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Long-Term Care Insurance: An Endangered Species

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I. INTRODUCTION

In our modern society, people are living longer[1] and the ability to afford long-term health care for this prolonged period has become increasingly difficult.[2] As a result, the issues of long-term care have become more challenging to address. Long-term care insurance (LTCI) was created to help assist with the affordability of long-term care.[3] Despite the intentions of its creators, LTCI has not proven to be a financially viable method of handling long-term care costs and therefore may cease to exist as discussed below.[4]

This article will discuss the extensive nature of long-term care and the magnitude its costs represent. Next, this article will discuss the explosive rise in long-term care costs and affordability. This article will then discuss the role LTCI plays to help mitigate these costs and address the obstacles private insurance companies face in providing LTCI to the marketplace. In addition, this article will discuss the goals and limitations of the government's answer to long-term care affordability: the CLASS Act. In this discussion of both the private and public sectors, this article will highlight how financial viability has proven to be elusive in both models of

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1. *See* LAURA B. SHRESTHA & ELAYNE J. HEISLER, CONG. RESEARCH SERV., RL32701, THE CHANGING DEMOGRAPHIC PROFILE OF THE UNITED STATES 14 (2011) [hereinafter THE CHANGING DEMOGRAPHIC PROFILE] http://www.fas.org/sgp/crs/misc/RL32701.pdf.

2. Karin C. Ottens, *Using Tax Incentives to Solve the Long-Term Care Crisis: Ineffective And Inefficient*, 22 VA. TAX REV. 747, 753 (2003).

3. Joshua M. Weiner et al., *Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance*, 8 ELDER L.J. 57, 57-58 (2000).

4. *See infra* Parts IV & V.

LTCI.

II. THE DEFINITION AND SCOPE OF LONG-TERM CARE

Long-term care constitutes a variety of services that include medical and non-medical care to meet health or personal needs over a long period of time.[5] Non-medical care is assistance with basic personal or household tasks of everyday life.[6] These tasks are called activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs), and include activities such as bathing, dressing, taking medication, preparing meals and eating.[7] Long-term care can be provided in various settings, e.g., in the home, in the community, in assisted living facilities or in nursing homes.[8] Individuals who require long-term care include the elderly, the disabled, and those suffering from chronic debilitating conditions such as Alzheimer's and paralysis.[9]

Of the various populations that require long-term care, the largest group is the elderly (sixty-five and older).[10] With the aging of the seventy-six million Baby Boomers, it is anticipated that the elderly will continue to make up a growing percentage of the U.S. population and the amount of money required to meet their long-term health care needs will increase.[11] In 2012, about nine million men and women over the age of sixty-five needed long-term care.[12] By 2020, twelve million Americans age sixty-five and

5. KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID'S ROLE IN MEETING THE LONG-TERM CARE NEEDS OF AMERICA'S SENIORS 1 (Jan. 2013), http://www.kff.org/medicaid/upload/8403.pdf.

6. *Id.*

7. *Id.*

8. U.S. Dep't of Health and Human Servs. (HHS), *Long-Term Care*, http://www.healthcare.gov/using-insurance/medicare-long-term-care/long-term-care/#longterm (last visited Feb. 18, 2013).

9. Ottens, *supra* note 2, at 748-749.

10. *Id.* at 751-752.

11. *Id.*

12. HHS, *What is Long-Term Care?*, [hereinafter What Is Long Term Care?]

older will need long-term care.[13] Of this group, it is expected that approximately 43% will spend some time in a nursing facility.[14] "About 10 percent of the people who enter a nursing home will stay there five years or more."[15] None of this care is free – it will come at the expense of the individual (private insurance and out-of-pocket expenditures) or the taxpayer (government program).[16]

As a subset of the elderly, those individuals aged eighty-five and older are most likely to need long-term care.[17] This age group is expected to reach seven million by 2020 and to double to fourteen million by 2040.[18] The aging of the Baby Boomer generation, coupled with the increase in life expectancy, creates a need for long-term care that is expected to grow exponentially.[19] Consequently, the costs of long-term care will also grow exponentially. It can be expected that increase in long-term care costs will create a tremendous financial burden on society in the future.

