

Long-Term Care Insurance Partnerships: New Choices for Consumers -- Potential Savings for Federal and State Government

January 2007

In February 2006, Congress approved legislation clearing the way for expanded, nationwide public-private long-term care (LTC) insurance partnerships. The law authorizes changes in state law to allow individuals to purchase private LTC insurance that coordinates with Medicaid. Specifically, in states adopting the Partnership approach, individuals can purchase private LTC insurance policies with the assurance that Medicaid will cover LTC costs incurred beyond the terms of the private coverage. In these states, under the terms of the Partnership, people with private insurance are not required to "spend down" their remaining assets to qualify for Medicaid.

As a result of the new law, many Americans who would have relied exclusively on Medicaid for LTC will have a new alternative that coordinates private coverage with Medicaid in a mutually beneficial way. First, consumers will have a greater opportunity to preserve their assets or be spared the awkward (but common) practice of transferring their assets to relatives in order to qualify for Medicaid. Second, widespread state adoption of the Partnership approach could lead to significant costs savings for both state and federal budgets. In this paper, we project that expanded LTC Partnerships could lead to federal budget savings of \$6 billion annually (using constant 2005 dollars) by 2050. That's equivalent to \$60 billion in federal savings over ten years in today's terms -- and \$100 billion if state savings are included. The following sections describe

the assumptions and modeling underlying our estimate.

Background: Understanding the Interaction between Public and Private LTC Coverage

Currently, about 10 percent of Americans over the age of 55 have private insurance protection for LTC costs. One might expect far more Americans to buy LTC insurance, given the financial risks associated with long-term care. Indeed, under the right circumstances, private insurance for LTC costs could give many risk-averse households the financial security they desire in their retirement years, with predictable disposable income regardless of their LTC needs.

Part of the explanation for low demand for LTC insurance may be lack of accurate information. Many people believe that they have private LTC coverage through their employers or public coverage through Medicare and Medicaid. In fact, however, they are not covered for extended LTC or nursing home stays.¹

Medicaid, the joint federal-state health-financing program for low-income individuals, pays for long-term care -- but only for those who have exhausted nearly all of their own resources first. Because Medicaid is a means-tested program, qualifying for assistance requires recipients to

¹ See a recent AARP study and survey: "The Costs of Long-Term Care: Public Perceptions Versus Reality in 2006," AARP (December 2006).

prove they are impoverished, or nearly so. To receive coverage, individuals must “spend down” their assets and demonstrate that virtually all of their income is being used to pay for their care.

To better understand why more Americans do not purchase LTC insurance, Jeffrey Brown and Amy Finkelstein, economists at the University of Illinois at Urbana-Champaign and the National Bureau of Economic Research, respectively, estimated the financial consequences for consumers who buy or forego LTC insurance.

Brown and Finkelstein's approach assessed consumers' financial conditions based on income and asset data, probabilities of long-term care episodes derived by actuaries, and premium and coverage assumptions drawn from prevailing standards in the marketplace.

Brown and Finkelstein concluded that the primary barrier to further expansion of private LTC insurance was the presence of last-resort public insurance -- namely the Medicaid program.

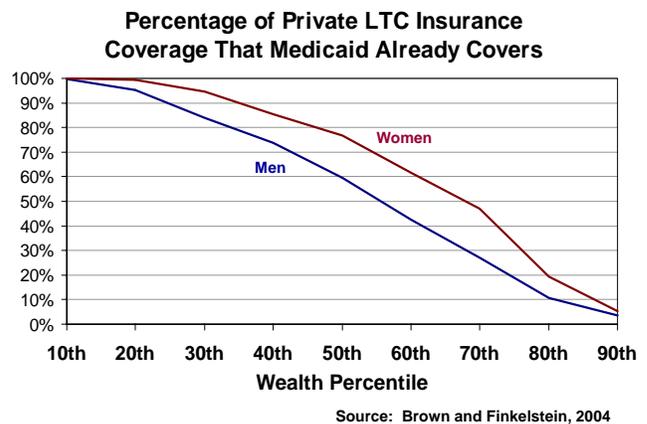
The disincentive for purchasing private insurance is tied, in part, to the fact that when a consumer buys private LTC insurance, the assets protected under that policy are not, in general, protected under Medicaid. This lack of public-private insurance coordination means that buying private insurance, for most near seniors, does not guarantee a certain level of asset protection because there remains the risk that they will need LTC beyond the terms of the private insurance. If that is the case, all of the premiums they paid to get private coverage would have been wasted, as Medicaid would require their assets to be used to offset the initial LTC costs beyond the

