The Feasibility of Implementing a Long-Term Care Insurance Partnership in Minnesota

Interagency Long-Term Care Planning Committee

April 1994

Pursuant to 1993 Minn. Laws First Spl. Sess. Chap. 1 Art. 5 Sec. 125

Interagency Long-Term Care Planning Committee

Department of Human Services • Department of Health • MN Board on Aging • Department of Finance • Housing Finance Agency

April 5, 1994

The Honorable Linda Berglin, Chair
Health Care Committee
Minnesota Senate, State Capitol
St. Paul, Minnesota 55155

The Honorable Lee Greenfield, Chair
Human Services Finance Division
Minnesota House of Representatives
State Office Building
St. Paul, Minnesota 55155

Dear Senator Berglin and Representative Greenfield:

The Laws of Minnesota 1993, First Special Session, Chapter 1, Article 5, section 125, direct the Interagency Long-Term Care Planning Committee to investigate on the feasibility of establishing a long-term care insurance program for the state of Minnesota.

This letter conveys a research paper and summary in fulfillment of that mandate. The research was done by a contractor, Dr. John Nyman of the University of Minnesota.

INTERCOM recommends that the state delay establishing a long-term care insurance partnership program until there is more information about it. The research indicates that these programs could greatly increase state Medical Assistance expenditures in the future.

Sincerely,

Elisabeth A. Quam
Department of Health
Co-convener, INTERCOM

Helen M. Yates
Department of Human Services
Co-convener, INTERCOM

cc: Senator Gene Merriam, Chair, Finance Committee
Senator Don Samuelson, Chair, Health Care and Family Services Finance Division
Representative Wayne Simoneau, Chair, Health and Human Services
Representative Bob Anderson, Chair, Health and Housing Finance Division

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Interagency Long-Term Care Planning Committee

Department of Human Services • Department of Health • MN Board on Aging • Department of Finance • Housing Finance Agency

April 4, 1994

A Summary of
The Feasibility of Implementing a Long-Term Care Insurance Partnership in Minnesota

The 1993 Legislature directed the Interagency Long-Term Care Planning Committee (INTERCOM)[1] to study the feasibility of implementing a long-term care insurance program, including a *partnership* program similar to those already adopted by four states, other incentives to encourage the private purchase of insurance, and the adequacy of the private long-term care insurance market in Minnesota. INTERCOM contracted with John Nyman, an economist with the Institute for Health Services Research at the University of Minnesota, to research this issue. The paper attached fulfills the mandate.

The main conclusion of the report is that *The adoption of a long-term care partnership program in Minnesota is likely to lead to a large increase in Medicaid expenditures over what they would have been without the partnership,* assuming that the program took the shape of other existing partnerships.

INTERCOM's analysis is that Minnesota should delay creating a long-term care insurance partnership program until more information about the effects of these programs is available.

Long-term care insurance partnership programs. These programs have attracted considerable interest. To summarize, under a partnership, the state agrees to let a person who has bought long-term care insurance and exhausted its coverage be eligible for Medicaid benefits without having to use most of her own assets first under the normal assets test. States are interested in these partnerships in the belief that they will encourage enough individuals to purchase long-term care insurance to lower Medicaid costs in the future.

[1] INTERCOM was established by the Legislature in 1983 to help coordinate and develop policy on long-term care for seniors. Its member agencies include the Department of Health, the Department of Human Services, the Minnesota Housing Finance Agency, the Finance Department, and the Minnesota Board on Aging.

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The reasoning is that the partnerships create stronger incentives for individuals to purchase long-term care insurance. At least some of these purchasers would otherwise spend down to Medicaid eligibility, or transfer assets to avoid having to use them for long-term care, and then rely on Medical Assistance to pay for long-term care. Thus, according to this reasoning, insurance would purchase long-term care services that would otherwise have been purchased by Medical Assistance, creating a savings to the state.

However, in fact, the final, actual effects of partnerships are not fully known at this time because they are so new. The report develops a comprehensive framework for analyzing what the effects are likely to be given the financial incentives of various types of purchasers. The report identifies six types of purchasers, traces the likely effects of each type on MA costs, and estimates the number of each type of purchaser. Thus, the report extends previous research by defining the types of purchasers in a way that encompasses all of the possible incentives to purchase insurance, and the probable impact on MA of each type of purchaser.

The fiscal effects of some types of purchasers who create savings for MA is likely to be small compared to the cost-increasing effects of others, so that the net effect of the partnership will be to increase MA costs. For example, few persons who would have been eligible for MA anyway could afford to purchase insurance. However, many of those who can afford it would not have needed MA in any case. Therefore, when these latter individuals become eligible for MA, the state will purchase long-term care services that it would not otherwise have done.

The report concludes that the partnerships may create a large transfer of MA funding to people who are not poor. The transfer would be greater than most analysts had thought would be created by the partnerships' targeting to middle-class purchasers.

Other incentives: The report briefly considers other incentives for the purchase of long-term care insurance, including allowing premiums to be paid with pre-tax income, making premiums tax deductible, creating refundable tax credits directed to the poor, and creating tax-free or tax-deferred savings accounts to pay for deductibles. In each case, there are potential problems with these untested incentives, such as directing resources to the well-to-do (regressivity), the limited appeal of a state-sponsored tax incentive given the relatively low marginal tax rate compared to the federal rate, and unknown demand for the products.

Availability of insurance: Private long-term care insurance is adequately available in Minnesota. Changes in long-term care insurance regulations in 1991 to permit the use of Activities of Daily Living measures in the determination of eligibility for benefits (rather than a physicians' decision only), created a more favorable environment for private insurance. New companies have entered the state since that time. If a partnership were enacted, with its strict definitions of eligibility and benefits, an even more predictable environment would be created, enabling private carriers to satisfy the market.