III. THE RISE AND AFFORDABILITY OF LONG-TERM CARE COSTS

The growing need of long-term care hinges on its affordability. The cost of health care has risen precipitously over the past three decades.[20] "The share of GDP [Gross Domestic Product] devoted to health care spending grew from 9% in 1980 to 16% in 2008."[21] In 2008, the per capita

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http://www.medicare.gov/longtermcare/static/home.asp (last updated Aug. 3, 2012).

13. *Id.*

14. Ottens, *supra* note 2, at 751.

15. What Is Long-Term Care?, *supra* note 12.

16. *See* HHS, *Paying for Long-Term Care*, http://www.medicare.gov/longtermcare/static/home.asp (last updated Aug. 3, 2012).

17. Ottens, *supra* note 2, at 751-52.

18. *Id.*

19. *See* U.S. Soc. Sec. Admin., *Life Expectancy for Social Security*, http://www.ssa.gov/history/lifeexpect.html (last modified Jan. 17, 2013).

20. KAISER FAMILY FOUNDATION, SNAPSHOTS: HEALTH CARE COSTS, (April 28, 2011) [hereinafter HEALTH CARE COSTS] http://www.kff.org/insurance/snapshot/oecd042111.cfm.

21. *Id.* This means that sixteen cents of every dollar changing hands in the United States is spent on health care.

expenditure in the U.S. was $7,538; nearly double the average of the top fifteen developed countries.[22] The amount spent on health care is expected to reach nearly $4 trillion by 2015, or 20% of GDP.[23]

The Department of Health and Human Services (HHS) estimates that about 70% of Americans over age sixty-five will need long-term care support.[24] About one-third of all Americans will spend some time in a nursing home during their lives.[25] The average cost of living in a nursing home is catastrophic for the average middle class American: $72,000 per year.[26] Assisted living environments that provide long-term care at a less intense level, average $38,000 per year.[27] Although only 14% of long-term care recipients live in institutions like nursing homes and assisted living facilities, the cost to care for them makes up 70% of all expenditures on long-term care in the United States.[28] The other 86% of long-term care recipients, comprised of disabled children and adults, as well as some elderly persons, receive their care in the home.[29]

Median income may serve as a proxy for assessing affordability.[30]

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22. *Id.* In 2008, the per capita expenditure for the top fifteen developed countries ranged from $2,729 (Japan) to $7,538 (U.S.). *Id.* The average per capita expenditure of these fifteen countries is about $3,922. *Id.*

23. Brendan W. Miller, *Your Money or Your Lifestyle!: Employer's Efforts to Contain Healthcare Costs-Lifestyle Discrimination Against Dependents of Employees?*, 5 IND. HEALTH L. REV. 371, 373 (2008).

24. HHS, Who Needs Care?, http://www.longtermcare.gov/LTC/Main_Site/Understanding/Definition/Know.aspx (last visited Mar. 24, 2013).

25. Gary A. Simon, *Can Long-Term Care Insurance Be Fixed?*, 37 J. HEALTH CARE FIN. 51, 51 (2010).

26. *See* KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID AND LONG-TERM CARE SERVICES AND SUPPORTS 1 (Oct. 2010), http://www.kff.org/medicaid/upload/2186-07.pdf.

