Marquette Elder's Advisor

Volume 15
Issue 1 *Fall*

Article 4

Confronting the Elder Care Crisis: The Private Long-Term Care Insurance Market and the Utility of Hybrid Products

CONFRONTING THE ELDER CARE CRISIS: THE PRIVATE LONG-TERM CARE INSURANCE MARKET AND THE UTILITY OF HYBRID PRODUCTS

Peter Kyle*

INTRODUCTION

Frequently lost in the debate over healthcare reform are the challenges posed by long-term care in the United States. Although the CLASS Act[1] – the long-term care component of the Patient Protection and Affordable Care Act[2] – represented nearly half the savings attributed to healthcare reform,[3] the CLASS program remained in the background of the healthcare discussion until the program's actuaries ultimately determined it was unsustainable and halted implementation.[4] The CLASS Act was one of many recent failed attempts to expand coverage of long-term care in the United States. In many respects the CLASS program failed because the program's structure displayed disturbingly little understanding of the challenges faced by

* B.A., English, Washington & Lee University, 2009; J.D., William & Mary Law School, 2013; M.P.P, Thomas Jefferson Program in Public Policy at the College of William & Mary, 2013. The author is deeply grateful to Professor Stephen Carney for his guidance and inspiration. He is also especially thankful for his family's unwavering support and encouragement.

1. Community Living Assistance Services and Supports Act ("CLASS Act"), Pub. L. No. 111-148, 124 Stat. 148 (2010).

2. The Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010).

3. Estimated to be $86 billion. *See* Congressional Budget Office, *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010: Testimony Before the Subcomm. On Health, Committee on Energy and Commerce*, 111th Cong. 25 (2011) (statement of Douglas W. Elmendorf, Director, CBO).

4. Louise Radnofsky, *Long Term Care Gets the Ax*, WALL ST. J., Oct. 15, 2011, http://online.wsj.com/article/SB10001424052970204002304576631302927789920.html (quoting Health and Human Services Secretary Sebelius as stating, "I do not see a viable path forward for Class implementation at this time.").

private long-term care insurers. In short, the CLASS program was doomed to fail, and in its absence, the urgent need to find a solution to the crisis in long-term care provision remains.

Some argue that the right mixture of benefits or an individual mandate could have saved the CLASS program,[5] but regardless of the merits of this argument, the political inertia in support of a comprehensive public program has long since passed and will not soon return.[6] An effective solution to the long-term care crisis must therefore substantially incorporate the private sector and spur the growth of private long-term care policies. Efforts to stimulate growth in the private sector have thus far achieved only modest success, but they also have faced significant barriers and in some respects have suffered from a lack of boldness. One theoretically and practically appealing avenue of expanding private coverage of long-term care that has not been sufficiently explored is the development and regulatory promotion of hybrid insurance policies that couple long-term care insurance with annuities and life insurance plans. In order to build an understanding of the utility of this potential solution, Part one begins by underscoring the demographic and structural challenges posed when insuring against the risk of long-term care. Part two then proceeds by highlighting the instructive shortcomings of attempts in the past decade to expand long-term care insurance both through private and public provision. Finally, Part three explores the viability of hybrid policies to create the right blend of incentives that will induce expansion of long-term care insurance coverage. Through this analysis, the potential utility of hybrid products becomes exceedingly clear,

---

5. Rep. Ted Deutch, *CLASS Act Tackles Problems of* Aging, POLITICO , Nov. 2 2011, http://www.politico.com/news/stories/1111/67429.html ("even as my Republican colleagues hail this as proof that the Affordable Care Act will not work, what they don't realize is that it shows that the opposite is true. CLASS was included in the Affordable Care Act as long as it could be financially self-sustaining. The administration's difficulty achieving that goal is proof that individual insurance mandates, first championed by Republicans, all work.").

6. Especially considering the increasingly dire straits of the nation's entitlement programs. CONG. BUDGET OFF., THE LONG-TERM BUDGET OUTLOOK, 3-4 figs.1-1 & 1-2 (2009), *available at* http://www.cbo.gov/ftpdocs/102xx/doc10297/06-25-ltbo.pdf.

along with the need to promote their growth through a more favorable tax and regulatory environment.

LONG-TERM CARE IN THE UNITED STATES

DEFINING LONG-TERM CARE

Conceptually, long-term care is very different from traditional healthcare. Long-term care does not seek to diagnose or treat an illness, but rather focuses on meeting the daily needs of the disabled.[7] Of the three aims of healthcare – to cure, to relieve, and to comfort – comfort represents the primary goal of long-term care services.[8] Long-term care encompasses a range of services that can include medical care – or skilled nursing care – but consists chiefly of assistance with basic "activities of daily living" (ADLs).[9] These activities typically include eating, dressing, bathing, and using the bathroom, as well as other necessary tasks such as cooking, housework, and shopping.[10] An insured claimant typically files for benefits when he cannot complete two of the enumerated tasks included in his particular policy.[11] Though coverage levels differ, the context of long-term care delivery can range from nursing home facilities and assisted living settings to home or community-based care, and the providers of such care can vary from for-profit agencies and self-employed individuals to non-profit agencies and family members.[12] In recent years, community-based care – which

7. *See* Mary F. Harahan & Robin I. Stone, *Who Will Care?: Building the Geriatric Long-Term Care Labor Force*, *in* BOOMER BUST?: ECONOMIC AND POLITICAL ISSUES OF THE GRAYING SOCIETY 233, 233-34 (Robert B. Hudson ed., 2009).

8. *See* Alan M. Garber, *To Comfort Always: The Prospects of Expanded Social Responsibility for Long-Term Care, in* INDIVIDUAL AND SOCIAL RESPONSIBILITY 143, 143 (Victor R. Fuchs ed., 1996).

9. *See* Moriah Adamo, et al., *Paying for Long-Term Care*, 83 N.Y. ST. B.J. 66, at 71 n. 45 (2011); Richard W. Johnson & Cori E. Uccello, *Is Private Long-Term Care Insurance the Answer*?, CENTER FOR RETIREMENT RESEARCH AT BOSTON COLLEGE, 2 (2005); Elizabeth P. Allen, *A Fast-Growing Area of Concern: Long-Term Care Insurance Litigation*, 45 DRI FOR DEF. 21, 21 (2003).

10. *See* Johnson, *supra* note 9, at 1.

11. *See* Johnson, *supra* note 9, at 3.

12. *See* Harahan, *supra* note 7, at 234 ("Long-term care services are delivered in

includes respite care, home health care from a nurse or physical therapist, home meal preparation or delivery, day care programs, and many other associated services – has been increasingly advocated in light of the comfort and stability it provides.[13] Of course, however, provision of these services requires greater flexibility in the benefits provided by insurance policies and can therefore lead to a concomitant increase in the policy's price.

COST OF CARE

Although long-term care is often unskilled, the costs of such care have risen exponentially, paralleling the traditional healthcare market. In 2004, the average daily rate for a private room in a nursing home was $192 and the cost for a semi-private room was nearly as much at $169 per day, amounting respectively to $78,100 and $61,700 each year.[14] These costs, moreover, are only expected to rise in coming years. By 2030, the average annual cost of a nursing home stay is expected to increase to $97,000.[15] On the other end of the spectrum of cost, home health services still represent a daunting burden to many in the aging population. In 2004, the average hourly rate of a home health aide providing assistance with activities of daily living was $18 per hour.[16] Although this rate may seem modest upon first impression, because assistance is typically required on

residential facilities such as nursing homes, assisted living facilities, board and care homes, and other residential care settings; by home- and community-based service organizations, including home health and personal care agencies, home care agencies, and adult day care centers; and by self-employed individuals hired directly by consumers and their families.").

13. *See* Garber, *supra* note 8, at 146; *See generally* Andrew I. Batavia, *The Growing Prominence of Independent Living and Consumer Direction as Principles in Long-Term Care: A Content Analysis and Implications for Elderly People with Disabilities*, 10 ELDER L.J. 263, 263 (2002) ("Recently, the concepts of 'independent living' and 'consumer direction' have become highly popularized among individuals with disabilities who choose to control their long-term care and assistance. This trend has enabled people with disabilities to live independently in their communities.").

14. *See* Johnson, *supra* note 9, at 2.