private insurance coverage before Medicaid would begin paying the bills.

Brown and Finkelstein quantified the impact of this disincentive -- essentially, the amount by which private LTC coverage would duplicate coverage that would be provided by Medicaid, once the person's assets were depleted. As shown in Figure 1, Medicaid would be duplicative of more than half the private LTC coverage purchased by men in the lower half of the wealth distribution. Three-quarters of private LTC insurance would be duplicative for women with assets in that range.²

Further, many middle-class elderly Americans, facing the prospect of high long-term care costs, willingly transfer their assets to family members in order to qualify for Medicaid prematurely. In essence, Medicaid's LTC coverage, which was intended only for the poor or those with no more assets to draw from, has evolved into a middle-class entitlement, allowing those willing

Figure 1: Private LTC Insurance and Medicaid



² See “The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market,” Jeffrey R. Brown and Amy Finkelstein, National Bureau of Economic Research, Working Paper 10989 (December 2004).

to transfer assets among family members to “qualify” for public coverage.

The Long-Term Care Partnership Program

Over the years, the rise in inter-family asset transfers has contributed to rapid spending increases in state Medicaid programs. States have implemented a variety of cost containment measures in the Medicaid program, and in the 1980s, they began experimenting with private LTC insurance options. The Robert Wood Johnson Foundation joined the effort by funding a demonstration program, starting in 1988, called the “LTC Partnership Program.” The Partnership was initiated to test how better coordination between private insurance and Medicaid might improve insurance protection for consumers and reduce costs for federal and state governments.

In general, the state Partnerships encouraged the purchase of private LTC insurance for a given level of asset protection and LTC duration. The critical innovation of the Partnership program was that Medicaid covered LTC costs incurred beyond the terms of the private coverage, and assets protected by the private LTC policies also were exempt from the Medicaid asset test.

In 1993, Congress imposed a moratorium on new states entering the demonstration project -- a moratorium that remained in effect until 2006. As a result, only four states -- California, Connecticut, Indiana and New York -- have been allowed to run Partnership programs for the past 13 years

Modeling the Federal Budget Impact of the Partnership Legislation

Because LTC costs are among the fastest growing components of the Medicaid budget, the Partnership approach to LTC financing

could be an important strategy to lower long-range government costs while providing new opportunities for consumers.

Partnership programs would allow middle-class Americans to set aside funds in advance to cover long-term care, without worrying that they were buying coverage partially duplicative of Medicaid. As more people who otherwise would rely exclusively on Medicaid instead purchase private LTC Partnership coverage, costs to federal and state governments will be reduced.

Allowing all states to establish Partnership programs thus removes a significant barrier to consumer demand for private LTC insurance coverage. As states expand Partnership programs over time, federal and state cost savings also will increase. These savings could be re-allocated to individuals most in need, or they could help reduce federal deficits and bolster state budgets.

Estimating the savings from the expanded Partnership program primarily requires the examination of the Medicaid savings and costs for two different groups of people:

- First, there are those older Americans who, in the absence of the Partnership, would forego insurance and depend entirely on Medicaid if they needed LTC. For this group, increased sales of LTC insurance should reduce Medicaid costs, because private LTC policies would cover much of the care that would otherwise be paid for by Medicaid. The model assumes that these people could cover about one year’s worth of LTC costs from their personal savings.