The Feasibility of Implementing a Long-Term Care Insurance Partnership in Minnesota

John A. Nyman, Ph.D.
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Introduction

A number of states are currently forming public/private "partnerships" with commercial insurance companies to encourage the purchase of private long-term care (LTC) insurance in those states. Under a partnership, the state agrees to let a person who has bought LTC insurance and exhausted its coverage be eligible for Medicaid benefits without having to meet the normal assets test. For example, a person who has two years of LTC insurance might be eligible for Medicaid, regardless of assets, once those two years of coverage are exhausted.

State governments are interested in these programs because they view them as a way to transfer state and federal Medicaid LTC costs to private individuals. Currently, middle class elderly, who were not originally intended to be Medicaid recipients, can become Medicaid by spending down their assets during a relatively long nursing home stay. LTC insurance would reduce the number of days Medicaid would need to pay for by reducing the number of people who spend down or it would reduce the number of days under Medicaid if a person were to still spend down after they had purchased LTC insurance for a limited term. Moreover, some middle and upper middle class elderly are divesting their assets in order to qualify for Medicaid payment of their LTC bills. A program that encourages the purchase of LTC insurance may also make this divestiture less likely, also reducing Medicaid expenditures.

This report is intended to examine the feasibility of implementing a partnership in Minnesota. It is in response to the following legislative mandate:

> The Interagency Long-Term Care Planning Committee must report to the legislature by January 15, 1994, on the feasibility of implementing a long-term care insurance program. The report shall evaluate the potential impact on the medical assistance budget of allowing persons with at least two years of long-term care insurance coverage to waive the asset test for medical assistance eligibility, or of other incentives to encourage the purchase of long term care insurance. The report shall also evaluate the availability of private long-term care insurance, and the feasibility of state-sponsored long-term care insurance if inadequate private long-term care insurance exists.

Although the legislative mandate specifically directs the report to consider the 2 year partnership described above, it also directs the report to consider other incentives to encourage the purchase of LTC insurance. In all cases, the central feasibility question is the impact of such programs on the state Medicaid budgets. It is the conclusion of this report that the State of Minnesota should delay creating a partnership program until better information about the effects of these programs is available. When existing numbers are placed in the correct analytical framework, the results suggest that the partnerships could greatly increase Medicaid long-term care costs.

This report is organized as follows. In the first section below, we describe the theoretical reasons why people might want to purchase LTC insurance, what are the principle reasons why LTC insurance might not be purchased, and the empirical evidence regarding why those who actually purchased LTC insurance purchased it. In the second section, we construct a theoretical model showing the demand- and supply-side reasons for implementing a partnership and the potential costs and savings to Medicaid from such partnerships.

In the third section, we show the errors in current estimates of the cost savings from the current literature and reestimate the net savings (costs) when the correct analytical framework is applied. We conclude that based on the numbers from the current literature, a public-private partnership like the one being considered by the legislature is likely to increase Medicaid costs substantially. In the fourth section, we consider alternative incentives to encourage the purchase of LTC insurance. In the fifth, we evaluate the current state of availability of LTC insurance in Minnesota and consider the feasibility of a state-sponsored LTC insurance program if the availability of insurance in the state is found lacking. The final section will summarize the findings.

The Decision to Purchase LTC Insurance

Theoreticians who analyze the decision to purchase insurance have become increasingly puzzled about motivation. Up until the last decade or so, most theoreticians had thought that the primary motivation was to disperse risk. While this view still has a strong following, research by psychologists and others has repeatedly shown that the decision to purchase insurance is more complex than simple theories once suggested. This is especially true for health insurance where the risk dispersion mechanism of insurance has be become intertwined with the financing mechanism.

With *LTC* insurance, the motivation appears to be even more complex. Nevertheless, four motivations can be identified. First, because elderly persons usually do not work, their income is derived from their assets. A long-term care stay may deplete their assets so that their standard of living would decrease should they return home after their long-term care. It would also reduce the standard of living of their spouse. LTC insurance would protect against the risk of this reduction of resources.

Second, because a LTC stay may exhaust the resources intended as a bequest to one's children, LTC insurance would protect against this sort of risk.

Third, some LTC can be so costly that it exhausts one's resources. Because of the lack of alternative sources of financing of health care for someone who is late in life and sickly, someone else--a relative or the state Medicaid program--will need to pay. LTC insurance, therefore, is protection against the risk of dependence on others and a financing mechanism to assure that the resources are available to pay for LTC.

Fourth, LTC insurance may permit a person to pay private rates for LTC services. In many states, private patients have a free choice among nursing homes whereas the choice by Medicaid patients is constrained to those with available beds. The free choice among nursing homes by private patients increases the probability that the person will choose a nursing home with higher quality care. Therefore, the purchase of LTC insurance may mean increased quality of care.

There are peculiarities with each of these motivations that make the purchase of LTC insurance less likely. Of course, the main barrier is Medicaid. The presence of Medicaid means that an alternative way of protecting from the risk of losing one's assets is to divest oneself of the legal claim to them in order to qualify for Medicaid payment of LTC. Even though divested, the assets could still be used to the original owner's benefit. A series of state and federal laws have made this alternative less and less available, but the presence of this as a possibility means that the purchase of LTC insurance is less likely.

Another alternative--especially for the second motivation--is the purchase of life insurance in order to guarantee a bequest (Pauly, 1990). Again, this possibility makes the purchase of LTC insurance less likely.

Medicaid also represents an alternative financing mechanism. As health technology has advanced and become increasingly expensive, the possession of health insurance has become increasingly necessary as a way of financing health care. This is also true of LTC and LTC insurance. Care of chronically ill has advanced so that the expense of a long nursing home stay is beyond many persons' resources. Without the possibility of Medicaid, LTC insurance would be as necessary to elderly as health insurance is to working aged adults and families. With Medicaid, however, a person can rely on their existing assets and know that if expenses exceed them, the state will pay. This reduces demand for LTC insurance.

