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AN ESSAY ON THE NEED FOR SUBSIDIZED, MANDATORY LONG-TERM CARE INSURANCE†

LAWRENCE A. FROLIK*

Imagine yourself in a room with 100 persons, all age sixty. Of the group, fifty-three are women and forty-seven are men. Racially and ethnically they mirror the population of Americans age sixty. Now answer the question: "Before the 100 die, how many will require long-term care and, on the average, for how many days and at what cost?" Give up? So do I. While it is common knowledge that many of us will need long-term care, no one seems to know how many will need such care or for how long.¹ And some of you will ask, "What do you mean by 'long-term care?'" Here again, there is no consistent answer.² Certainly, care provided in a nursing home and probably in an assisted living facility qualifies as long-term care, but are all residents of board and care homes receiving long-term care? And what of those receiving assistance from a spouse? How much assistance is needed to be considered long-term care? What of the elderly who live with a child or a relative? Surely some do so because of the need for care, but not all. We have no knowledge of how many elderly who live with another do so primarily to receive assistance or care. Other elderly live alone and contract for care in their home, but here too we have no idea of the number. Other forms of care may or may not qualify as providing long-term care. For example, is adult day care long-term care? Are the elderly who spend some or all of the day at a senior services

† On November 9, 2006, the *Notre Dame Journal of Law, Ethics & Public Policy* hosted a symposium entitled "Long-Term Care for America's Elderly: Who Is Responsible, and How Will It Be Achieved?". Professor Frolik was the third speaker at the Symposium. His remarks have been revised for publication.

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1. While there are data as to nursing home rates of occupancy, many elderly receive long-term care at home, in assisted living facilities and in board and care homes. We have no national statistics that compile the number of individuals receiving long-term care, in part because we have no consistent definition of what is "long-term care."

2. See, e.g., JOHN C. CAVANAUGH & SUSAN KRAUSS WHITBOURNE, *GERONTOLOGY: AN INTERDISCIPLINARY PERSPECTIVE* 433 (1999) (describing different situations that could be considered long-term care).

center recipients of long-term care or just lonely individuals in search of companionship and a good meal?

Because of the lack of information as to the current need for long-term care, we just do not know what the probability is of today's sixty year-olds needing long-term care. Even our sketchy idea of how many elderly are presently receiving long-term care tells very little of the prospects of today's sixty year-olds requiring long-term care. We do know that the age at which individuals require long-term care is growing older, so that the onset of the need for long-term care is delayed until later years.³ But we do not know if that translates into a shorter period of long-term care or whether it just means that where formerly the average age of long-term care recipients was age eighty and the length of care was eighteen months, on the average today's sixty year-olds will not need long-term care until age eighty-eight, but the average length of care may be longer than eighteen months. If our sixty year-olds do receive long-term care, it may or may not cost as much as the care provided today's recipients. For example, if the use of nursing homes declines in favor of receiving long-term care in assisted living facilities, the savings could be considerable. Or we might face an epidemic of diabetes, which might cause a sharp rise in both the number of individuals needing long-term care and the cost of that care. In short, we have no sure answer to at what age and for how long today's sixty year-olds will need long-term care.

What of the question, "What is long-term care?" Interestingly there is at least one source for an answer—long-term care insurance policies provide a definition as a means of defining when an individual has the need for long-term care and so triggers the payment of benefits under the policy.⁴ Still, equating long-term care with what an insurance company considers "long-term care" for purposes of paying benefits has some obvious drawbacks. The most apparent is that an insurer might limit the definition of long-term care in order to minimize benefit payments. True, but still, at least insurance companies have a definition and, more importantly, it works in the sense that the policy definition does provide a reasonably bright line test for when an individual qualifies for "long-term care" benefits. The policy definition distinguishes long-term care from other kinds of care such as acute or merely personal, elective care. It does so not by focusing on the type of care, but the nature of the need for care.

3. WILLIAM C. COCKERHAM, *THIS AGING SOCIETY* 29 (2d ed. 1997).

4. ABA, *LEGAL GUIDE FOR AMERICANS OVER 50*, at 188 (2006).

Typically, long-term care insurance benefits are paid when the insured has a medical condition that necessitates long-term care (certified by a physician), a cognitive deficit that necessitates supervision or custodial care (most commonly some kind of dementia), or when the insured cannot perform two of the activities of daily living.⁵ While these definitions can be seen as a bit too restrictive—for example someone whose only limitation is an inability to bathe without assistance might well be thought of as needing long-term care—at least these standards describe who needs long-term care. Moreover, the definition focuses on who needs care rather than where they receive it, which is the more relevant point. That is, most long-term care insurance policies pay benefits to insurees who qualify whether they live at home, with relatives, in an assisted living facility, or in a nursing home, though the daily benefit amount may be less if they do not live in an institution.

