House
Legislative
Analysis
Section

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MEDICAID LONG-TERM CARE PARTNERSHIP

House Bill 4328 (Substitute H-3)
First Analysis (5-3-95)

Sponsor: Rep. Walter J. DeLange
Committee: Human Services

THE APPARENT PROBLEM:

Many people work hard all their lives, anticipating that they will be self-sufficient in their senior years, only to watch their assets dwindle to pay for long-term care. Middle-income families are particularly vulnerable in this area, because they do not readily qualify for Medicaid, on the one hand, and, on the other hand, they cannot afford the out-of-pocket cost of long-term care or the high premiums associated with private long-term care insurance. In fact, nursing home costs -- which range from $30,000 to $60,000 per year -- are prohibitive for all but a few citizens. Medicaid is the only government program that covers these costs. However, Medicaid is a means-tested program: to be eligible a person must either be poor or must "spend down" his or her assets, excluding a home, to a certain amount. Some older Americans have traditionally avoided the high costs of long-term care by giving away their assets or setting up trust funds for their children or grandchildren. They are then eligible for Medicaid benefits if and when they enter nursing homes. However, the 1993 federal Omnibus Budget Reconciliation Act (OBRA) makes it difficult to shelter assets in a trust in order to become eligible for Medicaid.

According to press accounts, the states of New York and Connecticut have established new policies to alleviate the problem of high long-term care costs for their citizens. They have each established "partnership policies", under which long-term care policies are provided by insurers in partnership with state governments. In New York, where a standard long-term care insurance five-year plan costs approximately $1,500 for a 40-year old to more than $4,000 for a 65-year old, a citizen can purchase a three-year policy with, for example, $100,000 coverage, under the state's "partnership policy" at a cost of about one-third less than the conventional insurance cost. The insurer pays nursing home or at-home care and physical therapy costs for up to three years, at which time the resident becomes eligible for Medicaid. The advantage of the program is that the state disregards the first $100,000 of the person's assets when deciding Medicaid eligibility. Legislation has been proposed that would establish a pilot program, entitled the "Michigan Partnership for Long-Term Care," which would be similar to New York's "partnership policy." Since current Medicaid eligibility requirements would be affected if this plan were implemented, a federal waiver would be required from the federal Health Care Financing Administration.

THE CONTENT OF THE BILL:

The bill would add new sections to the Social Welfare Act to require the Department of Social Services (DSS) to obtain a federal waiver to create the "Michigan Partnership for Long-Term Care Program" that would provide for the financing of long-term care through a combination of private long-term care ("partnership") insurance policies and Medicaid. More specifically, Michigan residents who had three years of nursing home (or certain other specified kinds of long-term) care paid for under a private insurance "partnership policy" and who had exhausted the policy's minimum benefits would then be eligible to participate in the partnership program.

Partnership policy. A partnership policy would have to provide a minimum of three years of care and for a dollar amount equal to 36 months of nursing home care, with minimum daily benefit amounts of $100 for nursing home care and $50 for home health care. These minimum daily benefit amounts would be adjusted and rounded to the nearest dollar by the department on October 1 of each year, based on the Medicaid health care index for nursing home rate setting. The policy would have to cover nursing home care, home health care, and care management. The policy would also have to provide for home health care benefits on the basis

of two home health care days for one nursing home care day; and cover up to 14 days of nursing care in a hospital while the policy holder was waiting for long-term care placement, at a cost of not more than the daily benefit amount for nursing home care.

A third party would have to be designated to receive notice if a partnership policy was about to lapse for nonpayment of premium, and if that person were notified of such an event there would be an additional 30-day grace period to pay the premium. Partnership policies would have to offer the following options for an adjusted premium: an elimination period of up to 100 days, and nonforfeiture benefits for applicants between the ages of 18 and 75.

