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Long-term care partnerships: Are they fit for purpose?

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ABSTRACT

Long-term care partnership (LTCP) programs were designed to both encourage middle-income individuals to purchase private long-term care insurance, and defer the time when an individual would become eligible for Medicaid to pay her long term care services and supports (LTSS). This paper exploits the timing of state Partnership implementation (including four pilot states) to evaluate the program's effects on new yearly insurance applications and contract uptake. We draw upon data from the National Association of Insurance Commissioners (NAIC) on new long term care insurance (LTCI) purchases (traditional and Partnership) by US state (weighted by the population over age 65 to make the data comparable). We 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. Findings suggest no significant effect of LTCP on insurance uptake and an increase in insurance applications. This result points towards a substitution between traditional and partnership contracts.

Introduction

Long-term care services and supports (LTSS) encompass a range of services to assist people with limited capacity for self-care due to physical or cognitive disability.[1] Expenditures for LTSS can be a significant 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).[2]

Both the federal and state governments have developed strategies that attempt to shift long-term care costs away from Medicaid. These include *point of purchase* incentives, such as state and federal tax deductions, for purchasing long-term care insurance (LTCI). However, analyses of these strategies indicate limited returns of state tax deductions on the dollar (Goda, 2011).[3] An alternative strategy for increasing LTCI purchases has been incentives targeting *the point of use*. The latter includes strategies that aim to reduce the coverage costs and avoid an inefficient spend down of savings to qualify for Medicaid. One such approach has been the Robert Wood Johnson Foundation Long-Term Care Partnership Program (LTCP) initiative. This strategy allows people to sequester a portion of their assets – equivalent to the value of a special LTCI policy – from Medicaid requirements that they spend all of their assets (other than their home or car) before becoming eligible for Medicaid coverage. It was originally implemented in four states[4] (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 more homogenous, 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

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[1] Most LTSS refers to personal assistance for activities of daily living (ADLs), and includes both medical and non-medical care (Centers for Medicare and Medicaid Services 2012).

[2] The costs of LTSS can be catastrophic for the 5% incurring amounting to 260,000 US$. In 2011, the average annual cost for nursing home care was over $78,000, while assisted living communities cost an average of almost $42,000, $18,000-day care and $30,000 home help (O'Shaughnessy, 2012).

[3] The federal tax treatment of long-term care insurance premiums is that they may be counted as deductible medical expenses but medical expenses may only be deducted if they exceed 10 percent of a person's income (for people under age 65; for those 65 years of age and older, the threshold for deducting medical expenses is 7.5 percent of income through 2016).

[4] The LTCP programs were initially developed 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).

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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.[5] 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 LTCI 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.[6] 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 LTCI 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).[7]

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).[8] 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 LTCI 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

[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).