Unfortunately, a definition of who needs long-term care does not tell us how many persons need it today, much less how many of today's sixty year-olds will need it in the future. Of course, insurance companies must have some notion of the future demand for long-term care or how could they set the premiums for the policies that they sell? But that knowledge is proprietary, possibly not even very accurate, and pertains to those who purchase long-term care insurance, not to the universe of sixty year-olds. For example, those with lower incomes naturally are under-represented as purchasers of long-term care insurance, but given what we know about the poorer health of persons with lower incomes, they are likely over-represented in the population of those who need long-term care.⁶ Nevertheless, the deeper point is that long-term care can be defined and the demand estimated well enough to support the sale of long-term care insurance.

For the individual, however, the future need for long-term care is unknowable. It is an uncertain risk because an individual has no way of determining the odds of needing long-term care, nor the length of time it will be needed and not even the daily cost of such care. With all three of the variables up in the air, so

5. Activities of daily living, or ADLs, are most often defined as the ability of an individual to eat, bathe, dress, use the toilet, or transfer (get out of a bed or chair) without assistance. An individual could have an ADL deficit because of a medical condition such as a stroke, a cognitive deficit such as dementia, or merely because of extreme frailty. Joshua M. Wiener, et al., U.S. Department of Health and Human Services, *Measuring the Activities of Daily Living: Comparisons Across National Surveys*, reprinted in 45 J. OF GERONTOLOGY S229 (1990).

6. JOHN A. VINCENT ET AL., *THE FUTURES OF OLD AGE 50-52* (2006).

to speak, long-term care is a threat of unknown and unknowable proportions.

Even though it is an uncertain risk, it nevertheless represents a very serious financial threat. Currently, nursing home care can run \$5,000 to \$10,000 a month.⁷ Three years in a nursing home can cost over \$170,000. Assisted living costs about one-half that, but still exceeds the income of many elderly individuals.⁸ Home care, which is thought to be a better alternative, unfortunately can cost even more than a nursing home, particularly if an attendant is available around the clock.⁹ In contrast, not all long-term care costs are overwhelming. For example, an individual might only require care for five months so that even if the person is in a nursing home, the cost of care would be only \$30,000 to \$40,000. And of course some will never need long-term care and decline and die quickly. Finally, some will need a great deal of medical care before they die, but if that care is covered by Medicare, such as when a patient has cancer, Medicare will pay for almost all of the cost. For example, Mary contracts cancer and spends the last three months of her life in a hospital. Her medical care costs \$100,000, but Mary has sufficient coverage by Medicare to pay for almost all the cost of her hospitalization.¹⁰ In contrast, Mark spends the last eighteen months of his life in a nursing home suffering from dementia. He finally dies of pneumonia. The cost of the nursing home care was \$6,000 a month, or \$108,000 annually. Medicare does not pay for long-term custodial care, and so Mark has to pay over \$100,000 out of

7. AARP Bulletin, Average Daily Cost for Nursing Home Care by State, 2006 (citing Genworth Financial 2006, Cost of Care Survey, Nursing Homes, Assisted Living Facilities and Home Care Providers, March 2006), available at <http://www.aarp.org/bulletin/longterm/Articles/a2003-10-30-dailycost.html>.

8. Therubins.com, The Cost of Assisted Living in Select Areas Across the United States, <http://www.therubins.com/assisted/costof.htm> (last visited Mar. 30, 2007).

9. The Federal Long Term Care Insurance Program, How Much Does Long Term Care Cost?, http://www.ltcfeds.com/start/aboutltc_cost.html (last visited Mar. 30, 2007).

10. Medicare pays for the first sixty days of hospitalization less an annual deductible of \$992 in 2007. The next thirty days are also covered by Medicare with a daily co-pay of \$248 in 2007. U.S. Department of Health and Human Services, Medicare Premiums and Coinsurance Rates for 2007, http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std_adp.php?p_faqid=1847 (last visited Mar. 30, 2007). But if Mary has a Medigap policy, which she almost certainly does, the policy will pay the daily co-pay for days sixty-one through ninety. For information on Medigap coverage see LAWRENCE A. FROLIK & MELISSA C. BROWN, ADVISING THE ELDERLY OR DISABLED CLIENT 13-37 (1992 & Supp. 2006).

his pocket. In a sense, Mary was “lucky” to have contracted cancer because Medicare paid for almost all of the cost of her care.

So, returning to our 100 representative sixty year-olds, there they are without a clue as to whether they need long-term care or how much it might cost them. All they know for certain is that they face a potential risk that could bankrupt many of them.

When faced with an exceptionally costly, but uncertain financial risk, the answer is either to self-insure or purchase insurance. Self-insuring means either assuming that the extraordinary expense can be paid for out of income, or saving for the possible cost. Purchasing insurance in this case means buying long-term care insurance. Let us examine the two choices.

