CHCS Center for Health Care Strategies, Inc.

Issue Brief

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Medicaid Eligibility Issues for Long-Term Care Insurance Partnership Programs

By Mark R. Meiners, PhD, George Mason University

This issue brief outlines Medicaid eligibility rules that states should consider when implementing a Long-Term Care Partnership program. It is the second in a series of briefs produced through CHCS' *Long-Term Care Partnership Expansion* project, made possible by the Robert Wood Johnson Foundation.

Medicaid is the country's safety net health care program for people with low incomes as well as people who spend down their assets due to high health and long-term care expenses. Medicaid is also the primary source for long-term care payments. In 2003 Medicaid paid 46 percent of the $110.8 billion spent on nursing home care and 25 percent of the $40 billion spent on home health care.[1] This link between Medicaid and long-term care was the key motivator for the development of the Long-Term Care Insurance Partnership model in the late 1980s.[2]

The goal of the Long-Term Care Partnership model is to use Medicaid's safety net feature as an incentive for middle income people to buy private long-term care insurance and, by doing so, encourage them to prepare for the risk of needing long-term care. This, in turn, will help delay or avoid the need for Medicaid to pay for their long-term care. In the Partnership model, states offer the guarantee that if benefits under a Partnership policy do not sufficiently cover the cost of care, the consumer will qualify for Medicaid under special eligibility rules that allow a pre-specified amount of assets to be disregarded. (The consumer must also meet other Medicaid eligibility rules.) This is generally referred to as "asset protection" in the context of the Partnership program.

As a part of the package of reforms included in the Deficit Reduction Act of 2005 (DRA), Congress lifted the moratorium on Partnership programs that had been set in 1993. The expansion of the Long-Term Care Insurance Partnership model made possible by the DRA does not, for the most part, call for alterations in how Medicaid is administered. However, there are key aspects of Medicaid eligibility rules that states must consider when implementing a Partnership program. This issue brief outlines those issues for state consideration.

DRA Implications for the Partnership

The DRA provisions relating to Partnership programs and asset protection are part of a larger package of Medicaid eligibility rule changes that include new asset transfer and home equity provisions.[3] There are also a number of long-standing Medicaid eligibility rules that states still need to consider when determining Medicaid eligibility for Partnership policyholders.

Asset Protection

The asset protection feature of the Partnership program is an incentive to potential buyers because it allows consumers to retain a pre-specified amount of assets and still be eligible for Medicaid benefits if and when additional long-term care coverage (beyond what the policies provide) is needed. Without the asset protection provision of the Partnership, a person of limited means may not opt to purchase long-term care coverage at all.

The "dollar for dollar" asset protection model specified in the DRA is based on the program experiences of the original Partnership states: California, Connecticut, Indiana, and New York. Under those state programs, a policyholder is allowed to keep an amount of assets equal to the amount the insurance pays out for their long-term care. The assets protected are over and above any other asset that would normally be exempt or non-countable in the Medicaid eligibility determination process.

Asset Transfers

Through the DRA, the penalty for transferring assets to gain Medicaid eligibility was increased by extending the look back period from three to five years, and adjusting the start date for the penalty period to the date of Medicaid application. As a result, it becomes more difficult and costly for a consumer to give away assets to gain Medicaid eligibility. If a person transfers assets, then he or she must pay out of pocket an amount equal to the amount they had transferred, thus defeating the purpose of the transfer.

Home Equity

The DRA designates anyone with home equity above $500,000 ineligible for Medicaid benefits. States have the option of increasing this limit to $750,000. The goal of this provision is to encourage the use of home equity to pay for needed care. It is also intended to get people with significant home equity to think about purchasing insurance against the risk of long-term care so their home is not at risk if care is needed.

The home equity limit is new to Medicaid and has prompted questions from both the original Partnership states and those who are looking to become Partnership states. The Centers for Medicare and Medicaid Services (CMS) has been asked if the asset protection can be used to increase the home equity value provision. For example, could someone with a Partnership policy providing $100,000 in asset protection use that to increase the protected value of their home to $600,000 and still qualify for Medicaid?

