

Long-Term Care Partnership: State Considerations for Inflation Protection

AUGUST 2007

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Inflation protection is one of the most significant and controversial features in Long-Term Care Partnership insurance. Indeed, the four original Partnership states — California, Connecticut, Indiana, and New York — all required compound 5% inflation protection and viewed that requirement as the single most important feature that distinguished Partnership from non-Partnership insurance. Without this feature they felt that both the consumer and the state were at much greater risk of not having adequate protection when long-term care (LTC) was eventually needed.

The original Partnership states have all concluded that the absence of the inflation protection requirement would defeat the purpose of encouraging people to buy LTC insurance with special asset protection. The consumer would be at risk of having to use his or her protected assets to cover an increasingly larger portion of the bill thereby negating the value of asset protection.

Conversely, inflation protection adds significantly to the cost of the premium. Insurers and their agents have argued that the resulting higher cost reduces consumer demand for Partnership insurance. The net effect of these conflicting positions was a compromise in the 2005 Deficit Reduction Act (DRA), with inflation protection varying by age of purchase.

This technical assistance brief was written to help states address these issues and guide them in determining how to handle inflation protection in their Partnership programs.

The 2005 Deficit Reduction Act

To be a Partnership qualified policy, the DRA includes the following age-specific inflation protection requirements:

- Individuals age 60 or younger must have “annual compound inflation protection;”
- Individuals at least 61 but younger than 76 must have some type of inflation protection; and
- Individuals age 76 or older are not required to purchase any inflation protection option.

This structure was a political compromise designed to balance the positions of the original Partnership states and the concerns of the insurance industry. The logic behind this structure is that the importance of inflation protection diminishes as consumers get older because the time between insurance purchase and benefit payout is likely to be shorter. Thus, there is potentially less time for the benefit to erode if there is no inflation protection or if the inflation protection that is included does not keep pace with the cost of care.

It should be noted that no specific inflation adjustment factor, e.g. 5%, was listed in the DRA. Also, no further guidance on the issue of inflation protection was offered by the Center for Medicare and Medicaid Services (CMS), the agency responsible for approving the necessary Medicaid plan amendment provisions for a state to launch a DRA-based Partnership program. As a result, key details regarding inflation protection have been left to state discretion.

This technical assistance brief outlines considerations for states in developing inflation protection requirements for Long-Term Care Partnership programs. It is the first in a series of briefs produced through CHCS' Long-Term Care Partnership Expansion project.

A Case Study in State Discretion

Maryland wanted to require the amount of compound inflation protection to be at least 3%. The question then arose as to whether Maryland could do this because the DRA specifies that any requirement attached to Partnership insurance must also be required of all other long-term care insurance. This provision was put into the DRA to minimize the differences between Partnership and non-Partnership insurance. It is worth understanding the underpinnings of this provision.

The intent of the “no differences” provision was to avoid what occurred in the early phase of program development of the original Partnership states. At that time, insurers did not keep the Partnership policies up to date with non-Partnership policies, thereby rendering the Partnership products as a non-competitive option. This was rectified in 1996 when some of the original Partnership states began to require insurers to keep their Partnership and non-Partnership policies comparable in terms of benefits and premiums. In other words, a Partnership policy and non-Partnership policy with the same benefits would cost the same. Instituting this change dramatically increased the sale of Partnership policies.¹

A more subtle feature of the DRA “no difference” provision is that it protects the non-Partnership market from being forced to do something a state wants done for Partnership insurance, e.g., minimal daily benefit requirements. The law effectively creates a situation where the much larger non-Partnership insurance market could resist such a change as not relevant to those policies not intended for middle-income purchasers who buy because of the special asset protection. This thus keeps nearly all non-Partnership products as Partnership qualified as long as they meet the DRA inflation requirements.

It was in this context that Maryland asked CMS for clarification on its proposed regulations requiring that each applicant for a LTC insurance policy be offered a minimum level of inflation protection.² Maryland’s proposed Partnership regulations require that the purchaser accept this minimum inflation protection benefit. Maryland wanted to know if this was in violation of the DRA “no difference” provision by imposing a requirement on Partnership policies that is not imposed on non-Partnership policies.