27. *Id.*

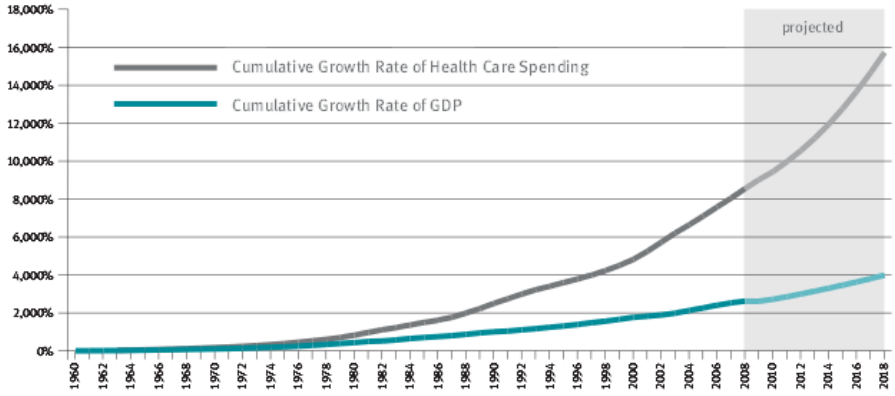
28. *Id.* Total long-term care expenditures total $177.6 billion. *Id.* Total nursing home care expenditures total $124.9 billion and that is roughly 70% of total long-term care expenditures. *Id.*

29. *Id.*

30. *See generally* DAVID A. VANDENBROUCKE, U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT, HOUSING AFFORDABILITY DATA SYSTEM 7-8 (2011).

Median income grew about 15% between 1980 and 2008.[31] During this same time period, however, the share of GDP spent on health care grew about 78%.[32] This far outstripped the growth rate of median income. If these dual rates of growth persist, health care will become increasingly more unaffordable in the future. To further illustrate, the per capita expenditure on health care during this period grew roughly 900% as seen in the graph below.[33]

Figure 1: Cumulative growth rates of GDP and health care spending: United States, 1960-2007 and projected for 2008-2018



Source: Office of the Actuary, Centers for Medicare and Medicaid Services, 2008[34]

The affordability of long-term care was and continues extending beyond the reach of the average American.[35] This precipitated the creation of LTCI.[36] Its role,

31. U.S. Dep't. of Commerce, *The 2012 Statistical Abstract - Money Income of Households – Median Income by Race and Hispanic Origin in Current and Constant (2009) Dollars*, http://www.census.gov/compendia/statab/ (last visited Mar. 16, 2013). In 1980, the median income was $43,892 and in 2008, the median income was $50,112. This represents an approximate 15% increase. *Id.*

32. HEALTH CARE COSTS, *supra* note 20. In 1980, 9% of GDP was dedicated to health care spending and in 2008, 16% of GDP was dedicated to health care spending. *Id.* This represents a 78% increase. *Id.*

33. SOC. SEC. ADVISORY BD., THE UNSUSTAINABLE COST OF HEALTH CARE 1 (Sep. 2009) [hereinafter UNSUSTAINABLE COST] http://www.ssab.gov/documents/TheUnsustainable CostofHealthCare_graphics.pdf. The cumulative growth rate of health care spending in 1980 was about 1,000%. *Id.* In 2008, the cumulative growth rate of health care spending increased to about 9,000%. *Id.* This represents about a 900% total increase. *Id.*

34. *Id.*

as is true for any insurance product, was to make long-term care affordable and attainable by managing and distributing the costs associated with it.[37] Unfortunately, this task proved to be unrealistic as discussed below.

IV. LTCI IN THE PRIVATE SECTOR

Personal financing and Medicaid have historically served to meet the costs of long-term care.[38] Those who could afford it paid for their own long-term care expenses out-of-pocket, while those who could not afford it relied on Medicaid for their long-term care needs.[39] More recently, the rising cost of health care has made it unaffordable for many individuals who do not qualify for Medicaid to personally finance their health care needs.[40]

Insurance companies in the private sector introduced LTCI in an attempt to bridge this growing financial shortfall that individuals faced.[41] This product was meant to enable individuals to afford the growing costs of their health care.[42] Insurance companies modeled LTCI on traditional health insurance metrics such as current health care costs, the anticipated rates of increase in these costs, historical policy lapse rates, historical yield on investments, and other operating expenses.[43]

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35. Weiner et al., *supra* note 3.

36. *Id.* at 58.

37. *See* Jeffrey R. Brown & Amy Finkelstein, *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market* 5-6 (Nat'l Bureau of Econ. Research, Working Paper No. 10989, 2004).