Preliminarily, it must be acknowledged that a few, but very few, elderly will be able to pay for all their long-term care costs solely out of their income.¹¹ For example, if the individual is age eighty-nine, single, and has an annual income of \$100,000, she will be able to pay a monthly nursing bill of \$7,000, or \$84,000 a year out of her annual income.¹² A caveat: twenty years from now, when our now sixty year-olds needs long-term care, what will be the monthly cost of a nursing home? Though \$7,000 a month seems high today, it may be a bargain in twenty years if the cost of long-term care continues to rise. And if our projected sixty year-old has an annual retirement income of \$150,000, it is unlikely that the income will rise at the same percentage that the cost of long-term care does. So even high-income sixty year-olds may find that they cannot pay for all of their long-term care costs strictly out of income.

In light of the limited income of the elderly, the great majority will need to use their savings to help pay for their long-term care, particularly if they enter a nursing home. By savings, I refer to savings accumulated for retirement income purposes such as a 401(k) account. And by “retirement income” I refer to income needed for the typical, predictable costs of living: food, shelter,

11. In 2004, for householders with someone age sixty-five or older the mean income was \$38,963 and the median was \$25,210. For fiduciary relationship households, the 75th percentile of average income was \$46,600. PATRICK PURCELL & DEBRA B. WHITMAN, CONGRESSIONAL RESEARCH SERVICE, TOPICS IN AGING: INCOME OF AMERICANS AGE 65 AND OLDER, 1969 TO 2004, at 28–29 (2006).

12. I use “she” deliberately because at any age past sixty, there are more women living than men. So the elderly individual is more likely to be a “she” than a “he.” See Denise Smith, U.S. Census Bureau, The Older Population in the United States: March 2002, available at <http://www.census.gov/prod/2003pubs/p20-546.pdf>.

entertainment and health care other than long-term care. Savings for retirement must be spent in a manner that stretches the spending out over the life of the individual. One way to do this is to purchase an immediate pay, lifetime annuity with the savings. The purchase of an annuity is a bet of sorts; a bet by the annuitant that she will live longer than her life expectancy. If she anticipated a premature death, she could spend down the savings at a rate projected to exhaust the fund in the year of her expected death. If the individual who needs long-term care has converted her savings into an annuity, however, her yearly income may still be insufficient to pay for the costs of the care. For example, if she uses her \$400,000 of savings to buy a lifetime, fixed annuity that pays \$50,000 a year, she will not be able to afford an annual nursing home expense of \$60,000.

Of course, high-income elderly and some not high-income elderly will have savings, considerable savings in some cases. These elderly, who may be able to afford the cost of their care by using their incomes and drawing down their savings, will not need to take any special pains to save for long-term care costs. For example, Stephen has annual income of \$50,000 and savings of \$300,000. Even if faced with annual long-term care costs of \$70,000 a year, he could pay for his care for fifteen years and if the cost rose over time to \$90,000, he could pay for eight years. Many more will have some savings but not enough to bear the cost of lengthy and expensive long-term care. For example, Susan has income of \$40,000 a year and savings of \$100,000. She enters a nursing home that costs \$70,000 a year. She has enough income and savings to pay for about three years of care. Perhaps that will be enough, perhaps not, but if Susan dies after three years, she will die penniless.

The number of elderly who are well prepared financially to pay for long-term care is small and becomes even smaller if they are married and so must use their income and savings for both their long-term care and also to support the spouse who is not in long-term care (the "community spouse" in Medicaid nomenclature). Spending the income and drawing down savings to pay for long-term care for the spouse in the nursing home can impoverish the community spouse. For example, Janet and Jim have an annual combined income of \$60,000 and savings of \$300,000 that produces \$15,000 a year of their income. Jim enters a nursing home at an annual cost of \$70,000. Janet pays \$25,000 of the cost from their income (leaving her with \$35,000) and the remaining \$45,000 from savings. After three years and some increase in the cost of the nursing home care, Jim dies with \$150,000 having been spent from the savings. Janet now faces

life with only \$150,000 in savings, meaning \$7,500 a year less investment income, and the loss of Jim's Social Security benefit of \$20,000 a year. As a result, her income is reduced to \$32,500 a year. While not impoverished, Janet will certainly not live as well as she did before Jim entered the nursing home.

Moreover, the community spouse may also need long-term care someday. But if all the couple's money has been spent on the first spouse's care, where are the funds to pay for the care of the second spouse? As we can see, paying for long-term care costs can be a disaster for married couples. In our example of Janet and Jim, if after Jim dies, Janet enters a nursing home at a cost of \$70,000 a year, she will have to use about \$40,000 a year from her savings with the result that in about three years she will be destitute. As demonstrated, income and savings may be enough to pay for long-term care, but only for a limited time for most elderly.

In sum, income plus savings (including the value of the house) that are not converted into an annuity (and many financial advisors recommend putting half of one's savings into an annuity) may meet the cost of long-term care, but only if: (1) the amount of savings is great enough, which means that it far exceeds the national average; (2) the duration of the need for long-term care is not too long; and (3) there is no community spouse dependent on the savings or living in the house. For many elderly, these conditions will not materialize with the result that if they need long-term care for any extended period, they will not be able to afford it.