CMS responded that this was not a violation of the DRA because the offer of a minimum level of inflation protection is required for all LTC policies in Maryland. As such, it imposes no additional requirement for policies covered under the Partnership or offered in connection with a Partnership. The offer of the inflation protection places the burden of choice on the purchaser. The purchaser may choose to buy a policy that meets all requirements under a State Qualified Long-Term Care Partnership program, or choose to buy LTC insurance that does not meet such requirements.

In the same context, CMS told Maryland that it did not expect to issue any further guidance with respect to a minimum level of inflation protection for individuals under 61. CMS believes that decisions regarding specific requirements as to what constitutes inflation protection are outside its authority but are within the purview of state insurance commissioners. Since the burden of choice is on the purchaser, it is imperative to have strong educational materials to help consumers understand the choices they are making.

The Controversy over Future Purchase Options

The CMS perspective on State vs. Federal authority relates to another controversy that results from the lack of detailed guidance on the inflation protection requirements in the DRA. Some in the insurance industry have been working hard to have states approve the “future purchase option”

(FPO) inflation adjustment to fulfill DRA requirements. In particular, some employer group insurers see FPO as a way to encourage younger purchasers to buy the insurance with greater premium payments being possible over time as their incomes increase.

FPO is one of two main types of inflation protection used in long-term care insurance.³ The other is “automatic benefit increase” (ABI), which is most commonly associated with compound inflation protection (more on the important distinctions later). FPO is also known in the insurance industry as “guarantee purchase option” inflation protection. The basic idea of FPO is that it is not built into the premium until it is offered and accepted. This is why premiums are lower at the beginning; they do not reflect any accumulation of reserves to help pay the higher expected costs of care as people age.

FPO guarantees a benefit increase without having to reapply for coverage and submit evidence of insurability. If the benefit increase is accepted, the premium is also increased with the increase related to the amount of benefit and the insured’s age at the time of the increase. Because the risk of needing care increases as a person ages, over time these increases become more expensive.

The option to upgrade coverage is offered at set intervals, e.g., annually or every three years. Sometimes there is an extra charge for this type of offer. If the consumer chooses (or cannot afford) to purchase the increased coverage, benefits remain level, even as the costs of long-term care services increase. The value of the benefit will erode over time unless the upgrades in coverage are always accepted and the level chosen keeps up with the cost of care. More worrisome is that when an insured person declines to increase his or her coverage, which is often the case, the insurer will at some point stop offering the option to increase. Also, FPO inflation protection does not continue once benefits begin to be used, whereas ABI usually does.

With ABI, the amount of coverage automatically increases by a set amount annually. The cost of those benefit increases are automatically built into the premium when the policy is first purchased, so the premium amount remains fixed. Policies that have ABI protection are generally more expensive upfront, but are more effective at ensuring that policy benefits will be adequate to cover costs down the road.

As CMS has declined to weigh in on the issue of FPO qualifying as compound inflation protection under the DRA, some members of Congress have become concerned. Senator Charles Grassley, Chairman of the Senate Financing Committee, and Congressman Joe Barton, Chairman of the House Energy and Commerce Committee, wrote a letter to CMS (July 19, 2006) to express their strong opinion that it was not Congress’ intent for FPO to satisfy the compound inflation expectation.⁴ He also was concerned that the inflation age band structure in the DRA should not be interpreted to allow policies that built in a hybrid form of declining inflation protection as people age.

CMS has commented on an extreme example of this type of benefit gaming. That is, what if a person purchased a policy with the required inflation protection then dropped it later on? CMS’ policy is to evaluate an individual’s circumstance, including the value of countable assets, as of the month of application for Medicaid. Therefore, if a policy does not include the required inflation protection as of the month of application for Medicaid, it will not be considered a Partnership policy and assets may not be disregarded based on benefits paid under the policy. However, it appears that it will be up to states to decide whether to permit downgraded levels of inflation protection that remain in force to still qualify for Partnership protection.