With regard to the argument that private insurance allow patients to select nursing homes of higher quality than a Medicaid patient would typically be able to select, Pauly (1990) notes that, whereas there might be an incremental difference in quality between a nursing home that caters to private patients compared to one that caters to Medicaid patients, the price of that incremental increase is the entire private cost of care. That is, private patients are likely to receive better care than Medicaid patients in states where the private price exceeds the Medicaid reimbursement. This incremental difference may be worth paying the difference between the Medicaid and private rates, but with the way that Medicaid is set up, this cannot be done. In order to get the private quality care, one must pay for the entire cost of care privately. This increase in quality may not be worth the LTC insurance premium that one must pay to become a private patient, which makes the purchase of LTC insurance less attractive.

In Minnesota, the private price is constrained to equal the Medicaid rate, so nursing homes do not have the same incentive to attract private patients differentially by providing higher quality care. Therefore, the quality of care motivation for purchasing LTC insurance is in theory totally absent in Minnesota.

Finally, Pauly (1990) argues that LTC insurance may be undesirable for those who want to be cared for informally by relatives. The purchase of LTC insurance would lower the costs of formal nursing home and home health care. As such, it makes it more likely that formal care would be chosen over informal care. This motive would make the purchase of LTC insurance less likely.

In 1991, the Health Insurance Association of America (HIAA, 1992) surveyed purchasers and non-purchasers of LTC insurance to determine why people purchased it. Purchasers were presented with a list of reasons why they purchased the insurance and asked how important each reason was. Five reasons were ranked "most important" the highest percentage of times. Two of the reasons correspond to the first motivation above: "to protect my assets" and "to protect my

family's standard of living." Two correspond to the third motivation: "to guarantee that I will be able to afford needed long term care services" and "to avoid depending on others for care and to preserve my independence." One was consistent with the fourth motivation: "to enable me to choose the nursing home or home health care services that I want if I ever need them." All the other reasons considered received markedly lower scores.

Interestingly, the bequest motive was viewed as being relatively unimportant by the respondents of this survey. This is consistent with other empirical evidence suggesting that bequests are relatively unimportant in explaining a person's consumption and savings decisions later in life.

In summary, two factors appear to be the most important motivators for purchasing LTC insurance in Minnesota: (1) the desire to preserve resources for the person's or spouse's own use and (2) the desire to be able to self-finance levels of LTC expenditures that might exhaust one's resources. Of the two, former may exerts more influence than the latter because the costs of the former are more real. Whether one purchases LTC insurance to achieve these goals depends on the cost of insurance relative to the actual and psychic cost associated with divesting to become a Medicaid patient.

Cost and Savings from a LTC Partnership

The Effect of a Partnership on LTC Insurance Premiums. Two models of LTC insurance partnerships currently exist. The first or "total assets" model is currently in force in New York. Under the total assets model, if a person buys a certified policy with a specified number of years of coverage for nursing home and home health care, and a minimum daily payment level, that person would automatically qualify for Medicaid if the policy were exhausted. Although assets are excluded, a person's income must be devoted to the cost of care. This is the model that the legislature explicitly wants this report to consider.

The second type of partnership--currently implemented in Connecticut, Indiana, and being implemented in California--is the "dollar-for-dollar" model. Under this model, a person who buys a precertified LTC policy and exhausts its benefits can disregard the total dollar amount of LTC costs the insurance policy paid out in determining their eligibility for Medicaid. That is, a person who exhausts a $50,000 policy will be able to have $50,000 of assets and still qualify for Medicaid.

These models encourage the purchase of LTC insurance in different ways. The total assets model encourages the purchase of insurance by lowering the price of policies that protect an unlimited amount of assets. For example, if a consumer wanted to protect her assets from being depleted under the eventuality that she were in a nursing home a very long time (say, for 6 years), the actuarially fair costs of insuring for such a long period may make the premiums prohibitively expensive. However, under a total assets partnership, if the person became eligible for Medicaid after a 2 year policy were exhausted, the insurance company's expected costs would be lower and so would the premiums. The purchaser could still be insured for an unlimited number of years, but the premiums would be lower and more private insurance policies would be purchased.

The dollar-for-dollar model does not lower the premiums for high coverage insurance. Instead, it works by essentially increasing the value of the coverage. That is, without the program, for every $1 in insurance premium that is paid, you expect to receive about $1 in payment for nursing home or home health services (loading fees aside). With a partnership program, for every $1 of insurance premium paid, you expect to receive about $1 in payment for LTC services (again loading fees aside) plus $1 in assets that you would not otherwise have had, if your policy were exhausted and you would have spent that $1 on LTC services. Because you are getting more coverage for the same amount of premium, insurance is more attractive and more will be purchased.

The dollar-for-dollar model allows one to tailor the amount of coverage needed to qualify for Medicaid to ones own resources. For example, suppose that the comparable total asset partnership were for 2 years of coverage and that a nursing home stay cost about $25,000 a year.

A dollar-for-dollar partnership would mean that a person with only $30,000 of assets would not need to purchase a policy with $50,000 worth of coverage in order to qualify. On the other hand, a person with $100,000 worth of assets would need to purchase 4 years of coverage to protect all her assets, whereas under the total asset model, she would only need to purchase 2 years. This implies that, given a certain coverage period under a total assets insurance policy, those with assets less than the qualifying amount will gain more from a dollar-for-dollar policy and those with assets more than that amount will gain more with the total asset policy.

It should be noted that there is likely to be a supply effect here, too. One of the reasons that LTC insurance was not available until recently was that insurers could not accurately predict expenses. It was thought that the insured had a great deal of control over the amount of expenditures (moral hazard), making the expected costs of newly introduced policies uncertain. The limiting to two years of cost exposure is likely to make these costs more predictable and therefore more insurable. Therefore, more companies are likely to enter markets where a total asset form of partnership exists. Of course, it is difficult to separate out the firm's supply response to an increased demand (caused by the partnership) from the firm's supply response to more predictable costs (also caused by the partnership).