I have not discussed saving specifically for long-term care because it makes no sense. No one is going to save, for example, \$200,000 beyond what they save for retirement and not touch it, not even the income, to protect against the rising cost of long-term care. To so imagine would be to assume that an elderly person would accept a lower standard of living just to preserve assets for possible long-term care costs. Yes, some elderly do not spend all the income produced by their savings, but they do so out of fear of outliving their savings or because they want to pass on a financial legacy to their heirs; not because they are holding back funds solely to pay long-term care expenses.

For those who cannot afford the cost of long-term care and who do not have long-term care insurance, the national solution is Medicaid, the federal-state subsidy for the cost of nursing homes.¹³ Medicaid is a need based program.¹⁴ To be eligible for

13. FROLIK & BROWN, *supra* note 10, at 10-12 (1992).

14. *Id.* at 10-3

Medicaid, the individual must exhaust her savings and apply essentially all of her income to paying for the cost of her nursing home.¹⁵ For married couples, some provision is made for reserving income and savings for the community spouse, but again, the intent is to squeeze out as much of the payments as possible from the savings and income of the couple with the result that many community spouses face a sharp reduction in their quality of life.¹⁶

If income or savings are not sufficient to pay for long-term care, the apparent alternative to personal impoverishment in order to qualify for Medicaid is to purchase long-term care insurance. Or is it?

The universal rule as to insurance is to buy it to protect against an unacceptable risk of loss.¹⁷ Does the cost of long-term care fit that model? Yes and no. Long-term care costs can be an unacceptable risk if the loss of income and savings to pay those costs is considered an unacceptable risk, which it can be. But merely because long-term care costs can be very high, even to the point of impoverishing the individual, does not prove that such costs pose an unacceptable risk. Even the risk of impoverishment can be an acceptable risk if it does not result in a diminution in the quality of the individual's life, and if the individual can accept dying with no estate. And Medicaid payment of nursing home costs fits that paradigm. Recipients of Medicaid who reside in a nursing home receive care that is indistinguishable from that received by all but a few residents who pay a premium for care that exceeds what Medicaid will pay for. Most private pay nursing home residents receive care that is the same as what is provided for Medicaid recipients. Whether an individual is willing to exhaust her estate in order to qualify for Medicaid is less certain. For some, dying without leaving an estate to children or others would be unacceptable. For others, it is an unpleasant but acceptable risk in light of the cost of the alternative: long-term care insurance.

Initially it should be observed that long-term care insurance is more like fire insurance on a home than like life insurance, because like fire damage on a home, the need for long-term care is not sure to occur. It is perhaps more likely than a home fire,

15. *Id.* at 10-8 to 10-9.

16. The community spouse is entitled a spousal resource allowance of no more than \$101,640 of assets (in 2007) plus exempt assets such as the house and a car, and a monthly Minimum Maintenance Needs Allowance of at least \$1,650 (as of July 1, 2006). *Id.* at 10-10 to 10-11.

17. *Cf.* EMMET J. VAUGHAN, *FUNDAMENTALS OF RISK AND INSURANCE* 21 (4th ed. 1986) (describing insurance as "the most formal" way of dealing with risk).

but unlike death, not 100 percent. So, the first question is how high is the risk of long-term care for the individual contemplating its purchase? Next, how much care or how long will the care be needed? For example, assuming that seventy percent of today's sixty year-olds will someday need long-term care (an arbitrary but plausible percentage), we must ask how many will need it for more than a year? Then we must ask how much will the long-term care cost? We know long-term care comes in many forms, from modest assistance in the home, to adult day care, to assisted living, and finally nursing home care. So even if the risk is twenty percent for needing care for at least eighteen months, the cost of that care may average only \$50,000 because most of it will not occur in a nursing home. Imagine for example, Jenna, who at age eighty-five must leave her apartment and move into assisted living because of mild dementia. She spends a year in assisted living at a cost of \$35,000. Her health declines, and so she moves into a nursing home at an annual cost of \$70,000. After a year, she dies. The total cost of her long-term care is \$105,000. Costly, but not overwhelmingly so.

Suppose, however, that ten percent of our sixty year-olds will need long-term care for two years or longer at a total median cost (not mean) of \$200,000, with five percent facing lifetime long-term care costs in excess of \$300,000 (such as five years of care at an average rate of \$60,000 per year), and two percent incurring costs of at least \$500,000. While these dollar amounts appear to be "unacceptable risks," they are not necessarily unacceptable except in context.