15. Karin C. Ottens, Note, *Using Tax Incentives to Solve the Long-Term Care Crisis: Ineffective and Inefficient*, 22 VA. TAX REV. 747, 752 (2003).

16. *See* Johnson, *supra* note 9, at 2.

a daily basis and often for multiple hours, these services quickly become very expensive. Accordingly, even if an elderly person needing care was only assisted for three hours per day, he would still face an annual cost of $19,710.[17]

COVERAGE

Given the uncertain but potentially devastating costs of long-term care, insuring against this acute risk is essential for all but the wealthy few who can afford to self-insure. Currently, Americans can seek coverage through private providers or through Medicaid.[18] Although a majority of Americans assume Medicare will cover the costs of long-term care,[19] Medicare only pays for "skilled care"[20] and only covers up to a 100-day stay in a nursing home facility.[21] Accordingly, Medicare covers only $42.2 billion, or 20 percent, of the nation's long-term care expenditures.[22] By far the largest insurer – public or private – of long-term care expenses is Medicaid. Of the $206.6 billion spent on long-term care in 2005, Medicaid covered nearly half of all expenditures – $101.1 billion or 48.9 percent.[23] Indeed, in 2005,

---

17. *See* Johnson, *supra* note 9, at 2.

18. *See generally* Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. REV. 543, 599 (2000) ("Medicaid is a means-tested, federal-state entitlement program that provides health care to low-income families with dependent children, the elderly, and the blind or disabled. The program provides federal financial assistance to states that reimburse medical costs incurred by the poor. Medicaid funding of nursing homes combines regulatory and contractual mechanisms. As a condition of receiving federal dollars, the federal government imposes obligations upon the states. Should they fail to comply with federal law and regulations, they can be disqualified from participation in the program. States in turn rely on a combination of licensing, regulation, and contract to impose obligations on private homes that provide care.").

19. *See* Jacob S. Hacker, *Restoring Retirement Security: The Market Crisis, the "Great Risk Shift," and the Challenge for our Nation,"* 19 ELDER L.J. 1, 45-46 (2011); Gardiner Harris and Robert Pear, *Still No Relief in Sight for Long-Term Needs,* NY TIMES, Oct. 24, 2011, at D1.

20. *See* Adamo, *supra* note 9, at 67.

21. *See* Harris, *supra* note 19.

22. Health Policy Inst., NATIONAL SPENDING FOR LONG-TERM CARE, Fact Sheet, fig.1 (Feb. 2007), http://ltc.georgetown.edu/pdfs/natspendfeb07.pdf [hereinafter NATIONAL SPENDING].

23. *Id.*

long-term care spending consisting primarily of nursing home reimbursements[24] represented one-third of Medicaid's budget.[25] Unlike Medicare, Medicaid imposes both an income and asset test, the former of which was recently increased to 133 percent of the poverty level under the Patient Protection and Affordable Care Act.[26] The asset test, however, represents the primary barrier to seeking public provision of care for many retired elderly patients. The asset test varies by state and by type of benefit sought, but for long-term care, the maximum amount of assets allowed is typically $2,000.[27]

Private expenditures on long-term care, both through out-of pocket payments and through private insurance, account for 28 percent of the nation's long-term care expenditures.[28] Developed in the 1980s, private long-term care insurance is a relatively new mode of insurance.[29] Despite the acute need for coverage, private insurance has struggled to grow and currently covers only $14.9 billion, or 7.2 percent of long-term care expenses.[30] When first implemented, long-term care plans were designed and marketed as nursing home insurance and offered little coverage for alternative care.[31] Mirroring Medicaid,

---

24. Medicaid also distorts the choice between institutional and home based care, by making it more difficult to receive subsidized care at home. *See* Johnson, *supra* note 9, at 2; The primary reason for this bias against community-based care is the institutional inertia that has remained since the program's initial mandate to fund solely institutional care. *See* Daniela Kraiem, *Consumer Direction in Medicaid Long Term Care: Autonomy, Commodification of Family Labor, and Community Resilience,* 19 AM. U. J. GENDER SOC. POL'Y & L. 671, 673 (2011); By the early 1980s, advocates demanded home-based care and Medicaid began to provide, but the remnants of the program remains geared toward the provision institutional care. *Id* at 673.

25. Note, *Public-Private Partnerships and Insurance Regulation*, 121 HARV. L. REV. 1367, 1378 (2008) [hereinafter *Public Private Partnerships*].

26. Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119, 271 (2010); Richard W. Johnson, *The Strains and Drains of Long-Term Care*, 10 AM. MED. ASS'N. J. ETHICS 397, 397 (2008); *See also* HENRY J. KAISER FAMILY FOUNDATION, FOCUS ON HEALTH REFORM: SUMMARY OF NEW HEALTH REFORM LAW 1 (2010).

27. Johnson, *supra* note 26, at 397.

28. *See* NATIONAL SPENDING, *supra* note 22, Fig. 1.

29. *See* Elizabeth Dietz & Jordan Pfunter, *Long Term Care Insurance Gains Prominence*, BUREAU OF LABOR STATISTICS (Jan. 28, 2004), http://www.bls.gov/opub/mlr/cwc/long-term-care-insurance-gains-prominence.pdf.

30. *See* NATIONAL SPENDING, *supra* note 22, Fig. 1.

31. *See* Frank N. Darras & Lissa A. Martinez, *Long-Term Care Insurance: It's Back*

however, private long-term care insurance has evolved to cover home-based and other non-institutional forms of care.[32] Most long-term care insurance is sold in the form of a fixed, daily indemnity benefit that is paid when the policy holder cannot perform a certain number of activities of daily living.[33] Because claims are often made decades after issuance of the policy, the pricing of premiums and the determination of the policy's future value prove crucial to ensuring both the solvency of the insurer and the ability of the insured to make a wise investment.[34] Initially, many policies did not offer inflation protection, which led to the acute danger that a policy's value would be eviscerated over time. Today, however, many states, including those that have adopted the National Association of Insurance Commissioner's (NAIC) model long-term care regulations, mandate that insurance companies offer inflation protection[35] and that carriers offer anywhere from 3 to 5 percent compound inflation protection.[36]

Even with the emergence of private insurance policies, out-of-pocket expenditures still represent a much larger portion of private long-term care expenditures–a proportion that is dramatically increased if one includes the unpaid labor of family members. In 2005, Americans spent $37.4 billion of their private assets on long-term care, accounting for 18.1 percent of long-term care expenditures.[37] If one incorporates the estimated $354 billion saved through the provision of in-home, unpaid long-

to the Wild Wild West of Bad Faith Litigation, 1 Ann.2006 ATLA-CLE 577 (WestlawNext).

32. Allen, *supra* note 9, at 22 ("policies cover nursing homes, assisted living facilities, home health care, hospice, respite, and alternative care services.").

33. *See* 3 A. KIMBERLEY DAYTON, ET. AL, ADVISING THE ELDERLY CLIENT § 24:11 (Thomson Reuters ed., 2013).

34. *See* Allen, *supra* note 9, at 22-23.

35. *See Public Private Partnerships*, *supra* note 25, at 1383.

36. *Increased Public Awareness of the Long-Term Care Partnership Would Contribute to the Program's Success*, Rep. No. 09-08 (Office of Program Policy Analysis & Gov't Accountability, Tallahassee, Fla.) Feb., 2009, at 11 tbl. A-1, http://www.oppaga.state.fl.us/reports/pdf/0908rpt.pdf.

