Joan Costa-Font Nilesh Raut May 14th, 2025

Expanding state private insurance partnership programs can help reduce public spending on long term care

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Americans are getting older, and the cost of caring for this aging population is continuing to rise. While health insurance in the US is common, even after five decades of development, the market for long-term care (LTC) insurance has failed to expand significantly. One major barrier is that individuals often rely on self-insurance or Medicaid, which requires people to spend down their assets to qualify. **Joan Costa-Font** *and* **Nilesh Raut** *examine the effects of LTC partnership contracts which have been introduced by some US states. They find that the rollout of the*

partnership program have increased LTC insurance uptake by 14 to 17 percent and reduced Medicaid spending.

The challenge of funding long term care

As the US population ages, the demand for long-term care services and supports (LTCSS) is growing rapidly. Estimates indicate that two-thirds of Americans over the age of 65 will require LTCSS at some point in their lives, and the cost is staggering. In 2017, the average monthly cost of a nursing home stay was $8,385—roughly four times the average monthly income of a senior. With such a high cost, it's no surprise that questions about how to finance long-term care loom large in public policy discussions. In the United States, where the elderly population is expanding and lifespans are increasing, the demand for long-term care continues to rise. However, funding such care presents a significant challenge. Medicaid has long been the principal payer for LTC, but its role is complex: it only kicks in after individuals have depleted most of their personal resources.

The average long-term care cost for individuals with low care needs, already 42 percent of the median income of older people (without public support), could reach 259 percent for those with severe care needs, and even after accounting for social protection they can represent 70 percent of the median income of older people across OECD countries, and overtly rates for older adults with long-term care needs are 31 percentage points higher than for the general older population. This system inadvertently discourages the purchase of private long-term care insurance and encourages individuals to "spend down" their assets to qualify for public assistance.

At the heart of the issue is a precarious reliance on Medicaid—a safety-net program meant for the poor that now funds more than half of all LTCSS spending in the US While Medicaid covers about 53 percent of all LTCSS costs, it was never designed to shoulder such a heavy burden. And with an

aging population, that burden is only growing. So, what's the solution? One potential answer: Long-Term Care Insurance (LTCI). But ownership of LTCI remains shockingly low—only 11 percent of Americans over 50 hold such policies.

What is stopping the market for LTC insurance from expanding?

There are both demand- and supply-side challenges:

- Adverse selection: Those who buy LTCI are often those most likely to need care, making it difficult for insurers to maintain balanced risk pools.
- Trust and perceived value: Premiums are high, and some policyholders have faced benefit cuts or premium hikes—leading to a lack of trust in the market.
- Family care alternatives: Many individuals expect informal care from family, making them less inclined to purchase insurance.
- Insurer exit: Many insurance companies have pulled out of the LTCI market due to high uncertainty and rising claims.

From a policy perspective, Medicaid itself may be crowding out LTCI. Because Medicaid requires individuals to "spend down" their assets before becoming eligible, which for middle income families can be a disincentive to buy private LTC insurance—why pay premiums if you'll qualify for government care after depleting your savings anyway? This dynamic has enormous fiscal implications. When people don't buy LTCI, they are more likely to turn to Medicaid—adding strain to already stressed federal and state budgets.

Long term care insurance partnerships (LICIP)

A number of US states have implemented Long-Term Care Insurance Partnership (LTCIP) programs, designed to incentivize middle-income

households to buy private LTCI policies. These programs offer an appealing trade-off: if you buy LTCI, the state lets you protect more of your assets when you eventually apply for Medicaid. But, do these LTCIP programs actually work?

Credit: By In-Press Photography via Centre for Ageing Better

The LTCIP was developed in the late 1980s, initially piloted in just four states: California, Connecticut, Indiana, and New York. These "permanent partnership states" allowed individuals who purchased qualified LTCI policies to protect assets equal to the amount paid by their policy when applying for Medicaid. For example, if your policy covered $75,000 in benefits, you could retain $75,000 in personal assets and still qualify for Medicaid—a 'dollar-for-dollar' asset protection model. After decades of dormancy, LTCIP saw renewed life following the Deficit Reduction Act of 2005, which allowed more states to adopt standardized partnership programs. Since then, many states have introduced LTCIP, creating a quasi-experimental environment to study its impact on LTCI ownership and Medicaid enrolment.