As of 1997, the average length of a nursing home stay was well over two years.³ So, if a person were relying entirely on Medicaid for coverage, they would become eligible for Medicaid financing at the end of one year. With the Partnership and the certainty of asset protection, more consumers, particularly those risk-averse households looking for more predictability in their financial situation, will find it attractive to protect their assets with insurance. If the private LTC insurance typically covers about two years' worth of care, then encouraging more insurance purchases could produce a year's worth of Medicaid savings for each nursing home resident who ends up needing extended LTC.

- Second, there are those persons who would have purchased private LTC insurance even if the Partnership legislation had not been enacted. For some of these people with extended LTC stays, Partnership coverage would speed up Medicaid coverage and increase federal costs, as people in this group would not be required to spend down all of their assets to qualify for Medicaid after their private LTC benefits were exhausted.

Figure 2 provides the assumptions that were used to estimate the net budgetary impact of nationwide adoption of LTC partnership programs. For simplicity, people are assumed to purchase private insurance at age 60 and begin to access LTC services in large numbers beginning at age 80.

The key to modeling the expansion of Partnership programs is estimating: (1) the number of new Partnership policies sold to people who otherwise would not have had

Figure 2: Key Base Case Assumptions

<u>Some Key Parameters:</u>	<u>Base Case Assumption:</u>
Insurance Sales	750,000 per year with new law; 500,000 per year if law had not passed
Age of New Policy Purchasers	60
Probability of LTC Use in a Year for Anyone Age 80 and Older	5%
For Persons Experiencing a LTC Episode, Probability of the Duration Exceeding...	1 Year: 40% 2 Years: 20% 3 Years: 10%
Average Additional Length of Stay for Persons Experiencing a LTC Episode Exceeding...	1 Year: 1.5 Years 2 Years: 1.0 Years 3 Years: 0.8 Years
Covered LTC Costs	\$70k in 2005, +1.5% real growth

private LTC insurance; and (2) the number of people who would have had non-Partnership LTC coverage had the Partnership program not been available.

As shown in Figure 2, the baseline for non-Partnership coverage is assumed to be 500,000 new policies sold per year, with no growth in the annual sales rate over time. The model assumes sales of new Partnership plans of 750,000 per year initially and increasing about 2 percent per year through 2020. These assumptions are, if anything, quite conservative. Prior to the February 2006 legislation, industry observers had been predicting a slowdown in new LTC insurance purchases. Sales had grown steadily for several years, reaching 900,000 in 2002, but have fallen ever since, with just over 500,000 policies sold in 2005.⁴

However, analysts now are optimistic that the Partnership law will enhance choice in the private LTC insurance market and stimulate

³ "Financing Long-Term Care for the Elderly," Congressional Budget Office (April 2004), p. 34.

⁴ LIMRA Data Bank (www.limra.com).

greater demand for private LTC policies.⁵ A slower phase-up to a higher level of consumer demand than assumed in the model would not significantly change the estimated government savings.

Moreover, as the baby boom generation retires, even modest increases in LTC insurance purchases would have a significant impact. As shown in Figure 3, the set of assumptions described above for increased demand for Partnership plans implies that approximately 35 million people would be enrolled in LTC insurance by 2050, compared with a baseline of fewer than 20 million.

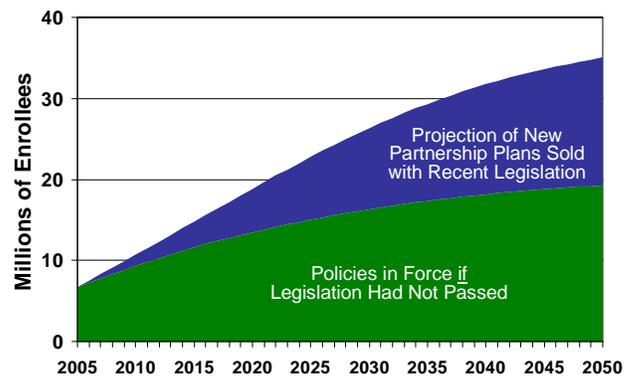
With these assumptions and this approach to modeling the cost savings, it is estimated that the legislation Congress passed in 2006 could reduce government costs by growing amounts, in real terms, after about 2025, with savings exceeding \$6 billion (in constant 2005 dollars) annually in 2050 (see Figure 4).