37. *See* NATIONAL SPENDING, *supra* note 22, Fig. 1.

term care services each year,[38] the portion of the market covered by uninsured private expenditures increases drastically and underscores the reality that "the family remains the backbone of our nation's long-term care system."[39]

RETIREMENT OF THE BABY BOOM GENERATION

In the coming years, the nation's long-term care support structure will become increasingly overwhelmed as more than 76 million baby boomers retire and technological advancements continue to extend life expectancy.[40] The population over the age of eighty-five, whose demand for long-term care will likely exceed that of any other age group, is predicted to double within twenty years and quadruple within forty years.[41] The inevitable aging of the baby boom population, moreover, ominously coincides with the "weakening of the so-called 'three-legged stool' of retirement security – Social Security, private pensions, and retirement savings," which is already causing significant unease among older Americans and their families.[42] Compounding this challenge, Americans have been saving at much lower rates than previous generations.[43] For example,

---

38. The AARP estimates that the economic value of family caregiving in 2006 was 354 billion. *See* AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP) PUBLIC POLICY INSTITUTE, VALUING THE INVALUABLE:

A NEW LOOK AT THE ECONOMIC VALUE OF FAMILY CAREGIVING, 2 tbl. 1 http://assets.aarp.org/rgcenter/il/ib82_caregiving.pdf; Ottens, *supra* note 15, at 761-62 ("family caregivers currently reduce the total national costs of long-term care by approximately $45-95 billion ($4800-$10,400 per caregiver) by providing in-home, unpaid long-term care services.").

39. Judith G. Gonyea, *Multigenerational Bonds, Family Support, and Baby Boomers: Current Challenges and Future Prospects for Elder Care*, *in* BOOMER BUST?: ECONOMIC AND POLITICAL ISSUES OF THE GRAYING SOCIETY 213, 228 (Robert B. Hudson ed., 2009); The family, moreover, is likely to remain the backbone in the coming years, as public expenditures become less sustainable and shift onto American families despite and perhaps because of the augmented demand for long-term care. *See generally* Jacob S. Hacker, *Restoring Retirement Security: The Market Crisis, the "Great Risk Shift," and the Challenge for our Nation,"* 19 ELDER L.J. 1, 2-3 (2011).

40. *See* Allen, *supra* note 9, at 21.

41. *See* Christopher C. Jennings & Christopher J. Dawe, *Long Term Care: The Forgotten Health Care Challenge*, 17 STAN. L. & POL'Y REV. 57, 62 (2006).

42. *Id.* at 58.

43. *See generally* THOMAS L. FRIEDMAN & MICHAEL MANDELBAUM, THAT USED

forty-two percent of Americans over the age of forty-five have saved less than $25,000 for retirement.[44] Thus, not only are Americans growing older demographically and facing steadily increasing costs of long-term care, they are also saving less and thus becoming increasingly incapable of confronting "the most unpredictable and the greatest financial, emotional, and physical threat" they will face in their old age.[45] In light of these demographic trends, the United States unquestionably faces a growing elder care crisis[46] that it must confront in the near future.

PROBLEMS FACING THE LONG-TERM CARE INSURANCE MARKET

In responding to the increased burden placed on families and on the Medicaid system by the demographic shift toward greater longevity and the retirement of the baby-boom population, states and the federal government face many structural challenges in attempting to expand the private long-term care insurance market. Although the barriers to growth permeate beyond the following categories, these four problems best categorize the challenges policymakers must confront: the cavernous information gap; uncertainty of the future; adverse selection and its corollaries; and the presence of Medicaid as a substitute.

INFORMATION GAP

Few individuals adequately evaluate the risk of needing

TO BE US: HOW AMERICA FELL BEHIND IN THE WORLD IT INVENTED AND HOW WE CAN COME BACK (2011).

44. Morris Klein, *The New Class Act*, 7 NAT'L ACAD. OF ELDER L. ATT'YS J. 35, 36 (2011).

45. *See* Jennings, *supra* note 41, at 58.

46. Seth J. Chandler, *Long Term Care: The Next Healthcare Frontier*, 19 ANNALS HEALTH L. 19, 20 (2010) ("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."); *See also* Gonyea, *supra* note 39, at 227.

long-term care, both because the risk is in the distant future and because few readily envision spending their final years completely dependent on others. To put the problem in perspective, the likelihood that a fire will damage one's home is 1 in 1200 and the likelihood that an accident will destroy one's car is 1 in 240, but the chance that a person will spend 2.5 years in a nursing home is *1 in 3*.[47] The undeniable message is that the vast majority of individuals, especially younger adults, routinely ignore or fail to recognize this serious risk. The chronic underestimation of the need for long term care has accordingly been dubbed "the 5% fallacy"[48] in reference to the disproportionately low rates of private long term care insurance coverage.[49] At its most fundamental level, the failure to appreciate the severity of the risk that one will need long-term care services is properly conceived of as part information gap, part irrational action. In other words, not only do individuals not understand the likelihood that they will face the costs of long-term care, but even when confronted with this likelihood, many dismiss this risk as for whatever reason inapplicable to them. The unfortunate reality, of course, is that many of the ailments that lead older Americans to become dependent (i.e. Alzheimer's disease and dementia) have little to do with one's physical health and even less to do with one's perception thereof. Compounding this problem is the hesitation of many to maintain expensive premiums to guard against a very distant risk that may never materialize, leaving the policyholder with nothing to show for his effort.[50] With seemingly infinite expenses and manifestly finite resources, would-be purchasers

47. *See* Darras, *supra* note 31.

48. Andrea L. Campbell & Kimberly J. Morgan, *Federalism and the Politics of Old Age Care in Germany and the United States*, 38 COM. POL. STUD. 887, 892 (2005).

49. *See* Hacker, *supra* note 19, at 22-23.

50. *See* Marc P. Freiman, *A Look at Hybrid Insurance Products with Long-Term Care Insurance*, AARP 24 (2007) ("Rather than viewing their premiums as having paid for insurance against a catastrophic risk that (fortunately) never came, some consumers may feel that they have 'lost' or 'wasted' all of their premium payments, even though they probably do not adopt similar perspectives towards home and car insurance."), http://assets.aarp.org/rgcenter/il/2007_11_hybrid.pdf.

find it difficult to prioritize guarding against a future risk over more imminent expenses. Of course, by the time the risk of long-term care looms, premiums are insurmountably high for the average American.[51]

UNCERTAINTY OF RISK

The role long-term care insurance plays in guarding against a uniquely distant risk not only affects the potential purchaser's behavior, but also poses significant challenges to insurers. An actuary attempting to price an insurance policy for a forty-year-old individual must predict that individual's likelihood of needing long-term care services several decades in advance.[52] When long-term care insurance policies were first introduced, underwriting decisions were predicated upon the same criteria that applied to health insurance coverage, but insurers swiftly recognized that this approach did not adequately capture the likelihood that an applicant would need long-term care.[53] Currently, underwriting for LTC insurance evaluates an individual's predisposition to cognitive impairment and functional disability, and is less concerned with the diagnosis of diseases.[54] Yet in making underwriting evaluations, "the informational asymmetries and inefficiencies that have characterized health care insurance are magnified,"[55] due in large part to the distant predictions required.[56] Even if insurers

51. *Long-Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services: Testimony Before the Finance Comm.*, 107th Cong. 13 (2001) (statement of William J. Scanlon, Dir. Health Care Issues) (reporting that one GAO study found that only ten to twenty percent of older Americans can afford long term care insurance coverage).

52. JOSHUA M. WIENER, LAUREL HIXON ILLSTON, & RAYMOND J. HANLEY, SHARING THE BURDEN: STRATEGIES FOR PUBLIC AND PRIVATE LONG-TERM CARE INSURANCE 15 (1994).

53. *See* Allen, *supra* note 9, at 22.

54. *Id.*

55. *See* Garber, *supra* note 8, at 154-55.

56. Wiener, *supra* note 52, at 15 ("Small changes in assumptions compounded over long periods of time can drastically change a product's profitability."); Chandler, *supra* note 46, at 22 ("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.").

could reliably assess future likelihood that a policyholder would develop a condition requiring long-term care, the uncertainty of the effects that technological advancement will have on such care inexorably complicates the equation. For example, researchers could find a cure for Alzheimer's, or they could simply enable patients with this disease to live even longer – the former would reduce costs while the latter would dramatically increase them. Finally, these uncertainties are compounded by the "actuarial infancy"[57] of long-term care insurance. Unlike in the life insurance context, actuaries attempting to price policies do not have the benefit of scores of data and experience to support their findings.[58] The result is a more expensive product with thinner coverage that is "riddled with exceptions."[59] The unattractiveness of these policies, in turn, contributes to the next and perhaps most acutely prohibitive challenge faced by the LTC insurance market: adverse selection.

