Stanford University • May 2010

SIEPR policy brief

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Long-Term Care Financing: Is Increasing Insurance Coverage Good Policy?

By Gopi Shah Goda

Introduction

An often overlooked part of the health care debate is long-term care, which refers to services provided when illness, disability, or age-related problems keep someone from being able to perform everyday activities. These services can be provided through a variety of sources including nursing homes, home health aides, and spouses or children. Long-term care represents a large financial risk for the elderly, as services are costly, the risk of needing them is substantial, and private insurance coverage is low.

Roughly $230 billion is spent directly on long-term care services, amounting to more than 10 percent of all U.S. health care expenditures (Iglehart 2010). Medicaid is the largest payer, covering 48.5 percent of the total. It does so by covering long-term care expenses for those with income and wealth below certain limits—or those who got that way because of catastrophic long-term care costs. Medicare, by contrast, pays only for short episodes of care after an acute health event. After Medicare and Medicaid, the next largest source of payment is out-of-pocket, with private insurance a distant fourth (see Figure 1).

With the population aging, there is a large amount of interest in policies that may reduce Medicaid's exposure to growing long-term care costs. The primary strategy: Stimulate insurance coverage.

Over the last two decades, attempts to increase coverage included offering tax subsidies for private insurance. More recently, President Obama signed the Patient Protection and Affordable Care Act into law, which establishes a new publicly run insurance program providing cash benefits to participants needing long-term care services.

My research addresses whether previous efforts to increase private insurance met the goals of (1) increasing coverage and (2) reducing Medicaid expenditures for long-term care. I find evidence that although tax subsidies raised insurance coverage by 30 percent, they did so mostly among wealthy and high-income populations who were unlikely to rely on Medicaid

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About The Author

Gopi Shah Goda is a Research Scholar and Coordinator of the Postdoctoral Fellows Program at the Stanford Institute for Economic Policy Research. She is also a Faculty Research Fellow at the National Bureau of Economic Research and a Fellow of the Society of Actuaries. Gopi's research interests include public finance, aging, health and retirement policy. Prior to joining SIEPR, she was a Robert Wood Johnson Scholar in Health Policy Research at Harvard University. She received her B.S. in Mathematics and Actuarial Science at the University of Nebraska in 2000, and her Ph.D. in Economics from Stanford University in 2007.

in the first place. Therefore, tax subsidies are unlikely to reduce Medicaid expenditures for long-term care by more than the cost of providing the subsidy. The results offer lessons for other public programs designed to increase insurance coverage.

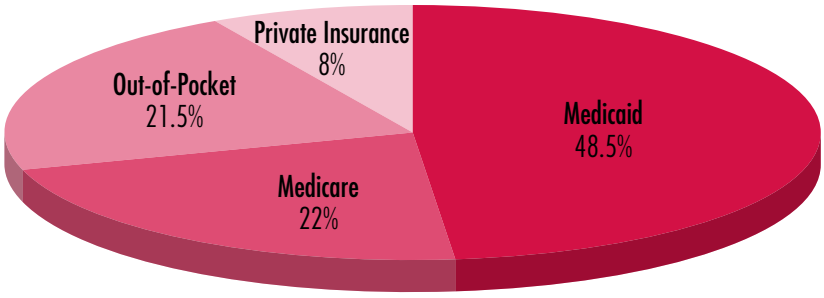
The Market for Long-Term Care Insurance

Private long-term care insurance provides payment for services needed when the insured person can no longer perform at least two activities of daily living, such as eating, bathing, or dressing. Premiums are based on the age at which the policy is bought and the insured person is generally subject to health exams and underwriting. Only 11 percent of the population ages 50-69 held private long-term care insurance in 2006.

There are several factors that may contribute to a thin market for long-term care insurance. Policies are largely sold on the individual market and premiums reflect administrative costs higher than most other types of insurance. Other factors include procrastination, limited knowledge of long-term care risks, and the availability of substitutes for formal insurance (such as care from family members or insurance through home equity).

