AHIP
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Financing Long-Term Care: Exploring the Benefits of the Expanded Public-Private Partnership

Policy Brief
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I. Introduction: An Improving Climate for Long-Term Care Insurance

With enactment of the Deficit Reduction Act (DRA) of 2006, many states are poised to establish public-private long-term care (LTC) insurance partnerships. These new partnerships will allow many Americans to secure the financial protection provided by private LTC insurance, while ensuring their investment will carry over into the Medicaid program should they require public assistance for an extended LTC stay.

The nation's emerging long-term care needs are as well-known as the underlying demographic changes driven by the powerful twin engines of population size and longevity. The U.S. Census Bureau estimates that between 2000 and 2040, the population age 65 and older will increase from 35 to 80 million, and that the population of those aged 85 or older -- those most likely to need long-term care -- will more than triple, increasing from about 4.2 million in 2000 to 15.4 million in 2040.[1]

Even under more optimistic projections – the Census Bureau concluded recently that the percentage of individuals over age 65 with a disability was declining – the imperative to expand access to long-term care insurance is clear. By 2050, the Alzheimer's Association estimates that 13.4 million persons age 65 and older, or 15 percent of that population, will find themselves living with the disease. Moreover, the Congressional Budget Office (CBO) has projected that national LTC spending on the elderly is expected to nearly triple in real terms over the next 40 years.[2]

Public attitudes about long-term care are skewed by three widespread misconceptions: that the risk of needing long-term care is relatively remote; that

the costs of such care are considerably lower than is actually the case; and, finally, that Medicare and Medicaid can fully provide care should the need arise.

Policymakers must address these misconceptions as part of any effort to elevate the national discussion about long-term care and to educate the public about the need to protect themselves with insurance.

This policy brief describes a model that has been developed to project the potential long-term budget impact of this legislation, and suggests an approach that may further enhance the market, while producing sustained savings for public programs.

II. Modeling the Federal Budgetary Impact of the Partnership Legislation

The Partnership approach to LTC financing will be an important part of lowering long-term government cost projections.

Chart 1 describes a simplified estimating approach for determining how the legislation will alter federal budgetary costs. This estimating approach is based on examining Medicaid savings and costs for two different groups of people:

- First, there are those older Americans who, in the absence of the Partnership, would forego insurance and depend entirely on Medicaid if they need LTC. For this group, increased sales of LTC insurance should reduce Medicaid costs because, with insurance, they will, on average, get Medicaid much later in a LTC episode. For instance, many Americans have enough financial assets to cover LTC for just one year, but, as of 1997, the average length of a nursing home stay was well over two years.[3] If private LTC insurance typically covers two years worth of care, then encouraging more insurance purchases could reduce Medicaid's expenses by one year for those beneficiaries who end up needing extended LTC.

- Second, there are those persons who would get insurance even if the Partnership did not pass. For these people, extending to them the Partnership concept is likely to speed up Medicaid coverage and increase federal costs, as they will not be required to spend down all of their assets to qualify for Medicaid.

Chart 1: Estimating Approach

	Length of LTC Stay Before Medicaid Coverage Begins:
Non-Partnership LTCI	3 years
Partnership LTCI	2 years
No Insurance	1 year

- **Model is built to estimate how much Medicaid must cover of an average person's LTC costs.**
- **Private assets are assumed to cover, on average, one year's worth of LTC costs.**
- **Giving Partnership status to policies that would have been Non-Partnership plans increases costs.**
- **Selling Partnership plans to persons who otherwise would not get insurance at all decreases costs.**

Over time and using reasonable assumptions, allowing all states to establish Partnership programs, thus removing a barrier to more demand for insurance coverage, will produce growing savings for the federal government and the states. The reason is simple: the market for private LTC insurance remains largely untapped, and enrollment among those who otherwise would rely exclusively on Medicaid should reduce public sector costs.

Chart 2 provides a set of assumptions that were used to estimate the net budgetary impact due to passage of the Partnership legislation. As shown, it is assumed that new purchases of Partnership plans will increase to about 400,000 in the first year after reform passes and remain steady over time. Persons are assumed to purchase this insurance at age 60 and begin to access LTC services in larger numbers beginning at age 80.