For technical reasons, the CMS response was negative.[4] The home equity value language falls under the Medicaid payments law provision, while the Partnership language of the DRA falls under Medicaid eligibility law provisions. As such, the home equity value provision creates a new test for Medicaid eligibility. The person must qualify regarding income, then assets, then the home equity value before being eligible for Medicaid long-term care payments. For the original Partnership states and insurers this policy is problematic because grandfathering exemptions on this

provision have not been offered for Partnership policies purchased before the home equity restriction was in place.

One option to handle this concern is through individual appeals to CMS when and if a problem arises.[5] To formalize this approach, the Connecticut Partnership program has adopted the following language:

The following individuals may be eligible to receive Medicaid payment for long-term care services, notwithstanding possessing home equity in excess of $750,000:

a. *individuals who demonstrate, to the satisfaction of the Department, that they cannot obtain a reverse mortgage, home equity loan or similar instrument; and*

b. *individuals eligible for a Long-Term Care Insurance disregard in an amount greater than or equal to the amount of home equity in excess of $750,000, plus the amount of any other counted assets.*[6]

These provisions will likely give policy holders the original expectation of asset protection that existed prior to the DRA provision. It remains to be determined if similar provisions could be implemented in new Partnership states to meet the special individual circumstances.

Exhaustion of Benefits Requirements

One issue that has sparked early controversy is whether or not the insured person could be eligible for Medicaid before exhausting his or her insurance benefits. Under certain circumstances, it is possible for a person to need to spend protected assets before exhausting his or her private Partnership policy benefits. This introduces some complexity that was resolved in the original states by allowing individuals to gain access to Medicaid while the insurance was still paying benefits. In such a situation, beneficiaries were allowed to protect assets equal to what their policy had paid out to-date. A person would then be able to have Medicaid pay along with the remaining insurance instead of using the protected assets to fill in remaining gaps in coverage. Over time, the asset protection amount would actually increase as the insurance continued to pay benefits. The continued accumulation of asset protection could serve to protect earnings on existing protected assets, an inheritance, or home equity that might otherwise be subject to recovery.

The CMS guidance document, issued in July 2006, reinforced this opportunity by noting that "*The DRA does not require that benefits available under a Partnership policy be fully exhausted before the disregard of resources can be applied. Eligibility may be determined by applying the disregard based on the amount of benefits paid to, or on behalf of, the individual as of the month of application, even if additional benefits remain available under the terms of the policy.*"[7]

However, additional questions were sparked by the CMS clarification at the end of that same paragraph. "*The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination.*"[8] This seemed to suggest to some that the beneficiary had to make a choice between the earlier but

less full protection vs. later full protection. For example, imagine a person has a Partnership policy worth $100,000 and as used $80,000 in benefits. He or she may still have $20,000 left under the policy, but may need additional funds to cover the costs of care. If this person applies for Medicaid, CMS suggests that only $80,000 (rather than $100,000) will be protected. It is up to the states to choose such a requirement.

Programs in Idaho and Minnesota require policy holders to exhaust their benefits before asset protection could be granted. Waiting until the policy benefits are exhausted could mean that the policy holder is spending protected assets in the near term, but then protecting more of the assets that might come from earnings on the remaining protected assets that might otherwise be subject to recovery. The concern with requiring exhaustion of the insurance benefit is that people could theoretically become impoverished before any asset protection was taken, defeating the intent of the Partnership program.

Other states are interpreting the CMS language in a way that is more similar to practices in the original Partnership states. The eligibility process is viewed as an ongoing process and not a one-time determination. The application and re-determination are viewed as part of the same eligibility process. Therefore, it is possible for the policy holder who is on Medicaid to continue to accumulate a level of asset protection consistent with what is paid out over the life of the policy. The amount that is protected when someone first applies is not capped at that amount, but can grow as benefits under the policy continue to be paid out. For example, Ohio recently clarified that while its Medicaid bulletin[9] says "The amount of resources disregarded at eligibility determination will be disregarded during estate recovery," it really means *the most recent eligibility determination* as the Ohio Medicaid division regards eligibility as an ongoing process since eligibility is re-evaluated at certain intervals. Ohio plans to clarify this more explicitly when program materials are revised.[10]

The Ohio approach reduces concerns on the timing of the eligibility status as it relates to the amount of asset protection allowed. It also eliminates any negative incentive that might encourage the policy holder to drop the policy when it still has benefits that can be paid. While this does not seem very likely to happen (most policies stop premiums when a beneficiary is in claim, at least for nursing home stays), it is clearly not in a state's interest for a consumer to drop his or her policy.