ADVERSE SELECTION

The low take-up rate for younger individuals, combined with the uncertainty embedded in any attempt to price long-term care policies, inflates premium prices that would already be high in light of the rising costs of long-term care.[60] These rising premiums trigger the adverse selection problem that has plagued the long-term care market since its inception. As premiums increase, low-risk users are priced out of the market. As these low-risk users exit, the risk pool remaining becomes increasingly dominated by relatively high-risk users. Even though this effect is limited by the rejection of as many as 15

57. Chandler, *supra* note 46, at 23 (noting that long-term care insurance is not like life insurance where risks are now modeled well enough that regulators are more capable of determining adequate premiums, and cautioning that "the inability of regulators to accurately assess LTCI pricing has serious consequences for the ability of a for-profit market to flourish," as regulators can blindly be over-restrictive or under-restrictive).

58. *See* Garber, *supra* note 8, at 156.

59. *See* Hacker, *supra* note 19, at 23.

60. *See infra p.* 112-113.

percent of all potential purchasers[61] – a likelihood that increases as one ages[62] – the relatively risky pool can nevertheless force insurers to increase premiums further.[63] Although adverse selection has not yet become severe enough to cause a "death spiral" in the national market for long-term care, it has inhibited the private market's ability to grow beyond its 7.2 percent share of overall long-term care coverage. Moreover, a "death spiral" has arguably taken hold in individual insurer's risk pools, as the past few years have seen the notable exit of a number of insurers, including Met Life.[64] Without significant changes in the structure of the market and policies supporting its growth, those insurers that have remained will continue to struggle and may ultimately face the same fate.

MEDICAID AS A SUBSTITUTE

Perhaps the most basic and recognizable inhibitor of the long-term care insurance market is the presence of Medicaid as an ostensibly free substitute for long-term care insurance.[65] As one economist studying the long-term care market noted, "[y]ou can't sell apples. . .on this side of the street if someone. . .is

61. *See* Johnson, *supra* note 9, at 5.

62. Twenty-five percent of those between the ages of 60 and 69 and forty-five percent of those between the ages of 70 and 79 are denied coverage. *See* Eileen Ambrose, *As America Ages, Issue of Long-Term Care Emerges*, BALTIMORE SUN, Nov. 6, 2011.

63. Insurers, in fact, must increase premiums in view of the solvency requirements imposed by regulators. TOM BAKER, INSURANCE LAW AND POLICY 25 (2d ed. 2008)("To promote insurer solvency, state statutes limit the organizational structures in which the insurance business can be conducted; regulate relationships among insurers and their affiliates or holding companies; impose minimum capitalization, surplus, and reserve requirements; require disclosure of various kinds of financial information; regulate rates; control the kinds and proportions of investments insurers can make; and create guaranty associations to cover the financial obligations of insolvent insurers through assessments on all insurers.").

64. The "death spiral," however, has caused the exit of a number of individual companies from the market, including Met Life. *See* Brett Norman, *CLASS Dismissal Leaves White House Without a Plan B*, POLITICO, October 24, 2011, http://www.politico.com/news/stories/1011/66730.html.

65. *See* Ottens, *supra* note 15, at 765 (quoting the President of the Center for Long-Term Care financing as stating that "[t]he reason more people don't buy long-term-care insurance is that the government has been paying for [long-term care] for 35 years, and the public has become anesthetized to the risk.").

giving them away on the other side of the street."[66] Although Medicaid of course is by no means free, as the taxpayer incurs a substantial expense,[67] those faced with the daunting cost of private long-term care insurance premiums nevertheless view it as such. To a great extent, the perceived preference for Medicaid is not illogical. Many insurance consumer advocacy groups discourage low to moderate income individuals from purchasing private long-term care insurance, claiming that private coverage is unwise for those who would quickly qualify for Medicaid if they became disabled and required long-term care services.[68]

The key distinguishing feature of Medicaid is that it requires impoverishment by imposing an asset test. The asset test varies by state and type of benefits sought through Medicaid, but typically hovers around $2,000.[69] For many in the middle class, however, no viable alternative exists and Medicaid thus perversely causes elders to deplete the vast majority of their private savings in order to become eligible.[70] This spend-down phenomenon leaves elders with nothing to pass on to their heirs and becomes particularly problematic when those who have only temporary long-term care needs return to the community with no income or savings. Moreover, while Medicaid reforms have increased the amount of assets reserved for spouses, these reserves have proven woefully insufficient to ensure the financial stability of husbands and wives who may live decades

66. Joshua M. Wiener, Jane Tilly, and Susan M. Goldenson, *Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance*, 8 ELDER L.J. 57, 98 (2000).

67. In 2002, long-term care accounted for 19 percent of all Medicaid spending, and, in 2005, Medicaid represented the single largest budget item in state budgets. *See* Johnson, *supra* note 9, at 5.

68. *See, e.g.,* Ottens, *supra* note 15, at 766 (quoting one consumer insurance advocate as stating that "long-term care insurance is not appropriate for certain people and should not be sold to them, particularly those who would quickly qualify for Medicaid if they were to require long-term care services.").

69. *See* Johnson, *supra* note 27 and accompanying text (noting that Medicaid recipients must "surrender all of their assets, except for about $2,000" in order to qualify for coverage).

70. *See* Jennings, *supra* note 41, at 62; Johnson, *supra* note 9, at 5.

longer than their spouses.[71] While some argue that Medicaid's *de facto* coverage of the middle class represents the legislative intent of the program,[72] others argue that the middle class is abusing the Medicaid system and policymakers should "restrict eligibility to the truly poor."[73] Part of this latter argument is grounded in the legitimate concern about the dishonest practice of divesting or hiding assets in order to become eligible for Medicaid.[74] The only viable solution to this facet of the problem is closer monitoring of asset transfers prior to application for benefits, a costly strategy of limited marginal utility. Further, the alternative suggestion that policymakers restrict benefits to the "truly poor" quickly proves myopic, even after a cursory examination. Such an attempt would draw a troubling line between individuals who did not save their resources who would remain eligible for Medicaid and middle-class individuals who exhausted their savings on private long-term care provision who would not. The suggestion that middle class individuals are somehow less entitled is not only illogical, but also politically untenable. Indeed, the broader political intractability of addressing the availability of Medicaid as a substitute led one leading actuary studying the long-term care market to describe Medicaid as "the elephant in the room."[75] Accordingly, in the absence of a desirable alternative, Medicaid will in all likelihood remain the lesser of two evils for middle class individuals evaluating their long-term care insurance options.

---

71. *See* Johnson, *supra* note 9, at 5.

72. *See* Joshua M. Wiener, *Long-Term Care and Devolution*, *in* MEDICAID AND DEVOLUTION: A VIEW FROM THE STATES 185, 185 (Frank J. Thompson & John J. DiIulio Jr. eds., 1998). ("Many policymakers and analysts disparage the large role that long-term care plays in the Medicaid budget, claiming that it was unintended. That role, however, is consistent with the program's historical antecedents and legislative intent.").

73. *See* Jeffrey L. Soltermann, *Medicaid and the Middle Class: Should the Government Pay for Everyone's Long-Term Health Care?*, 1 ELDER L.J. 251, 289-90 (1993).

74. *See id*. at 289.

75. Allen Schmitz, *Living Up to Its Name: How to Fix the Class Act,* URBAN INSTITUTE SYMPOSIUM at 47:33 (March, 24, 2011, 9:00 AM), http://www.urban.org/events/How-to-Fix-the-Class-Act.cfm.

EFFORTS TO EXPAND THE LONG-TERM CARE MARKET

The difficult challenges posed by the aging population, increasing costs, and gap in coverage among the middle class have not gone unnoticed by lawmakers. Long-term care served as a key issue in both George W. Bush's presidential campaign in 2004 as well as Bill Clinton's presidential campaign in 1996.[76] Further, policymakers at both the state and federal level have, over the years, addressed the long-term care challenge through a diverse set of initiatives aimed at encouraging the expansion of private sector provision of long-term care insurance. The primary modes of incentivizing individuals to purchase long-term care insurance have been tax incentives, public-private partnerships, and the creation of insurance plans for government employees. Each of these measures aims both to decrease the burden placed on Medicaid and to facilitate the risk sharing capacity of private insurance.