Theoretical Effect of the Partnership on Medicaid Expenditures. To determine whether any policy is cost-increasing or cost-decreasing, it is simply necessary to describe the world with the program in question and without the program in question, and calculate the difference in costs. Here, we are interested in determining the net savings (if any) to Medicaid that would occur from the implementation of a partnership program. Therefore, the net amount saved by Medicaid **that is attributable to the partnership** can be calculated from the following equation:

Medicaid savings = Medicaid expenditures without the partnership -
Medicaid expenditures with the partnership (1)

One way to operationalize this equation is to run through the various types of persons that could be affected by the implementation of a partnership program and determine whether each of these types of persons would contribute to savings or instead be associated with increased Medicaid costs.

There are three different classes of persons affected by the implementation of the partnership. First, there are those who would not have bought any type of LTC insurance policy without a partnership program in the state but because of the availability of the partnership, purchase insurance. We will refer to this class of persons as the "**new purchasers**." Second, there are those who would have purchased LTC insurance anyway without the partnership, but because of the partnership program purchase a partnership policy instead. We will refer to these persons as the "**insured purchasers**." Third, there are those who have already purchased LTC

insurance before the partnership policies were available, but convert to a partnership policy when the partnership policies become available. We will refer to these persons as "**converters**."

The **new purchasers** exist because a partnership policy is better than a conventional long-term policy in some way and that induces them to buy insurance (specifically, a partnership policy) when they otherwise would not have. The total assets model encourages new purchases of insurance by lowering the price of policies that protect a large amount of assets. For example, if a consumer wanted to protect her assets from being depleted under the eventuality that she were in a nursing home a long time (say, for more than 6 years), the actuarially fair costs of insuring for such a long period may make the premiums prohibitively expensive to that consumer. However, under a total assets partnership, the consumer could purchase protection against a 6-year stay with a 3-year policy. That is, the insurer can charge premiums commensurate with a 3-year policy but sell a policy that gives unlimited years of protection of assets because Medicaid will pick up the costs of any expenditures over 3 years. Because of the lower prices, more policies would be purchased.

The dollar-for-dollar model does not lower the premiums for high coverage insurance but, instead, increases the value of the coverage. That is, without the program, for every $1 in insurance premium that is paid, a person *expects* to receive about $1 in payment for nursing home or home health services (loading charges aside). With a partnership program, for every $1 of insurance premium paid, a person expects to receive about $1 in payment for services (again, loading charges aside) plus $1 in assets that the person would not otherwise have had, if the policy is exhausted and the person would have spent that $1 of assets on LTC services. Because people are getting more value for the same amount of premium, insurance is more attractive and more will be purchased.

The new purchasers can be subdivided further. The intent of the partnership is to draw new purchasers primarily from the ranks of those who have divested their assets in order to become eligible for Medicaid. Under the total asset partnership, these "**new divestor purchasers**" would save Medicaid expenditures because if their stays are less than the 2- or 3-year qualifying period, insurance pays what Medicaid would have paid. If their stays exceed the qualifying period, Medicaid would have paid anyway. Under the dollar-for-dollar partnership, insurance would cover stays that Medicaid would otherwise cover. At the point when the policy is exhausted, Medicaid would have paid anyway because without the policy, the person's assets would have generally been exhausted at the same point.

A second type of new purchaser might come from the ranks of those who would have spent down to Medicaid status: "**new spend down purchasers**." As a result of their becoming insured, some Medicaid expenditures would be assumed by the insurance company. Under the total asset partnership, if their stays are shorter than the qualifying period, there may be no Medicaid savings because they might have had sufficient assets to cover these costs privately.

Medicaid savings would occur to the extent that these short stayers would have been on Medicaid and instead are now insured. If their stays exceed the qualifying period, there may be additional costs to the extent that this portion of their stay would have been paid for privately, but is now paid for under Medicaid.

Under the dollar-for-dollar partnership, Medicaid savings would depend on similar considerations. If the stays are short and cost less than the amount insured for, it is unlikely but not impossible that there would be Medicaid savings because the person is unlikely to insure for more than the value of their assets. The availability of partnership policies would need to have enticed the person to purchase a level of insurance that is greater than their assets for Medicaid to experience savings. If the stays are long and cost more than the amount insured for, Medicaid is likely to have covered these costs anyway so no Medicaid savings is likely to occur.

A third type of new purchaser might come from the ranks of those with sufficient assets to cover almost any stay privately. To the extent that insured dollars replace private dollars, there would be no savings or cost to Medicaid. However, to the extent that Medicaid dollars replaced private dollars, this would mean additional costs to Medicaid. Under a total asset partnership, private spending could be replaced by Medicaid spending for these "**new private purchasers**," thus adding to Medicaid costs. Under a dollar-for-dollar partnership, these types would mean no Medicaid expenditures at all because once the policy was exhausted, the person would have sufficient private funds to pay for the remainder of the stay (by definition). Still, new private purchasers are important under a dollar-for-dollar because they could represent a relatively significant portion of the total number of new purchasers, and a portion to which no Medicaid saving could be attributed.

A fourth type of new purchaser might come from the ranks of the true poor who would qualify for Medicaid from the beginning. These "**new Medicaid purchasers**" would generate savings for Medicaid under either a total assets or dollar-for-dollar partnership, but would probably be so few in number (because of the relatively high premiums that they face) that their impact on Medicaid costs would be negligible.

The **insured purchasers** are those who would have purchased insurance anyway, but because of the introduction of the partnership program, purchase a partnership policy instead. That is, we know that the number of persons purchasing conventional LTC insurance is increasing every year throughout the country. This trend would be expected to continue, whether or not partnership program was available. However, if there is a partnership policy available, many if not most of those who would have bought conventional LTC insurance now purchase partnership LTC insurance either because the coverage costs less or because it is a better value. These are people who, once their conventional insurance ran out, would have paid for care from their own private assets. Because they now qualify for Medicaid to pay for their care, these persons would increase Medicaid expenditures. This is true for either type of partnership. Under a total asset

partnership, if the qualifying period is exceeded, Medicaid pays for what insurance or private assets would have paid for. Under the dollar-for-dollar arrangement, when the policy is exhausted, Medicaid pays for expenditures that private assets would have paid for.