The original Partnership states with the dollar-for-dollar model of asset protection indicate that it is rare for policyholders to spend down their protected assets before their insurance benefits are exhausted. In all of the original dollar-for-dollar states, less than 0.5% have done so (though the sample size is very small in terms of the number of policyholders accessing Medicaid in the original states).[11] Still, the requirement to exhaust insurance benefits before getting asset protection could produce unintended consequences. If Partnership policy holders are required to use all of their benefits before gaining asset protection, it could lead purchasers to buy less coverage so that they would be less likely to be faced with such a choice. This would work against the goal of the Partnership program to have people buy as much coverage as they can comfortably afford.

Services Qualified for Asset Disregard

Another issue raised and resolved in the original Partnership states relates to whether there would be any special limits placed on the types of services paid for by the private long-term care insurance. For example, if the policy paid for assisted living and a state did not cover assisted living as a Medicaid benefit, was it acceptable for the insured to gain asset protection by using such a benefit? Though there was some early resistance to this, the original Partnership states decided that this situation was no different than if the person had used his or her own money in paying for such care, which could impoverish them and qualify them for Medicaid. However, it must be noted that the insured person, upon applying for Medicaid, would not be eligible for assisted living if assisted living was not a Medicaid-covered benefit in that state. If the person wanted to continue in assisted living, he or she might have to use some protected assets to secure the necessary mix of housing along with Medicaid home care support.

Tracking Protected Assets

Tracking protected assets is an additional consideration in the Medicaid eligibility process for Partnership states. One option states may use to track protected assets is to require that beneficiaries designate assets to be protected. The rational for tracking protected assets is to avoid double counting, i.e., allowing policyholders to spend protected assets, and then also claim exemption from estate recovery for the original protected amount.

With any Medicaid applicant, asset identification is part of the normal eligibility process. Total assets remaining that need to be spent before Medicaid eligibility must be compared to the amount of protected assets per the dollar-for-dollar Partnership insurance payout rules in the state. The only assets protected (over and above those protected under the regular Medicaid rules in the state, e.g., burial plots and spousal protection benefits) are those that are equal to or less than the amount of asset protection earned with the Partnership insurance.

With the amount of protected assets identified and eligibility established, states can use periodic eligibility redetermination checks to review the client's financial transactions over the most recent period. In Connecticut, one of the original Partnership states, if a protected asset is sold or transferred, then the original amount is reduced for both asset disregard and estate recovery. When assets grow in value, the extra money must be spent on the cost of care. However, if an asset had lost value, earnings are allowed to increase to the most recent protected amount. David Guttchen, Director of the Connecticut Partnership, points out that from Connecticut's perspective "there is a big difference between the value of assets declining and the asset being spent." He does not think states have to identify the specific assets that are to be protected.

Eligibility Reciprocity Among Partnership States

It is still not clear how important reciprocity of Medicaid eligibility will be to widespread multi-state replication of the Partnership. With reciprocity, a state may worry that it will end up having to provide Medicaid benefits to insured persons who exhaust their private Partnership policy benefits but who were not originally tax-paying residents. Conversely, a state may see the benefit of having new incoming residents who already have long-term care insurance.