38. *See* Weiner et al., *supra* note 3 at 59.

39. HHS, *Eligibility*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html (last visited Mar. 16, 2013). To be eligible for Medicaid, an individual must have a low income and meet a federal or state recognized eligibility group, such as children, the elderly, or those with disabilities. *Id.*

40. Lawrence A. Frolik, *An Essay on the Need for Subsidized, Mandatory Long-Term Care Insurance*, 21 NOTRE DAME J.L. ETHICS & PUB. POL'Y. 517, 521 (2007).

41. Seth J. Chandler, *Long Term Care: The Next Healthcare Frontier*, 19 ANNALS HEALTH L. 19, 19-20 (2010). LTCI was introduced as early as the 1970's. *Id.*

42. *Id.*

43. Comment, *Cost and Coverage of Industrial Life Insurance*, 61 YALE L.J. 46, 50 (1952). Policy lapse rate refers to the rate at which insurance policy holders stop paying their premiums thereby allowing their policy to lapse. *Id.* at 54. Once this occurs, an insurance company is released from any payment obligations and retains all premiums paid to date. Sharo M. Atmeh, *Regulation Not Prohibition: The Comparative Case Against the Insurable Interest Doctrine*, 32 NW. J. INT'L L. AND BUS. 93, 134 (2011).

In addition to the aforementioned criteria, insurance companies accounted for circumstances like the present and future cognitive capacity of the insured.[44] These capacities may be compromised, for example, in people suffering from Alzheimer's and dementia.[45]

The private LTCI market initially grew slowly due to low participation and high premiums.[46] Eventually, some insurance companies felt it was not possible to offer LTCI and remain profitable owing to an increase in anticipated costs, a decrease in policy lapse rates, and a decrease in rates of return.[47] It is important to remember that in addition to accomplishing the beneficial outcomes that LTCI affords, the underlying goal of insurance companies is profitability.[48] As a result, ten out of the top twenty insurance companies exited the LTCI market.[49] Other companies that chose to continue to offer LTCI have made continuous changes to their policies by decreasing discounts and increasing premiums.[50] The likelihood of private insurance companies to continue selling LTCI is questionable in a world where the ability to offer LTCI and remain profitable is diminishing.

V. LTCI IN THE PUBLIC SECTOR

Given the growing elderly population and rising costs of health care, Medicaid faces its own fiscal predicament as these factors compromise the government's ability to maintain the current level of benefits.[51] As many elderly persons cannot afford private long-term care insurance and also cannot afford to pay the high costs

44. Ottens, *supra* note 2, at 749.
45. *Id.*
46. Simon, *supra* note 25.
47. Howard Gleckman, *What's Killing the Long-Term Care Insurance Industry*, FORBES, Aug. 29, 2012. In 2010, Met Life, one of the biggest players in the LTCI market, decided to no longer offer the product. Ron Lieber, *When A Safety Net Is Yanked Away*, N. Y. TIMES, Nov. 12, 2010. In 2012, Unum discontinued selling LTCI and was soon followed by Prudential Insurance. Gleckman, *supra* note 47.
48. Whitney R. Maudlin, *Good Business/Bad Faith: Why the Insurance Industry Should Adopt a Good Faith Model*, 44 TORT TRIAL & INS. PRAC. L.J. 151, 151 (2008).
49. Kelly Greene, *Long-Term Care: What Now?*, WALL ST. J., Mar. 9, 2012.
50. Gleckman, *supra* note 47.
51. Diane L. Dick, *Tax and Economic Policy Responses to the Medicaid Long-Term Care Financing Crisis: A Behavioral Economics Approach*, 5 CARDOZO PUB. L. POL'Y & ETHICS J. 379, 383 (2007).

