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Long Term Care: The Next Healthcare Frontier

*Seth J. Chandler**



The current debate over healthcare reform has focused on the estimated 36 million persons who lack health insurance at any point in time. Deteriorated health does not cause merely a need for skilled medical services of the sort health insurance covers; a frequent consequence of deteriorated health is heightened costs of services variously called “informal care” or “social care.” And a much larger group of Americans—almost 300 million—continues to lack insurance to protect them from these prevalent financial risks, which amount to more than \$400 billion annually.¹

The need to either socialize the broader set of risks associated with deteriorated health or to pool them through private “long-term care insurance” (LTCI) is compelling. With good health, toileting, dressing, eating, moving around and other behaviors often called “activities of daily living” (ADLs) are relatively cheap. People generally perform the tasks themselves with extraordinary efficiency in non-market transactions. Many illnesses or conditions such as general old age that are not labeled as “illness” render people unable to perform these tasks themselves. They are forced either to forego them, further harming their health, or to procure services in substitute transactions. These substitutes may take place out of the market in ways that nonetheless create considerable expense such as the enlisting/dragooning of friends and family. They also take place in the market through hiring of workers at considerable expense, which in turn creates significant costs of monitoring performance.

The private insurance market has managed to transfer only a small portion of these risks. Long term care insurance, which generally reimburses insureds with more than a specified number of impaired ADLs

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1. Market transactions to hire services to help individuals with impaired ADLs that do not require “skilled” medical care—exceed \$200 billion, about the same economic cost of automobile accidents. Rough estimates of the “cost” of non-market care—what services would have cost had they been purchased on the market—are on the order of an additional \$250 billion.

for some portion of the expenses arising therefrom, has now existed in the United States for over three decades, but is still at most a \$15 billion industry. Fewer than seven million persons in the United States are currently protected by individual LTCI.

Thus, even as the United States grapples with providing better access to certain forms of “healthcare,” it has not yet succeeded in socializing the risk of needing long term care nor improving the functioning of a private risk transfer market. The states likewise have largely failed in this endeavor. Finance of long term care thus remains very much a frontier, one whose conquest becomes ever more imperative as the nation’s changing age distribution and the advances of modern medicine collaborate to increase the number of persons living for long periods of time in need of services to assist with ADLs.

American governments have, of course, made some efforts in the area. The Medicaid program pays for long term care at low rates for persons who are either already paupers or who have “spent down” to become paupers. It behaves somewhat like an LTCI policy in which the deductible is equal to most of one’s assets and the copay is equal to most of one’s income.² And, while the amount spent by federal and state governments under the Medicaid program is high—an estimated \$100 billion according to recent computations—these these payments represent less than half the materialized risk each year and require individuals often to endure degrading dependency on a government that saves money by meeting less than the full needs of the individuals.

The federal government, sometimes working in collaboration with the states, has created some tax and other incentives to enhance the private LTCI market. The ambition and success of these provisions in stimulating the market must be regarded as quite modest and, in some instances counterproductive. The Internal Revenue Code in section 7702B, for example, purports to stimulate purchase of “qualified” private LTCI by conditionally permitting a limited amount of LTCI premiums to be deducted from income while exempting policy payments from income taxation.³ The draconian requirements, however, Congress has imposed on these qualified LTCI policies to prevent them from becoming vehicles of undesired tax avoidance or deferral have made them unattractive to sophisticated buyers. The prohibition, for example, on cash surrender

2. Mark R. Meiners & Hunter L. McKay, *Private Versus Social LTC Insurance: Beware the Comparison*, 14 GENERATIONS 32 (1990).

3. LTCI premiums are deductible up to an age-adjusted and inflation adjusted amount, but only to the extent that those premiums plus those for conventional health insurance exceed 7.5% of income. Section 9013 of the Senate version of health care reform, passed on December 24, 2009, would increase the threshold to 10% starting in 2011. H.R. 3590, 11th Cong. § 9013 (1st Sess. 2009), 155 CONG. REC. S13,891 (2009) (hereinafter Senate bill).

values, forces an uninsurable risk of lapse onto policyholders who are mathematically compelled to overpay for their policies during the early years relative to actual risk. The prohibition against cash dividends effectively induces insurers to protect against unforeseen cost increases not by charging a predictable high premium and paying dividends when costs remain moderate—the model employed by many life insurance companies—but by reserving a frightening and not infrequently exercised unlimited right to raise premiums should costs increase or perhaps merely if the insurer can just get away with it. And the requirement that two ADLs be impaired before benefits can be paid forces an incomplete transfer of risk.