The marketing message to consumers is simpler and cleaner if both the basic benefits of the insurance and the Medicaid eligibility rules regarding asset protection are portable. However, without special provisions only the insurance benefits themselves (not the asset protection provisions) can be accessed in a state other than the state where the Partnership policy was purchased. To remedy this, Congress required the development of reciprocity standards under the DRA Section 6021(b). It states in its entirety:

(b) STANDARDS FOR RECIPROCAL RECOGNITION AMONG PARTNERSHIP STATES – In order to permit portability in long-term care insurance policies purchased under State long-term care insurance partnerships, the Secretary of Health and Human Services shall develop, not later than January 1, 2007, and in consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care partnership plans, other States, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships under which—

> *(1) benefits paid under such policies will be treated the same by all such States; and*
>
> *(2) States with such partnerships shall be subject to such standards unless the State notifies the Secretary in writing of the State's election to be exempt from such standards.*

In response, the Department of Health and Human Services (HHS) drafted reciprocity standards. All states with approved Partnership program State Plan Amendments are required to accept those standards unless they explicitly opt out by notifying the Secretary of HHS. States can choose to opt in or out of the reciprocity agreement at any time. Policyholders, however, are subject to the reciprocity policy in the state of current residence. If that state has opted out of the reciprocity agreement, these policyholders may not be entitled to the asset protection that would be due to them in their original state of purchase. Conversely, if the state where a policy is purchased has opted out, a beneficiary may not be eligible for asset protection, even if they move to a state that has adopted the reciprocity standards.[12]

Income Eligibility and Qualified Income Trusts

One final topic that is related to the Partnership has to do with Medicaid income eligibility. The Partnership incentive relates to the protection of assets, not

income. If the insured person's income is above the state's income eligibility limits, the income will have to be spent on the cost of care down to the income limit allowed in the state. But not all states allow spending down income in order to qualify for Medicaid. In some states there is a strict limit on the level of income a person can have to be eligible for Medicaid. In these states, where income spend down is not allowed, a person could need care that costs more than they had to spend while at the same time they could have more income than was allowed for Medicaid eligibility. This poses a special problem for Partnership programs, because consumers may fear that even though they have asset protection, they may never qualify for Medicaid due to income that exceeds eligibility limits.

Congress addressed this problem in 1993 through an amendment to section 1917 of the Social Security Act that allows for Qualified Income Trusts (QIT). This option permits a person to legally divert their excess income into a trust, after which the income is not counted toward the Medicaid eligibility income cap. Income paid to the trust can be used to purchase institutional services, home and community-based waiver services, or medical services for the beneficiary and not be countable for income eligibility purposes. The QIT must be irrevocable and include a reversion clause that requires it to payback to the state any funds remaining after the death of the beneficiary, up to the amount that Medicaid had paid for care that had not already been repaid.

While none of the original Partnership states prohibited income spend down, it was clear in the early development of the program that this would be a barrier to the ability of some states to launch a Partnership program. New states with strict income rules, such as Texas, should consider incorporating the QIT into their Partnership program rules.[13]

Conclusion

Medicaid is not uniform across states and it is not possible to predict what the program will look like in the future. It does, however, represent a safety net needed by those who are low income, and increasingly by a broader constituency — those who are unable to cover the costs of long-term care services. This broader constituency includes many people who could shoulder some of their own long-term care costs, but do not have enough resources to guarantee never needing the safety net.

The Partnership long-term care insurance model offers consumers a way to prepare for their long-term care needs, while still having the assurance that the safety net will be there for them if necessary. The risk of impoverishment is greatly reduced because consumers can have confidence that their assets will not need to be totally depleted before that assistance is available. The Medicaid eligibility policies discussed in this brief are likely to influence how long-term care planning, including decisions about purchasing a Partnership-qualified insurance policy, are made.

Endnotes

[1] CMS, National Health Accounts, 2005.

[2] For background on the Partnership model, see *Long Term Care Partnership Expansion: A New Opportunity for States*. Robert Wood Johnson Foundation Issue Brief, May 2007. Available at: **http://www.chcs.org/publications3960/publications_show.htm?doc_id=482463**

[3] J. Stone. "Medicaid Coverage for Long-Term Care: Eligibility, Asset Transfers, and Estate Recovery, as Modified by the Deficit Reduction Act of 2005," CRS Report for Congress, April 2006.

[4] Suggested by CMS staff in Partnership technical assistance call sponsored by the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, April 3, 2007.

[5] Ibid.

[6] Section 4030.20.E.4 of the Connecticut Department of Social Services Uniform Policy Manual (UPM).