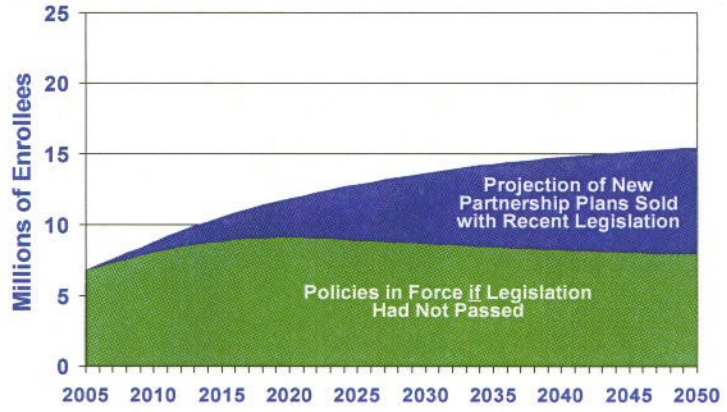
With Partnership insurance, Medicaid's responsibility for LTC costs should not begin for about two years, which means a lower percentage of LTC users than those who need Medicaid after one year, with a shorter expected duration at that point. On the cost side, those who get Medicaid coverage under the Partnership after two years instead of after three years, as would be the case for non-Partnership insurance, increases Medicaid costs but by less than the savings from expanded Partnership demand because there are fewer people and the estimated average LTC duration that is picked up by Medicaid is shorter.

Chart 2: Key Assumptions

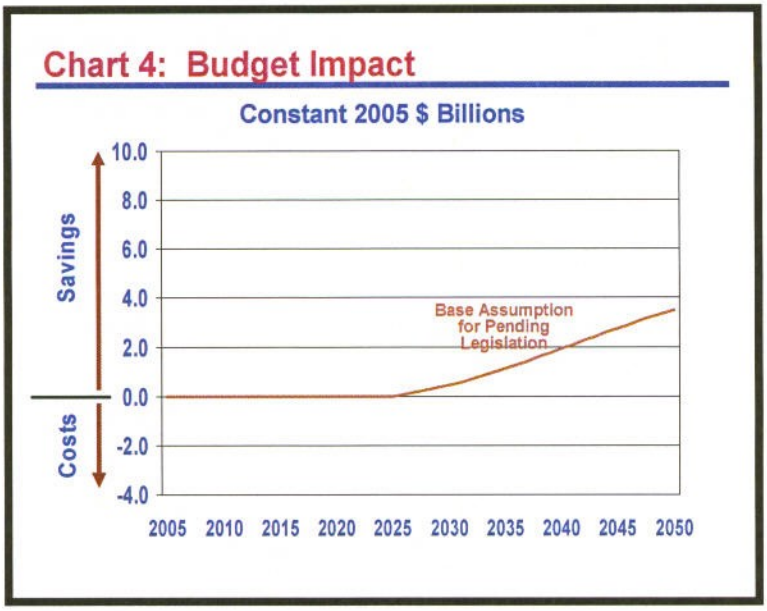
Some Key Parameters:	Assumptions
Insurance Sales	400,000 per year with new legislation; 250,000 per year and declining if legislation had not passed
Age of New Policy Purchasers	60
Probability of LTC Use in a Year for Anyone Age 80 and Older	5%
For Persons Experiencing a LTC Episode, Probability of the Duration Exceeding...	1 Year: 45% 2 Years: 20% 3 Years: 10%
Average Additional Length of Stay for Persons Experiencing a LTC Episode Exceeding...	1 Year: 1.5 Years 2 Years: 1.0 Years 3 Years: 0.8 Years
Covered LTC Costs	$70k in 2005, +1.5% real growth

As shown in Chart 3, this set of assumptions represents an increase in demand for Partnership plans, with more than 15 million people enrolled in LTC insurance in 2050 with the legislation as opposed to well below 10 million without passage of the legislation.

Chart 3: Insurance Enrollment



As shown in Chart 4, with these assumptions, greater private LTC insurance coverage will reduce government costs by growing amounts, in real terms, after about 2025, reaching nearly $4 billion annually in 2050.