For a single individual (or a surviving spouse), long-term care costs exceeding as much as \$300,000 are only unacceptable if she wants to protect the value of her estate. Otherwise even spending \$500,000 has no deleterious effect. For example, imagine Gail, a ninety year old widow with assets and a house worth \$400,000, plus annual income of \$40,000. If she moves into a nursing home that costs \$8,000 a month, or \$96,000 a year, she has income and assets sufficient to pay for at least seven years. That is, she will spend all of her annual income, plus \$56,000 a year from her savings, which will last for about seven years. If she dies after seven years, her estate will be almost completely depleted, but she will not have suffered; only her potential heirs will be out significant sums.

Suppose Gail has only \$200,000 in savings and annual income of \$20,000. If she incurs annual nursing home costs of \$96,000, she will exhaust her funds in about two and a half years. The response is, "So what?" Having impoverished herself, she will be eligible for Medicaid. If she lives in a nursing home for

another five, six, or even ten years, it makes no difference, as Medicaid will pay for the same level and quality of care that she received as a private pay individual. Yes, her estate will be reduced to zero value and her heirs will receive nothing, but her need for long-term care will be met. True, if she had the funds, she might have purchased care in a nursing home that offers somewhat better care than that paid for by Medicaid, such as having a private room. But only a very small percentage of the elderly in nursing homes, even though they are private pay residents (at least until their funds are exhausted), receive care that differs in any way from what residents receive who are on Medicaid.¹⁸

Because Medicaid provides the same quality of care for most recipients that they would have purchased with their own funds, they have little incentive to avoid using Medicaid as the source of payment for their long-term care. The most compelling incentive for avoiding Medicaid is the need of the community spouse, who will almost always suffer economically if the institutionalized spouse (the Medicaid term for the spouse in the nursing home) is on Medicaid. Although the community spouse will be permitted to keep all her income from her pensions and Social Security, she will no longer have the income of the institutionalized spouse to help support the household, unless she qualifies for additional income from the institutionalized spouse as part of the Minimum Monthly Maintenance Needs Allowance.¹⁹ But that additional income ceases at the death of the institutionalized.²⁰ A married couple's purchase of a couple of long-term care insurance that would cover both of them could provide additional income that would delay or avoid having the institutionalized spouse go on Medicaid to pay for nursing home expenses. The benefits paid by the insurance would protect the income of the community spouse as well as the couple's assets, thereby helping to financially protect the community spouse.

The other reason to avoid the need for Medicaid by purchasing long-term care insurance is to protect the value of the estate of the individual or the couple. That is, insurance protects the savings from depletion. Even if Medicaid is never going to be needed because the income and savings are adequate to pay for the care, long-term care insurance will insure that the estate will suffer less or no shrinkage on account of paying for long-term care.

18. Because of the need to qualify for Medicaid, almost all nursing homes provide care that meets the Medicaid standard such as two residents per room.

19. FROLIK & BROWN, *supra* note 10, at 10-20 to 10-22.

20. *Id.*

Of course, the degree of protection of the community spouse and the estate depends on the amount of insurance benefits. For example, if the daily benefit of the insurance is \$150 for five years, the maximum benefit equals \$54,750 per year, or \$273,750 for five years.²¹ A lot of money to be sure, but not an exceptional amount in terms of estate protection, as it is likely less than the value of the individual's house. If the insurance benefit was not time limited, it could be a larger amount, but that assumes that the insured individual buys long-term care insurance that pays benefits for more than five years. Still, even if we assume that the benefits are not time limited and are paid for eight years, the total benefits would be \$438,000. If the daily benefit is raised to \$200 the numbers are not that much different: an annual benefit of \$73,000 or five years' worth of benefits of \$365,000—still not an overwhelming sum. For eight years the total is \$584,000, an impressive amount, but one that is unlikely ever to be paid given how few elderly would qualify for eight years of long-term care insurance benefits.

The question is whether the advantages of long-term care insurance are sufficiently appealing to induce our mythical group of sixty year-olds to buy it. To date, the answer appears to be no, as only a small percentage of the elderly own long-term care insurance.²² For many, the advantages are not compelling. For single elderly individuals, the need to protect a spouse is absent. For couples, the desire to protect an estate may be lacking or they may simply not see the reason to bear the cost of the premiums to buy insurance that will not benefit them but only their heirs. Most are not aware of the potential financial disaster that can befall a community spouse, and so do not realize the value of long-term care insurance in terms of protection of the community spouse.

Some single persons purchase long-term care insurance because they fear that Medicaid may not be available in the future when they need it or they wish to be able to purchase better care than that provided by Medicaid. Some may buy long-term care insurance because they want the benefits in the event they need assisted living. Modern long-term care insurance policies pay the same benefit whether the individual lives in an

21. This ignores inflation adjustments because present value is used to make the comparison. Future projected inflated dollar amounts would make the same point.

