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Feasibility Of Long-Term Care Insurance Partnerships

by John A. Nyman

At least six states have adopted or are in the process of adopting public/private partnerships for encouraging the purchase of long-term care insurance. Through such partnerships the asset levels for a person’s Medicaid eligibility are relaxed if that person buys an approved long-term care policy.

There are two models for public/private partnerships. Under the “total-assets” type of partnership, if a person purchases a partnership policy that covers a certain number of years of long-term care and then exhausts that coverage, the state will disregard all of his or her assets in determining Medicaid eligibility. Under the “dollar-for-dollar” type of partnership, whatever the level of insurance coverage a person has and exhausts, that level of assets is disregarded.

The Robert Wood Johnson Foundation originally funded eight states to explore the possibility of implementing a partnership. Of those, four states chose to implement partnerships. The partnership in New York, the only state so far to have adopted a total-assets model, has been in operation since March 1993. Dollar-for-dollar policies went on sale in Connecticut in April 1992 and in Indiana in August 1993. California planned to implement its program in late spring 1994; and Iowa and Massachusetts are developing similar programs.

The central policy question for partnerships is whether such programs will reduce Medicaid expenditures. A number of simulations have been done in which uninsured persons purchase partnership policies, and their Medicaid expenditures with and without a policy are compared. These studies have concluded that partnerships are likely to reduce Medicaid spending.

Here I argue that these studies have not made the correct comparison because they have excluded the increased Medicaid costs of those who would have been insured anyway and who now buy partnership policies. This more comprehensive analytical framework shows that Medicaid expenditures are likely to increase. This calls into question both the economic and the political feasibility of these studies, because it explicitly recognizes that additional Medicaid expenditures are going to middle-class recipients.

Theory

To determine whether a government policy will increase or decrease Medicaid costs, it is necessary to determine what the Medicaid costs would be with the program and compare these costs to Medicaid costs without the program. One way to estimate net savings to Medicaid is to identify the various types of persons who would purchase a partnership long-term care insurance policy, then, for each type of person, to estimate what their Medicaid costs would be if they had and had not purchased a partnership policy. Once this cost differential is determined, net savings can be determined simply by estimating the number of partnership policy purchasers in each of these categories.

Theoretically, we can identify three types of persons affected by the partnership. First, new purchasers are those who would have been uninsured without a partnership program but, because of its existence, purchase

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insurance. Second, insured purchasers are those who would have purchased a conventional long-term care insurance policy without the partnership program but purchase a partnership policy instead. Third, converters are those who had already purchased long term care insurance before the partnership policies were available but convert to a partnership policy.

New purchasers. New purchasers exist because a partnership policy is better than a conventional long-term care policy in some way, and this improvement induces persons to buy insurance (specifically, a partnership policy) when they otherwise would have been uninsured. The total-assets model encourages new purchases by lowering the price of policies that protect a large amount of assets. For example, if a consumer wanted to protect his or her assets from being depleted in the event of a long nursing home stay (say, for more than six 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 six-year stay with a three-year policy. That is, the insurer can charge premiums commensurate with a three-year policy but sell a policy that gives unlimited years of protection of assets. 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 dollar of insurance premium paid, one expects to receive about a dollar in payment for long-term care services (loading charges aside). With a partnership program, for every dollar of insurance premium paid, one expects to receive about a dollar in payment for services (again, loading charges aside) plus a dollar in assets that one would not otherwise have had, if the policy were exhausted and one would have spent that dollar of assets on long-term care services. Because one receives more value for the same amount of premium, insurance is more attractive, and more will be purchased.

New purchasers can be subdivided further. The original intent of the partnership was to draw new purchasers primarily from the ranks of those who have divested their assets to become eligible for Medicaid. Under the total-assets partnership, these new divestor purchasers would reduce Medicaid costs because if their stays are less than the qualifying period, insurance would pay what Medicaid would have paid. If their stays exceed the qualifying period, Medicaid would have paid anyway. Under the dollar-for-dollar partnership, Medicaid savings would be reduced because insurance would cover stays that Medicaid otherwise would have covered. When the policy is exhausted, Medicaid would have paid anyway because without the policy, the person’s assets would have been exhausted at about the same point.