The Medicaid program itself may create large disincentives against purchasing private policies. Brown and Finkelstein (2008) show that private insurance often pays for benefits that would have otherwise been provided by Medicaid and, by protecting assets, reduces the chances of qualifying for Medicaid. The fact that benefits from insurance are partially redundant means that the presence of Medicaid introduces an "implicit tax" on insurance premiums. This tax is highest for low-wealth groups.

Figure 1
Sources of Long-Term Care Financing in the U.S.



Source: Iglehart (2010), National Health Accounts

Tax Subsidies for Private Insurance

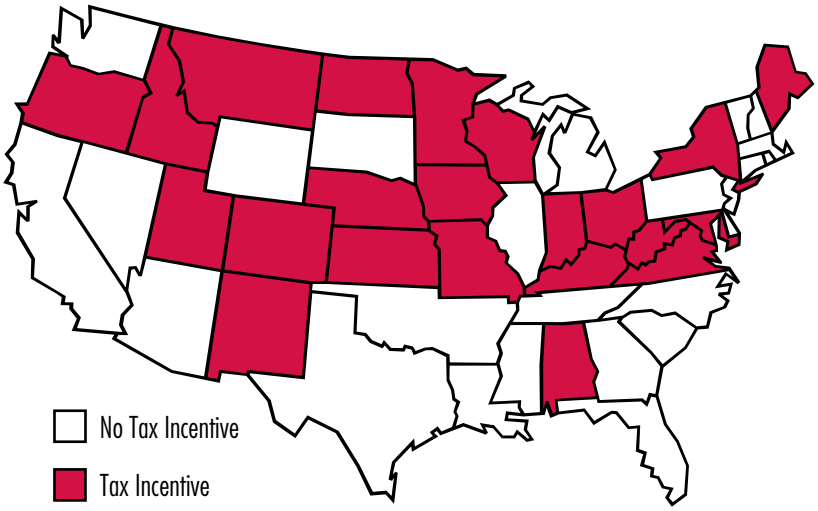
Initiatives to stimulate private insurance coverage through tax incentives have gained traction in recent years: 24 states plus the District of Columbia currently offer tax subsidies for long-term care insurance. Figure 2 depicts the states with tax incentives in 2006.

There is wide variation in the generosity and structure of the subsidy across states, but on average a state tax subsidy is worth 4.6 percent of the annual premium. Within states, the value of the subsidy differs across individuals because it is often tied to one's marginal tax rate. For example, if taxpayers can deduct insurance premiums from their income, the deduction is worth more to those in higher tax brackets. Taxpayers with less than $15,000 in income receive an average subsidy of 2.7 percent of premiums, while taxpayers with at least $40,000 in income are eligible to receive an average discount of 5.7 percent.

The rationale for these policies is almost universally the thought that increased rates of private insurance coverage will reduce Medicaid expenditures for long-term care. Legislative documentation contains a body of evidence that supports this view. New York legislators stated, "This tax credit will expand private insurance coverage…and over time dampen the growth in state Medicaid spending for long-term care as payments from private insurers replace payments from the Medicaid program."[1] The

1 Justification of New York Bill S04884 in 1999, Introducer's Memorandum in Support, obtained January 22, 2009.

Figure 2
States with Tax Incentives in 2006



Source: Goda (2009)

state comptroller in Connecticut calls implementing a tax incentive for long-term care insurance "the best investment the state can make."[2] Are they correct?

Did Tax Subsidies Increase Insurance Coverage?

The first step in the analysis is to determine the effect of tax subsidies on insurance coverage. The fact that these tax subsidies were implemented in several different states over a span of two decades provides a ripe opportunity to deduce the causal effect of tax incentives on long-term care insurance coverage. States that have no subsidy can be thought of as "control" states, and states with a subsidy are labeled "treatment" states. The effect of the tax subsidy on insurance coverage can then be found by comparing the change in coverage rates among treatment states relative to control states. Looking for *changes* over time helps control for the fact that, for example, North Dakota has much higher coverage than West Virginia.

Figure 3 shows that coverage did in fact increase when tax incentives were put into effect. While the coverage rate was fairly flat in the control states with no subsidy, coverage jumped up within a year or two of subsidies being put in place in treatment states. In my empirical analysis in Goda (2009), I formally estimate this effect using regression analysis to control for a variety of factors and find evidence that tax subsidies increased long-term care insurance coverage by approximately 3 percentage points in states that implemented a tax incentive.

