Medicaid Crowd-Out of Long-Term Care Insurance

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The financing of long-term care in the United States

- 44 percent of men and 58 percent of women will enter a nursing home at some point after age 65.
- Among those who enter, mean durations of stay are 0.85 and 1.37 years, respectively.
- Average annual cost is $78,110 (2011).

The financing of long-term care in the United States (cont'd)

- Medicare – the social insurance program for the elderly – pays for care only in limited circumstances.
- Medicaid – the social insurance program for the indigent – is subject to a stringent means test.
- Only 16 percent of individuals over age 65 hold private long-term care insurance.

What effect does Medicaid have on the demand for insurance for single individuals?

- Brown and Finkelstein (2008) show that less than half of single individuals would optimally purchase private insurance.
- Except among the wealthy, each dollar of insurance benefits displaces close to a dollar of Medicaid benefits, which amounts to an implicit tax.
- So much of the benefit of insurance accrues not to the individual, in the form of higher consumption, but to the government, in the form of lower Medicaid spending.

But married couples face different considerations.

- Couples must consider the impact of care costs on the non-institutionalized spouse.
- Couples may benefit from care cost risk pooling.
- Couples can more easily qualify for Medicaid, due to higher asset and income limits, so each dollar of insurance benefits displaces an even larger amount of Medicaid benefits.
- But couples have greater wealth than singles, reducing both the likelihood of qualifying for Medicaid and the Medicaid implicit tax.

How Medicaid treats singles and couples

- Singles – permitted to retain $2,000 assets and $30 a month income.
- Couples – so-called spousal protection rules vary by state.
- Stingy states – non-institutionalized spouse can retain half the couple's financial assets, subject to a minimum of $23,448 and a maximum of $117,480, and monthly income of $1,939.
- Generous states – non-institutionalized spouse can retain $117,240 of financial assets, plus monthly income of $2,931.
- Non-institutionalized spouse can also retain the house.

Estimating couples' hypothetical willingness-to-pay for insurance

- Consider married couples age 65 at the 10th, 20th, through 90th percentile of the wealth distribution.
- Assume plausible preference parameters (CRRA utility with coefficient of risk aversion of three).
- Husband and wife are initially healthy.

Estimating couples' hypothetical willingness-to-pay for insurance (cont'd)

- Each month, husband and wife face probability of transitioning between five care states:
  - healthy;
  - requiring home health care;
  - residing in an assisted living facility;
  - residing in a nursing home; or
  - dead.
- Each care status has an associated care cost.
- Medicaid payments depend on care states of husband and wife.
- Calculate optimal consumption each period and note expected discounted lifetime utility.

Estimating couples' hypothetical willingness-to-pay for insurance (cont'd)

- Require household to purchase long-term care insurance.
- Calculate age-65 lump sum transfer to/from household that will give a household with insurance the same expected utility as one without.
- When transfer is positive, household is better off buying insurance.

