

Private Long-Term Care Insurance: The Medicaid Interaction

Does long-term care insurance help purchasers preserve their assets and avoid Medicaid? The purpose of this issue brief is to explore the complex interaction of Medicaid and private long-term care insurance and highlight the policy implications for those who may “fall through the cracks” in their coverage.

Introduction

The potential cost of long-term care is high, exceeding the budgets of most Americans. The average cost of a year in a nursing home is \$55,000,¹ and it exceeds \$100,000 in some areas.² The hourly cost of home care from a home health agency averages \$18 for a home health aide and \$37 for a licensed practical nurse.³ While some people can afford to pay for all the services they need out of their accumulated savings and current incomes, many deplete their resources and ultimately turn to Medicaid for help.⁴

Medicaid was designed to assist those with few resources and either limited incomes or incomes too low to cover needed health (and long-term care) services. All state Medicaid programs provide nursing home services and a varying amount of home- and community-based long-term care services to individuals who meet their financial and functional eligibility criteria. But many Americans want to avoid depleting their resources, as Medicaid requires – preferring to pass on their life savings to their heirs. Moreover, individual choices are limited under the Medicaid program. Not all nursing homes participate in Medicaid, and many that do participate limit the number of Medicaid beds. Access to the services most people prefer – home-based services or residential alternatives, such as assisted living – varies considerably from state to state.

For these and other reasons, many see private long-term care insurance as an alternative to Medicaid impoverishment or complete self-financing. Yet the cost of high-quality private insurance coverage exceeds the resources of many Americans. Most estimates show that only 10 to 20 percent of households age 65 and older can afford this coverage.⁵ This finding is not surprising when one considers that nearly half (49 percent) of people ages 65 and older have incomes below 250 percent of the poverty line⁶ (\$21,570 in 2002).⁷ In 2001, the average premium for a good-quality policy for a 65-year-old purchaser was \$2,273⁸ – more than 10 percent of an income at 250 percent of poverty. In addition, a report published by the Kaiser Family Foundation⁹ analyzed the affordability of long-term care insurance among *younger* households, after considering the adequacy of their retirement savings and life, health, and disability insurance coverage. It found that only 20 percent of married couples with heads aged 35 to 59 have adequate retirement savings, insurance coverage, *and* adequate incomes for the purchase of long-term care insurance for two adults.

In an effort to broaden the sale of private long-term care insurance, some suggest that consumers who cannot afford a “Cadillac” policy purchase less comprehensive coverage with more affordable premiums. Yet this approach may have unforeseen pitfalls. The adequacy of benefits is critical in analyzing the value of long-term care

insurance. In an effort to reduce the cost of the policy, most purchasers of private long-term care insurance already select a daily benefit amount that is lower than the average cost of nursing home care. Data on individuals who have received payments from their long-term care insurance policies (claimants) reveal an average daily nursing home cost of \$125, of which their insurance pays about \$81 per day.¹⁰ Using these data, *even those who purchase long-term care insurance may be spending more than \$16,000 out-of-pocket for a year of nursing home care.* For some consumers, this combination of insurance benefits and out-of-pocket spending is appropriate. But if there is a spouse at home, the couple's income also may be needed to pay for his or her expenses in the community. Therefore, a high out-of-pocket expenditure can create hardships for a spouse remaining at home. No data are available on the extent to which purchasers of long-term care insurance will ultimately need to tap into savings to help finance the cost of their long-term care. But, to the extent that this becomes necessary, even long-term care insurance purchasers may ultimately "spend down" their assets.

As important as the daily benefit amount, especially for younger purchasers, is inflation protection. Only about 40 percent of all new buyers of long-term care insurance purchase inflation riders, although 59 percent of those under age 65 do so.¹¹ But even for those who purchase 5 percent compound inflation protection, given current trends in service use and average inflation, it is expected that the policy and rider will cover between 72 percent and 90 percent of future long-term care costs.¹² The lower figure is for those who use nursing home care; the higher figure is for those who use home care or assisted living. Given these facts, even individuals who purchase private long-term care insurance may ultimately incur substantial out-of-pocket costs for long-term care, especially if they require

nursing home care. Those who fail to purchase compound inflation protection will almost certainly incur substantial costs if they need services.