22. The total number of individual policies appears to be fewer than six million. See Insurance Information Institute, *Facts and Statistics: Long-Term Care Insurance*, <http://www.iii.org/media/facts/statsbyissue/longtermcare> (last visited March 30, 2007).

assisted living facility or nursing home, assuming the individual otherwise qualifies for the benefits. Because assisted living costs about half of what is charged by nursing homes, long-term care insurance benefits combined with the individual's savings and income, may permit a single individual to stay in an assisted living facility until death. Without the long-term care insurance benefits, the individual might exhaust her savings and, lacking enough income to pay for assisted living, she would have to move into a nursing home because Medicaid will not pay for long-term care delivered in an assisted living facility. Of course, that could change; Medicaid might become liberal in what it will pay for, but that is not the case today and may never be the case. Long-term care insurance benefits give the insured the comfort that the insured will have more choices as to where to receive long-term care.

Other single individuals and couples buy long-term care insurance because it now typically pays for home health care benefits, albeit often at one-half the daily rate of the benefits paid if the insured is in an institution. The insurance is sold as a means of staying in one's house rather than moving to an assisted living facility or a nursing home. Interestingly, purchasing long-term care insurance for its home health care benefits is probably the least compelling reason to do so because the reduced benefit amount is very unlikely to be sufficient to purchase care in the home for any length of time. For example, if the policy pays a benefit of \$150 a day for an institutionalized insured, the home health care benefit would be \$75 a day. To qualify for the benefit, the insured will have to submit documentation of a medical need for care, deficits in two activities of daily living, or have significant cognitive impairment. If any of these three conditions prevail, the individual will need a good deal of assistance in order to remain at home. And the policy may require a showing that care is being provided by non-family members in order to trigger the payment of benefits. It is difficult to imagine that \$75 a day would be enough to meet the cost of the needed care. Yes, it would be a base that could be supplemented by income or savings, but \$75 a day is only \$2,250 a month and \$27,000 annually, which is hardly a sum that in most cases would be a tipping point as to whether the individual could stay at home. Yet, despite these limitations, benefits paid for home health care are an attractive feature in the eyes of many purchasers of the insurance.

Even if buying long-term care insurance can be a rational and effective response to a significant financial risk, those for whom it would be a wise choice nevertheless often do not

purchase it. Why? It seems that the underlying reasons for the relatively low sales of long-term care insurance are cost, ignorance, and blind hope that it will never be needed. These reasons are intertwined in ways that reinforce each other.

The younger the age at which the policy is commenced, the lower the premium. However, selling long-term care insurance to, for example, a fifty year old, is difficult. I have a single friend who purchased long-term care insurance at age forty-five, but she teaches elder law and is acutely aware of why she might want long-term care insurance. She is the rare exception. Most of us do not even imagine a need for long-term care, much less insurance, until we are in our sixties or, more likely, our seventies. Even though most of us will have been alerted to the cost and possibility of long-term care by the experiences of our parents and other older relatives, we still refuse to admit that some day we too may be a demented resident of a nursing home. It is just too painful to contemplate.²³ Just as a life insurance agent knows that it is difficult to focus a potential customer on the possibility of his or her own death despite it being an absolute certainty, it is even more difficult to persuade a healthy sixty-five year-old to buy insurance to pay for the much less than certain need for long-term care. In short, individuals find it difficult to purchase long-term care insurance at an age when it is affordable in part because it is easy to ignore an uncertain and unpleasant risk. Not surprisingly, even someone who rationally considers the need for long-term care insurance might decide not to purchase it largely because she underestimated the need for it or undervalued it. That is, a childless sixty year-old single woman might not be aware of her very long life expectancy or not understand that if she is single and childless she has a higher probability of residing in a nursing home. Likewise, even if a seventy year old single male understands the risk, he might well conclude that the annual cost of long-term care insurance is just too high in light of his limited income.

Other factors also inhibit the sale of long-term care insurance. The paradox is that the risk of long-term care costs increases with age, while the ability to purchase the insurance declines with age. As the premiums increase with age and the ability to qualify decreases, the probability of letting a policy lapse increase. It is interesting to note that premiums do not rise after the policy is purchased merely because the insured ages. Premiums can and do increase, but only as a general increase for

23. See Elisabeth Belmont et al., *A Guide to Legal Issues in Life-Limiting Conditions*, 38 J. OF HEALTH L. 145, 149 (2005).

all policy holders. Initial annual premiums do not just grow actuarially to reflect the fewer years of anticipated premium payments, but also to account for adverse selection factors.

As individuals age, those who suspect that they will have long-term care costs will be disproportionate purchasers of long-term care insurance and their suspicions will be statistically accurate. Individuals with poorer health, who lack a spouse, or who observe older siblings with long-term care needs are more likely to purchase insurance than healthy, married individuals whose family history does not suggest a higher risk of long-term care. Premiums also rise faster than age because the insurer takes on more risk the fewer years it can expect to collect premiums from the insured. For example, if Acme Insurance Company sells long-term care insurance policies only to those age sixty-five to seventy or younger, it can expect on the average to collect premiums for fifteen to twenty years, the average life expectancy for that age group. Beta Insurance Company, in contrast, only sells policies to those aged eighty to eighty-five. Its average premium collection period will be eight to twelve years. Naturally Beta will charge higher premiums to reflect the fewer years that it expects to collect them, but it also must charge more for two additional risks.