Modeling New Policies to Encourage Even More LTC Insurance Enrollment

This estimating model allows adjustments to test different policies or assumptions regarding how the program will evolve over time. For instance, to further stimulate demand for Partnership insurance, policymakers could consider providing tax assistance or direct premium assistance for the purchase of Partnership plans. Adding subsidies to the model would increase federal budget costs in the short term. However, such a change ultimately would produce larger savings in the long run, because more people would be relying on private LTC insurance than on Medicaid for

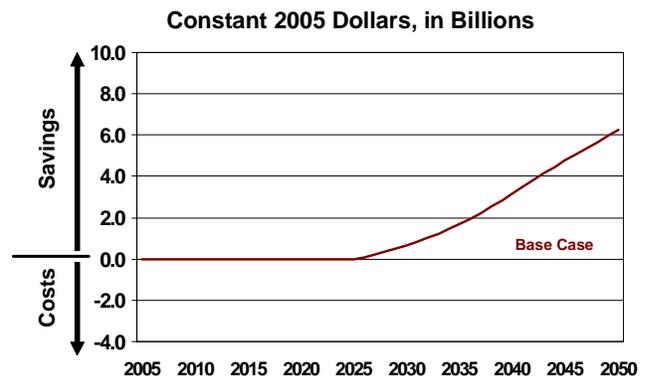
the initial months of their long-term care. These estimates are calculated assuming that a relatively small annual premium subsidy would be sufficient to raise the number of new purchasers of Partnership insurance by about 150,000 in the first year.

Figure 3: Base Case Insurance Enrollment



Other policy options could include: providing incentives to encourage private LTC Partnership insurers to use chronic care tools such as health coaching and intensive case management -- which could reduce costs -- and converting the remaining stock of non-Partnership policies into Partnership plans -- which would increase costs.

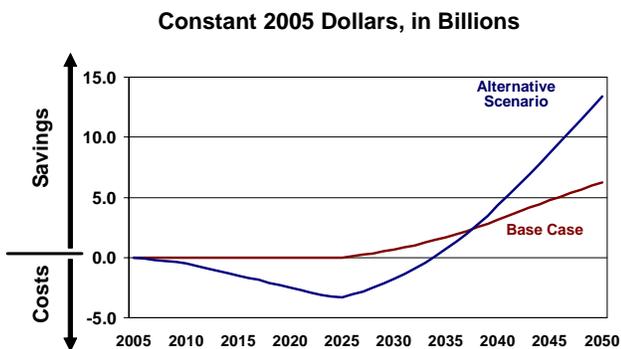
Figure 4: Base Case Budgetary Impact



⁵ “Long-Term Care is Poised for Growth,” Ty Wooldridge and Dawn Helwig, Society of Actuaries (www.soa.org).

Figure 5 illustrates the likely impact of this combination of policy changes. Assuming that widespread use of chronic care and case management programs by private LTC insurers reduced the annual real cost growth by half a percentage point annually, this alternative scenario would increase costs through about 2033, at which point the additional savings from higher Partnership enrollment would exceed the premium subsidies and the costs of “grandfathering” current plans.

Figure 5: Alternative Budgetary Impact



Conclusion

Nationwide adoption of the LTC Partnership concept, together with effective education and clear financial incentives to purchase private LTC coverage, would create a more robust market for private LTC insurance. This change would benefit consumers, whose assets would be protected even if they needed extended long-term care services and required assistance from Medicaid. It also would be good for U.S. fiscal policy, helping to limit growth in Medicaid spending and thus reducing pressure on federal and state budgets.

Acknowledgements

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