of long-term care, they turn to Medicaid.[52] It is true, however, one cannot be a Medicaid beneficiary without meeting certain low-income and asset criteria.[53] Thus, many people, including the elderly, make gifts of property to others and voluntarily impoverish themselves in order to meet these criteria.[54] The elderly make up a considerable portion of Medicaid's beneficiaries.[55] In 2004, more than one-third of total Medicaid dollars were spent on long-term care for the elderly.[56] The number of elderly persons will only drastically increase as the Baby Boomers continue to age and this demographic change jeopardizes the ability of Medicaid to remain financially solvent.[57] As more elderly people become Medicaid eligible, unfortunately, the available funds will be severely inadequate.[58]

The federal government decided to introduce its own version of LTCI as a vehicle to work in conjunction with Medicaid to help meet the rising costs of long-term care.[59] On March 23, 2010, President Barack Obama signed the Community Living Assistance Services and Supports Act (CLASS Act) into law as part of the Patient Protection and Affordable Care Act.[60] The federal government intended the CLASS Act to be a voluntary, national long-term care insurance option for employees via their employer.[61]

The CLASS Act was designed to provide a cash benefit to individuals with functional limitations for the purchase of non-medical services and supports[62]

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52. *Id.* at 382.
53. *Id.*
54. *Id.*
55. *Id.* at 383.
56. *Id.*
57. *Id.*; *See generally* Symposium, *Market Principles: The Right Prescription for Medicaid*, 17 STAN. L. & POL'Y. REV. 33, 34 (2006). (This article references the state of Florida, however, the Medicaid situation in Florida can be extrapolated to the Medicaid situation across the nation.)
58. Joshua Tenzer, *Reaching the Final Frontiers in Medicaid Managed Care*, 62 N.Y.U. ANN. SURV. AM. L. 329, 345 (2006).
59. KAISER FAMILY FOUNDATION ON HEALTH REFORM, HEALTH CARE REFORM AND THE CLASS ACT 1 (Apr. 2010), [hereinafter CLASS ACT] http://www.kff.org/healthreform/upload/8069.pdf.
60. *Id.*
61. 42 U.S.C. § 3201 (2010); 42 U.S.C. § 3204(a)(1) (2010).
62. Examples of community living services and supports include housing modification,

necessary to maintain community residence.[63] The goal of the legislation was to provide workers with a financing alternative for long-term care that supports community living and does not require people to turn to Medicaid, an option that would only drive Medicaid costs up.[64]

The program was financed through monthly premiums paid by voluntary contributions of working individuals.[65] An individual's monetary benefit was not subject to any lifetime or aggregate limit.[66] Equally important to note is that only the payer was eligible for benefits.[67] This was in contrast to many employer-offered, traditional health insurance plans that may include spouses and dependents as beneficiaries.[68] The CLASS Act mandated that the program be self-funded over a seventy-five year period and not require any monies from taxes.[69]

One of the privileges that private insurance companies enjoy is to decide who they want to insure, and to impose limits on which conditions would be covered, for what period of time, and the maximum amount they are willing to pay in benefits.[70] The CLASS Act, while having some latitude in setting its own parameters, differed in one significant aspect: it could not turn anyone away that met the minimum qualifications of eligibility, i.e., being a working individual.[71]

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assistive technologies, personal assistance services and transportation. CLASS ACT, *supra* note 59, at 2.

63. *Id.* at 1; 42 U.S.C. § 3201(1) (2010).

64. *See* 42 U.S.C. § 3201.

65. CLASS ACT, *supra* note 59, at 2. To qualify for benefits, individuals had to be at least eighteen-years-old and have contributed monthly premiums to the program for at least five years. Additionally, individuals must have been unable to perform multiple ADLs or had a cognitive disability that required supervision to perform daily tasks, e.g. Alzheimer's. Eligible individuals would receive a cash benefit based on the degree of their disability or impairment and averaging no less than $50 a day. The Secretary of Health and Human Services set the benefit amount relative to the functional limitation. *Id.*

66. 42 U.S.C. § 3203(a)(1)(D)(iv).

67. CLASS ACT, *supra* note 59, at 2.

68. Nat'l Ass'n of Ins. Commissioners, *Health Insurance Open Enrollment: Choosing the Best Option for You and Your Family* (Oct. 2008), http://www.naic.org/documents/consumer_alert_health_insurance_open_enrollment.htm.