While early evidence of LTCIP did not reveal immediate effects, we used 24 years of longitudinal data from the Health and Retirement Study (HRS), the underlying study analysed here investigates whether LTCIP adoption in

various states led to higher LTCI ownership and lower Medicaid enrollment (as shown in Figure 1a and 1b).

Figure 1(a) – Impact of partnership on private long-term care insurance

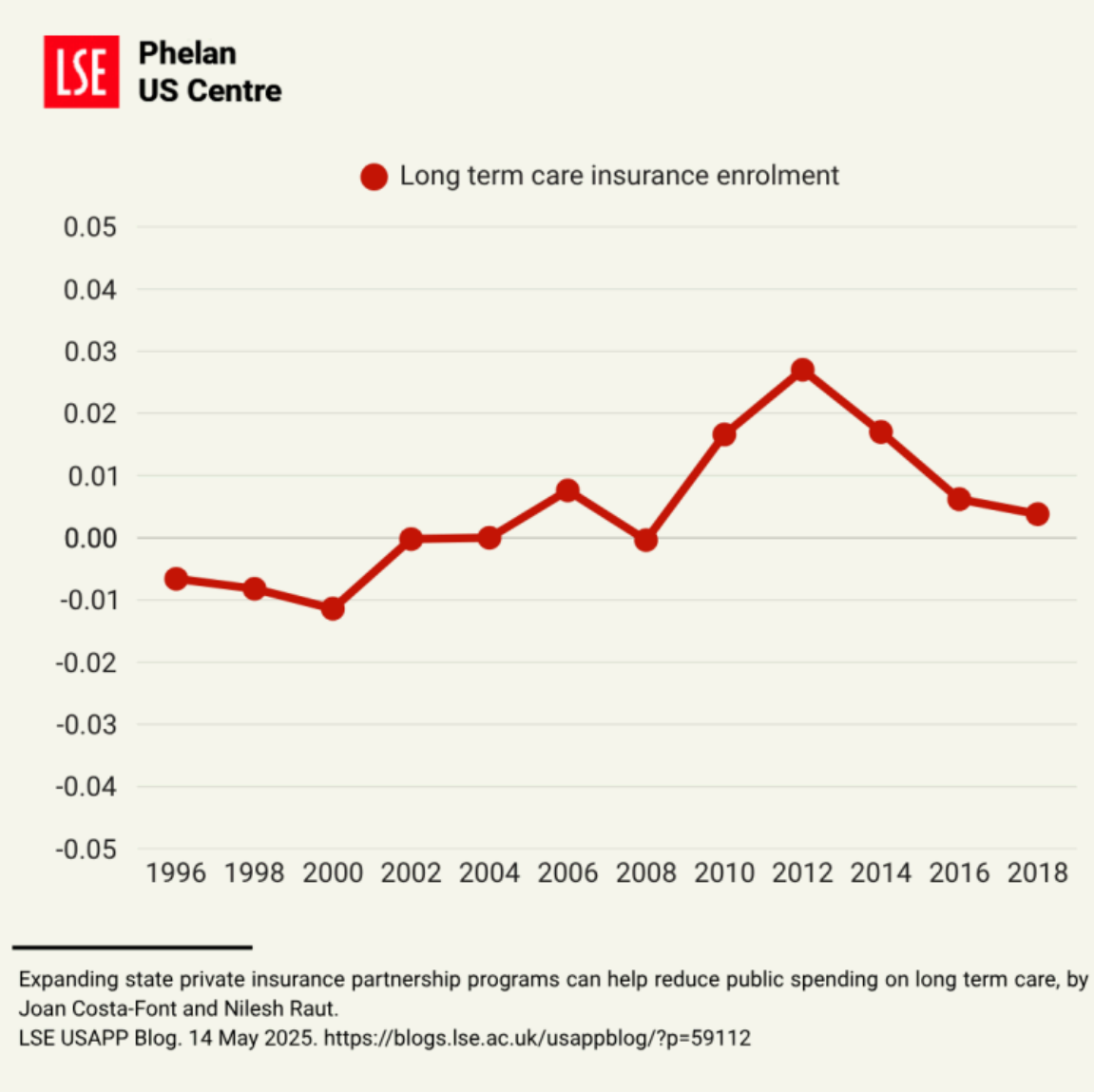
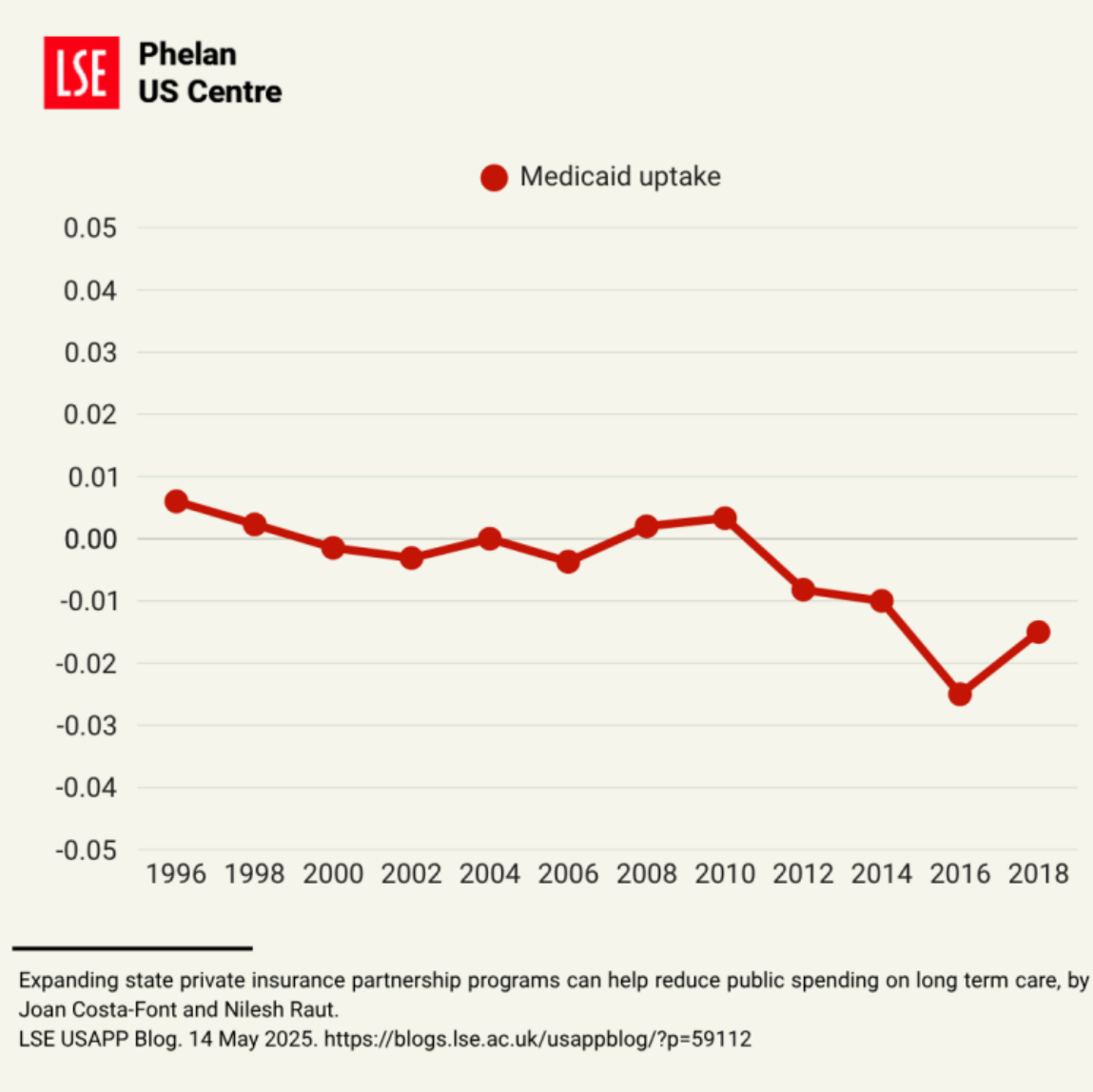