TAX INCENTIVES

Tax incentives relating to the purchase of long-term care insurance exist both for individuals and employers at both federal and state levels. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), out-of-pocket payments for qualified private long-term care insurance policies are deductible as medical expenses if they exceed 7.5 percent of an individual's adjusted gross income (AGI).[77] However, the amount of qualified premiums that may count toward a deduction is capped based on age.[78] After the federal implementation of tax incentives for long-term care insurance

76. *See* Robert Pear, *Bush and Kerry Push Domestic Plans, Leaving Off Price Tags*, N.Y. TIMES, Oct.13, 2004, http://www.nytimes.com/2004/10/13/politics/campaign/13spend.html#; *See Bill Clinton 1996 On The Issues Fighting for Quality Health Care*, 4PRESIDENT.US, (Dec. 2, 2013) http://www.4president.us/issues/clinton1996/clinton1996healthcare.htm.

77. Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936, 2041-42 (1996); *See* Wiener, *supra* note 66, at 63.

78. *See* Wiener, *supra* note 66, at 63.

policies, states followed suit with their own tax deductions and credits for long-term care premium payments.[79] For example, since 2006, individuals in Virginia have been able to receive a tax credit equal to fifteen percent of the total long-term care policy premiums paid in a given year.[80]

In addition to individual tax incentives, legislatures have also turned to employer tax incentives in an attempt to encourage younger adults to take part in the long-term care insurance scheme. Not only do younger purchasers face more affordable premiums,[81] their inclusion enhances the sustainability of long-term care insurance primarily by counterbalancing the adverse selection tendencies of long-term care insurance pools.[82] In addition to encouraging purchase by younger adults, group policies reduce costs and improve quality because of the better negotiating position of benefit managers for employer sponsored groups.[83] As with individual policies, both federal and state tax incentives exist for employer contributions to long-term care. Under HIPAA, for example, employer contributions are deductible as business expense.[84] Some states allow a deduction to the extent provided by the federal government, while others have developed more nuanced approaches.[85] On the whole, state tax incentives have proven more modest than federal tax incentives and, when coupled with lower state tax rates, have had a minimal impact on purchase.[86]

Although the impetus behind the use of tax incentives term care insurance was sound, the efficacy of these measures has proven less certain. Tax incentives are notably ineffective for

79. *Id*. at 67-68.

80. *Facts About Long-Term Insurance in Virginia* (Va. St. Corp. Comm'n, Bureau of Ins., Richmond, Va.) Aug., 2007, http://www.ltcconsultants.com/pdfdocs/ taxincentivesbystate020508.pdf.

81. *See* Wiener, *supra* note 66, at 71.

82. *See* Wiener, *supra* note 52, at 63.

83. *See* Wiener, *supra* note 66, at 71.

84. *Id.* at 72.

85. *See* AMERICAN COUNCIL OF LIFE INSURERS, *supra* note 80.

86. *See* Wiener, *supra* note 66, at 72-73.

individuals without a tax liability, and few taxpayers itemize their deductions while still fewer claim a deduction for medical expenses.[87] As a result, the use of tax incentives to stimulate the market has been criticized as an "ineffective and inefficient solution[] to curb the costs of long-term care"[88] and, at the very least, insufficient to engender substantial increases in coverage.[89] In her Note on *Using Tax Incentives to Solve the Long-Term Care Crisis*, Karin Ottens argues that tax incentives are inadvisable, because instead of encouraging taxpayers to plan for and finance the future costs of long-term care, they merely provide deductions to those who likely "would have purchased the insurance policy even without the deduction."[90] Ottens argues that, as a result, these deductions and credits "merely create an extremely large tax revenue loss."[91] Although Ottens offers no empirical support of her assertion, her conclusion is somewhat supported by the correlating stagnation of the private market for long-term care insurance. Ottens' argument, however, is perhaps properly reformulated as supportive of the contention that current tax incentives are insufficiently strong,[92] rather than inherently unsuitable. While the success of tax provisions in stimulating the long-term care insurance market has proven "quite modest,"[93] such modesty also characterizes the tax provisions themselves. Few would conclude that tax incentives

87. "In 1997…only four percent claimed a deduction for medical expenses." Wiener, *supra* note 66, at 65.

88. *See* Ottens, *supra* note 15, at 750.

89. *See* Wiener, *supra* note 66, at 64.

90. *See* Ottens, *supra* note 15, at 762.

91. *See id*.

92. *See* Chandler, *supra* note 46, at 21-22 (noting that in section 7702B, for example, the Internal Revenue Code endeavors to encourage purchase long-term care insurance policies, but by imposing a prohibition on cash surrender values "forces an uninsurable risk of lapse onto policyholders" and "effectively induces insurers to protect against unforeseen cost increases not by charging a predictable high premium...but by reserving a frightening and not infrequently exercised unlimited right to raise premiums should costs increase.").

93. *See* Chandler, *supra* note 46, at 20 ("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.").

do not have the capacity to adapt behavior when structured properly. It seems, therefore, that while tax incentives have had little success, this apparent deficiency should not obviate their use in the future.[94]

PUBLIC-PRIVATE PARTNERSHIPS

Another mode of stimulating the private market for long-term care insurance is the use of public-private partnerships. In 1987, the Robert Wood Johnson Foundation facilitated the development of public-private partnerships for long-term care in four states: California, Connecticut, Indiana, and New York.[95] In 2005, the Deficit Reduction Act reduced restrictions on state establishment of public-private partnerships for long-term care.[96] Following the flurry of program implementation that resulted, 41 states now offer partnership policies and four others have plans for such policies in the works.[97] The primary objective of the partnerships is to provide higher levels of asset protection under Medicaid to those who purchase private long-term care policies approved by the state.[98] When a policyholder's benefits are exhausted, his assets are protected up to the level of benefits he recovered from the partnership approved policy on top of the typical asset limit.[99] For example, if a policy holder received a benefit of $200,000 over three years but still required care, he could be eligible for Medicaid as long as his assets did not exceed $202,000. The goal of asset protection, accordingly, is to encourage middle-class Americans to purchase private long-term care insurance instead of either divesting or spending

94. *See supra* p. 133-134.

95. ALLIANCE FOR HEALTH REFORM, *Long-Term Care Partnerships: An Update* (2007) (hereinafter "ALLIANCE"), http://www.allhealth.org/publications/long-term_care/long_term_care_partnerships_53.pdf.

96. *See Public Private Partnerships*, *supra* note 25, at 1380.

97. AMERICAN ASSOCIATION FOR LONG-TERM CARE INSURANCE, *Long-Term Care Insurance Partnership Plans* (2008), http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php.

98. *See* Wiener, *supra* note 66, at 83.

99. *See* ALLIANCE, *supra* note 95.

down their savings in order to become eligible for Medicaid.[100] Critics argue, however, that offering eligibility to Medicaid is inconsistent with the traditional method of advertising private insurance policies by highlighting the deficiencies of public programs such as Medicaid.[101] Still others maintain that offering Medicaid as a benefit unintentionally underscores the availability of Medicaid as a resource and therefore unwittingly discourages the purchase of private policies. Yet asset protection is not the only feature of public-private partnerships. Another feature common to many partnership programs is mandatory availability of inflation protection, usually 3 to 5 percent compounded annually.[102] Although inflation protection is desirable to the extent that it protects the value of the policies, it also inexorably raises premium levels and further exacerbates the problem of premium affordability that has plagued the long-term care insurance market.[103] In addition to the two chief benefits of partnership programs touted by advocates – asset and inflation protection – partnership programs also facilitate more stringent and protective regulation of approved policies.[104] The standardization and simplification of the purchasing process reduces the woeful complexity of standard long-term care insurance policies and shifts the balance from flexibility of policies to consumer protection. Unfortunately, although this

100. *See Public Private Partnerships*, *supra* note 25, at 1380.

101. *See* Wiener, *supra* note 66, at 90 ("A significant factor in the limited sales under a partnership is that relaxing eligibility requirements for obtaining Medicaid benefits is inconsistent with the primary message that insurance agents use to sell long-term care insurance. Long-term care insurance is sold primarily by stressing that Medicaid is a 'terrible' program with inferior access to poorer quality facilities.").