The Long Term Care Partnership program described in section 1917 of the Social Security Act indirectly stimulates purchase of private LTCI in participating states by letting owners of these policies qualify for Medicaid long term care with a greater value of non-exempt assets. But, the program has had limited success perhaps because there were already ways for the sophisticated to shelter income and assets, because Medicaid-provided long term care was sufficiently unattractive that greater access to it proved an insufficient reward, and because it did essentially nothing to improve the performance of the private insurance market it intended to stimulate.⁴

Finally, as of this writing, the Senate and House have passed, each as Title VIII of their mammoth healthcare reform bills,⁵ the Community Living Assistance Services and Supports Act (CLASS). CLASS establishes a federal LTCI program available without medical underwriting to those who have worked for at least three years since purchasing a policy and who have paid premiums for at least five years. Benefits will range from an inflation-adjusted \$50 up to an administratively determined and inflation-adjusted \$100 to \$300 depending on the number of ADLs impaired. The program purports to bar use of any external government funds to pay benefits.

While the proposed CLASS act would create an important outpost on the long term care frontier, several factors reduce the probability of its long term success. First, because the federal government reserves the right to raise premiums on most enrollees should it find those premiums insufficient, CLASS policies may prove as unattractive as their private counterparts containing similar provisions. Cynics may see expected low initial premiums charged by the CLASS program for the first ten years as

4. Stephen A. Moses, *The Long-Term Care Partnership Program: Why It Failed and How to Fix It*, in WHO WILL PAY FOR LONG TERM CARE?: INSIGHTS FROM THE PARTNERSHIP PROGRAMS 207 (Nelda McCall ed. 2001).

5. See Senate bill, *supra* note 3 (Senate bill); H.R. 3962, 111th Cong., (1st Sess. 2009), 155 CONG. REC. H12693 (2009) (House bill). Both these bills amend the Public Health Service Act.

simply an accounting slight-of-hand by which the government (a) reduces the apparent cost of healthcare reform by teasing money from taxpayers under the guise of an insurance program but (b) fully intends to raise rates (thereby inducing lapse) when benefits need to be paid as policies mature. Second, the absence of medical underwriting, while of course a benefit to those likely to need long term care, poses a significant risk that the premiums will need to increase beyond expectations and possibly throw the program into an adverse selection death spiral, particularly as genetic and medical tests make the individual need for long term care more predictable. Third, the \$50 per day benefit will prove inadequate to cover most of the expenses of many persons needing long term care and will thus have only slightly diminished the need either to repair private LTCI markets or socialize the remaining risk.

A number of steps, however, could make the private market more robust. To repeat many prior cries in the wilderness, private LTCI policies remain stunningly difficult to understand and yet more difficult to compare. Numerous studies report widespread consumer ignorance and confusion about the contents of long term care policies. In most states, insurance companies are largely free to include as many complex features in their policies as they wish; few have attempted creating any standards as, for example, exist with Medicare Supplemental Insurance (Medigap) in which elderly consumers sacrifices the benefits of complete customization in favor of a limited menu of comparable policies. Although the health reform bills currently pending in Congress may create “health insurance exchanges” that are touted as increasing the transparency of conventional health insurance purchasing, neither of the proposals extend the exchanges to LTCI. Nor are there presently any readily available calculators that would permit a 52 year old male in good health to determine or even approximate the actuarially fair price of a long term care policy with a 6 month waiting period, \$250 per day of benefits with 4% compound inflation or to compare the value provided by that policy to one with a three month waiting period, \$200 per day of benefits and 3% compound inflation.

Little has been done at either the federal or state levels to address the difficulty private insurers have of actually writing LTCI where the scope and magnitude of future risks are so difficult to discern. LTCI is not like its much older cousin, life insurance where risks are now modeled well enough that regulators can fairly well determine the adequacy of premiums. LTCI, by contrast, is in its actuarial infancy. Neither governments nor private bodies have been keeping statistics for centuries about ADL impairment—and certainly not on the weekly basis needed to model contemporary LTCI policies. And, critically, as discussed further below, the dynamics of medicine, the difficulty of predicting how LTCI will coordinate with public insurance schemes, and the difficulty of predicting the meaning of

contractual terms about “activities of daily living” make it extraordinarily difficult to use limited past statistics and actuarial models to make the needed predictions benefit obligations thirty and forty years hence, particularly where the LTCI policies contain complex features such as “bed reservation” benefits cover more than one person. The efflorescence of long term care risk created by the recent advances in medicine and changes in family mores has given rise to a premature birth of long term care insurance.

