SOCIETY OF ACTUARIES

Article from:

Long-Term Care News

March 2006 – Issue No. 17

A Solution to the Long-Term Care Financing Crisis?

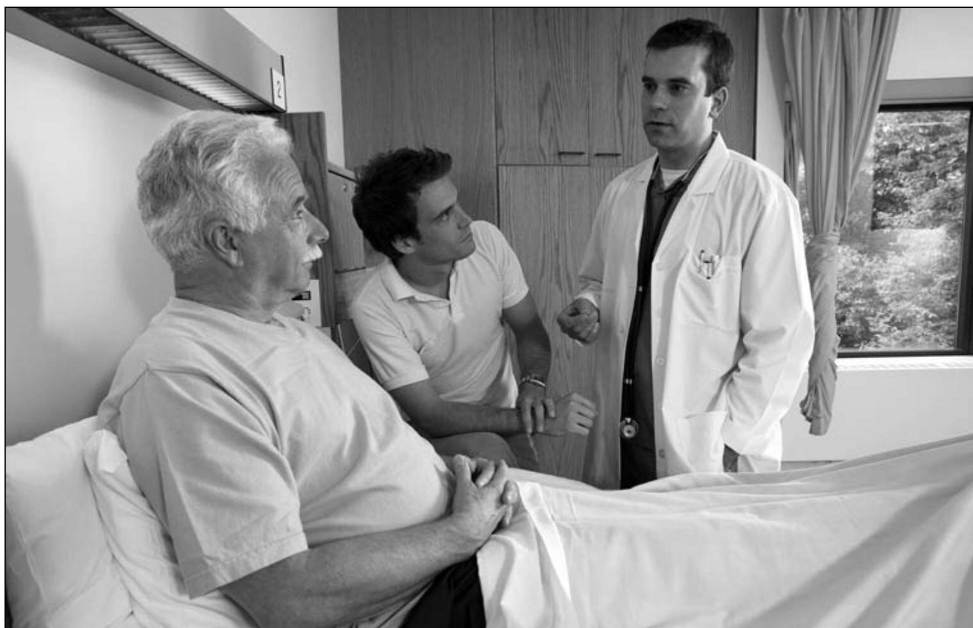
The New York State Compact for Long-Term Care

by David Bilson

The financing of Long-Term Care (LTC) is an issue that has long perplexed state and local government, as well as the insurance industry and recipients of LTC. This article examines a plan recently proposed to address the LTC financing conundrum in one state. The success or failure of that plan could alter the landscape of the LTC insurance industry.

The cost of LTC can be financially catastrophic. For many, the only assistance available is Medicaid, and the price they pay is impoverishment. Although we tend to view the effects of this mandatory impoverishment from the perspective of the individual, the impact of this policy goes beyond the fiscal devastation of a single person. Ideological arguments aside, many find it unfair to require those in need of LTC to lose their independence, security and life savings in exchange for mere survival—particularly if no other options are offered. Over time, this perceived unfairness can create resentment, which informally encourages circumvention of the rules. Even those who believe in personal responsibility begin to feel justified in divesting or concealing their assets to avoid losing them. Divestiture or concealment of assets increases reliance on Medicaid funding, increased reliance on Medicaid funding increases Medicaid costs, increased Medicaid costs lead to higher taxes, higher taxes lead to public pressure on government for tax relief, public pressure on government fuels enactment of more stringent Medicaid rules, more stringent Medicaid rules cause more resentment in those who need LTC, which leads to additional divestiture or concealment of assets. This cycle ultimately causes a drain on public funds that cannot be sustained.

There have been many ideas on how to resolve the LTC financing problem. Some seek to expand the number of possible payers by encouraging the purchase of private insurance (e.g., the state LTC partnerships established in the early 1990s). Some ideas center on increasing revenue sources, such as proposals to impose or raise various excise taxes in an effort to supplement Medicaid funds. Others believe eligibility rules are too lenient, while still others think controlling provider charges would alleviate the problem. None, however, have addressed the cycle or questioned the role inherited by Medicaid in the financing of LTC—that is, until recently.



Perhaps the most promising alternative for alleviating the LTC financing crisis is the New York State Compact for LTC (the "Compact"). It is also the most intriguing in terms of its authors and supporters. Based on an original proposal by Gail Holubinka, vice president of business development for MedAmerica Insurance Company, the idea is the product of a collaborative effort between unlikely allies—an LTC insurer and the Elder Law Section of the New York State Bar Association.

continued on page 22

Design of the Compact

The Compact proposes to reshape the structure of LTC financing by removing Medicaid as the central player under the assumption that need due to poverty and need due to a single overwhelming expense differ and should be managed differently. The new structure is an agreement between the State of New York and its citizens to adhere to a pledge of mutual responsibility. Specifically, if an eligible New York resident agrees to privately fund the cost of his/her qualified LTC services up to an amount equal to the established program maximum or one half of his/her non-housing assets, whichever is less, the State agrees to provide financial support for certain subsequent LTC services through the payment of a subsidy.

A person may apply for the Compact when they are determined to be chronically ill.[1] Enrollment and management of the pledge portion of the Compact is the responsibility of a private organization chosen to administer the Compact. Through that organization, participants pledge to pay the cost of their qualified LTC services[2] in an amount equal to one half of their non-housing assets (a Dollar Pledge) or an amount equal to the cost of 36 months of facility care in their region (the Maximum Pledge). The Dollar Pledge protects the other one half of the participants' assets while the Maximum Pledge protects all of their assets. Pledge amounts can be fulfilled through any non-government source, such as cash or insurance.

