and have products ready to sell by 2020.

In Conclusion

It's important to note that while insurers and agents want changes made to the program, consumer protections must be maintained and benefits and costs must meet consumer's needs. Just because a product or benefit is offered outside the Partnership does not justify including that product or benefit inside the Partnership. The goal of the program should continue to focus on those consumers most in danger of spending down and on designing a product or products that can meet that goal. If private insurance can't in the long run save Medi-Cal money while providing affordable, meaningful benefits to middle income consumers then the program should be abandoned as unworkable.

¹⁰ SB 1834 may accomplish this task.