

Minnesota Department of Health

Adding Long-Term Care Coverage to Medicare Supplemental Insurance *Report to the Legislature*

January 2000



Health Policy and Systems Compliance Division
Health Economics Program
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As required by Minnesota Statute 3.197: This report cost approximately \$3,487 to prepare including staff time, printing and mailing expenses

INTRODUCTION

The 1999 Minnesota Legislature directed the Department of Health to report on the fiscal impact of mandating coverage for Medicare supplemental products to include long-term care services, including home health services, homemaker services, and nursing facility services. In addition, the Department was asked to report on the fiscal implications of the State paying the premiums for this coverage for low-income seniors, including potential savings to the Medical Assistance program. This report has been produced in consultation with the Departments of Commerce and Human Services.

In order to respond to the Legislature's request, the report first puts the strategy of adding long-term care coverage to Medicare supplemental products into the larger context of how the State might go about controlling long-term care spending. Private long-term care insurance either separately or as a mandated benefit for Medicare supplemental coverage is generally viewed as a way to limit Medical Assistance long-term care spending by increasing private contributions for those people who are not poor until they need long-term care services.

STRATEGIES FOR CONTROLLING LONG-TERM CARE SPENDING

There are a wide range of strategies used to limit long-term care spending. Minnesota has already utilized many of these in one way or another. Most strategies fall into one of three broad categories 1) traditional strategies, 2) system reform, and 3) increasing private and federal contributions. This report will briefly touch on the first and second strategies; however, its primary focus will be on increasing private resources especially through encouraging purchase of private long-term care insurance. (For a more complete discussion of all three strategies and what other states are doing see Wiener, 1996; and Wiener and Stevenson, 1998^a, Wiener and Stevenson, 1998^b.)

Traditional strategies

The three most common strategies for limiting the rate of increase of public long-term care spending are to control nursing home bed supply, control Medical Assistance reimbursement, and limit eligibility for Medical Assistance. Minnesota has employed all three strategies to some degree.

Because most nursing home beds are filled with Medical Assistance residents, Minnesota placed a moratorium on bed growth in 1985 to control Medical Assistance expenditures. In addition, over the last several years, competition from nursing home alternatives in the community, among other things, has led the industry itself to delicense 2,302 beds, or about 5% of the total stock of beds in 1993 (Minnesota Health & Housing Alliance, 1999).

The State has utilized a number of different reimbursement systems for nursing homes. Most recently, it established an alternative payment system (APS) in which two-thirds of the nursing homes now participate. Under the APS, instead of being reimbursed for their actual costs (subject to certain limits), nursing homes instead receive an annual cost-of-living adjustment calculated against the base year when the facility entered the project. Generally, the State has more control over expenditures under a "price-based" system like the APS than the earlier "cost-based" systems.

Finally, Minnesota extends Medical Assistance categorical eligibility to elderly individuals only up to about two-thirds of the federal poverty level. This is below the 100 percent of poverty that federal rules allow for and below what one-quarter of other states were using in 1996 (Rosenbach and Lamphere, 1999).

System reform

Minnesota has also put considerable effort into making the delivery system more efficient and effective. Included in the system-level reforms the state has employed are extending managed care to include long-term care, integrating acute and long-term care, and expanding home care and residential long-term care. Indeed, Minnesota's effort through the Minnesota Senior Health Options demonstration is considered groundbreaking in its goal to bring together acute and long-term care services for a dual eligible population under a capitated system. Unfortunately, this demonstration is small in scale (only about 3,400 of the approximately 47,000 dual eligibles are enrolled) and its effects are not yet studied. Minnesota also hopes to include a 90-day nursing home liability to its Prepaid Medical Assistance Program (PMAP) in 2000 for elderly Medical Assistance beneficiaries living in the community.

Through Medical Assistance home health and personal care benefits as well as home and community-based services waivers, Minnesota has sought to expand options in the community. Thusfar, the results are marginal with only a small fraction, less than 8 percent, of Medical Assistance long-term care expenditures going towards home and community-based care (Department of Human Services, 2000). Minnesota also uses state-only funds to provide care in the community through the Alternative Care program. Using state-only funds allows more flexibility in determining eligibility, services, and budgets but foregoes federal Medical Assistance matching funds.

Increasing private and federal contributions

Other Medical Assistance cost containment efforts involve offsetting state spending with either federal spending through Medicare or private spending through asset transfer restrictions, estate recovery efforts, and encouraging private long-term care insurance purchase. Again, Minnesota has utilized several of these avenues.