As we shall see, an important question is what portion of those who would have purchased insurance anyway become "insured purchasers" of partnership policies. At the extreme, all of the otherwise insured could become partnership insured. This is consistent with the argument that, if you were going to purchase insurance anyway, a partnership policy allows you to do so either at a lower costs (total assets) or at the same costs and gives you a policy with more value (dollar-for-dollar).

Yet the true proportion is likely to be less than that because of the other features of the policy. Those who want insurance in order to avoid dependence on Medicaid would probably still purchase a conventional LTC policy. Those who have income and assets that would enable them to purchase a 1 year policy may not be able to purchase a total asset partnership policy with a qualifying period of 2 or 3 years. Once, however, the availability of these policies becomes well known and the market has matured, it is difficult to contemplate that the proportion of the otherwise insured who purchase partnership policies instead would ever drop below, say, 50 percent.[1]

Finally, the **converters** are those who have purchased LTC insurance before partnership policies were available. If they now convert to partnership policies, they would represent increased Medicaid costs for the same reasons that the insured purchasers would. This is a stock of persons whose importance in the Medicaid savings equation will diminish over time. But in the initial years of the partnership, accounting for their presence may be very important in determining whether the partnership is enticing sufficient numbers of new purchasers to save Medicaid dollars. Table 1 summarizes this typology and their predicted effect on Medicaid savings.

[1] It should be noted that those who would have purchased insurance without the partnership and, after the implementation of the partnership, purchase a conventional policy do not represent either costs or savings to Medicaid, even though some might eventually incur costs paid for by Medicaid. These people do not change their behavior as a result of the introduction of the partnership program, so they can essentially be ignored.

Table 1

Type of Purchaser	*Medicaid Effect*	*Estimated Number*
New divestor purchasers	Reduces Medicaid costs	Unknown
New spend down purchasers	Either reduces or increases Medicaid costs	Unknown
New private purchasers	Increases Medicaid costs	Unknown
New Medicaid purchasers	Reduces Medicaid costs	Few
Insured purchasers	Increases Medicaid costs	Large number
Converters	Increases Medicaid costs	About 20 percent of policies sold

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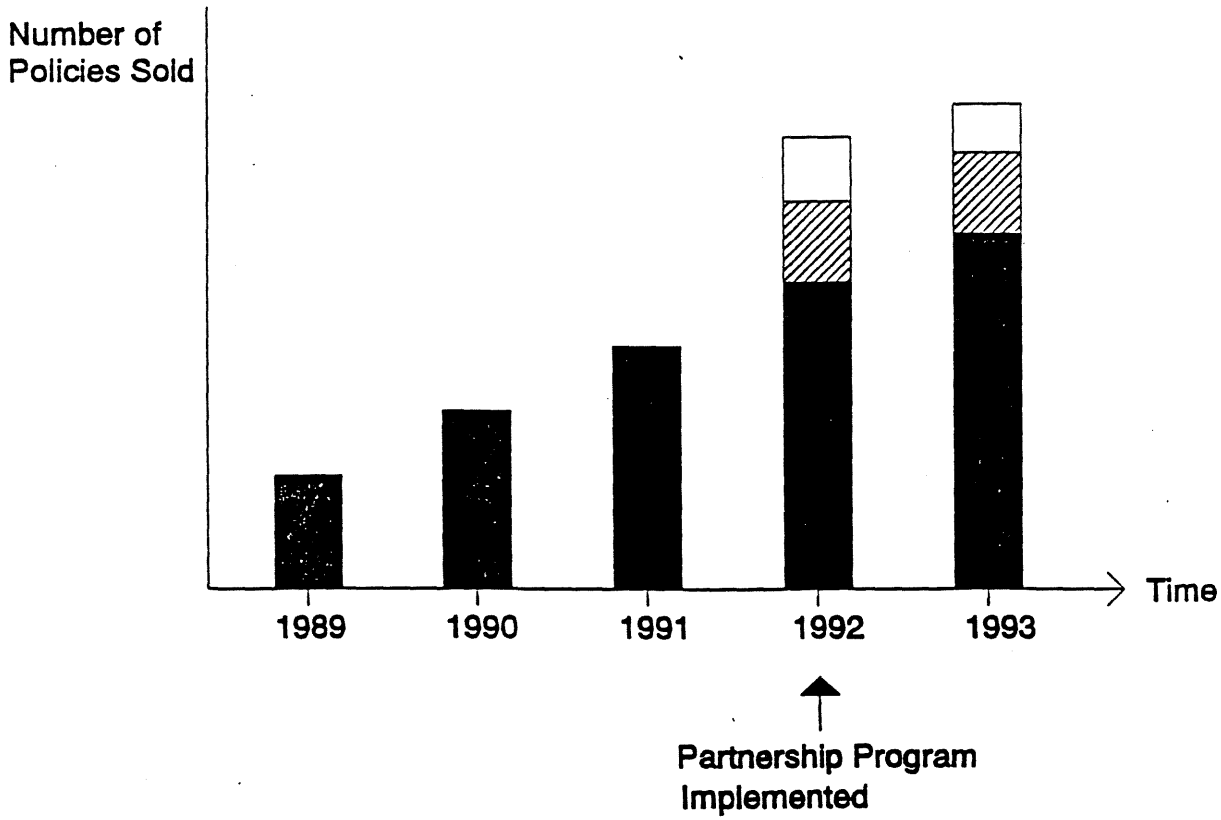
Figure 1 (see next page) shows these groups schematically. The Figure shows the growth in the number of policies sold is increasing for a hypothetical state, commensurate with national data (Health Insurance Association of America, 1993). This growth underlying growth is represented by the black portion of the histogram. In 1992, assume that the imposition of a partnership program caused the number of policies sold to be greater than it otherwise would have been. The new purchasers would be represented by the gray portion of the histogram and the converters by the white portion. All of the white and the portion of the black who bought partnership policies represent additional expenditures for Medicaid. The portion of the grey that represent the divestors and the true Medicaid purchasers represent savings. The portion of the grey that represent new spend down purchasers may either (1) contribute to savings, (2) contribute to costs, or (3) not contribute to either depending on the characteristics of the patient and the policy purchased. The portion of the grey that represents new private purchasers may either contribute to costs or not contribute to either costs or savings, depending on the type of partnership imposed.