Industry Innovation

Long-term care insurers may not speak with one voice, but they do try to support those among their rank who favor FPO as the preferred form of insurance. As such, America's Health Insurance Plans (AHIP) training materials suggest that some states may be convinced to accept FPO, but caution agents that in order to sell a policy with annual compound inflation protection there would have to be annual benefits adjustments that reflect compounded increases.⁵ AHIP also suggests that states allowing FPO will need to set rules on such things as whether the increase offers must continue for the life of the policy regardless of whether they are taken up. Also, whether the offers must continue even when the insured person goes into benefit. As noted earlier these are not typically the way FPO plans work.

To meet these guidelines, a draft proposal has been floated by AHIP suggesting the following parameters as the basis for qualified inflation protection for Partnership insurance:

- Offers would be made every year through at least the insured's attained age 76. The policy/certificate will guarantee the insured the opportunity to increase benefit levels on an annual basis without providing evidence of insurability or health status.
- The policy/certificate shall be structured so that benefit levels increase annually and must otherwise satisfy the requirements of the Deficit Reduction Act of 2005, e.g., compound inflation protection must be provided under policies purchased when the insured is under age 61. Benefit increases include, but are not limited to, increases at a fixed interest rate or at a rate determined by an index-based formula.
- The additional premium for increased benefits will be no higher than the rate based on the insured's attained age at the time of each offer.
- Benefit increases shall occur automatically unless the insured specifically rejects the option to increase.
- All offers through age 76 need to be accepted to retain Partnership policy status. There will be no "lock-out" of regular coverage provision if offers are declined.
- Offers will continue to be made regardless of the insured's age while the insured is in claim if the claim begins at or before age 76.

In summary, this approach would automatically adjust the premium and benefits upward to keep abreast of some (unspecified) level of inflation and the beneficiary would have to choose to opt out of it as opposed to the more typical requirement with FPO products to choose the extra benefit. At the time of opting out of the benefit increase, the consumer would also be choosing to withdraw from the Partnership benefit, but would retain the level of insurance protection in his or her policy. The key distinction between FPO and ABI remains. That is, with FPO the premiums are lower than ABI at the beginning, but get substantially higher as one gets older and closer to claim.

Another twist would be to provide some kind of cross-over option where ABI could be chosen at a later date to level out the premium increases. This suggestion was floated by Claude Thau in a recent *Brokers World* article.⁶ He sees employer groups as an important new market for sales that needs further development. Insurers who want to sell to employer groups have been most vocal in their desire to adopt FPO for Partnership insurance. Thau points out that the Federal long-term care insurance offering provided this option and that about half of current group offerings have some similar capability to allow such a shift. However, he fears that it may be too confusing for many employers to feel comfortable explaining the requirement of ABI vs. FPO. This could lead to employment-based offerings not being in the Partnership. This is seen as a problem because group offerings are considered important to the future of long-term care insurance. Others in the industry have suggested this cross-over would be quite complicated to price and administer.

The AARP Public Policy Institute has also weighed in on FPO by noting the following concerns for state implementation:

“If the purchaser declines the option to increase her benefit ... the insurance benefit will stagnate. Alternatively, if the purchaser wants a benefit that will continue to increase over time, the premiums will increase at a staggering rate The major concern with FPO is that people will price themselves out of their policies. This can happen because premiums increase later in life when incomes generally are lower. The result is that people who intended to buy a policy with inflation protecting find that they can’t afford this coverage and end up with a benefit that only covers a small fraction of future costs.”⁷

To help the consumer make an informed decision, representatives of the insurance industry have suggested that a personalized illustration be presented at the point of sale. It would show the expected pattern of future premiums and benefits under the option compared to the premiums and benefits for a policy/certificate with automatic inflation protection that qualifies for Partnership status. This type of consumer education approach was used in the Federal long-term care insurance with the result that 69% of the purchasers chose 5% compound ABI over the FPO-base offering.⁸ The illustrations from the Federal Offering comparing ABI to FPO are shown in Figure 1.