What happens when the cost of long-term care services exceeds one's insurance benefit, available income, and assets? Presumably the Medicaid program is then available to finance services. Or is it? The discussion that follows addresses the unintended consequences that sometimes occur in the interaction of Medicaid and private long-term care insurance and their policy implications. It also describes some actions that can address potential problems.

The Medicaid/Private Long-Term Care Insurance Interaction

Once an individual has sufficient disabilities to qualify for benefits under a private long-term care insurance policy, benefits generally are paid in one of three ways. A limited number of policies use a disability model that pays a cash benefit to the insured, regardless of services used. Most policies follow an indemnity model in which the insurer reimburses the insured for covered services used. A limited number of policies provide payments directly to the service provider, bypassing the insured party. Most indemnity policies allow claimants to exercise the option of "assigning" their benefit to the service provider, an option that may not be available in disability-model coverage. (Under assignment of benefits, the insurer pays the provider directly, bypassing the insured party.) How benefits are paid has implications for Medicaid eligibility.

To understand the interaction between public and private long-term care benefits, it is necessary to understand how Medicaid eligibility and financing work – never an easy task. To simplify the process, this issue brief focuses on nursing home *income* eligibility, because nursing homes are where

the costs are largest – both for individuals and for the Medicaid program. Issues of functional eligibility and asset eligibility, while also important, are discussed elsewhere in the literature and are not central to this discussion. This issue brief does not address Medicaid eligibility for home- and community-based services, because spend-down procedures for these programs are generally even more complex than establishing medically needy eligibility for nursing home services.

The following principles are critical to understanding the Medicaid/long-term care insurance interaction:

- Medicaid eligibility is based on income that is determined to be available to the individual.
- The Medicaid payment rate to nursing homes is determined by each state and is, in general, considerably lower than the rate charged to private payers.
- Medicaid is the payer of last resort; if a third party (such as a private insurer) is legally obligated to pay for benefits, Medicaid considers the third party to be the primary payer.
- There are two main ways that state Medicaid programs determine income eligibility for nursing homes:

1. The “Income Cap” Rule: States may find individuals eligible for nursing home benefits if their income does not exceed 300 percent of the federal Supplemental Security Income (SSI) benefit – \$1,692 per month in 2004.
2. “Medically Needy”: This Medicaid option allows individuals to deduct their health and long-term care expenses from their income. If the result is within Medicaid limits, they may be eligible, provided they meet all other Medicaid eligibility criteria.

Thirty-five states, including the District of Columbia, have medically needy programs for older persons and persons with disabilities. Of these, 25 also use the income cap rule to establish Medicaid nursing home eligibility. Of the 16 states that do not have medically needy programs, 14 allow individuals to qualify for nursing home services under the income cap rule. The remaining two states use a spend-down methodology similar to the medically needy provisions.¹³

Numerous variables can affect Medicaid eligibility and its interaction with private long-term care insurance. The hypothetical example that follows uses fairly typical data to illustrate how the interaction can become problematic, with unintended consequences for both the consumer and the Medicaid program.

Hypothetical Example

- Mrs. Smith, age 83, has a private long-term care insurance policy that reimburses her up to \$80 per day for nursing home care – an amount that was considered adequate when she purchased her policy (and is close to the current average nursing home insurance payment of \$81 per day).
- She now needs nursing home care and wants to enter a facility that charges private pay residents \$150 per day (the current national average).
- Her only income is her \$900 monthly Social Security benefit (\$30 per day – close to the average monthly Social Security benefit of \$922 in 2004).
- Mrs. Smith's insurance policy and Social Security income are inadequate to cover the private pay rate in her nursing home of choice.

[$\$150 - \110 (\$80 private insurance + \$30 Social Security) = \$40 per day shortfall.]

- Assuming that Mrs. Smith meets functional eligibility requirements and has few assets, she would be eligible for Medicaid...or would she?
- Unless her insurer paid the nursing home directly (which few do), or she was able to assign her benefit to the nursing home, the Medicaid program would consider Mrs. Smith's \$80 daily insurance benefit to be income. Combined with her Social Security benefit, Mrs. Smith's monthly income,* for the purpose of determining Medicaid eligibility, would be \$3,300.