[7] CMS, "Qualified Long-Term Care Partnerships Under the Deficit Reduction Act of 2005, July 27, 2006. Available at: **http://www.dehpg.net/LTCPartnership/federal%20guidance%20documents/CMS%20LTC%20Partnership%20Guidance%20.pdf**

[8] Ibid

[9] Medicaid Bulletin: 5101:1:38:10 (G) (1)

[10] Personal conversation with Phyllis Shelton in the context of her development of agent training materials for use in Ohio.

[11] Informal survey of Partnership Directors in California, Connecticut, and Indiana, July 2007.

[12] The latest draft of the detailed provisions can be found at the following link: **www.dehpg.net/LTCPartnership/federal%20guidance%20documents/Reciprocity%20Standards%20Draft%202.pdf**

[13] For more information on the Texas QIT as it relates to Medicaid see following links: **http://www.dads.state.tx.us/handbooks/meh/2000/2313.45.3.htm** and **http://www.dads.state.tx.us/handbooks/meh/res/me-ap36.htm**.

About the Author

Mark R. Meiners, Ph.D., is a Professor of Health Policy in the College of Health and Human Services at George Mason University. Among his noteworthy recent accomplishments is his leadership of the Robert Wood Johnson Foundation (RWJF) Medicare/Medicaid Integration Program, an initiative designed to help states develop new systems of care that better coordinate acute and long-term care. In addition he has led the Partnership for Long-Term Care since its beginning in 1987.

About the Center for Health Care Strategies

The Center for Health Care Strategies is a nonprofit health policy resource center dedicated to improving the quality and cost effectiveness of health care services for low-income populations and people with chronic illnesses and disabilities. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve people with complex and high-cost health care needs.

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Resources for States

The Long-Term Care Partnership Expansion project, coordinated by the Center for Health Care Strategies (CHCS), is providing 10 states — Arkansas, Colorado, Georgia, Michigan, Minnesota, Oklahoma, Ohio, South Dakota, Texas, and Virginia — with extensive technical assistance to help develop Partnership programs. This brief is one in a series of technical assistance resources that CHCS will make available to help additional states design effective long-term care strategies.

For information about state activities and a library of resources, visit **www.chcs.org**.

CHCS Center for Health Care Strategies, Inc.

200 American Metro Blvd. Ste. 119
Hamilton, NJ 08619-2311
Phone: (609) 528-8400
Fax: (609) 586-3679
www.chcs.org

Medicaid and Long Term Care â€“ Qualifying for Medicaid, Eligibility Requirements, Benefits and Care Services.Â Medicaid refers to more than one program, as there are many different eligibility groups within each stateâ€™s Medicaid program. On this page, Medicaid long-term care for the elderly and disabled is the focus. Medicaid has different names in many states (e.g. Medi-Cal, MassHealth, TennCare, MaineCare).Â Medicaid â€“ Medicaid is a jointly funded state and federal health insurance program for low-income people of all ages. For the relevancy of this page, the focus will be on Medicaid Long Term Care for seniors and disabled individuals. Long-term care insurance (LTC or LTCI) is an insurance product, sold in the United States, United Kingdom and Canada that helps pay for the costs associated with long-term care. Long-term care insurance covers care generally not covered by health insurance, Medicare, or Medicaid. Individuals who require long-term care are generally not sick in the traditional sense but are unable to perform two of the six activities of daily living (ADLs) such as dressing, bathing, eating, toileting, continence... b. individuals eligible for a Long-Term Care Insurance disregard in an amount greater than or equal to the amount of home equity in excess of $750,000, plus the amount of any other counted assets.6. These provisions will likely give policy holders the original expectation of asset protection that existed prior to the DRA provision.Â The Partnership incentive relates to the protection of assets, not. Medicaid Eligibility Issues for Long-Term Care Insurance Partnership Programs. 6. income. Congressional Research Service. Medicaid Financial Eligibility for Long-Term Services and Supports. general eligibility requirements. Then it describes federal statute as well as selected regulations and guidance regarding these financial eligibility requirements, including rules related to spousal impoverishment, asset transfers, treatment of certain assets, post-eligibility treatment of income, and estate recovery.Â Long-term services and supports (LTSS) refer to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition. Often the individualâ€™s disability or condition results in the need for hands-on assistance or supervision over an extended period of time.