A second type of new purchaser might come from the ranks of those who would have spent down to Medicaid status, that is, new spend-down purchasers. As a result of these purchasers’ becoming insured, some Medicaid expenditures would be assumed by the insurance company. Under the total-assets partnership, if their stays are shorter than the qualifying period, there may be no Medicaid savings because their assets might have been sufficient 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 Medicaid savings because their assets might have been reduced because insurance would cover 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, Medicaid savings would be unlikely because persons probably would not insure for more than the value of their assets. The availability of partnership policies would need to have enticed persons 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 are
likely to occur.

A third type of new purchaser, new private purchasers, might come from the ranks of those with sufficient assets to cover almost any stay privately. To the extent that Medicaid dollars replaced private dollars, this would mean additional costs to Medicaid. Under a total-assets partnership, Medicaid spending could replace private spending, thus increasing Medicaid costs. Under a dollar-for-dollar partnership, new private purchasers probably would incur no Medicaid dollars replaced private dollars, thus increasing Medicaid costs. Under a total assets partnership, Medicaid spending could replace private spending, thus increasing Medicaid costs. Under a total assets partnership, Medicaid spending would have incurred no Medicaid dollars replaced private dollars, thus increasing Medicaid costs. Under a dollar-for-dollar partnership, new private purchasers probably would incur no Medicaid dollars replaced private dollars, thus increasing Medicaid costs. Under a total assets partnership, Medicaid spending could replace private spending, thus increasing Medicaid costs. Under a dollar-for-dollar partnership, new private purchasers probably would incur no Medicaid dollars replaced private dollars, thus increasing Medicaid costs.

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

**Insured purchasers.** Insured purchasers are those who would have purchased insurance anyway but, because of the introduction of the partnership program, purchase a partnership policy instead. It is clear that the number of persons purchasing conventional long-term care insurance is increasing every year.' This trend would be expected to continue, whether or not a partnership was available. If partnership policies are available, many of those who would have bought conventional long-term care insurance may now purchase a partnership policy instead, either because the coverage costs less or because it is a better value. If they had bought conventional insurance and it had run out, insured purchasers would have paid for care from their private assets. Because they now qualify for Medicaid, these persons would increase Medicaid expenditures.

**Converters.** Converters are those who had already purchased long-term care insurance before partnership policies were available. In converting to partnership policies, they would represent increased Medicaid costs for the same reasons insured purchasers would. The importance of convertors will diminish over time, but accounting for their presence in the initial years may be important in determining whether the partnership is enticing enough new purchasers to save Medicaid dollars.

### Economic Feasibility

Mark Meiners and colleagues report the results of a simulation using the Brookings/ICF Long-Term Care Financing Simulation Model. The model is only sketched out in the report, but it is clear that the authors are comparing those who are uninsured with those who become insured under a dollar-for-dollar partnership policy. They estimate that under their model total Medicaid spending would decrease by about 11 percent. The correct comparison, however, would be to identify a typical cross-section of long-term care users—some without insurance, some with—and compare their Medicaid expenditures without a partnership program with their expenditures if a portion of those without insurance and some with insurance were to purchase partnership policies.

As part of the Robert Wood Johnson studies, Stephen Goss and Meiners also estimated the size of the potential markets. Between 18 and 31 percent of elderly households would be capable of purchasing a conventional long-term care insurance policy, depending on the assumptions, but between 35 percent and 47 percent would be able to purchase a dollar-for-dollar partnership policy, suggesting a 50 to 100 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 purchased partnership policies instead, this suggests that for every new purchaser, there would be between one and two insured purchasers.

New York State also attempted to calculate the cost-effectiveness of the partnership by comparing the Medicaid costs for a typical composite person without insurance
with Medicaid costs if that person had a partnership policy, where the qualifying period is three years. The composite person is 75 percent one who spends down to Medicaid and 25 percent one who qualifies for Medicaid by virtue of divesting assets. Within each type, the New York estimates include four different income/asset subtypes and whether or not each of these will exceed the three-year Medicaid qualifying period. They estimate that the state portion of Medicaid costs would be about $3,201 if the composite person were uninsured and $1,409 if the person were partnership insured, suggesting a $1,792 (56 percent) savings.