102. OFFICE OF PROGRAM POLICY ANALYSIS & GOV'T ACCOUNTABILITY, INCREASED PUBLIC AWARENESS OF THE LONG-TERM CARE PARTNERSHIP WOULD CONTRIBUTE TO THE PROGRAM'S SUCCESS 11 tbl. A-1 (2009), http://www.oppaga.state.fl.us/reports/pdf/0908rpt.pdf.

103. *See Public Private Partnerships*, *supra* note 25, at 1381-82.

104. *See Public Private Partnerships*, *supra* note 25, at 1381 (noting that partnership programs are usually more "consumer-protective" than standard long-term care insurance products, as partnership regulations generally require standardized benefit triggers, broader coverage of home- and community-based care, increased data reporting requirements, and enhanced measures designed to prevent unintentional policy lapse).

simplification was much needed, partnership policies, like tax incentives, have not engendered a substantial increase in participation rates.

GOVERNMENT AS ROLE MODEL

In addition to stimulating the private market for long-term care insurance through tax incentives and public-private partnership programs, the federal government and many states have attempted to serve as role models for employers by offering employees the opportunity to buy into group policies. As with tax incentives, the federal government set the trend in 2000 through the Long-Term Care Security Act, under which the Office of Personnel Management contracted with qualified insurance carriers to administer a long-term care insurance program for federal employees.[105] Like Employee Retirement Security Act (ERISA) plans, the federal long-term care insurance plan includes an administrative appeals process that, along with the benefits of a group plan, further incentivizes purchase.[106] In recent years, a number of states followed suit and began offering long-term care insurance plans to civil servants.[107] Yet, as with the partnership programs and tax incentives, these plans have not yielded significant results. Many policymakers consequently began to perceive the attempt to expand the private market as a fool's errand and started to consider the potential utility of public programs. The result of this shift in focus was the cursory development and correspondingly abrupt failure of the CLASS Act.

THE CLASS ACT

The most recent attempt to expand the market for long-term

105. Long-Term Care Security Act, 5 U.S.C.A. §§ 9001-9009 (2000); *See* Robin Miller, *Construction and Application of Long-Term Care Insurance Policies*, 30 A.L.R. 395, 400 (6th ed., 2008).

106. *See* Garber, *supra* note 8, at 26.

107. *See* Miller, *supra* note 105, at 400; Wiener, *supra* note 66, at 73-74.

care insurance was the development and passage of a voluntary public long-term care insurance program, the Community Living Assistance Services and Supports Act (CLASS Act).[108] The CLASS Act was passed in 2010 as Title VIII of the Patient Protection and Affordable Care Act, better known as "Obamacare," and was aimed at improving access to more cost-effective, community-based long-term care options.[109] In order to become eligible to receive its benefits, enrollees were required to maintain premium payments for five years, three of which must have been spent working.[110] This five year waiting period, however, was not required to be consecutive, and with only an age-adjusted increase in premiums for re-enrollees, individuals could cycle on and off depending on their perceived needs.[111] Additionally, the earnings requirement amounted to as little as $1,120 per month, thus serving as a poor substitute for the ability of CLASS administrators to underwrite enrollees.[112] If eligible and functionally disabled, beneficiaries would receive a flexible cash benefit based on the severity of their disability with no time limit, as often included in private policies.[113] While the benefit could thus vary from person to person, the average benefit in the aggregate was required to be $50.[114] In order to encourage the use of cheaper alternatives to institutional care, the act allowed beneficiaries to use the cash benefit to fund a variety of services,

---

108. Community Living Assistance Services and Supports Act ("CLASS Act"), Pub. L. No. 111-148, 124 Stat. 828 (codified at 42 U.S.C.A. § 201 (2010)).

109. Richard L. Kaplan, *Analyzing the Impact of the New Health Care Reform Legislation on Older Americans*, 18 ELDER L.J. 213, 229 (2011); Video: Brenda Spillman, *Living Up to Its Name: How to Fix the Class Act,* URBAN INSTITUTE SYMPOSIUM at 14:00 (March 24, 2011, 9:00am), http://www.urban.org/events/How-to-Fix-the-Class-Act.cfm.

110. CLASS Act, *supra* note 108, at § 300ll-1(6)(A) (repealed 2013).
Securities Act of 1933, ch. 38, 48 Stat. 74 (codified as amended at 15 U.S.C. §§ 77a–77aa (2006)).

111. *Id.* at § 300ll-2(b)(1)(C) (repealed 2013).

112. OFFICE OF THE CHIEF ACTUARY, SOCIAL SECURITY ONLINE, AUTOMATIC DETERMINATIONS: QUARTER OF COVERAGE (2011), http://www.ssa.gov/oact/cola/QC.html.

113. CLASS Act, *supra* note 108, at § 300ll-2(b)(1) (repealed 2013).

114. *Id.* at §§ 300ll-2(a)(1)(D)(i) and (ii), (repealed 2013).

including those provided by family members.[115]

The CLASS program's coupling of voluntary enrollment with no underwriting and a generous benefit package swiftly struck many as creating a problematic mixture of incentives. Doubts about the program's feasibility crossed both sides of the political aisle[116] and even emerged within the Obama administration.[117] Critics argued that the only reason the CLASS Act was being considered was its illusory $60 billion in deficit reduction over the relevant 10-year projection made by the Congressional Budget Office.[118] Of course, these savings only accrued in the first ten years because the program would collect premiums while paying no benefits for 5 of the 10 years. Despite doubts of the program's feasibility, Health and Human Services Secretary Kathleen Sebelius assured Congress in February of 2011 that she believed that with some tweaking, the program could be implemented.[119]

Yet, on October 14, 2011, after a 19-month effort to develop a solvent program in keeping with the statutory requirement that the CLASS program remain self-sustaining for 75 years,[120] the actuaries, attorneys, and administrators within DHHS came to the conclusion that the program could not be implemented.[121]

---

115. *See* Kaplan, *supra* note 109, at 229 ("CLASS Act benefits can also be used to modify an elder's personal residence to enable that person to continue living at home. They can even pay a family member who provides caregiving services, without necessarily having a formal family caregiving agreement. In this sense, the CLASS Act is more flexible than long-term care insurance policies that typically have numerous restrictions on the payment of family caregivers, if they cover such payments at all.").

116. *See* Lori Montgomery, *Proposed Long-Term Insurance Program Raises Questions*, WASHINGTON POST, Oct. 27, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/10/27/AR2009102701417.html.

117. *See* Avik Roy, *CLASS-Gate: Internal Emails Reveal Administration Knew All Along that Obamacare's Long-Term Care Entitlement Was a "Fiscal Disaster,"* FORBES, Sept. 19, 2011, 4:59 PM, http://www.forbes.com/sites/aroy/2011/09/15/class-gate-internal-emails-reveal-administration-knew-all-along-that-obamacares-long-term-care-entitlement-was-a-fiscal-disaster.

118. *See generally* Montgomery, *supra* note 116.

119. *See* Robert Pear, Long-Term Care Needs Changes, Officials Say, N.Y. TIMES, Feb. 21, 2011, http://www.nytimes.com/2011/02/22/health/policy/22care.html?_r=1.

120. CLASS Act, *supra* note 108, at § 300ll-2(a)(1)(A) (repealed 2013).

121. U.S. DEP'T. OF HEALTH AND HUMAN SERV., 112TH CONG., A REPORT ON THE ACTUARIAL, MARKETING, AND LEGAL ANALYSES OF THE CLASS PROGRAM 46 (2011)

Although the CLASS team developed a number of mechanisms to improve the risk pool, these efforts varied along a spectrum of legality.[122] As a result, the CLASS team could not find an appropriate balance between a program that remained solvent and one that complied with even a strained interpretation of the statutory language.[123] Contributing to this difficulty, the Act was both fatally narrow in its construction and naively bereft of an adequate understanding of the extensive challenges that the private market has faced for years.[124] Thus, the CLASS Act failed ultimately because it was "a program. . .built on the heart and especially on the current political environment, [but] not on sound technical advice in advance of drafting."[125] In the wake of the CLASS Act's failure and the marginal success of the existing efforts to expand the private market, policymakers must seek a new and comprehensive path forward.