A 3 percentage point increase may sound small but it represents a statistically meaningful 30 percent boost in private long-term care insurance coverage. However, the results also suggest that even if the most generous tax subsidy (a tax credit worth up to 20 percent of premiums in New York) were implemented nationwide, coverage rates may rise to only 16 percent. Therefore, a substantial percentage of seniors would still remain without insurance.

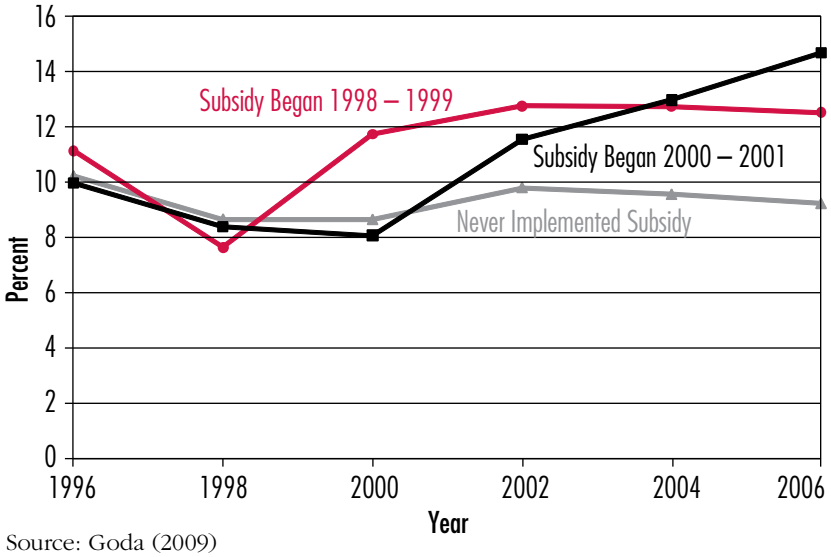
Moreover, I find that the response varied significantly across different subgroups. There is no detectable response among low-wealth populations, only modest response among middle-wealth groups, and a large and pronounced response among the upper third of the wealth distribution. This result is important because if the people who respond to the tax subsidy are not likely to rely on Medicaid to fund their long-term care in the absence of insurance, the extra insurance coverage from the tax subsidy will do little to defray Medicaid's tab for long-term care, while still reducing tax revenues.

How Will Tax Subsidies Affect Medicaid Expenditures?

A low-income, low-wealth individual who has no long-term care insurance will quickly

2 Committee Report, Connecticut Joint Select Committee on Aging, March 2, 2006, obtained on February 20, 2009.

Figure 3
Private Long-Term Care Insurance Coverage by Tax Subsidy Status, Ages 50-69



Source: Goda (2009)

become eligible for Medicaid if he or she needs long-term care services. However, someone with more assets or income will likely begin paying for long-term care services out-of-pocket until his or her resources are exhausted, at which point Medicaid takes over if the individual is still in need of care. As a result, Medicaid's costs decrease much more if a person with less wealth purchases insurance than if a person with more wealth purchases insurance. Unfortunately, the tax incentives appear to have had the opposite effect.

The estimated net benefit from the tax subsidy by wealth decile is shown in Figure 4.[3] On average, providing an average-sized tax subsidy to a 65-year-old has a net cost of $26 when the cost of the subsidies and the present value of future Medicaid long-term care savings are taken into account. This cost translates into a return of $0.84 in Medicaid savings for each dollar of forgone tax revenue.

The net benefit varies substantially over the wealth distribution: Tax subsidies are net costly for low- and high-wealth groups but are net savings for middle-wealth groups. Net costs at the low end arise from the absence of a response in insurance coverage and the subsidization of a small but nontrivial set of individuals who held private insurance prior to tax subsidies being enacted. At the high end of the wealth distribution, net costs are a result of high costs of subsidization (because subsidy rates increase with wealth) and the low amount of Medicaid savings attributed to this group. These large costs overwhelm the net savings that occur for the middle of the wealth distribution.