An estimate of the true savings, however, also would estimate the increased Medicaid costs for a conventionally insured person who becomes insured under a partnership policy. Then, for every new purchaser, one would estimate how many converters and insured purchasers there would be and multiply that number by the difference between conventional and partnership Medicaid costs. Finally, one would subtract that product from $1,792. For example, suppose that the state Medicaid cost for a person under a conventional policy is $186, implying that insured purchasers cost Medicaid an additional $1,223. If the ratio of new purchasers to insured purchasers and converters were one-to-one, 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 were one-to-five, 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 had a 20 percent increase in sales, compared with its sales of conventional policies in other states. This would imply that for every new purchaser, five insured purchasers are adding to costs.

Another estimate, by Greg Arling, Shelley Hagan, and Harald Buhaug, used the Wisconsin Use and Cost Model to estimate the Medicaid costs of three types of patients: (1) the base uninsured case, representing the proportions of payment sources of a typical person with private long-term care insurance; and (3) the partnership insurance case, representing the proportions of payment sources of a typical person who has a dollar-for-dollar partnership policy. They compare the base uninsured 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 savings to Medicaid of $893 (6 percent) per person.

The correct comparison would be to net this savings against the additional costs of those conventionally insured purchasers and converters who buy partnership policies instead. Based on individual cost estimates from Arling, Hagan, and Buhaug, a conventionally insured person would cost Medicaid $8,352, implying that for every insured purchaser or converter, Medicaid costs increase by $5,059. If the ratio of new purchasers to insured purchasers and converters were one-to-one, then every new insured person would increase Medicaid costs by $4,166 (29 percent). If the ratio were one-to-five, then every new insured person would increase Medicaid costs by $24,402 (171 percent)!

These estimates are speculative, but they give the flavor of the discrepancy caused if the correct framework is not used. To accurately predict the costs of a partnership program, it is necessary to estimate the effect of the partnership in creating new purchasers. This information can be found by comparing total long-term care insurance sales in partnership states (net of sales to converters) with sales in similar nonpartnership states. It is also necessary to estimate the proportion of persons purchasing partnership policies who would have purchased insurance anyway. This information can 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 such estimates have been made. With regard to converters, data are already being collected by some states. New York recently found that 19 percent of its partnership policies are sold to those who had already purchased long-term care poli-
cies, and Connecticut found that 25 percent of its policies were replacements.8

Political Feasibility

Partnership programs are intended to reduce Medicaid spending by increasing the number of Medicaid patients who would buy long-term care insurance. The only Medicaid patients who are likely to afford such policies are those who spend down to Medicaid or who would have divested to qualify. It is usually assumed that very few poor persons who start out on Medicaid could purchase partnership policies.

Recent studies suggest that those who spend down constitute a relatively small portion of nursing home patients.9 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 are wealthy enough to divest their assets is less so. Indeed, the main political opposition to these plans seems to come from those who object to transferring Medicaid funds to those nonneedy recipients and their heirs. Another potentially nonneedy group—insured purchasers and converters—has been overlooked in the economic analysis and likely in the political analysis as well. Transfers of Medicaid funds to those who are wealthy enough to purchase long-term care insurance without a partnership program also may represent a politically unjustifiable transfer of taxpayer funds. An accounting of the political advantages and disadvantages of a partnership program would need to consider these transfers as well, and whom these funds could have helped instead.

NOTES
5. Because Medicaid costs would be incurred if a person ran out of coverage and assets after a long stay, this figure was estimated by finding the uninsured's Medicaid costs in the first thirty-six months.
8. A. Takada and S. Nussbaum, The New York State Partnership for Long Term Care Quarterly Update (Albany: New York State Partnership for Long Term Care, 29 December 1993); and W. Cibes Jr., The Connecticut Partnership for Long-Term Care: A Progress Report to the General Assembly (Hartford: State of Connecticut, Office of Policy and Management, January 1994). It should be noted that since the RWJF partnerships were developed, Congress passed the Omnibus Budget Reconciliation Act (OBRA) of 1993, which stimulated that in any future partnership programs, assets could be protected only 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 RWJF group (New York, California, Indiana, and Connecticut), Iowa, and Massachusetts were exempted from this provision. Clearly, OBRA 1993 would reduce the attractiveness of partnership policies and therefore sales, and it also would reduce Medicaid expenditures for those purchasing partnership policies, unless ways could be found to circumvent this provision. With this provision, it seems more likely that a partnership program would bring Medicaid savings. Because no analyses of this type of policy have been made, it was excluded from consideration here.