THE UTILITY OF HYBRID PLANS

As the failure of the CLASS Act has demonstrated, the attempt to fulfill the nation's long-term care needs through a public program will not prove viable in the near future. Aside from being a political non-starter,[126] the burden of such a program would simply be too difficult for the country to bear alongside the outlays already required to sustain the Medicare and Social Security systems.[127] Moreover, although outside the pale of the

---

[hereinafter "CLASS REPORT"].

122. *Id*.at 43.

123. *See generally* Memorandum from Kathy Greenlee, CLASS Administrator, to Secretary Sebelius (Oct. 14, 2011) [hereinafter "CLASS MEMO"] (describing the CLASS team's inability to craft a policy that was both actuarially and legally sustainable).

124. *See* CLASS REPORT, *supra* note 121, at 44-6; CLASS MEMO, *supra* note 123, at 2.

125. *See* Spillman, *supra* note 109, at 14:21.

126. *See* Wiener, *supra* note 66, at 95.

127. CONG. BUDGET OFFICE, THE LONG-TERM OUTLOOK FOR MEDICARE, MEDICAID, AND TOTAL HEALTH CARE SPENDING, 25 tbl. 2.2, http://www.cbo.gov/ftpdocs/102xx/doc10297/chapter2.5.1.shtml; Garber, *supra* note 8, at 161 ("even if general funds could pay for long-term care of the elderly today, any such approach offers only a temporary solution, since the burden of subsidizing the care of elderly baby boomers will be heavier and will fall on a

debate over the CLASS Act, a public program for long-term care would in all likelihood suffer from a tremendous moral hazard problem, given the unique characteristics of long-term care services. Medicare, particularly with the emergence of Medigap policies, certainly provides a stern warning of the moral hazard problems a public program would face–especially one with lifetime benefits.[128] In fact, a public program for long-term care offering front-end coverage would suffer from an assuredly more acute moral hazard problem in light of the broad utility of long-term care services.[129] Unlike conventional healthcare, which treats specific diseases and ailments, long-term care consists of services and goods that would convenience a wide range of elderly individuals.[130] While conventional healthcare such as dialysis, for example, has a discrete benefit to those with kidney failure, many forms of long-term care, such as food preparation, provide a nearly universal benefit to the elderly, including those on the margins of qualification. Compounding this problem is the relatively vague determination of functional disability and subsequent need for long-term care services.[131] With a malleable standard of need – inability to perform 2 to 3 activities of daily living – the risk of over-utilization is further increased. This practical danger, in conjunction with the political intractability of a public program in the current environment, underscores the utility of a plan to expand the private market.

Although recent efforts to expand the private market

---

smaller population of working adults.").

128. *See* Mark V. Pauly, *Medicare Drug Coverage and Moral Hazard*, 23 HEALTH AFF. 113 (2004); Willard G. Manning & M. Susan Marquis, *Health Insurance: The Tradeoff Between Risk Pooling and Moral Hazard*, 15 J. HEALTH ECON. 609 (1996); John H. Goddeeris & John R. Wolfe, *Adverse Selection, Moral Hazard, and Wealth Effects in the Medigap Insurance Market*, 10 J. HEALTH ECON. 433 (1991).

129. This moral hazard problem, however, would prove less severe if a catastrophic care benefit were offered through a public program.

130. *See* Garber, *supra* note 8, at 164.

131. *See id*. ("Because the criteria used to determine the 'need' for long-term services are less precise and more easily manipulated than, say, the diagnosis of a heart attack, the close substitutability of housing and other services means that long-term care insurance is likely to increase utilization substantially, and that the distortions will be larger than for conventional medical insurance.").

through tax incentives and public-private partnerships have not yielded dramatic success,[132] one should not conclude that the private market cannot be strengthened. The continued viability of a more vibrant long-term care insurance market is perhaps most properly illustrated by the reality that, with perfect information regarding the risks of long-term care, many more users would purchase long-term care insurance policies. In other words, there is not a shortage in need for long-term care coverage, but rather an informational and structural deficiency that has prevented the market's growth. Private insurance therefore is not unsuitable to the task of extending long-term care coverage even though it inarguably faces a complex array of challenges to expansion.[133] Yet, a successful plan could counteract the compounding problems facing the market by engendering correspondingly compounding benefits–a capacity that leaves the successful expansion of the private market more attainable than many critics may suggest. One solution that has the potential to craft the right balance of incentives to increase long-term care coverage is the development and promotion of hybrid insurance policies that bundle long-term care coverage with either whole life insurance or annuities.

STRUCTURAL BENEFITS

Bundling long-term care insurance policies with life insurance or annuities offers significant structural benefits that have the potential to make great inroads into the long-term care coverage gap. First, long-term care insurance naturally complements annuity and life insurance policies, as it aims to achieve the same fundamental goal – purchasers of long-term care insurance, annuities, and life insurance policies all wish to avoid burdening their families, whether because of untimely death, prolonged life, or functional disability.[134] Second, as with

132. *See infra* p. 118-126.

133. *See infra* p. 111-118.

134. Although, in the case of life insurance, purchasers technically wish to prevent their death from becoming a burden on their relatives, but the underlying

life insurance and annuities, long-term care risk pools best mitigate adverse selection by attracting younger populations.[135] By marketing long-term care insurance as a bundling option to younger life insurance or annuity purchasers, insurers could both expand awareness of the benefits of long-term care coverage while simultaneously decreasing the average age of purchase. Any decrease in the age of purchase, of course, would enhance the risk pool and begin to mitigate the adverse selection problems the market faces.[136]

Perhaps most importantly, however, hybrid policies would have a transformative effect on another facet of the information gap. In addition to failing to appreciate their risk adequately, potential consumers of long-term care insurance also face a severe psychological barrier to purchasing a product they believe may be "lost" or "wasted." Unlike the case of auto insurance, in which people more readily accept the risk[137] of not using their policy, potential purchasers of long-term care insurance products have a unique fear of non-use that stems from the distant nature of the long-term care risk.[138] Hybrid policies, however, assuage this risk almost entirely. In the case of annuities, the insured has the capacity to accelerate or modify annuity payments to provide for long-term care needs, but failure to capitalize on this function of the policy does not render

---

motivation is the same. *See* Wiener, *supra* note 66, at 88.

135. *See* Garber, *supra* note 8, at 162-63 ("Many private long-term care insurance policies are structured like either whole-life or level-premium term life insurance. They are relatively inexpensive for people who begin purchasing coverage at a time when the probability of a claim is very low and adverse selection is unlikely to be a significant problem. Adverse selection is a far more serious problem at advanced ages, when functional impairment is frequent, because methods to screen for risk factors for institutionalization are imperfect. There would be difficulties even if adverse selection could be overcome, since actuarially fair insurance would be prohibitively expensive for many of the at-risk elderly.").

136. *See infra* p. 114-115.

137. Assuredly, those who do not have to use their policies are more properly considered lucky, not victims of risk.

138. Marc P. Freiman, *Can 1+1=3: A Look at Hybrid Insurance Products with Long-Term Care Insurance*, (AARP Public Policy Institute), May 2007, at iv ("some consumers may feel that they have 'lost' or 'wasted' all of their premium payments, even though they probably do not adopt similar perspectives towards home and car insurance.").

the policy "worthless," as the insured still receives annuity payments as scheduled. Similarly, in a hybrid life and long-term care insurance policy, the insured receives a benefit to help pay for long-term care needs that diminishes the total value of the policy. Again, however, the insured does not suffer the risk of "wasting" the policy in the alternative, as the death benefit and cash value remain undisturbed if no long-term care needs arise. As a result, when bundled with life insurance or with annuities, long-term care insurance hybrids would all but completely eliminate the danger – whether real or illusory – that purchasers would not derive full value from the product. In addition to the structural benefits that accrue to hybrids with life insurance and annuities, both forms of hybrids also carry with them a unique set of benefits.

LIFE INSURANCE HYBRID

When bundling long-term care insurance with life insurance, whole life insurance seems to serve as the best platform, given the dual savings and death components of whole life plans.[139] Similar to a partial withdrawal in a universal life insurance policy, upon the emergence of long-term care needs, the policyholder can file a claim that will carry with it a subsequent reduction of the death benefit.[140] Perhaps the greatest advantage of bundling long-term care with whole life insurance is the incorporation of a savings component into the long-term care insurance scheme, the absence of which is a long

139. *See* ROBERT H. JERRY, UNDERSTANDING INSURANCE LAW 37 (3d ed. 2002) (observing that whole life insurance "is really two things in one: it is a policy of term insurance *and* a savings plan. Part of every premium covers the cost of the insurance, and the remainder goes into the savings component of the product.").