A person may apply for the Compact when they are determined to be chronically ill.

During the pledge period, the participant is private pay. Documentation evidencing the amount of private funds paid (not incurred) by or on behalf of the participant is sent to the Compact administrator. Qualified LTC services need not be covered or paid by Medicaid to be credited to a participant's pledge amount.

Once the pledge is satisfied, the participant's remaining assets (including the homestead) are protected. The participant remains private pay, but becomes eligible for a Subsidy from the State (the "Subsidy"). The Subsidy equals the amount Medicaid would have paid for the qualified LTC service received by the participant. Participants who have met their pledge are charged a Compact Rate (the "Compact Rate"), which may not exceed 110 percent of the Subsidy amount.

Participants who have satisfied their pledge and are entitled to receive the Subsidy are responsible for paying the State a participation fee equal to 25 percent of their monthly income. In addition, participants must pay out-of-pocket the difference between the Compact Rate and the Subsidy, as well as any expenses not arising from the receipt of qualified LTC services. Participants who have satisfied their pledge and are entitled to receive the Subsidy could use any provider willing to accept Compact Rates, even if the provider has not contracted with the Medicaid program.

Rationale of the Compact

The seeming simplicity of the Compact belies the year of work that has gone into testing its underlying assumptions. Cost effectiveness, inclusiveness, regulatory compliance and operational ease were just a few of the issues with which the Compact's authors grappled. "The hardest part," according to Ms. Holubinka, "was constantly reminding ourselves that this was not a Medicaid program. Whatever we did had to be compatible with, but not governed by, the Medicaid paradigm. Each of the issues was examined from the viewpoint of all

1 For purposes of the Compact, the definition of "chronic illness" is taken from the Health Insurance Portability and Accountability Act of 1996. *See* 26 U.S.C. § 7702B(c)(2) (2005). Under the Compact, determinations of whether a person is chronically ill would be made by that person's health insurer or, in the case of a person making cash payments for his or her care, a state approved assessment organization. Assessments would be paid for by the person or his or her insurer.

2 For purposes of the Compact, the definition of "qualified long term care services" is taken from the Health Insurance Portability and Accountability Act of 1996. *See* 26 U.S.C. § 7702B(c)(1) (2005).

involved. No matter how appealing an idea, if it didn't result in a benefit to all, it had to be adjusted or discarded."

For example, a primary goal of the Compact's authors was to relieve some of the LTC costs currently shouldered by Medicaid. Because the majority of LTC costs are incurred within the first three years after the onset of a chronic illness, the Compact shifts much of this significant financial burden away from Medicaid by effectively requiring Compact participants to privately fund all or most of the expenses associated with their initial years of LTC. At the same time, participants will have less incentive to conceal or divest their assets because they know that they will not only qualify for the Subsidy once their pledge is satisfied, but will be able to maintain some or all of their assets once they qualify for the Subsidy.

Another factor that received considerable attention from the Compact's authors was the effect the Compact would have on the sale of LTC insurance. Would the Compact support sales of LTC insurance policies as well as the state LTC partnership concept? A program that begins at the point of need would seem to discourage the public from planning ahead. On the other hand, one of the greatest drawbacks of partnerships in terms of reducing public costs is that they do not address those who are uninsurable or simply do not plan how they will finance their long terms care. Because the Compact does not discriminate regarding the source of pledge payments (pledge payments can be made from cash or insurance benefits), it is more inclusive and expands privitization. Concurrently, the incentive to purchase LTC insurance likely would increase, as purchasing insurance is a more attractive option than risking half or more of one's assets. Furthermore, since the financial stakes associated with the Compact are known, the LTC market might expand as a result of the Compact. Those with smaller at risk assets or buyers who, faced with unlimited risk, may have rejected any coverage, could, under the Compact, become purchasers of LTC insurance coverage.

Progress of the Compact

In New York, legislation to establish the Compact is due to be introduced in the new session with support from both houses. "But," as Ms. Holubinka says, "regardless of the outcome of the Compact bill, the circumstances surrounding its development demonstrate that an intense concern regarding LTC financing is shared by even the most disparate sources. It also shows that a concerted effort to meet the needs of each stakeholder and innovative thinking are concepts that resonate." According to Ms. Holubinka, this fact is demonstrated by, "the broad scope of interest the concept has created. Providers, legislators, public interest organizations, and even nascent groups in other states have weighed-in with inquiries, suggestions and offers of help. It's exciting to be part of the dialogue."

Although there is no single solution for all of the problems associated with the financing of LTC, the Compact is a promising alternative to the untenable program that is currently in place. By focusing on Medicaid's proper role in the financing of LTC and shifting the perception of Medicaid from the primary source of funding to a "safety net" of last resort, the Compact has the potential to alleviate some of the financial burden from Medicaid while allowing the chronically ill to retain their dignity and a measure of financial independence. As such, the fate of the Compact in New York warrants close attention by state and local governments, recipients of LTC and the insurance industry. ❋

David Bilson is an associate with Drinker Biddle & Reath, LLP. He can be reached at *david.bilson@dbr.com*.

Gail Holubinka is vice president of Business Development for MedAmerica Insurance Company. She can be reached at *Gail.Holubinka@medamericaltc.com*.