[$\$80 \times 30 = \$2,400$ (private insurance) + \$900 (Social Security) = \$3,300]

- The simplest way for states to determine nursing home eligibility is the income cap rule, which most often is 300 percent of SSI. With her insurance payment, Mrs. Smith's income would far exceed the 300 percent amount. [$\$80$ per day insurance payment + \$30 per day Social Security = \$110 per day x 30 days = \$3,300 per month – nearly double the 300 percent of SSI standard of \$1,692 per month.] However, *without* the insurance benefit, her \$900 Social Security benefit would easily qualify her for coverage under the income cap rule.†
- Even if the state had a medically needy eligibility program for nursing home residents, Mrs. Smith is likely to have too much income to qualify for Medicaid. This is because the Medicaid nursing home payment rate is generally considerably lower than the private pay rate. Let's say the Medicaid daily rate in her state is \$90 (close to the national average of \$96).

* Note that the \$80 per day insurance payment is only available to Mrs. Smith if she receives nursing home services. Her actual disposable income is still \$900 per month.

† States often use longer budget periods in calculating eligibility. Daily and monthly figures are used here for illustrative purposes.

- **In making the Medicaid eligibility determination, the state would subtract \$90 (the Medicaid rate, not the private pay rate of \$150) from Mrs. Smith’s daily income of \$110. The result would be \$20 per day in countable income, or \$600 per month. This amount exceeds the monthly federal SSI payment of \$564 – the most common income guideline used to determine Medicaid eligibility for the elderly. (Some states require even lower levels of income in order to qualify.) Unless the state allows additional deductions from income, Mrs. Smith may not qualify for nursing home coverage under the medically needy rules. If Mrs. Smith’s policy required her to pay premiums even while in the nursing home, this would be one more eligible deduction from her income that could possibly help her to qualify for Medicaid. Many (but not all) private insurance policies allow the insured person to stop paying premiums when they are in claim status.**
- **If, on the other hand, Mrs. Smith did *not* have private insurance, the \$90 daily Medicaid nursing home cost would be subtracted from her \$30 daily Social Security benefit. She would be income-eligible for benefits, since her (negative) income would be far lower than the Medicaid payment rate.**
- **The net result is that Mrs. Smith could find herself in a “catch-22” situation, in which her insurance benefit is inadequate to pay privately for care, yet affords her too much income to qualify for Medicaid. Mrs. Smith has two alternatives:**
 - **Keep her policy, disqualifying herself for Medicaid, and try to find a nursing home that will accept \$110 per day; or**
 - **Cancel her policy and qualify for Medicaid, resulting in increased public expenditures. (Under this alternative, she also loses the benefit of all the premiums she has paid.)**

Policy Issues

The interaction between Medicaid and private long-term care insurance has the potential to penalize individuals with modest incomes who purchase policies that fail to cover all or nearly all the full private-pay cost of nursing home care. Unless the policyholder has sufficient additional income or savings to finance any shortfall between the insurance benefit and the cost of care, the dollars paid in insurance premiums may seem like a poor investment.

Unfortunately, those purchasers who are most likely to “skimp” on their insurance benefit (to make the premium more affordable) are *least* likely to have the

additional income and assets to supplement their private insurance. While people with lower incomes may actually need better insurance coverage, data on purchasers indicate that, as income increases, so do daily benefit amounts and the likelihood of purchasing inflation protection.¹⁴ This result highlights the importance of long-term care insurance suitability standards, which discourage insurance agents from selling policies to individuals who cannot afford a policy that will provide a meaningful benefit. Insurers who encourage prospective purchasers to buy a “more affordable” policy (usually by purchasing a lower daily benefit or foregoing compound inflation protection) may ultimately do a great

disservice to consumers. This concern also should be noted by those who advocate private long-term care insurance as an adequate way to address long-term care financing for middle- and lower-middle-income Americans.