Figure 1

LTC Insurance Sales
in a Hypothetical State



Policies sold (or that would have been sold) without partnership

Policies sold as a result of partnership

Policies sold to converters

The savings and additional costs from these various patient types can also be summarized in another version of the Medicaid saving equation expressed as the product of nursing home patient days times the corresponding payment rates:

$$\textbf{Medicaid savings} = M*R - P*R - I*R \qquad (2)$$

where **M** refers to the otherwise Medicaid patient days that are paid for by insurance as a result of the partnership, **P** refers to the otherwise private patient days that are paid for by Medicaid as a result of the partnership, and **I** refers to the otherwise insured patient days that are paid for by Medicaid as a result of the partnership. **R** is the average Medicaid reimbursement rate.

The **M** patient days come principally from any new divestor purchasers, but they could also come from the new Medicaid purchasers (to the extent that there is any) and possibly from the new purchasers who would have spent down. The **P** patient days come from the new private purchasers and possibly the new purchasers who would have spent down. They also come from the insured purchasers and converters who would have used their own assets to pay for care once their insurance coverage ran out.

The **I** patient days come from the insured purchasers and the converters who now buy less comprehensive policies because of the Medicaid coverage. This point should not be overlooked. While partnership policies increase the number of policies purchased, the level of coverage in each partnership policy may not be as great as it would have been without the policy. Measures of the success of the partnership must take this into account in order to paint an accurate picture of the partnership's impact.

Equation (2) is expressed in nursing home expenditures. It should be noted that the LTC insurance packages also include coverage of home health care and other services. The same analysis, however, could be done for these other Medicaid expenditures and simply added to the equation. We have dispensed with a discussion of this complication in order to focus on the calculation of the net savings.

Another complicating effect would be the presence of moral hazard effect. As a result of this program, the price of insurance decreases and more people have insurance who would have otherwise paid for care themselves. Moral hazard refers to the change in behavior that occurs as a result of becoming insured. In this case, it refers to the increased quantity demanded that occurs when a private patient (paying the full private rate) becomes insured and pays only a fraction of the full private rate. This may result in nursing home stays that are longer than they otherwise would have been. For example, a relatively well-off elderly person may refuse formal care longer if she pays for it herself than if she has insurance that will pay for formal care, either at home or at a nursing home.

Moral hazard or the demand effect is not an issue for Medicaid patients who become insured as a result of the program because in either case, someone else (insurance or Medicaid) is paying for their care. (There might be differences depending on the difference between the price of an additional patient day to the Medicaid patient compared to the price to the Medicaid patient if she were to become insured, but these differences are assumed to be small.) Moral hazard would also have no effect on the already insured because the already face lower marginal prices for care. It would, however, increase the number of patient days by those who would have been private patients but became insured and eligible for Medicaid as a result of this program because the price of an additional patient day drops dramatically. In other words, any moral hazard or demand effect is likely to lower the net saving to Medicaid by increasing P to a larger level than it would otherwise have been.

Economic Feasibility and Political Considerations

There are two central feasibility questions. The first is whether a public/private partnership is likely to save Medicaid dollars and the second is whether cost-saving partnership is likely to be politically acceptable. These questions will be considered in that order.

Economic Feasibility. In this section, we will summarize the literature that concludes Medicaid savings are possible. Where possible, we will attempt to estimate the likely Medicaid costs, given the correct analytical framework and reasonable assumptions about the numbers of insured purchasers and converters.

Meiners and McKay (1991) report the results of a simulation done with the Brookings/ICF Long-Term Care Financing Simulation Model. The model is only sketched out in the report, but it is clear that the comparison being made is between those who are not insured and those who become insured under a dollar-for-dollar partnership policy. They estimate that total Medicaid spending will decrease by about 11 percent. The correct comparison, however, would be to estimate the Medicaid expenditures of a typical cross-section of people--some with insurance, some without--and compare them with the expenditures if a portion of those with insurance and some of those without insurance were to become insured under a partnership.

As part of the Robert Wood Johnson studies, Goss and Meiners (1993) also estimate the size of the potential markets. These authors estimate that between 18 and 31 percent of the elderly household would be capable of purchasing a conventional LTC insurance policy, depending on the assumptions, but between 35 and 47 percent would be able to purchase a dollar-for-dollar partnership policy, suggesting a 100 to 50 percent increase in sales attributable to the partnership. Although Goss and Meiners do not estimate what proportion of conventionally insuring persons would instead purchase partnership policies, if all erstwhile conventional insurance purchasers became purchased partnership policies instead, this suggests that for every 1 new purchaser, there would be between 1 and 2 insured purchasers.

New York State also attempted to calculate the cost effectiveness of the partnership by estimating the Medicaid costs of a typical composite person both without insurance and with partnership insurance, where the qualifying period is 3 years. The composite person is 75 percent persons who spend down to Medicaid and 25 percent persons who are Medicaid by virtue of divesting their assets. Within each type, the New York estimates include 4 different income/asset subtypes and whether each of these will exceed the 3 year Medicaid qualifying period or not. They estimate that the state portion of Medicaid costs would be about $3,201 if the composite person were uninsured and $1,409 if he or she were partnership insured, suggesting a $1,792 or 56 percent savings.