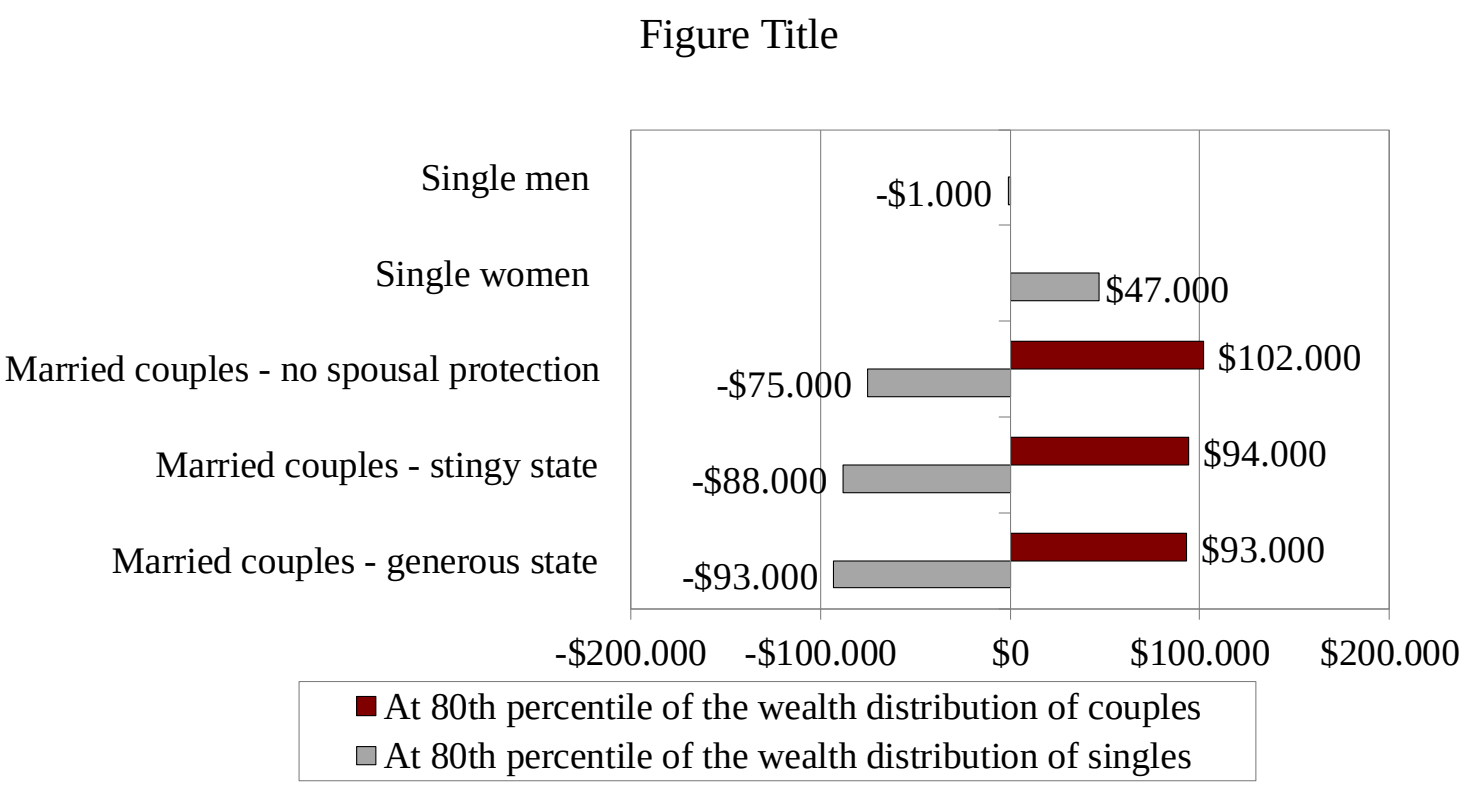
Our transition probabilities differ from those used by Brown and Finkelstein

- Brown and Finkelstein use probabilities estimated by Robinson (1996).
- These underestimate the probability of ever using care and overestimate the conditional mean duration of care.
- We re-estimate transition probabilities and match them to *Health and Retirement Study* sample statistics.

Comparing willingness to pay of singles and couples

- Comparison is tricky because couples have much greater wealth than singles.
- Compare the following household types:
  - Single male/single female at the 80th percentile of the wealth distribution of single individuals.
  - Couples who have the same amount of wealth as the above singles.
  - Couples who are at the 80th percentile of the wealth distribution of married couples.
  - Assume the couples: 1) have no spousal protection, 2) are subject to stingy Medicaid spousal protection rules, 3) are subject to generous spousal protection rules.

Comparing willingness to pay of singles and couples (cont'd)



Source: Authors' calculations.