First, if Beta has under-calculated the total benefit payments paid by the policies, it will have to raise the premium for the entire class of beneficiaries, because the policy will prohibit a rise in premium merely because the insured is older. But Beta will have fewer years to correct the initial miscalculation and collect sufficient premiums to make up the unanticipated shortfall. Acme, in contrast, has more years to collect higher premiums to correct for an initial under-pricing of the product.

Second, premiums are not the only source of benefit payments. Insurance companies invest premiums, and the income earned on the premiums is a significant source of benefit payments. Naturally, in our example, Beta knew when it sold policies to older purchasers that it had fewer years to invest the premiums, and so earnings on those premiums would supply a smaller percentage of the benefits than they would in Acme's case. Beta also knows that in addition to having fewer years, it has less opportunity to have its premium investments recover from low or even negative earnings. If Acme makes a poor investment or gets caught in a down stock market, its investments have more time to recover, thus it has less risk. The higher investment risk faced by Beta can only be offset by higher premiums.

The older the individual, the less likely he or she will be able to qualify for long-term care insurance because of health problems. Unfortunately, the very health problems that may make individuals uninsurable also alert them to the wisdom of purchasing long-term care insurance. For couples, the decline of one spouse may alert them to the need for long-term care insurance, but if the ill spouse is too impaired or sick, the couple might not qualify as purchasers. However, in most cases, the triggering cause will not disqualify the couple from insurance but only serve to motivate them to purchase it. At any age, individuals with poorer health are more likely to purchase long-term care insurance than their healthier compatriots. Those with declining health who buy insurance drive up the cost of the premiums because their poorer health leads both to an acceleration of benefit payments and to more benefits being paid per policy sold.

Finally, the longer the insured lives, the more likely he is to let the policy lapse. The percentage of lapsed long-term care insurance policies is the little secret that insurance companies carefully guard. From the point of view of the insurance company, a lapsed policy is a "good" policy. Ideally the policy would lapse just before the insured qualified for benefits under the policy. Next best is an insured who pays premiums for a number of years and then lets the policy lapse. Coming in last, but still good for the insurance company (or at least the agent who sold the policy), is the insured who lets the policy lapse after two or three years. While lapsed policies are good for the insurance company, they represent a financial loss to the insured—not a complete loss because the insured did have the advantage of the insurance coverage for some period of time, but a loss because the risk of long-term care costs rises with age. Thus, the value to the insured of a long-term care insurance policy value rises with advancing age, even though the premiums do not. Allowing the policy to lapse means that the insured has "overpaid" for the period of covered risk.

Why do individuals allow policies to lapse? Cost is the main reason. Premiums can rise over time. What may have seemed like a relative bargain at age sixty may seem like an unnecessary and too costly expense at age eighty-five. While the premiums are likely to rise, the income of the insured is probably not rising at the same percentage, meaning that the premiums represent a greater relative cost to the insured. Many individuals become very cautious about their expenses as they age. Faced with a fixed income and rising expenses for food, housing, and medical expenses, many older individuals begin to cut back on their living expenses, particularly reoccurring expenses. A quarterly

long-term care insurance premium may seem a burden that is not worth the cost because it may not provide actual benefit. Other elderly, who suffer from a decline in mental capacity, may fail to appreciate the importance of the insurance and focus only on its cost with the result that they stop paying the premiums. A few become too incapacitated to even realize that they are letting the policy lapse.

Faced with these and other impediments to the sale and continuation of long-term care insurance, it is hardly surprising that the product has such a low rate of market penetration. Even if sales increase dramatically, however, long-term care insurance is not likely to be a solution or even a significant source of funding for long-term care. Unless a large percentage of the elderly purchase it, long-term care insurance will remain a minor source of funding for long-term care and, in particular, for nursing home care.

If insurance is not the answer to a payment source for long-term care, the income and savings of those in need of long-term care are the initial source of payment. When those funds are exhausted, only two other sources are available. First, the children or other descendants of the person in need, and second the government.

Although there is some support for forcing children to pay for the long-term care of their parents, that support is tepid and often totally disappears when confronted with reality. It is easy to picture a very well-to-do child and a parent impoverished by the costs of long-term care. Requiring that child to pay for the care of the parent does not seem unreasonable. But that picture has little to do with reality. If a \$60,000 annual nursing home expense has impoverished the parent, it will also soon impoverish most adult children. If we do not want to impoverish the child, how many assets or how much income do we permit the child to retain? Should a child be permitted to retain savings for his child's education? Must a child sell or mortgage real property to pay for a parent's care? Which children should be required to pay? A state has jurisdiction only over those in the state. If the parent lives in Indiana and the child in Arizona, the state has no way to collect from the child. If there are two or more children, should the obligation to pay for the parent be only on the child who lives in the state of the parent? Even if the state has jurisdiction over all the children, which children should be expected to pay? Should the burden be assigned in proportion to the income and wealth of the child? What if the assets of the child are in the name of the spouse? Surely, we are not going to force a son- or daughter-in-law to support a father- or mother-

in-law? What of children who were “abandoned” by a non-custodial parent who did not pay court mandated child care? Do we think that the child is now responsible for the long-term care expenses of the parent who did not meet his obligation? For these and many other compelling reasons, states have long since abandoned any expectation that children should be compelled to bear the costs of their parents’ long-term care.