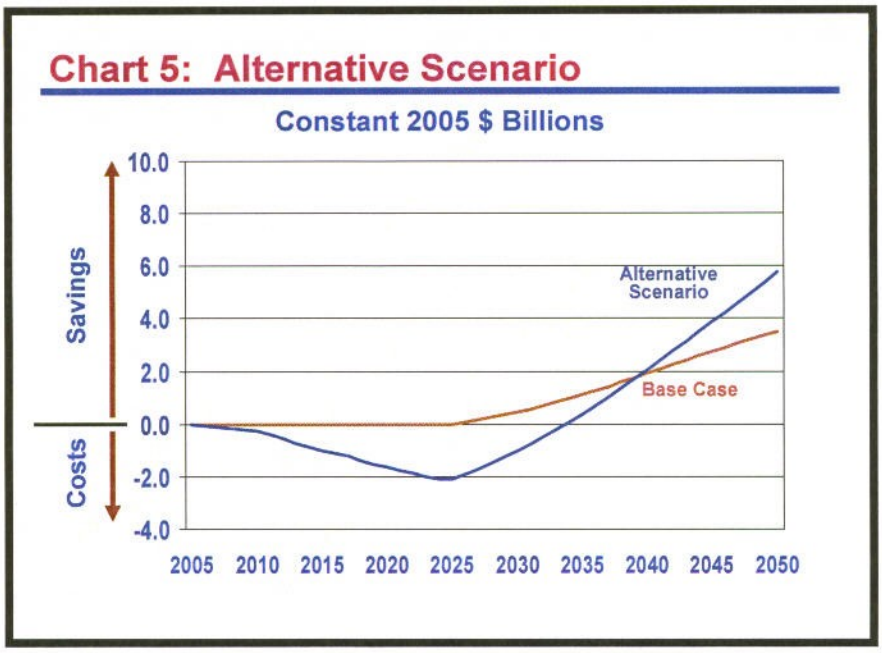
The estimating model allows adjustments to test different policies or assumptions regarding how the program will evolve over time.

For instance, to further invigorate demand for Partnership insurance, policymakers could consider providing additional financial incentives for persons who purchase Partnership coverage, either in the form of tax assistance or perhaps direct premium assistance. Adding premium subsidies to the model increases short term costs but also increases long term savings because it will induce higher demand among persons who otherwise would rely entirely on Medicaid.

New provisions could also be explored to encourage widespread care management and more efficient benefit options, including cash and counseling, which will slow the projected rising cost of care. Cash and counseling has been shown in successful demonstrations to foster beneficiary independence and reduce government costs by empowering consumers with the financial control to make choices among competing care options. Although the program has been directed at younger, disabled populations, the concept of beneficiary financial control and choice should be able to produce better financial performance among the elderly LTC population as well.

The estimating model can be further adjusted to assume the existing stock of non-Partnership policies is fully converted into Partnership plans.

Chart 5 shows the results from incorporating all three of these alternative assumptions -- subsidies, slower growth in LTC costs, and "grandfathering" of existing policies -- into a new projection. As shown, the alternative scenario would increase costs through about 2040, at which point the additional savings from higher Partnership enrollment would exceed the premium subsidies and costs of "grandfathering" current non-partnership plans.



III. Conclusion

The aging of the U.S. population is likely to require adjustments throughout society and in particular in government spending and tax policy. It is important for the government to begin now to plan for the added fiscal burden an aging society represents.

A critical component of that preparation is a renewed effort to promote private insurance for LTC costs. It is clear that LTC is an event that needs insurance: it is an expensive and unpredictable event in one's life, and yet it is also an event that will occur in a significant percentage of elderly households.

Congress should be commended for the foresight it is showing in enacting the Partnership legislation. It is a common sense approach to LTC. Americans who protect their financial assets with private LTC insurance should not be forced to spend down their resources if their LTC needs exceed what can reasonably be purchased in the private market. Widespread use of the Partnership concept, together with effective education and clear financial incentives, will invigorate a much more robust private insurance marketplace. Using reasonable estimating assumptions, such a marketplace will be good both for enrollees and long-term fiscal policy.

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[1] Ibid.

[2] "Projections of Expenditures for Long-Term Care Services for the Elderly," Congressional Budget Office, March 1999, p. 5.

[3] CBO, 2004, p. 34.