Eligibility. A Michigan resident would be eligible to participate in the partnership program if the person bought a policy, maintained it in effect throughout his or her participation in the partnership program, and exhausted the minimum benefits under the policy (that is, had used a minimum of three years of the long-term care services covered under the policy). However, benefits received from a policy before the effective date of the bill would not count toward the required "exhaustion of benefits." The policy would have to have been delivered, issued for delivery, or renewed on or after the bill took effect.

Medicaid component. The Department of Social Services would be required to seek appropriate amendments to the Medicaid state plan and apply for any necessary waiver of Medicaid requirements by the federal Health Care Financing Administration (HCFA) in order to implement the partnership program. The department couldn't implement the program unless federal law exempted individuals who receive Medicaid under these provisions from the estate recovery requirements of Title XIX of the Social Security Act, and any necessary waiver of Medicaid requirements was obtained.

Upon application, the DSS would determine a person's eligibility for Medicaid in accordance with both of the following:

* After disregarding financial assets exempted under Medicaid eligibility requirements, the DSS would also disregard an additional amount of financial assets equal to the dollar amount of coverage under the partnership policy.

* The individual's income would be considered in accordance with Medicaid eligibility requirements.

Rules promulgation. The Department of Social Services could promulgate rules to implement the partnership program.

MCL 400.112b et al.

FISCAL IMPLICATIONS:

According to House Fiscal Agency estimates, the provisions of the bill could potentially result in lower state Medicaid costs for long term care, since, presumably, more individuals would purchase long term care policies rather than become eligible for Medicaid. It is impossible to calculate the exact savings, since it is uncertain how many persons would purchase long term care policies. (5-1-95)

According to Department of Social Services estimates, the potential savings initially incurred under the bill could be offset in the future through the additional costs that would be incurred by those who became Medicaid eligible after exhausting their long term care benefits. (4-6-95)

ARGUMENTS:

For:

The exorbitant cost of long-term health care insurance is probably the most pressing financial problem older Americans face. The costs of this insurance vary widely from company to company. According to a survey conducted annually by the National Association of Life Underwriters' "Life Association News," the cost of premiums ranges from $210 annually to almost $1,000 annually for $100-per-day benefits for a 55-year-old non-smoker. Premiums are higher, of course for those in the 60- or 65-year-old age brackets. However, it is difficult to compare these costs, since benefits, too, vary widely from company to company. In addition, such insurance is mostly provided to cover short (two- to five-year) benefit periods. The advantage to an elderly person of the program that would be established under the bill is that the state would disregard a person's resources when deciding Medicaid eligibility in an amount equal to the amount of the long-term care insurance benefit payments. Therefore, if a person purchased a $300,000 policy, the first $300,000 of that person's assets would not be taken into account. The advantage to the state is that its Medicaid costs

would be reduced, since fewer people would transfer their assets to hide their wealth. The advantage to insurers is that they can offer lower premiums since Medicaid will pick up the costs for those who remain in nursing homes beyond the three- or five-year period provided.

Against:

The Medicaid program was established to help the poor, and not the middle class, nor the wealthy. Congress recognized this fact when it passed the 1993 Omnibus Budget Reconciliation Act (OBRA), under which states must tighten the eligibility requirements for Medicaid coverage, and adopt estate recovery programs. In addition, according to recent statistics, only 30 percent of people over 75 stay in nursing homes for more than three years; the other 70 percent are cared for by their families. The bill, however, would undoubtedly allow more older Americans to tap into Medicaid without liquidating their assets, and Michigan taxpayers would have to shoulder the increased Medicaid costs. It is unfair that those who take care of their elderly relatives at home should be required to shoulder that burden and also be taxed to support Medicaid benefits for the other 30 percent of the elderly population.

POSITIONS:

The Department of Social Services supports the bill. (5-1-95)

The Health Care Association of Michigan supports the bill. (5-2-95)

Woodhaven Insurance Marketing in Fremont, Michigan, supports the bill. (5-1-95)

The Citizens for Better Care - Michigan LTC Ombudsman Project has no position on the bill. (5-2-95)

The American Association of Retired Persons (AARP) has not yet analyzed the bill. (5-1-95)