A crude estimate of the true savings, however, would first find the Medicaid costs for a conventionally insured person and find the difference between those costs and the Medicaid costs of a partnership insured person. Then, for every new purchaser, estimate how many converters and insured purchasers there would be, and multiply that number times the difference between conventional and partnership Medicaid costs. Finally subtract that product from $1,792. For example, suppose that the state Medicaid cost for a person under a conventional policy is $186,[2] implying that insured purchasers cost Medicaid an additional $1,223. If the ratio of new purchasers to insured purchasers and converters were 1 to 1, this would imply a $596 reduction in Medicaid costs for every new purchaser. If, however, the ratio of new purchasers to insured purchasers and converters in 1 to 5, this would imply a $4,323 increase in Medicaid costs. This last estimate reflects reports that one insurance company selling partnership policies in New York experienced a 20 percent increase in sales compared to its sales of conventional policies in other states. This would imply that for every 1 new purchaser, 5 insured purchasers are adding to costs.

Another estimate was done by Arling, Hagan and BuHaug (1992). They use the Wisconsin Use and Cost Model to estimate the Medicaid costs of three type of patients: (a) a base case,[3] representing the proportions of payment sources of a typical person who does not have insurance, (b) the insurance case, representing the proportion of payment sources of a typical person who has private LTC insurance, and (c) the insurance with a Medicaid eligibility waiver case, representing the proportions of payment sources of a typical person who has a dollar-for-dollar partnership policy. They compare the base case, which would cost Medicaid $14,304 per person in 1990 dollars, with the partnership case, which would cost Medicaid $13,411 and conclude that the partnership would result in a per person saving to Medicaid of ($14,304 - $13,411 =) $893 or about ($893/$14,304 =) 6 percent.[4]

The correct comparison would be to net this savings against the additional costs of those insured purchasers and converters that take advantage of this program. In contrast to the other published work, Arling, Hagan and Buhaug (1992) also estimate the Medicaid costs of a conventionally insured person. They estimate that a conventionally insured person would cost

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[2] Because Medicaid costs would occur if a person ran out of insurance coverage and assets after a long stay, this figure was estimated by finding the Medicaid costs of the uninsured in the first 36 months.

[3] The base case was calculated by determining the Medicaid expenditures for an typical person who first exhausts Medicare, then private resources, and then goes on Medicaid. The two insurance cases also exhaust Medicare, use some private funds, and then insurance, and then either (1) Medicaid or (2) other private assets and Medicaid, depending on whether the insurance is (1) a partnership policy or (2) not.

[4] These calculations are made under the assumption that no moral hazard occurs. They also compare Medicaid spending without insurance and with partnership insurance under various moral hazard assumptions and conclude that partnerships would increase Medicaid costs. The accuracy of these estimates would also benefit from using the correct analytical framework.

Medicaid $8,352, implying that for every insured purchaser or converter, Medicaid costs increase by ($13,411 - $8,352 =) $5,059. If the ratio of new purchasers to insured purchasers and converters was 1 to 1, then every new insured person would increase Medicaid costs by ($5,059 - $893 =) $4,166 or ($4,166/$14,304 =) 29 percent. If the ratio were 1 to 5, then every new insured person would increase Medicaid costs by ($25,295 - $893 =) $24,402 or ($24,402/$14,304 =) 171 percent!

These estimates are crude, but they give the flavor of the discrepancy caused by not using the correct framework. To more accurately predict the expected costs of imposing a partnership, it is necessary to have reliable estimates of the effect of the partnership in creating new purchasers. This information can be estimated by comparing total LTC insurance (both partnership and conventional) sales net of sales to converters in partnership states with conventional sales in non-partnership states. It is also necessary to determine the proportion of persons purchasing partnership policies who would have purchased insurance anyway. This information could be found by taking total partnership policy sales in a partnership state and subtracting the estimated number of new purchasers and converters. As yet, no estimates of this number have been done. With regard to converters, data on these persons are already being collected by the individual states. Early evidence suggests that 19 percent of New York partnership policies are being sold to those who had already purchased LTC insurance (Takada and Nussbaum, 1993) and 25 percent of Connecticut's policies are replacements (Cibes, 1994). Although sizable now, these numbers are likely to diminish significantly in the future.

Since the Robert Wood Johnson partnerships were developed, Congress passed OBRA 1993. OBRA 1993 stipulated that in any future partnerships programs, assets could only be protected during the life of the patient. After the beneficiary's death, OBRA requires that states recover all Medicaid expenditures from the beneficiary's estate. The original Robert Wood Johnson group (New York, California, Indiana, and Connecticut), Iowa and Massachusetts were exempted from this provision. Clearly, OBRA 1993 would reduce the attractiveness of LTC insurance within a partnership arrangement and reduce sales, but it would also reduce Medicaid expenditures, unless ways could be found to circumvent this provision. Because no data exist on this type of a policy, it was not included in this analysis. It is possible that with the estate recovery provision, such a partnership would be economically feasible. As yet, nothing is known about the effectiveness of such recovery programs.

When placed in the proper analytical framework, the available studies on the existing LTC insurance partnerships suggest that such partnerships are likely to cost the state large additional Medicaid expenditures. As such, the economic feasibility of such programs is called into question.

Political Considerations. Partnership programs are intended to reduce Medicaid expenditures by increasing the number of Medicaid patients that would buy LTC insurance. The

only Medicaid patients who are likely to afford to pay for such policies are (1) those who spend down to Medicaid or (2) those who would have divested in order to qualify for Medicaid. It is usually assumed that very few of the poor who start out as Medicaid could purchase LTC insurance if a partnership arrangement were added to it.

Recent studies suggest that those who spend down constitute a relatively small portion of nursing home patients. One study by Liu, Doty and Manton (1990) suggests that only about 7 percent of all nursing home residents spend down to Medicaid eligibility during their stays in a nursing home. Almost nothing is known about the proportion of nursing home patients who divest. While providing partnership-generated Medicaid funding for the relatively small portion of nursing home patients who spend down appears to be politically desirable, providing partnership-generated Medicaid funding to those who a wealthy enough to have been private patients but who have divested is much less so. Indeed, the main political opposition to these plans seems to come from those who object to transferring Medicaid funds to these non-needy recipients and their heirs.