Increasing federal contributions

The State has two initiatives that are aimed at ensuring that Medicare pays for home health and skilled nursing facility care whenever appropriate. The 1996 Minnesota Legislature mandated a Medicare Maximization Initiative to assist providers and counties to ensure appropriate Medicare payment for home care and hospice services and certain durable medical supplies and equipment. This strategy includes requiring that all home health providers who do not participate or accept Medicare assignment refer and document the referral of dual eligible recipients to Medicare providers when Medicare is determined to be the appropriate payer. Those who do not will be terminated from the Medical Assistance program. For determining Medicare coverage, providers must use the manual payer determination system, which will be replaced March 2000 with a new automated system. Both systems determine Medicare coverage for the dates of services, coverage for home care services, and create an audit trail and report.

The Medicare Revenue Enhancement Program (MREP) is a program within the Department of Human Services that provides consultation and training to skilled nursing facilities regarding Medicare to promote full utilization of Medicare benefits. MREP also reviews and appeals Medicare denials on the behalf of individual recipients to recoup Medicare days and to ensure that full Medicare benefits are being paid for individual cases, prior to Medical Assistance.

Increasing private contributions

These next four strategies build off of the observation that a substantial proportion of Medical Assistance nursing home residents were not poor before they entered the nursing home but were impoverished by the \$40,000 per year average cost of nursing home care. One way to reduce Medical Assistance long-term care expenditures might be to encourage the purchase of private long-term care insurance. For the initially nonpoor Medical Assistance nursing home population, private long-term care insurance could possibly prevent both impoverishment and subsequent Medical Assistance expenditures. Minnesota has taken a number of approaches to encourage the purchase of private long-term care insurance. First, the premiums for qualified private long-term care insurance products are, for the purposes of state tax deductibility, treated the same as medical expenses. For an individual whose medical expenses exceed 7.5 percent of adjusted gross income, annual long-term care insurance premiums are deductible up to certain age-based limits. The proceeds from long-term care insurance coverage are also excluded from taxable income but are subject to a cap of \$175 per day.

Second, the Department of Employee Relations is in the final stages of developing the Public Employees Group Long-Term Care Insurance Program (PEGLIP). Modeled after a successful program in California, PEGLIP seeks to offer to public employees, their spouses and parents good quality group long-term care insurance at reasonable costs.

And, finally, it is believed that hand-in-hand with encouraging the purchase of private long-term care insurance goes discouraging middle-class Minnesotans from transferring assets to become Medical Assistance eligible and recovering Medical Assistance expenditures for nursing home care from the estates of deceased Medical Assistance beneficiaries. All transfers of assets involving recipients of Medical Assistance will be subject to a 36-month “look back” to see that these transfers were not done at less than fair market value. If a transfer of assets for less than fair market value is found, the State must withhold payment for nursing facility care (and certain other long-term care services) for a period of time that reflects the amount of the transfer.

The home is an excluded asset in determining financial eligibility for Medical Assistance and has been, for some time in Minnesota, a target for recouping Medical Assistance expenditures. In 1993, the federal government mandated that states recover Medical Assistance expenditures for nursing homes from the estates of deceased beneficiaries—principally, from the sale of their houses—and gave states additional authority to place liens on real property (i.e. real estate or any interest in real estate). In the case of a home, expenditures are not recovered from beneficiaries estates until a surviving spouse is also deceased or under other special circumstances.

POTENTIAL IMPACT OF PRIVATE LONG-TERM CARE INSURANCE

Private long-term care insurance is unlikely to substantially affect Medical Assistance nursing home expenditures or the number of Medical Assistance nursing home beneficiaries in either the short-term or long-term unless substantial changes occur in the private insurance market. This is because very few people actually purchase

private long-term care insurance. These results hold up even under the most optimistic scenarios (Wiener, Illston and Hanley 1994). A number of barriers must be overcome in order to get more people to purchase long-term care insurance, including affordability and general misunderstandings about long-term care.

Affordability

On the demand side, the biggest barrier to the purchase of long-term care insurance is affordability. Most studies have found that only 10 to 20 percent of the elderly can afford private long-term care insurance (Crown, Capitman and Leutz, 1992; Friedland, 1990; Rivlin and Wiener, 1988; Wiener, Illston and Hanley 1994; Zedlewski and McBride, 1992.) Premiums vary greatly from policy to policy depending on age, lifetime benefit, daily benefit, length of waiting period, inflation protection and the types of benefits provided. Table 1 illustrates how premiums for three major Minnesota insurers vary on these factors.