Considerations of Affordability

The key issue emphasized with FPO is near term affordability. FPO-style inflation protection can help make LTC insurance affordable at younger ages. People of working age, especially in the 40-55 age bracket, have many other demands on their resources. FPO can help people get started, and then they can increase their contributions when their incomes increase and their children are out of college. Each new benefit increase is priced to reflect the age at which it is taken up. In essence, each new benefit increase is like a small new insurance policy that reflects the higher cost associated with being older. As such the premiums will begin to increase dramatically with age, exceeding the level ABI premium structure as the person ages. This pattern is what prompts the AARP and others to worry that people might stop paying the optional increases and leave themselves with coverage that erodes over time relative to the cost of care.

Individual buyers make up about 85% of all LTCI sales. Life Insurance and Market Research Association (LIMRA) estimates for 2005 indicate that only 16% of individual policies come with FPO.⁹ In the much smaller group market, FPO is more common, comprising about 40% of sales according to the LIMRA data. The higher adoption of FPO in group sales is mostly because that is the type of coverage that has been more commonly emphasized. In addition to allowing for a lower initial premium, it has also been suggested that it may lead to more employers helping pay premiums for a starter product. If employers want to contribute to the premium it can be done easier and cheaper by paying on a term basis with no pre funding of the future risk of inflation. That part of the benefit can be left to the consumer to select. Currently, however, very few employers contribute anything to long-term care premiums even when they sponsor a group offering.

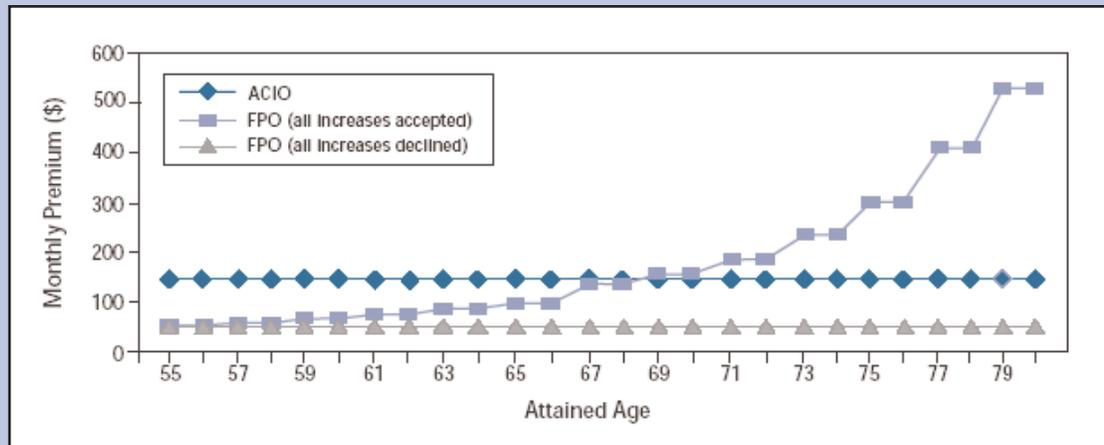
The LIMRA data indicate that within the much larger individual market, half of all products sold have compound ABI inflation protection and two-thirds of those products increase at the 5% annual rate. This puts the original Partnership inflation requirements right in the mainstream, if not an industry standard. The Partnership model is specifically designed to deal with the affordability issue without compromising inflation protection. It does this by emphasizing shorter duration coverage as a way to balance the tough cost vs. quality trade-offs that are implicit in product marketing.

Figure 1: Comparing Inflation Options for Federal Long-Term Care Insurance Offering