Figure 1(b) – Impact of long-term care insurance partnership on Medicaid



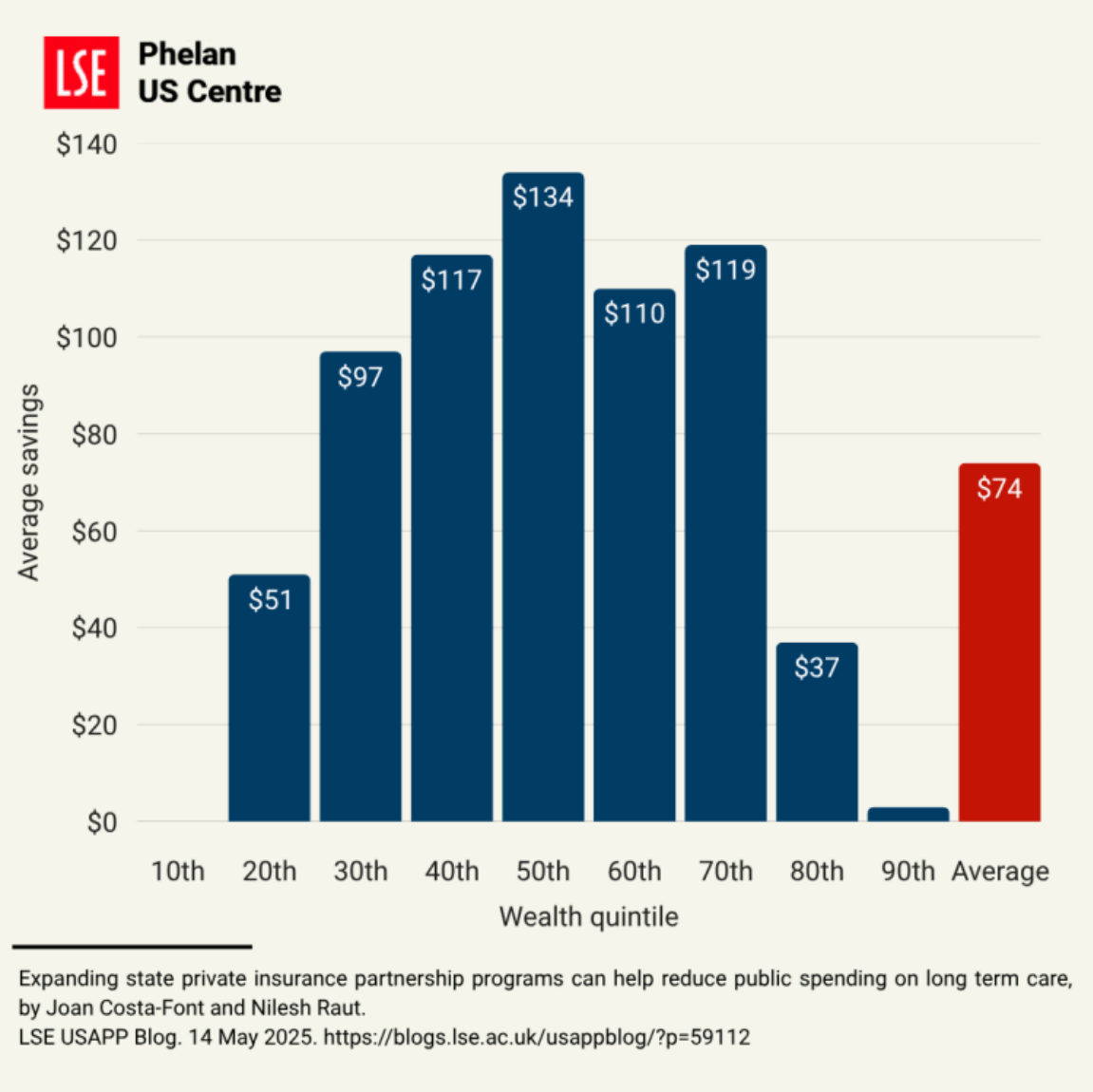
Notes: Each point in the figure 1(a) and 1(b) indicates the effect of partnership on LTCI and Medicaid relative to event time estimated using event study in equation (1), with survey wave for the year 2006 reporting the partnership for the first time after DRA-2005 is designated as year 2006. As the HRS is a biannual survey, the points on X-axis are two years apart. The bars associated with each point on the plot represent standard errors associated with coefficient. All the coefficient estimates are weighted using survey weights at person-level.