TABLE 1
Private Long-Term Care Insurance Annual Premiums*
Minnesota, 1998

Age	90-day waiting period (deductible)			30-day waiting period (deductible)		
	Company 1	Company 2	Company 3	Company 1	Company 2	Company 3
40	\$299	\$378	\$429	\$659	\$852	\$1,170
50	\$355	\$537	\$530	\$960	\$1,278	\$1,450
60	\$715	\$992	\$835	\$1,850	\$1,825	\$2,205
65	\$1,110	\$1,671	\$1,075	\$2,780	\$2,787	\$2,700
70	\$1,770	\$2,835	\$2,025	\$4,180	\$6,983	\$4,500
75	\$2,830	\$5,043	\$2,730	\$5,920	\$6,983	\$8,315
80	\$4,440	\$11,781	\$3,650	\$7,920	\$14,832	\$8,581

**The policies used in this illustration have a \$100 daily benefit with a lifetime maximum, and cover nursing home care, assisted living, adult day care, home health and homemaker services.*

Source: Unpublished data from the Minnesota Department of Commerce, 1999.

The average annual premium for the high-quality insurance policies (30-day deductible, 5% inflation) used in the illustration is \$1,229 if bought at age 50; \$2,749 if bought at age 65; and \$10,218 if bought at age 80. It is interesting to note the great disparity between premiums for equivalent policies.¹

Recall, Minnesota already uses the tax code to make the purchase of long-term care insurance more affordable. Premiums and benefits are subject to favorable tax treatment. The estimated cost of this in lost revenue is \$4 million in fiscal year 2000 (Minnesota Department of Revenue, 1997)

¹The disparity between premiums illustrates insurers inability to price policies accurately, which makes some insurers reluctant to offer long-term care policies (Illston and Wiener, 1997). Policies are difficult to price because there is likely to be a very long time between initial purchase of an insurance policy and its eventual use. For example, a policy bought by someone at age 65 probably will not be used for 20 years. Unforeseen changes in disability or mortality rates, utilization patterns, inflation in nursing home and home care costs, or in their rate of return on financial reserves, can also dramatically affect the profitability of a long-term care policy

Table 1 also shows that policies are more affordable when purchased at younger ages. Unfortunately, less than 0.1 percent of the non-elderly population currently has private long-term care insurance (Wiener, 1996.) One way to encourage purchase at younger ages is to offer it in the work place. If, on a wide-spread basis, the state could encourage employers to offer private long-term care insurance as an employee benefit, then younger people might purchase private long-term care insurance at a greater rate. Employer sponsorship can help reduce some of the costs that are built into the insurance premiums such as marketing and collection of premiums. The Public Employees Group Long-term Care Insurance Program builds off of this understanding

Unfortunately, those few employers that do offer private long-term care insurance, do so on an “employee-pay-all” basis. So, although the premiums may be somewhat more affordable, younger people still have many other competing demands on their disposable income which edge out purchase of private long-term care insurance including child care, home mortgages, and college tuition for their children. Plus, the risk of needing long-term care is too distant to galvanize many people into buying insurance. The greater impact would come if employers were to contribute towards the premiums.

Understanding long-term care need and financing

Another reason why so few people purchase long-term care insurance is that few of them understand that they face a significant lifetime risk of becoming disabled and needing nursing home or home care. Indeed, by age 65, there is a greater than 40 percent risk of spending some time in a nursing home and a one in four chance of spending more than one year in a nursing home (Kemper and Murtaugh, 1991). Moreover, many people incorrectly believe that Medicare covers long-term care (Employee Benefit Research Institute, 1993). Although Medicare covers some services in a skilled nursing facility, they are time-limited services associated with an acute episode not the traditional long-term care stay associated with ongoing functional decline. If people think they already have coverage through Medicare, they are likely not motivated to buy private long-term care insurance.

Adding long-term care to Medicare supplemental products

Mandating a long-term care benefit be added to Medicare supplement insurance products is unlikely to eliminate any of the barriers discussed above. Moreover, it would likely be detrimental to the existing Medicare supplemental market.