While the state providing the tax subsidy bears the entire cost of providing the subsidy, Medicaid savings are borne both by federal and state budgets because Medicaid is jointly funded by both entities. Therefore, the $0.84 in Medicaid savings per dollar of forgone revenue is split into $0.34 for the state and $0.50 for the federal government, even though the state was the one that saw its revenue decline. The joint funding of Medicaid by states and the federal government implies that it is difficult for either entity to capture all of the savings that may result from a tax policy that encourages private long-term care insurance coverage.

Lessons for the Future

To have a larger effect on the allocation of long-term care financing, tax incentives would need to increase private insurance coverage for those who are at higher risk of spending down to Medicaid eligibility. Structuring tax incentives such that they target low-wealth populations and increasing awareness of long-term care risks among these

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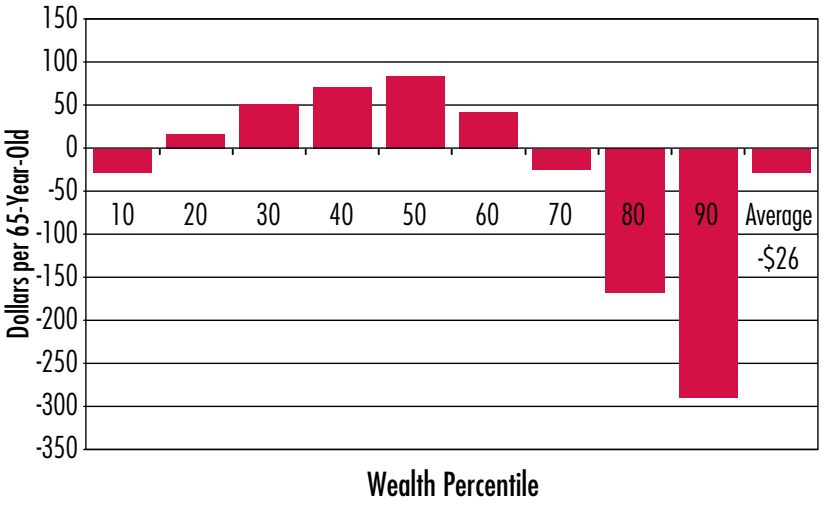
3 More details regarding this calculation can be found in Goda (2009).

Figure 4
Net Savings from Tax Incentives by Wealth Decile



Source: Goda (2009)

groups may be influential, but the Medicaid program itself may create large disincentives against purchasing private policies. Therefore, it may be that only more comprehensive Medicaid reform can pave the way to more universal coverage of the financial risks associated with long-term care.

The Community Living Assistance Services and Supports Act (CLASS Act) was signed into law as part of the health reform package on March 23, 2010, by President Obama and aims to move in this direction. While many of the details are yet to be determined, CLASS will establish a new, voluntary long-term care program that will provide modest cash benefits ($50-$75 per day) to eligible beneficiaries who suffer from at least two limitations in activities of daily living. Recipients must have paid premiums for at least five years before they are eligible to receive benefits, and enrollment into the program is limited to workers.

High participation rates are key to ensuring enough healthy people are in the risk pool to mitigate adverse selection and keep the cost of premiums low. However, the interaction of the CLASS program with Medicaid may depress demand for CLASS enrollment, as a portion of cash benefits from the CLASS program is required to be paid to the Medicaid program if someone is eligible to receive benefits from both. A provision in the bill that allows employers to automatically enroll their employees in the CLASS program (unless they choose to opt out) may counterbalance the resulting decline in demand, but the popularity of the program remains to be seen. The program's effect on Medicaid expenditures will largely depend on the participation among low-wealth populations.

It is important to note that despite the fact that efforts to stimulate insurance coverage may not reduce Medicaid expenditures, they may have other desirable consequences. Higher levels of private insurance coverage imply a reduction in out-of-pocket expenditure risk and perhaps better quality care for those who take up coverage. In addition, higher rates of private insurance coverage may reduce reliance on informal caregiving from spouses and children and have labor market consequences for those affected. Further research on these issues is needed to fully evaluate the effects of such policies.

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A publication of the
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