Suitability

The term “suitability” means determining whether the insurance product is appropriate for the consumer: does it take into account his or her ability to pay, need for coverage, priorities, and so forth? According to standards established by the National Association of Insurance Commissioners (NAIC), insurance agents should look at the following individual factors when selling long-term care insurance: income, expected changes to income, assets, and existing coverage. With regard to insurance coverage, suitability issues include the local cost of services, the waiting period, the purchaser’s age, and the appropriateness of inflation protection.

If a state adopts the NAIC suitability guideline, insurance companies that sell long-term care insurance in that state must develop suitability guidelines, have potential purchasers fill out an individualized worksheet, inform the consumer about things he or she should know before purchasing the product, and decline to sell if the product is inappropriate for the consumer. As of 2003, some 28 states had adopted the NAIC suitability standard, but there are no uniformly agreed-upon income and asset standards below which long-term care insurance is considered inappropriate.

In addition, Medicaid’s treatment of insurance reimbursements as income may have unintended consequences for the Medicaid program. There have been anecdotal reports that some individuals have cancelled their private long-term care

insurance policy so that they could qualify for Medicaid. Nursing home residents who are covered by Medicaid surrender virtually all their income to cover the cost of services, and Medicaid pays the gap between the beneficiary’s income and the Medicaid daily payment rate. Therefore, the Medicaid program pays out less per individual for those with relatively higher incomes. If an individual foregoes private insurance payment to qualify for Medicaid, the program ends up paying considerably more than it would if the insurance payment went to the nursing home.

States can revise their rules to make them more rational in their treatment of private long-term care insurance. Under section 1902(r)(2) of the Social Security Act, states are allowed to develop more liberal methods for counting income than those required by the SSI program.¹⁵ In the absence of a specific exception, the SSI income and asset rules are the default position in the Medicaid program’s eligibility guidelines for persons age 65 and older. According to the Centers for Medicare and Medicaid Services (CMS), no state has requested a more liberal disregard of private long-term care insurance payments.¹⁶ It would seem to benefit the Medicaid program if states revised their treatment of long-term care insurance payments. Such revisions could ensure that otherwise-eligible individuals would not be disqualified for Medicaid simply because their private insurance benefit and their income exceeded the state’s Medicaid payment rate, but was lower than the private payment rate.

Another option would be to ensure that all consumers are able to assign their private insurance payment to the nursing home or other provider. In these cases, Medicaid considers the insurance payment to be a third-party vendor payment, which does not count as “income” available to the individual. Consumers who are attracted to

the flexibility of disability-type policies may be unaware that losing the option of assigning benefits could have consequences for their future Medicaid eligibility. State insurance commissioners could prohibit the sale of policies that do not allow assignment of nursing home benefits. Alternatively, the provisions of the Health Insurance Portability and Accountability Act that determine which long-term care insurance policies are federally tax qualified could be revised to require assignment of benefits.

Returning to the example of Mrs. Smith: let's say her \$80 daily insurance payment went directly to the nursing home. Mrs. Smith would use her Social Security income to pay the remaining \$10 per day of the Medicaid \$90 daily rate. Her remaining income of \$20 per day (\$600 per month) would qualify her for Medicaid coverage under the income cap rule (once she had depleted her assets). Yet her nursing home payments would be borne entirely by her private insurance and Social Security income. If her state used medically needy eligibility instead of the income cap rule, it could change its income methodology to "disregard" her insurance payment. Under this scenario, Mrs. Smith would still need to contribute her own income to reach the nursing home's Medicaid rate. While her remaining income of \$600 per month still exceeds the SSI standard of \$564, she would be able to deduct other medical expenses from her income in order to meet the medically needy standard. If she pays a Medicare Part B premium (\$66.60 per month in 2004), that alone would bring her below the SSI standard. Under either scenario, the cost to the state would be far lower than if Mrs. Smith cancelled her insurance policy and let Medicaid pick up the bulk of her nursing home costs.

Most people who purchase private long-term care insurance do so in the hope of maximizing their choices, protecting their

assets, and avoiding Medicaid. However, those whose policies prove to be inadequate to cover the cost of care may find themselves at a disadvantage both in qualifying for Medicaid and in paying for nursing home care privately. Rationalizing the way state Medicaid programs treat private long-term care insurance payments could, ultimately, save Medicaid dollars. Unfortunately, these "fixes" do little to improve the financial circumstances of consumers with modest incomes who purchased inadequate long-term care insurance policies.