140. *See* Elizabeth Ody, *Insurers Pair Long-Term Care with Life to Entice Older Buyers*, BLOOMBERG, May 17, 2011, http://www.bloomberg.com/news/2011-05-18/insurers-pair-long-term-care-with-life-to-entice-older-buyers.html. One example of this dollar-for-dollar reduction is an accelerated death benefit that acts as an optional rider on a life insurance policy and permits the policyholder to "accelerate" all or part of the death benefit when certain qualifying events or triggers occur. *See* Freiman, *supra* note 138, at id.

heralded deficiency of long-term care insurance policies.[141] As one industry expert observed:

> [M]ost people have only limited resources, and many are unwilling to purchase insurance where the policy offers no accumulation feature; i.e., where the premiums paid are lost to the policyholder if the insurance is not used. Without some sort of 'savings' feature, consumers with limited resources often were not willing to purchase insurance, including long-term care insurance, even though they recognize its importance.[142]

At least one empirical study confirms this observation, finding that demand for long-term care insurance policies would be higher if a savings component were included.[143] The savings component of the life insurance hybrid would therefore substantially increase the desirability of the hybrid product relative to the individual long-term care policy. In addition to providing a savings component, the bundling of long-term care with life insurance also has the potential to reduce premium costs through decreased administrative costs and savings associated with the dual benefit structure. Accordingly, the savings component and the potential for premium reduction of life and long-term care hybrids, along with the structural benefits outlined above, point to the viability of life and long-term care insurance hybrids as a means of expanding long-term care coverage.

ANNUITY HYBRID

As with the life insurance hybrid model, annuities bundled with long-term care coverage also offer an investment component; indeed, annuities are considered an investment

141. *See supra* note 49 and accompanying text.

142. *Planning for Long-Term Care: Testimony Before the Subcomm. on Health, Comm. on Energy and Commerce*, 109th Cong. 8 (2006)(statement of Gregory F. Jenner, American Council of Life Insurers).

143. NEW YORK DEPARTMENT OF HEALTH, NEW YORK STATE MANAGED LONG-TERM CARE, REPORT TO THE GOVERNOR (2005), http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_final_rep.pdf.

rather than insurance by most courts.[144] Yet the annuity hybrid carries with it the particularly unique benefit of offsetting the respective adverse selection risks of individual long-term care and annuity policies.[145] Individuals more likely to need long-term care services are also less likely to live a long time, as they are typically less healthy.[146] Accordingly, by bundling the two products, the relative need for underwriting is diminished.[147] In a 2001 study, Murtaugh, Spillman, and Warshawsky found that the hybrid product would reduce premium costs by at least five percent relative to the individually sold products.[148] Building off this analysis, Webb confirms that the selection effects for each particular market work in opposite directions and that the bundling of the two products creates an equilibrium allocation that not only benefits from this offsetting selection effect, but also proves more attractive than the stand-alone products.[149] While both of these analyses were hypothetical, their findings are no less illuminating and likely represent conservative estimates of the potential of hybrid policies. Just as there is a critical level of adverse selection that can lead a risk pool into a "death spiral," so too is there a level of risk diffusion that can spur the growth of the market. Accordingly, the initial cost-savings benefit that insurers and insured's would derive from hybrid long-term care annuities would likely have compounding effects.

---

144. *See, e.g.*, Jerry, *supra* note 139, at 44; NationsBank of North Carolina v. Variable Annuity Life Ins. Co., 513 U.S. 251, 251-2 (1995); Sec. & Exch. Comm'n v. Variable Annuity Life Ins. Co. of America, 359 U.S. 251, 252 (1995).

145. *See* JUDITH FEDER, HARRIET KOMISAR, ROBERT B. FRIEDLAND, LONG-TERM CARE FINANCING: POLICY OPTIONS FOR THE FUTURE, GEORGETOWN UNIVERSITY LONG-TERM CARE FINANCING PROJECT 27 (2007), http://ltc.georgetown.edu/forum/ltcfinalpaper061107.pdf.

146. *See* David C. Webb, *Long-Term Care Insurance, Annuities and Asymmetric Information: The Case for Bundling Contracts*, LONDON SCHOOL OF ECONOMICS 21 (2006), http://eprints.lse.ac.uk/24507/1/dp530.pdf.

147. *See* FEDER, *supra* note 145, at 27.

148. Christopher Murtaugh, Brenda Spillman, and Mark J. Warshawsky, *In Sickness and in Health: An Annuity Approach to Financing Long-Term Care Insurance*, 68 J. RISK & INS. 225, 227 (2001).

149. *See* Webb, *supra* note 146, at 26.

STRATEGIES FOR STIMULATING THE HYBRID MARKET

Given the potentially significant benefits of an expanded hybrid market, the need to encourage growth of the market seems self-evident. Although a comprehensive plan to develop the hybrid market is beyond the scope of this Article, a few strategies and challenges bear mention. First, while the creation of tax incentives to spur the growth of the long-term care market has not yielded dramatic results thus far, this apparent inadequacy does not lead to the conclusion that tax incentives are an inapt vehicle for growth.[150] Under the Pension Protection Act of 2006, tax free exchanges are now possible between annuities, life insurance, and long-term care contracts, but in order to compensate for the lost revenue, legislators implemented a requirement that insurers capitalize a percentage of their policy acquisition expenses for a particular line of insurance.[151] This percentage varies by product – 1.75 percent for annuities, 2.05 on group life, and 7.7 on other insurance including hybrid products – thus creating a disincentive for sale of hybrid products.[152] Not only should policymakers remove this functional inhibition, but they should also create additional incentives specifically for hybrid products. Further, in order to cultivate a sustainable hybrid market, lawmakers must address the fragmented regulatory system insurers will face and the difficulty consumers will have in understanding a hybrid of two products that are complicated in their own right.[153] The reality that regulators already struggle to adequately monitor individual long-term care insurance products only further underscores the need for an improved regulatory structure.[154] One initial strategy to combat these difficulties could be to incorporate the hybrid products into the already existing

150. *See infra* p. 118-121.

151. Pension Protection Act of 2006, Pub. L. No. 109-280, 120 Stat. 780 (2006) (codified in scattered sections of the I.R.C. and 29 U.S.C.).

152. *Id.; See also* Freiman, *supra* note 138, at 19.

153. *See* Freiman, *supra* note 138, at vi, 19.

154. *See supra* notes 56-57 and accompanying text.

structure of state partnership programs for long-term care.[155] The framework provided by the partnership programs could provide a valuable platform for developing a unified regulatory format and for aiding consumers in choosing the product that best suits their needs.

These suggestions, however, are merely intended as a springboard for further analysis and inquiry by scholars, lawmakers, and regulators into the viability of different strategies for expanding the hybrid market. Regardless of the perceived utility of the strategies outlined above, the central point remains that the present regulatory incentive structure will not prove adequate in the effort to expand the hybrid market.

CONCLUSION

The development and promotion of hybrid policies has significant potential to expand coverage of our nation's long-term care needs by addressing the structural problems that the private and public sectors have faced in their effort to provide long-term care insurance. The long-term care insurance market, however, faces a complex array of issues that demand a correspondingly comprehensive response. Hybrid plans can provide a catalyst for growth, but their promotion will not act as a panacea. If the nation is to meet its long-term care needs, hybrid plans must be part of a broader framework of policies aimed at alleviating the overburdened Medicaid system and widely expanding private coverage. For example, the development of a catastrophic public benefit program could serve as a relatively inexpensive but valuable complement to the private market that would incentivize participation in the private market.[156] Still other mechanisms exist, but they require both the devotion of energy on the part of policymakers and, most importantly, a recognition of the serious challenges that the private market and Medicaid face. As the nation ages, these

155. *See infra* p. 121-123.
156. *See* Garber, *supra* note 8, at 164.

challenges will only continue to grow more daunting. Delayed action and maintenance of the status quo are no longer viable options.