Medicare supplemental products have in their favor widespread purchase across income categories, something private long-term care insurance does not enjoy. However, the purchase of these Medicare supplemental products themselves is both optional and purchasers have been shown to be somewhat sensitive to price (Harris and Keane, 1999, Rice, McCall, Boismier, 1991). Adding a long-term care benefit to Medicare supplemental policies would drive the price up substantially, likely causing current purchasers to drop their coverage. Recall, the average monthly premium for a long-term care policy purchased at age 65 is \$229²; the average monthly premium for the most popular Medicare supplemental policy is \$65³. In this case, traditional price elasticity of demand estimates would not be reliable because the long-term care premium is so much higher than the Medicare supplemental insurance premium and the estimate would be forecasting a change that is bigger than anything seen in the actual data. However, it's likely that substantial numbers of people will drop coverage as it becomes unaffordable.

The state could subsidize the premiums for moderate to low-income purchasers. This would, by definition, make policies more affordable and might keep individuals from dropping coverage. This kind of subsidy however, has a number of drawbacks and is unlikely to meet a test of cost-effectiveness. First, the state would likely start subsidizing premiums for low-income purchasers at age 65, but these individuals are unlikely to use services for another 15 to 20 years. Second, as described above, a 65 year old only has a one in four chance of spending a year or more in a nursing home. Consequently, subsidies would be paid for a majority of people who will never need nursing home care. In other words, this strategy is very inefficient in its ability to target expenditures.

On the other end of the income spectrum, those people with incomes high enough that the increased cost would not cause them to drop their existing Medicare supplemental policies might already be purchasing private long-term care insurance. Moreover, people with incomes this high tend not to spend down to Medical Assistance eligibility standards. As a rule, encouraging upper income people to purchase private long-term care insurance does little to save Medical Assistance dollars in the short run or long run.

²The \$229 figure may somewhat understate the marginal cost of adding long-term care benefits to Medicare supplemental policies. The pricing of long-term care insurance policies today is based on assumptions about lapse rates among other things. Currently insurers assume fairly high lapse rates. People whose policies lapse or who die without using benefits, implicitly cross-subsidize the premiums of others. It is likely that actuaries will assume lower lapse rates for policies that include both Medicare supplemental and long-term care benefits and, therefore, will price premiums higher. The magnitude of this would be very hard to quantify.

³The "basic" Medicare supplemental policy that does not cover prescription drugs is the most popular product purchased by Minnesotans (Minnesota Department of Health, 2000.)

Finally it is also worth considering whether or not insurers would leave the market if a long-term care benefit were mandated. There are already a number of significant barriers to entering this market from an insurers perspective, including moral hazard, adverse selection, and the uncertainty associated with the assumptions about disability, mortality, and rate of return on investments used for pricing⁴ Long-term care products and Medicare supplemental products take very different insurance approaches. Medicare supplements are merely filling in the gaps of Medicare coverage; long-term care is adding catastrophic expense coverage. Companies interested in offering one type of coverage might not be interested in offering the other.

DISCUSSION

In terms of its ability to target expenditures to the most needy (both financial and functional), the current method of Medical Assistance long-term care financing is relatively efficient compared to favorable tax treatment for or subsidization of private purchase of long-term care insurance. Individuals receive government help only after depleting almost all their assets, and they must contribute virtually all their income toward the cost of care. Plus, the institutional bias of the delivery system limits services to persons with the most severe disability and those with few family supports. Public expenditures on private long-term care insurance are cost effective only if, ultimately, they save the State Medical Assistance dollars. To do so, private insurance policies must be sold to people of moderate to low incomes and with little in the way of assets.

Currently, information about exactly who is purchasing long-term care insurance in the State is unavailable. It is possible that a significant portion of the \$4 million in tax expenditures that the State is estimated to spend in 2000 is flowing to upper income people who would never have qualified for Medical Assistance. In other words, what the State is doing now with regards to encouraging purchase of private long-term care insurance might not fare well in a cost effectiveness analysis.

What may be the most encouraging aspect of the strategy of combining Medicare supplemental insurance with long-term care insurance is the concept that different kinds of insurance coverage (e.g. life, disability, long-term care) could logically be linked. Indeed, some insurers are starting to look at offering a long-term care product that, if never used, converts to a life insurance benefit.

⁴Moral hazard is the increased use of a service that is seen when an individual has insurance coverage for that service. Adverse selection is a term used to describe when there is greater purchase of an insurance product among people who are more likely to use it. And, finally, as previously noted, changes in disability, mortality, or rate of return on investments can quickly turn a profitable product unprofitable because there is often such a long time between purchase and the ultimate use of the insurance product.

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