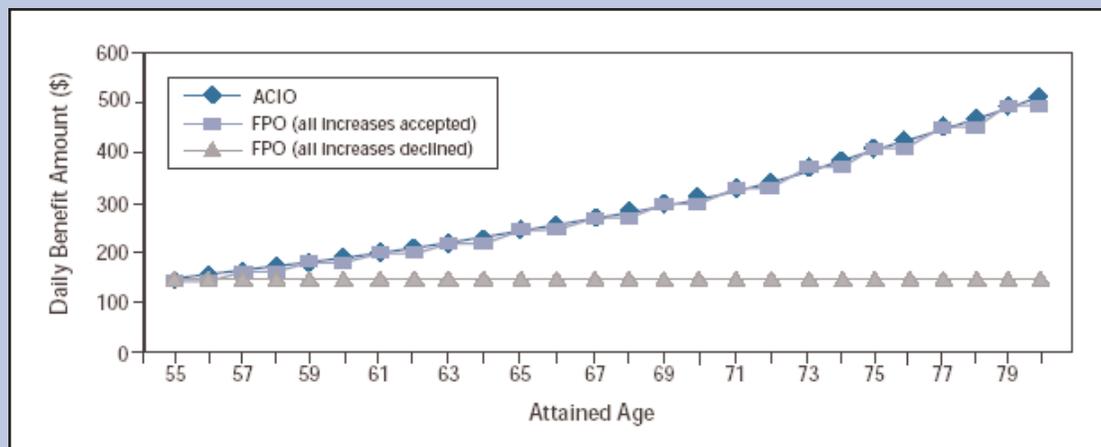
The following information is excerpted from the “Outline of Insurance Coverage for the Federal Long-Term Care Insurance Program.”¹⁰

Comparing Inflation Options for ISSUE AGE 55

The two graphs on this page illustrate the monthly premium and the daily benefit amount over time under the automatic compound inflation option (ACIO) and the future purchase option (FPO). The graphs assume a Comprehensive Option, with an initial daily benefit amount of \$150, a 90 day waiting period, and a 5-year benefit period. The graphs below only illustrate the first 25 years of premium and benefits.



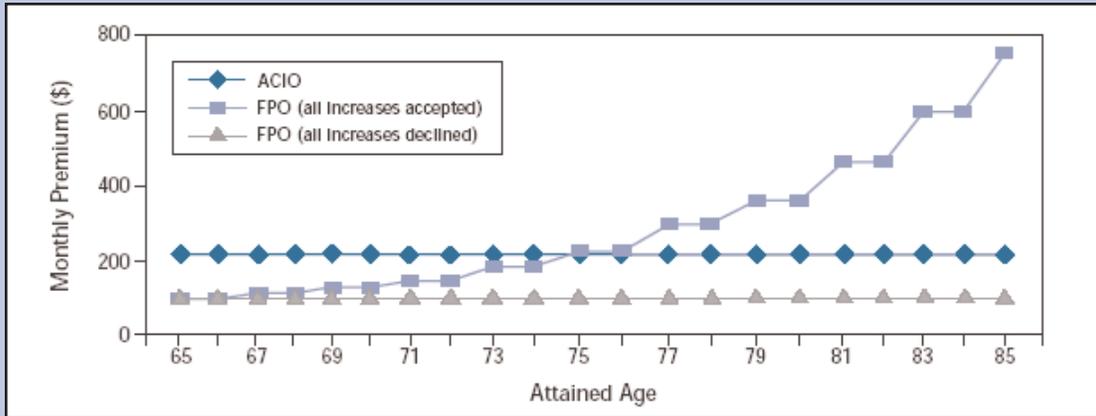
As you can see from the first graph, your ACIO premium does not increase as the benefit increases. With FPO, your premium starts out lower than with ACIO. But, as your benefit increases, your FPO premium increases and eventually becomes greater than the ACIO premium. Since the FPO premium increases steeply during normal retirement ages, you should consider whether you will be able to afford the higher premium under the FPO. If you decline an FPO increase, your coverage doesn't end, it just does not increase.