The inability of regulators to accurately assess LTCI pricing has serious consequences for the ability of a for-profit market to flourish. If state insurance regulators place too high a floor on LTCI pricing, the product is almost fatally unattractive and vulnerable to being undercut if federally sponsored insurance such as CLASS comes to pass. If insurance regulators place too low a floor on pricing, however, and individuals are as unable as regulators to discern a reasonable price, clever or self-deceived insurers can capture the market by selling cut rate policies. These insurers then either externalize the insolvency risk substantially on policyholders and state guarantee funds or hurt policyholders and increase lapse rates by raising premiums years after the policy has been issued. Indeed, such rate increases are almost invited by current “contingent non-forfeiture” laws that generally permit long term care insurers to raise premiums by up to 200% without any adverse consequence. These laws further permit insurers who raise rates beyond the “caps”—e.g. a 300% increase—to expropriate wealth from the policyholder by giving those who refuse to pay the higher premiums a policy with a maximum benefit that is no longer the contractually negotiated amount but only the generally lower amount of premiums thus far paid in.⁶

Third, little has been done at the federal or state level to remove the severe problem of lapse risk that plagues current LTCI policies and renders them unattractive to knowledgeable purchasers. As it stands, potential LTCI purchasers face a dilemma. They can always wait until they are reasonably sure they will have enough money to pay the premiums and they are sure that the insurance company has an accurate enough model of benefits that it will not need to raise premiums. These prospective insureds minimize lapse risk but (a) pay high premiums; (b) incur the risk of “premature” long term care; and (c) incur the risk of becoming “uninsurable” while they are deferring purchase. Prospective insureds can buy a policy when they are relatively young and reduce these downsides of deferred purchase but in doing so run two risks that the policy will not be in

6. See Seth J. Chandler, *Modeling Long Term Care Insurance*, available at <http://library.wolfram.com/infocenter/Conferences/7442/>, (last visited Dec. 31, 2009) (containing presentations and links to related materials)

force when needed. Unless these “early adopters” are among the very few who purchase non-forfeiture benefits at considerable expense, they face a heightened risk that a time will come when adverse financial developments (including divorce) will force them to let a yet-not-paid-up policy lapse. If lapse indeed occurs, the policyholder will have grossly overpaid for the policy in the same way lapsing life insurance policyholders overpay when statutory “non-forfeiture” laws are not in effect. Moreover, there is substantial risk that the insurer will go insolvent during a 50 year time span between purchase of a policy and the time when it must pay benefits of uncertain magnitude.

Just as those advocating substantial healthcare reform in recent years have pointed to the apparently greater success of other nations in both curbing costs and improving access, so too may they contrast other nation’s success in providing long term care with the failings of the United States. The fundamental problem faced by the United States (and the rest of the world) in developing either a private LTCI market or creating a public one is, curiously, one of medical advance. Insurance works best when the pooled risks are uncorrelated such that the occurrence of an insured event befalling one insured or even a group of insureds conveys little information about the likelihood or magnitude of a covered event befalling another insured or group of insureds. The unpredictability of medical advances and the dependency of long term care benefits on it mean that the law of large numbers does not apply as well to long term care as to many other forms of insurance. Medical advances enhancing longevity can create a typhoon of long term care needs. Cures for Alzheimer’s disease or abilities to reverse the effects of stroke can, on the other hand, reduce the need for long term care. And no one today can say which effect will predominate.

Problems with an insurance market are, of course, no obstacle to the government provision of long term care. Government can always view long term care as a form of welfare. But if the recent debates about conventional healthcare reform prove anything it is that, unlike some but not all industrial democracies,⁷ we are a long way from mass socialization of long term care risk or even conceiving that unmitigated longevity could have adverse consequences. Until those conceptions change, we face a hostile though not impossible frontier of trying to improve an LTCI market that enhances the dignity and function of persons whose health no longer permits them to perform the activities of daily living.

7. See John Creighton Campbell & Naomi Ikegami, *Long-Term Care Insurance Comes to Japan*, 19 HEALTH AFFAIRS 26 (2000); Allison Evans Cuellar & Joshua M. Wiener, *Can Social Insurance For Long-Term Care Work? The Experience of Germany*, 19 HEALTH AFFAIRS 8 (2000); AARP International, *European Experiences with Long-Term Care*, available at http://www.aarpinternational.org/usr_doc/ldrstudy_longterm_030507.pdf, last visited Dec. 31, 2009 (October 2006 AARP European Leadership Study).