Because the long-term care insurance industry is still relatively new, only a relatively small number of individuals have claimed benefits. As insurance sales expand, more purchasers will develop disabilities and begin to use their coverage. It would be prudent to address these issues now, before the problem grows.

"Partnership" Policies: A Special Case
Four states (California, Connecticut, Indiana, and New York) currently operate long-term care insurance "partnership" programs. Under special Medicaid rules, individuals who purchase designated long-term care insurance policies may qualify for Medicaid (after their private benefits are exhausted) and are allowed to protect a certain amount of assets over and above the normal Medicaid limit. Partnership policies have standards for a minimum daily benefit that consumers must purchase – intended to cover at least 80 percent of average daily nursing home costs. A detailed analysis of these policies is beyond the scope of this issue brief. It should be noted, however, that while these policies address asset eligibility for Medicaid, they are silent on income eligibility.

Written by Enid Kassner, Senior Policy Advisor,
AARP Public Policy Institute
May 2004

AARP
601 E Street NW, Washington, DC 20049
<http://www.aarp.org/ppi>
© 2004 Reprinting with permission only.

Notes

¹ Scanlon, William J. "Baby Boom Generation Increases Challenge of Financing Needed Services" (GAO-01-563T), Washington, DC: General Accounting Office, March 27, 2001.

² De Simone, Marcella. *Nursing Home Care Tops \$85,000 a Year In Most Expensive Markets: Survey*, "National Underwriter," August 4, 2003: 31.

³ Gibson, Mary Jo, et al. "Beyond 50.03: A Report to the Nation on Independent Living and Disability," Washington, DC: AARP, 2003.

⁴ Wiener, Joshua M., Catherine M. Sullivan, and Jason Skaggs. "Spending down to Medicaid: New Data on the Role of Medicaid in Paying for Nursing Home Care," Washington, DC: AARP, 1996.

⁵ Wiener, Joshua M., David G. Stevenson, and Jessica Kasten. "State Cost Containment Initiatives for Long-Term Care Services for Older People," Washington, DC: Congressional Research Service, May 8, 2000.

⁶ US Census website
(<http://www.census.gov/hhes/poverty/resized%20age65%20pov%20ratios%20by%20state%2099-01.xls>).

⁷ US Census website
(<http://www.census.gov/hhes/poverty/threshld/thresh02.html>).

⁸ Coronel, Susan A. "Long-Term Care Insurance in 2000–2001," Washington, DC: Health Insurance Association of America, January 2003. This premium is for a policy providing a \$150 daily benefit, 5 percent compound inflation protection, four years of coverage, and a 90-day elimination period.

⁹ Merlis, Mark. "Private Long-Term Care Insurance: Who Should Buy It and What Should They Buy?" Washington, DC: The Kaiser Family Foundation, March 2003.

¹⁰ Cohen, Marc. Statement to the Advisory Council on Employee Welfare and Pension Benefit Plans, September 11, 2000.

¹¹ Cohen, Marc, Maurice Weinrobe, and Jessica Miller. "Inflation Protection and Long-Term Care Insurance: Finding the Gold Standard of Adequacy," Washington, DC: AARP, August 2002. The

likelihood of purchasing inflation protection decreases with age. Among purchasers age 65–69, 46 percent purchased inflation protection, compared with 32 percent among those age 70–74 and 14 percent among those age 75+.

¹² *Ibid.*

¹³ Kaiser Commission on Medicaid and the Uninsured. "Medically Needy Programs: An Important Source of Medicaid Coverage," Washington, DC, January 2003.

¹⁴ Health Insurance Association of America. "Who Buys Long-Term Care Insurance in 2000?" Washington, DC, October 2000.

¹⁵ CMS communication to State Medicaid Directors. "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers," May 11, 2001, <http://www.cms.hhs.gov/medicaid/eligibility/elig0501.pdf>.

¹⁶ Private communication with Roy Trudell, CMS, April 2003.