This paper has argued that another potentially non-needy group--the insured purchasers and converters--has been overlooked in the economic analysis, and has probably also been overlooked in the political analysis. Transfers of Medicaid funds to those who are sufficiently wealthy to purchase LTC insurance without a partnership program also may represent a politically unjustifiable transfer of taxpayer funds. Clearly, an accounting of the political advantages and disadvantages of a partnership program would need to consider these transfers as well, and the opportunity costs of the transferred Medicaid funds.

Alternatives

There are a number of alternative ways to encourage the purchase of LTC insurance. One approach is to subsidize long-term care insurance in the same way that government subsidizes general health insurance: allow long-term care **premiums to be paid with pre-tax income**. This tax subsidy would lower the effective price of LTC insurance, but it is unclear how much additional insurance would be purchased. This tax subsidy, however, is as regressive as the tax system is progressive. Moreover, we do not know how effective the subsidy would be in encouraging the purchase of LTC insurance. There are no studies estimating the demand for LTC insurance, so we know nothing about the responsiveness of the population to changes in the price. Furthermore, in order to save Medicaid expenditures, this would need to be directed at the low income population. It is likely that most tax subsidy expenditures would be directed at the relatively well off, those who would have purchased LTC insurance anyway. Finally, the health insurance tax subsidy is primarily a federal program. Whether a state such as Minnesota could use a such a subsidy effectively is in question because of the state's relatively small marginal tax rate.

Another possibility is to make the **premium payments tax deductible.** Again the same problems would apply: regressivity, unknown demand effect, and the wealthy as the likely recipients of the tax expenditures, and the state/federal problem. **Refundable tax credits** could be directed at the poor through a means test. Tax credits require people to fill out tax forms, but the elderly often do not file.

Another option is to create special **tax-free or tax-deferred savings accounts for deductibles** similar to individual retirement accounts (IRAs). Savings could be put into these accounts to be used in case of a need for long-term care. This amount could then be spent as the deductible for insurance. The insurance policy would cost less because of this large private front-end payment, inducing persons to purchase it. Again, we do not know how effective such programs would be in reducing Medicaid expenditures.

The Brookings-ICF Long-Term Care Financing Model has been used to estimate the effects of these various programs. This is the only attempt to evaluate these alternative program, but it is not due to be published until April, 1994, which is too late to be included in this report.

Availability of Long-Term Care Insurance In Minnesota

Until 1991, although 17 insurance companies had registered to sell long-term care insurance in Minnesota, only 3 or 4 were active. In 1991, long-term care insurance regulations were changed in the state. Since that time, 6 new firms have registered to sell policies in the state.

According to Ron Johnson of LTC Insurance Resources, Inc, Minneapolis, the first long-term care policy sold in the United States was sold in Minnesota in 1973. Early policies were sold under a Minnesota law that provided for a liberal specification of both the benefit and the eligibility for payment. In other states, insurance companies were permitted to write policies where the benefits were specified as a certain amount of dollar coverage for nursing home care and another amount for home health care and so on for the rest of the covered services. If you exceeded your nursing home coverage, your policy would pay no more for those services. In Minnesota, insurance companies had to write policies where the benefits were specified as a certain pot of money that could be used for any of the specified long-term care services. This flexibility with which funds could be applied where needed was attractive to purchasers, but it increased the risk to sellers because they were less able to predict losses under a flexible benefit policy than under a more structured benefit one.

Eligibility was also mandated to be more liberal in Minnesota. To receive benefits, all that was necessary was that the purchaser and *the purchaser's* doctor agree that the care is necessary and that the purchaser incur the care. In other states, much more restrictive--often those consistent eligibility requirement for public programs--eligibility requirements existed. Again, this liberalness has made long-term care insurance attractive to buyers but, because of the relatively large degree of discretion, unattractive to sellers.

In 1991, Minnesota began to permit the use of activities of daily living (ADL) in the determination of eligibility for benefits. This change made the expected cost more predictable. It is perhaps no coincidence that in the last 3 years, 7 new firms have registered to sell LTC insurance in the state. As of September, 1993, there were 24 companies with approved long-term care policies in the state.

The partnership policies, perhaps because they must be consistent with the Medicaid program theyare connected to, have specified eligibility requirements that tend to be more restrictive still. Because of this, expected cost would be even more predictable and it is likely that, were a partnership to be adopted in Minnesota, many of the existing firms and perhaps some new firms would offer partnership policies. In all other state partnership policies, the benefits must be paid out of a single benefit fund, so there would be no increase in cost variability in Minnesota owing to the partnership policy requiring more liberal benefits.

Conclusions

The adoption of long-term care partnership program in Minnesota is likely to lead to a large increase in Medicaid expenditures over what they would have been without the partnership program, if the partnership is similar to those sponsored by the Robert Wood Johnson Foundation. OBRA 93, however, altered the law so that any new state partnership programs must provide for the state to recovery the partnership Medicaid expenditures from the estate of the person after death. We have little evidence regarding the ability of states to recover these assets, so it is difficult to speculate on whether this provision would be sufficient to offset the other losses.

Moreover, a partnership program would direct Medicaid funding mostly to people who are not poor. While many have realized that the intended targets of this program--the economically secure middle class elderly who divest in order to qualify for Medicaid--were never intended to receive Medicaid funds, it has not been clear until this report that an even larger portion of the Medicaid expenditures will be directed toward those who would already have purchased insurance. Clearly, by virtue of their being able to afford LTC insurance, most of these persons would not be worthy of a transfer of taxpayers dollars through Medicaid. This implies that most of the Medicaid funds will be diverted to middle class elderly and there heirs. The opportunity cost of this is fewer public funds to pay for programs for the truly poor.

Finally, were Minnesota to adopt a partnership, there are a sufficient number of firms selling long-term care insurance in the state so that it does not need to consider a state-sponsored long-term care insurance program. Indeed, because Minnesota already requires relatively liberal eligibility and coverage language, any partnership policy approved in the state is likely to be less liberal (in order to be consistent with the Medicaid eligibility requirements), making the insurance company's expenditures more predictable. This increased predictability may result in a greater number of companies being approved in this state.

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