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It was originally implemented in four states (with heterogeneous designs) but starting in 2005 it was extended to most US states after a decade moratorium (see Appendix D for dates of inception). In this paper we exploit primarily the LTCP extension. More specifically, after 2005, 36 additional states created LTCP programs, which have been much more homogeneous, and hence the short-term effects of LTCP can be more clearly identified. In addition to spreading the financial risk of LTSS needs and reducing Medicaid costs (of individuals financial burden to families, and they account for more than a third of Medicaid expenditures (Eiken et al., 2014). There is growing concern that as the baby-boomers age many of them will not have sufficient incomes to pay for LTSS and will become eligible for Medicaid if they require costly formal LTSS. Barely 14 percent of Americans over the age of 50 are covered against the costs of long-term care needs (Health and Retirement Study 2012). 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It was originally implemented in four states (California, Connecticut, Indiana, and New York – with variations among the four) in the early 1990s, with grants from the Robert Wood Johnson Foundation (RWJF).
who spend down to qualify for Medicaid eligibility), the LTCP programs attempted to increase private LTCI coverage by linking the purchase of specific LTCI policies to special eligibility rules for accessing Medicaid benefits. However, they did not address the issue of insurance underwriting, where individuals apply and are denied coverage despite being willing to pay the insurance premium.

To date, there have been limited evaluations of the LTCP that draw upon econometric techniques. Lin and Prince (2013), using the Health and Retirement Study (HRS), examines the effects of a state adopting a LTCP, and find only modest effects on total LTCP uptake. Greenhalgh-Stanley (2014) draws upon data from the HRS and finds similar results except when a sample of highly risk-averse and forward-looking individuals is evaluated. However, the empirical identification of both studies is limited by the biannual data of the HRS, which bundles together the introduction of LTCP in different states. The HRS only identifies individual insurance subscription at the time of the interview but not yearly new contracts, which requires supply side data. Similarly, Lin and Prince (2013) do not take account of the heterogeneous partnership penetration among partnership states. Importantly, one would expect differences between those states that adopted the program in the 1990s (RWJF states) and the states that did so after 2005. Finally, the HRS does not include data on applications for LTCI and does not have information on contract details. In contrast, our study accounts for purchases, and allows us to distinguish Partnership and non-Partnership contracts and applications in the early adopting states.

In this paper, we contribute to the following question: how did Partnership programs affect the number of applications filed for long-term care insurance policies? We primarily draw upon data from the National Association of Insurance Commissioners (NAIC) on new LTCI purchases (traditional and Partnership) by US state (weighted by the population over age 65 to make the data comparable). We then use a difference-in-differences strategy to obtain estimates of the program effect of the LTCP on the overall uptake of private LTCI, and specifically of LTCP contracts and applications for a subsample of states. We further adopt a flexible difference in differences (DD) specification that allows separating the pre-existing trends in the market for LTCI from the LTCP effect. In addition, we undertake a number of placebo and robustness checks. Our findings broadly indicate modest to no evidence of any robust effect of the LTCP on LTCI uptake overall. We find that there was an expansion of total LTCI contracts only in the year when a state implemented a LTCP program, which indicates some level of substitution between traditional and partnership contracts. Finally, there is some evidence of an effect on applications, which is consistent with the presence of insurance underwriting, that is, the estimation of the expected profitability, and recommended coverage of insuring each new applicant.

The plan of the paper is as follows. In the next section, we describe the market for LTCI and the Partnership program. In section three, we discuss the data and our econometric strategy for analyzing the data. We then report our results and different robustness and other checks in section four, and conclude with a discussion of the results’ policy implications in the final section.

Background

The market for long-term care insurance

Private LTCI was first offered in the United States in 1974 but it was not until the late 1980s that the National Association of Insurance Commissioners (NAIC) issued a model act for LTCI establishing minimum standards and practices for companies selling LTCI as well as regulations for state insurance commissioners (Society of Actuaries, 2014). Since then, demand for LTCP has remained anemic despite the consumer safeguards embodied in the NAIC’s initial and subsequent adoption of standards for LTCI (Somers and Merrill, 1991). Given the small number of Americans over age 50 who hold policies, the LTCI market is only a fraction of its potential size (Stoltzfus and Feng, 2011; AHIP, 2012).

The theoretical and empirical evidence indicate that price and affordability are strong factors in individuals’ decision to purchase long-term care insurance (Robert Wood Johnson Foundation, 2014). Contributing to suggestions that LTCI is not for every-one, the NAIC discourages consumers from buying a policy if premiums account for more than 7 percent of their income or if they have less than $100,000 in assets (excluding the value of a home) (Society of Actuaries, 2014). Moreover, many people believe that Medicaid is available to cover LTSS costs (creating what is known as Medicaid crowd-out), and that Medicare covers more of the costs of LTSS than it actually does. Further, because a number of large LTCI insurers stopped selling policies after 2008, there are well-founded concerns that LTCI companies may not exist by the time an individual might need to use a policy.

The Partnership for Long-Term Care

The Partnership program promotes the purchase of private long-term care insurance by offering policyholders access to Medicaid under special eligibility rules regarding asset levels (Meiners et al., 2002; Bergquist et al., 2015). Cost-effectiveness is a key rationale behind the Partnership program. Proponents of the program believe it can reduce Medicaid spending in the future by creating an incentive for individuals to assume responsibility through LTCP for at least the initial phase of their need for LTSS (Rothstein, 2007). It is the inter-twining of private insurance with a public program that makes it a public-private partnership program. The goal is to attract individuals who might not otherwise purchase private LTCI, so that if they need formal LTSS the insurance will pay at least their initial LTC costs and thereby reduce the amount Medicaid otherwise would have spent for their LTSS (Stone-Axelrad, 2005; Meiners, 2009).

The LTCP is a strategy to promote private LTCI purchases and reduce Medicaid expenditures in the future. But for this to occur, LTCP needs to alter historical trends in purchases of LTCI and attract middle-income individuals who otherwise might not believe they can afford LTCI. Further, if people who already are purchasing traditional LTCI choose to shift to the Partnership policies, contract substitution will occur and one would expect Medicaid expenditures not to decline. Thus, the overall effect of the LTCP is ambiguous. Although the Partnership plans were intended to appeal to middle-income individuals, there are no income restrictions or eligibility criteria regarding who may purchase a LTCP policy. In addition, they did not address the traditional problems of LTCI (Norton, 2000; Barr, 2010); specifically, uncertainty about future costs of LTSS, large administrative costs, insurance lapses due to premium increases over time, and the existence of insurance underwriting.

The RWJF initiated its Partnership program demonstration in 1987 and, as noted, the initiative led to four states implementing Partnership programs: California (1994), Connecticut (1992), Indiana (1993), and New York (1993) (Alper, 2006). These state programs are referred to as the RWJF Partnership programs. Table A1 in the Appendix provides an

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5 There has been considerable literature – which we substantiate later in the text – devoted to the effect of Medicaid as an implicit tax on long-term care insurance. The Partnership program has been conceived as a potential solution that groups both public and private insurance entitlements, which could plausibly eliminate the so-called implicit tax on Medicaid.

6 As we show below, there is wide variability in the uptake of LTCP over time, and some states show a poor uptake, which makes the assumption of all states adopting a LTCP scheme quite heroic.

7 Norton (2000) provides summary explanations for a limited market for LTCI, including adverse selection, moral hazard, Medicaid crowd out, high administrative costs, and the long period between purchase and pay out.

8 In the years our data cover (the early 2000s), the NAIC discouraged people from purchasing LTCI if the value of their assets was less than $35,000 (Feder et al. 2007).
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