As for government bearing the cost of long-term care, that is the world we live in, though it is not a world that many of us would have designed. This is not the place to offer an extended critique of Medicaid, which pays for over forty percent of the cost of nursing home care. Suffice it to say, the program as currently constituted appears to be unsustainable. First, because states collectively pay for about half the cost of Medicaid, they are under great financial pressure to reduce its cost. States have responded in a variety of ways to reduce or at least limit the growth in the cost of the program including urging the federal government to restrict eligibility and force beneficiaries to expend more of their assets before they qualify for Medicaid reimbursement of their nursing home expenses. More state resistance can be expected in the years to come, with additional efforts by Congress to limit eligibility by, among other ways, attacking Medicaid eligibility planning techniques.

Limitations on Medicaid eligibility do not create a source of payment for long-term care. They merely create greater impoverishment of those in need of long-term care and their families. What is needed is a fresh source of funding for long-term care. The answer is to compel the public to save for the possible need for long-term care through mandatory long-term care insurance. While insurance is not normally thought of as a form of savings, when viewed in the aggregate, it is. For example, return to our imaginary group of 100 individuals, all age sixty. Now assume that they create a joint long-term care insurance fund. Actuaries calculate what level of premiums are necessary to sustain up to five years of benefits for each one of the group who may need long-term care, however that is defined. Each of the group pays into the insurance fund, which in turn is invested and held until needed to pay benefits. Collectively the group will have saved enough over their respective lifetimes to pay for the cost of their long-term care. Of course, some of the group will not need long-term care and hence, they will never collect benefits. For them, the cost of the premiums will be an expense rather than a form of savings. But for the group, the premiums represent savings held and invested to meet an actuarially predictable need—payment for the costs of long-term care.

The earlier the age at which the group begins to pay premiums, the smaller the premium must be because of the more years it is paid and, more importantly, the more the investment return.²⁴ To overcome the reluctance of individuals to purchase long-term care insurance necessitates that it be mandated. All contribute and all are potential beneficiaries.

Federally mandated long-term care insurance could be paid for by a tax on wages (or income for those with no wages) with a subsidy of the premium for those with very low incomes. The premiums could begin at age forty or perhaps fifty. The earlier the payment, the smaller the annual premium. The payment of the premiums could continue for an individual's life or they could be stepped down with advancing age or terminated upon retirement or an arbitrary age, such as eighty. Benefits would be paid based upon standards similar to current long-term care insurance, such as deficits in activities of daily living, significant cognitive impairment, or a medical need for such care. The premiums would be invested in order to reduce the cost of the insurance. Individuals could purchase additional long-term care insurance if they thought the benefits paid by the government mandated insurance were inadequate. Medicaid would continue to pay for nursing home care for those for whom the mandated insurance was inadequate, even when supplemented by their income or savings, or those who had exhausted their benefits.

The advantages of mandatory long-term care insurance are obvious. It would create a pool of funds from which to pay for much of the future long-term care costs. It would create national savings to meet a national expense. How much it would pay for each individual would depend upon the amount of the benefits, and that in turn would depend upon how high were the premiums. The rich, the middle class, and the poor would all benefit. The rich, who might be able to pay for their long-term care, would receive benefits that would increase the size of their estates or permit them to purchase better care. The middle class would be better able to preserve assets for their heirs and provide for a more comfortable life for a community spouse. In contrast to Medicaid, which only pays for nursing homes, mandated long-term care insurance benefits would also pay for assisted living and possibly home health care, thus providing the poor with funds to purchase long-term care in a variety of settings, and often at a lower price. And if the premiums of those with limited income were subsidized, they would have received even greater

24. The risk of paying benefits also increases slightly, but not in proportion to the greater investment return.

value from the insurance. Those of any economic class, who died after only modest or even no long-term care expenses, would have received the value of the insurance coverage in the same way that fire insurance has value even if the house never has a fire. In short, all economic segments of society would benefit from mandatory long-term care insurance.

The costs of long-term care must be borne by someone. Why not by all of us through an insurance arrangement? By collective action, we can meet the need of the individual to pay for long-term care and thus reduce by a bit our being "exposed to every risk and hardship."²⁵

25. JANE AUSTEN, *PERSUASION* 254 (Janet Todd & Antje Blank eds., Cambridge Univ. Press 2006) (1818).