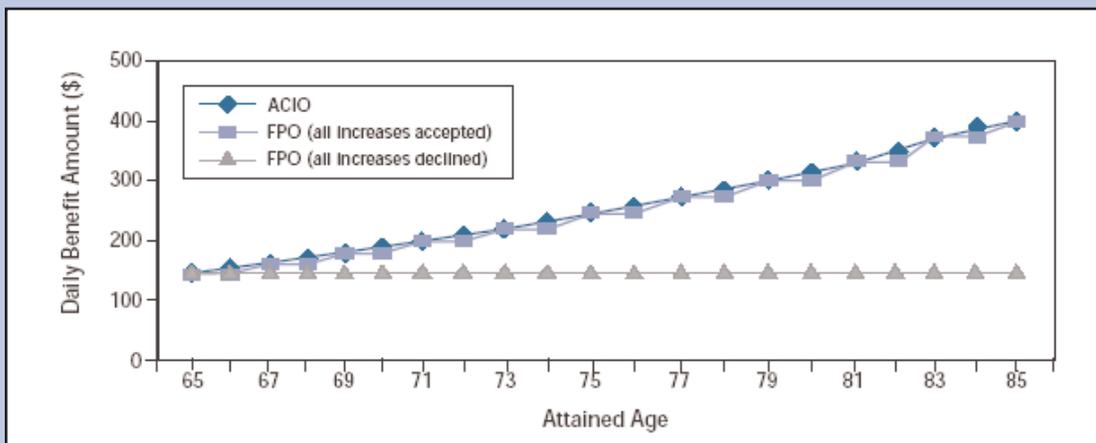
The second graph shows how your daily benefit amount increases over time under ACIO and how it increases under FPO if you do not decline the benefit increases and they take effect. However, if you decline the benefit increases, your FPO benefit will not increase and becomes substantially less than the ACIO benefit.

Comparing Inflation Options for ISSUE AGE 65

The two graphs on this page illustrate the monthly premium and the daily benefit amount over time under the automatic compound inflation option (ACIO) and the future purchase option (FPO). The graphs assume a Comprehensive Option, with an initial daily benefit amount of \$150, a 90 day waiting period, and a 5-year benefit period. The graphs below only illustrate the first 20 years of premium and benefits.



As you can see from the first graph, your ACIO premium does not increase as the benefit increases. With FPO, your premium starts out lower than with ACIO. But, as your benefit increases, your FPO premium increases and eventually becomes greater than the ACIO premium. Since the FPO premium increases steeply during normal retirement ages, you should consider whether you will be able to afford the higher premium under the FPO. If you decline a FPO increase, your coverage doesn't end, it just does not increase.



The second graph shows how your daily benefit amount increases over time under ACIO and how it increases under FPO if you do not decline the benefit increases and they take effect. However, if you decline the benefit increases, your FPO benefit will not increase and becomes substantially less than the ACIO benefit.

The Partnership model emphasizes that the premium dollar should be spent on comprehensive benefits (home and community services along with nursing home coverage) that keep pace with the cost of care. Sometime referred to by the catch phrase “short and fat” coverage, the idea is to make sure what you have is solid coverage even if for a limited period rather than “long and thin” coverage that trades off important policy features like compound inflation protection for longer durations of more limited benefits.

Here the discussion could get more complex in that product quality involves a wide variety of considerations beyond those just mentioned. These include such things as the deductible period before benefits begin, base benefit amounts covering the cost of care (e.g., a nursing home day or home care visits per week), and any of many other policy features currently available in the market. What makes these issues different for new Partnership states is that there will be few if any requirements other than inflation protection that distinguish a Partnership from a non-Partnership product. So consumers will first need to choose the benefits that are important to them, and then choose the duration of those benefits that matches the amount they are willing to pay in premium.

The original Partnership states also imposed other requirements such as covering at least 75-80% of the daily nursing home bill so that co-pays do not get unwieldy if the 5% compound inflation adjustment fell behind actual increases in the cost of care. Since most product choices are now left up to the consumer, it will be important for states to encourage insurers to offer lower duration products in the 1-5 years worth of benefits range to ensure affordability of the Partnership approach. This will help consumers to choose solid inflation protection such as the 5% compound rate required in the original Partnership states.

How Much Is Enough?

Since the DRA does not specify an amount of inflation protection that must be selected up to age 76, it is possible to choose a low level of inflation and still qualify as a Partnership policy. That is unless, like Maryland, a state decides to require a certain minimum inflation protection that must be chosen to qualify. The reason for considering such an approach is predicated on wanting the benefits that are meaningful to the consumer in terms of covering the growing cost of care. This will also serve to better protect the state from having to pay Medicaid benefits for that beneficiary. But just how much is enough?