69. 42 U.S.C. § 3208(a)-(b) (2010).

70. *See* Nat'l Ass'n of Health Underwriters, *Consumer Guide to Individual Health Insurance* (2013) http://www.nahu.org/consumer/IndividualInsurance.cfm.

71. Morris Klein, *The New Class Act*, 7 NAELA J. 35, 37-38 (2011).

As a result, workers that could not obtain or afford LTCI in the private sector would choose the public option.[72] More importantly, because participation in the CLASS program was voluntary, it was likely that younger, healthier workers would opt out of paying the premium.[73] Therefore, those workers most likely to need the CLASS program would be its sole enrollees representing the most risk and requiring a greater amount of paid benefits.[74]

Congress legislated two criteria for the CLASS Act: voluntary participation by working individuals and a self-funded program for seventy-five years without any tax dollars.[75] These mandates created a challenging environment within which the program had to operate and remain viable.[76] Consequently, nineteen months after the passage of the CLASS Act, HHS concluded that the CLASS Act was not financially sustainable.[77] On January 2, 2013, Congress repealed the CLASS Act.[78] The federal government clearly recognized that this version of LTCI was not a financially viable solution to address the nation's long-term care needs.

VI. LTCI AND ITS INHERENT PROBLEMS

LTCI began as a promising means to contain escalating long-term care costs, but has not met with the success that was originally anticipated.[79] LTCI may not be a bad product by nature, however, two main factors are leading to its eventual demise. First, the limitations of the structures of both private and public LTCI and, second, the escalating long-term care costs.[80]

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72. Alexander N. Daskalakis, *Public Options: The Need for Long-Term Care, Its Costs, and Government's Attempts to Address Them*, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 181, 201 (2011).
73. *Id.* at 203.
74. *Id.*
75. CLASS ACT, *supra* note 59, at 2.
76. Memorandum from Kathy Greenlee, *CLASS Adm'r to Kathleen Sebelius, Sec'y Health and Human Serv*. (Oct. 14, 2011), *available at* http://aspe.hhs.gov/daltcp/reports/2011/class/CLASSmemo.shtml.
77. *Id.*
78. American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 642 (2013).
79. Gleckman, *supra* note 47.
80. *See supra* Parts III, IV & V.

One way to help understand this dichotomy is to envision a swimming pool as representative of an LTCI instrument. The pool has one intake pipe, and two outlet pipes to regulate the water level. The purpose of these three pipes is to maintain an adequate water level within the pool so that it does not run dry. The intake pipe represents funding for the LTCI instrument. The first outlet pipe, and by far the larger of the two, represents the instrument's financial obligations. The second outlet pipe represents the cost associated with administering the LTCI instrument. If the drainage rate exceeds the fill rate, the pool will eventually run dry. The current problem that the LTCI universe faces is precisely this: expenditures are far exceeding funding. Therefore, the LTCI model is not financially viable in its current avatar. In an effort to remedy the situation, the funding needs to increase, expenditures need to decrease, or a combination of both needs to occur.

VII. CONCLUSION

On a macro level, the issue of long-term care should be addressed with regard to both its cost and the ability of individuals to cover that cost. The exponential growth in the cost of health care severely handicaps the individual and overburdens the system.[81] At no other time since the inception of Medicaid, have health care costs escalated as fast as they have today.[82] LTCI was a measure introduced to help mitigate the high costs of long-term care.[83] Perhaps some consideration should be paid to the task of containing the elevated costs of health care versus solely trying to pay for them. The eventual and necessary goal is to ensure that the "LTCI pool" does not run dry. By entertaining *both* sides of the problem, it may afford a solution that is more attainable. Unfortunately, LTCI has not yet proven itself to be the panacea that it was originally touted to be.

81. Weiner et al., *supra* note 3, at 58.
82. *See* UNSUSTAINABLE COST, *supra* note 33.
83. Chandler, *supra* note 41.