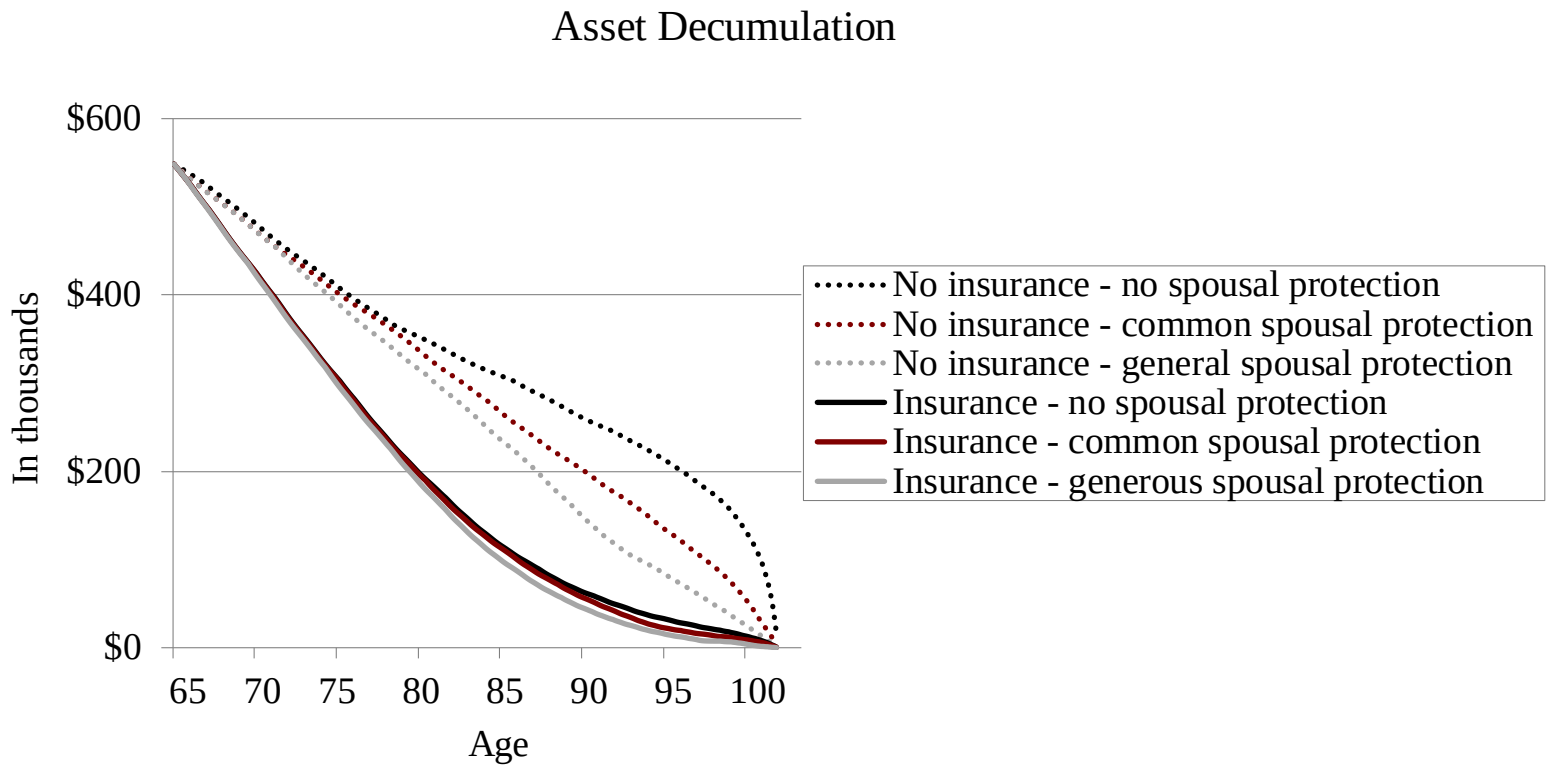
What explains differences in willingness to pay?

- Spousal protection rules play only a small part – by the time most people go into care, they are widows or widowers.

- The greater wealth of couples substantially increases their willingness to pay.

- But, holding wealth constant, couples who do not benefit from spousal protection have a lower willingness to pay than singles. Why? - Long-term care cost risk pooling and differences in decumulation paths more than offset concerns about impoverishing the community spouse.

Medicaid distorts the asset decumulation path.



Source: Authors' calculations.

Secondary payer status of Medicaid causes substantial welfare losses.

- Households would be willing to pay substantial amounts for a policy that topped up Medicaid.
- But making Medicaid the primary payer would be very expensive.

Conclusion

- Brown and Finkelstein argued that Medicaid crowd-out could alone account for the lack of demand for private insurance among single individuals.

- Our paper shows that although married couples face quite different considerations, they are also affected by Medicaid crowd-out and suffer substantial welfare costs.

- But there is no easy policy fix.