Let us examine what consumers might buy to meet the DRA “some inflation protection” requirement in the age band 61-75. A common option that can confuse people is the “simple” inflation adjustment. For example, a 5% simple inflation adjustment increases the base benefit by 5% a year so a \$100 benefit would increase to \$105 in year 2, \$110 in year 3, \$115 in year 4 and so forth. This part is straightforward. What is not so apparent is that the benefit is not mirroring how inflation really works which is to compound itself over time by adding increases to increases. A 5% simple increase built into a level premium will double the benefit amount available in 20 years. To double the amount of benefits in the policy with 5% compound adjustments it will only take 15 years.

Of course, compound inflation protection costs more than its simple counterpart so we come back to the basic question of what level to encourage consumers to purchase. Health care costs, in general, have exceeded the general inflation rate, often by substantial amounts. With the aging of the population, the demand for long-term care is likely to grow and while there may be technological advances that can help, most experts see the cost increasing dramatically over the foreseeable horizon. Looking back, Phyllis Shelton notes in her most recent long-term care financial planning book that “since 1913, the Consumer Price Index (CPI) for all items has averaged 3.5 percent, and medical CPI usually runs 4%-5%, according to the Bureau of Labor Statistics.”¹¹ The California Partnership brochure for consumers shows the cost of a nursing home increasing from an average of \$42 a day in 1980 to \$180 a day by 2005. Even in the relatively modest inflation period of 1986 to 2005, California reports the cost of long-term care increasing at an average rate of 5.4% annually.¹²

In 2002 AARP commissioned LifePlans to examine whether the “industry standard” of 5% compound inflation protection was even enough. Using multivariate analysis and actuarial modeling along with government inflation forecasts the study concluded that “a 5% compound inflation rider is likely adequate to finance the future long-term care costs of most policyholders.”¹³ The details suggest that more than 80% of the costs of care will be covered by such policies, but the answer also depends on where one obtains care and whether the amount of coverage for the daily benefit is adequate. For this reason, the original Partnership states also required that the basic beginning daily benefit cover a significant amount of the cost of care at the time of purchase. The importance of both the 5% compound inflation rider and the initial daily benefit amount chosen is reinforced by the LifePlans study.

Conclusion

The issue of inflation protection is a hard one to tackle. Compound inflation protection adds substantially to the cost of the premium. This gets in the way of a key goal of the Partnership: getting more people to buy this form of protection. But unless the policy has solid inflation protections, neither the state nor the consumer will have the kind of benefits that can help avoid the transition to Medicaid. This is especially true for middle-income purchasers who have a modest amount of assets they would like to protect with a basic long-term care insurance product. With the special asset disregard feature of the Partnership, states can support them in this desire but only if the benefits provide meaningful cost of care protections.

In the end it is really quite simple: create a market for solid, simple, *short and fat* long-term care insurance coverage. FPO in whatever form it might be approved under the DRA is likely to introduce the need for substantial consumer and agent education. A major concern with FPO is the increased chance that an individual will not choose an inflation upgrade and, therefore, lose his or her Partnership status. Individuals, and their families, might not fully understand that their actions could result in losing their Partnership status. Potentially, someone could take increases for 20 years under the FPO option, but in the 21st year not take the increase and lose his or her Partnership status. States should do whatever they can upfront to avoid such occurrences and provide clear information to help consumers understand what they are purchasing. Consumer groups are likely to weigh in against FPO. The result may be that consumers will be confused rather than engaged and sales will not meet hopes, expectations, and needs.

Endnotes

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This brief was made possible through funding from the Robert Wood Johnson Foundation.

Acknowledgments

This brief was developed in consultation with Hunter McKay in the Office of the Assistant Secretary for Planning and Evaluation as well as Kathy Moses and Stephen A. Somers from the Center for Health Care Strategies. Thanks also to David Guttchen, Connecticut Partnership, and Raul Moreno, California Partnership, for their help in reviewing the document.

Additional Resources

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 more information, visit www.chcs.org.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving the quality and cost effectiveness of health care for Americans with chronic illnesses and disabilities, the elderly, and racially and ethnically diverse populations. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs to better serve adults and children with complex and high-cost health care needs. Its program priorities are: advancing regional quality improvement, reducing racial and ethnic disparities, and integrating care for people with complex and special needs. For more information, visit www.chcs.org.

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