The findings may reshape how policymakers think about financing long-term care in America. They show that the adoption of LTCIP resulted in an increase of 1.54 to 1.75 percentage points in LTCI ownership—about a 14 to 17 percent relative increase from the pre-policy average of 10.5 percent in the partnership states. This finding held even after accounting for staggered rollouts across states and years. This might seem like a modest gain, but in a market with such low baseline ownership, it's a meaningful shift. It also suggests that LTCIP succeeded in overcoming at least some of the barriers that discouraged middle-income households from purchasing LTCI.

Alongside increased insurance ownership, they found that states that had rolled out Long term care insurance partnerships experienced a reduction in Medicaid uptake of 0.82 to 0.87 percentage points—a 13 percent decrease from a pre-policy average of 8.6 percent. In other words, for every seven individuals who took up LTCI due to LTCIP, approximately one delayed or avoided Medicaid enrolment. However, the effect of LTCIP did not appear immediately after adoption. It took four to six years for the increase in LTCI ownership and in-turn reduction in Medicaid uptake to materialize. This lag may be due to the slow rollout of marketing efforts, awareness campaigns, and the time it takes for individuals to plan for care needs that may be years away. The study also found that the effects of LTCIP were strongest among middle-income individuals—those with sufficient assets to protect but not enough wealth to self-insure comfortably. This group includes households with monthly incomes between $1,000 and $5,000 and total assets between $100,000 and $350,000—what policymakers refer to as the “Middle-Middle” class.

A simple simulation we conduced suggests that this shift in behavior could lead to significant Medicaid savings per person, as shown in Figure 2, which averages to $74 and varies across wealth deciles including $134 among the individuals in the 50^{th} wealth quantile. This result aligns with the policy’s goals: encouraging the take up of private insurance to delay or reduce reliance on public assistance.

Figure 2 – Estimated total net savings from LTCIP, for 65 years old individual by wealth deciles, adjusted for increase in Medicaid share of EPDV post-reform



Note: These saving estimates are calculated using the estimated effects across wealth levels obtained from Column (2) of Table 7 and using the post-partnership reform increase in Medicaid share of EPDV from the Table 9. Average Medicaid savings for 65 years old calculated using a simulation technique similar to Goda (2011). Authors calculate, with reference to year 2006, the expected present discounted value (EPDV) of long term-care costs or E(LTC) of $21021 for men and $52523 for women, using the values assumed by Brown and Finkelstein (2007) and Goda (2011) for the year 2000. Low, Middle, and High wealth levels correspond to 30th, 60th, and 80th percentile respectively. The horizontal axis represents wealth percentiles, and the vertical axis represents amount saved in USD.

Policy implications

While LTCIP alone won't solve the problem of long-term care, its positive effects suggest that well-crafted incentives can move the needle—especially when they target middle-income households who fall through the cracks of traditional safety nets. Interventions to improve financial protection for LTC should especially target those on middle-incomes. However, combining LTCIP with other tools, such as tax incentives or broader Medicaid reform, may further enhance its effectiveness.

- *This article is based on the paper,"Long-Term Care Partnership Effects on Medicaid and Private Insurance" in Health Economics.*
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Nilesh Raut

Dr Nilesh Raut is a Research Officer in LSE Health on a project with Vitality. Previously, he worked as LSE Fellow in the Department of Health Policy at the London School of Economics. He is a recipient of BA Leverhulme Small Research Grant (2024) and LSE Phelan United States Centre's Summer Research Grant (2021). Nilesh has also conducted research for the World Health Organization (WHO), and coathored the Global Report on Long-term care financing commisioned by the WHO. His research examines how health, long-term care insurance, and housing interact. He is mainly focused on how economics can improve health, wellbeing, and care financing of low- and middle-income populations in the US and elsewhere

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