Choosing Long-Term Care Insurance

Let the market settle the choice between indemnity- and disability-type insurance, but offer Medicaid enrollees a subsidy to purchase either.

by Mark V. Pauly

Developing a method of insuring the cost of care for chronic and long-term illness that contains spending, that is attractive to potential insurance buyers, and that is acceptable to patients has proved difficult. Robyn Stone’s imaginative paper proposes a solution that is, in a sense, a return to the roots of health insurance and that on a priori grounds may have some merit. In addition to making some comments on insurance terminology and the conceptual pros and cons of this different approach to risk protection, I focus primarily on the broader question of how public, private, and mixed financing systems could deal with the problem of choice of insurance type.

The idea in Stone’s paper is that insurance should pay cash benefits to those whose ability to care for themselves has diminished, with the amount of the benefit depending only on the magnitude of impairment and not on the amounts, types, or persons supplying services. Paradoxically, this idea of paying a dollar amount conditional on the occurrence of an adverse event is not only a good example of pure insurance coverage, it is also the form that private health insurance in the United States took before the provider-dominated Blue Cross and Blue Shield plans changed the nature of coverage (but greatly expanded the market) in the 1930s and 1940s.

The earliest forms of health insurance were what are usually called “pure indemnity insurance”; they paid a specified fixed-dollar amount conditional on the occurrence of an adverse (usually accidental, but broadly defined) health event—so many dollars for the loss of a finger, more for the loss of a leg, and so forth. In theory, this is the best kind of insurance to have, both because it gives the insured maximum flexibility on how to use the benefit—repair, prosthesis, or compensating trip to Niagara Falls—and because it gives the insured ideal incentives to consider the cost as well as the benefit from any use of the funds. If the indemnity level is set properly, not only will the person be properly compensated for the loss, but the insurance-induced stimulation of the use of care (what is usually called “moral hazard” but inside the Beltway is named the “woodwork effect”) will not occur, since the insured person could have retained and used for other purposes the money that might go to an unnecessary test or hospital day.

Indemnity versus disability approach. What Stone labels “indemnity insurance” here is insurance that pays out for only a defined and limited set of medical services, sometimes in the form of a per day indemnity (for example, up to $100 for every day in a nursing home), especially characteristic of Medicaid and Medicare coverage. (Note that her version of the term indemnity, like the term liberal, now means something else.)
nearly opposite of its nineteenth-century use and definition.) This kind of insurance, whatever we call it, limits choice, leads to moral hazard, and probably has a higher administrative cost than the cost of simply cutting checks to pay cash benefits. So at first glance it appears that the “disability” approach is so superior to the service-benefits or “indemnity” approach that it is amazing that no one has discovered it before now.

Restraining excess claims. As someone who has advocated a greater use of the “true indemnity” (or disability) approach, I have considerable sympathy with the ideas Stone discusses. But I do think that the negatives for this approach are somewhat more severe than is apparent from the discussion. The problem with using cash payments conditional on the state of health is that one needs to be able to measure the state of health objectively and accurately. The issue is not primarily the cost of measurement—it would be very cheap to administer long-term care insurance that mailed money to every insured person who said that they had difficulty climbing stairs. The primary issue is the imprecision and the manipulability of the measurement. The issue is whether the insurance dollars—which will be reduced to some extent by insurers’ administrative costs—will be delivered to people only when they need them the most. If (as I fear) not, then “disability” insurance will be coverage that is great to have but too expensive to buy.

There have been methods that service-benefits long-term care insurers have developed to measure health state, primarily in the form of measures based on activities of daily living. However, these measures are not the only way that this kind of insurance limits benefits to persons with the most to gain from them. Not only is there scrutiny of the quality of care provided, but the requirement that care be received before benefits are paid (to the person or to the provider) helps to restrain moral hazard. If I have to live in a nursing home to collect benefits, and if (like most people) I would prefer not to do so unless I was so frail that I really could not do well otherwise, I am less likely to claim that my ADL score is worse than it really is. But insurers are terrified by the thought that if people can make money from insurance and do not have to do anything that healthy people would not do, there will be very substantial (and very clever) excess claims. There is a real problem with long-term care: Most of the services are not the medical services that healthy people would want to avoid but, rather, are the “low-tech” or “servant” services that anyone would find helpful, whether well or ill.

Letting the market decide. I would not presume to let my skepticism about disability long-term care insurance settle the matter. Far better to let such products be offered on the market, in an unsubsidized and not overly regulated way, and let people decide what they like best. So far, most people have decided that they do not want private long-term care insurance. Even more, as noted in Stone’s paper, “disability” long-term care insurance is more expensive than even the service benefits long-term care insurance few elderly can afford to buy and few nonelderly see the need for. The only places where disability-type insurance appears are in group-insurance offerings by a pair of insurance companies, and it is not growing there. Such evidence as we have is therefore consistent with the hypothesis that the free-choice advantages of this type of insurance are more than offset by the cost of additional claims.

Modifying Medicaid. Using the market to settle the choice for the 5–8 percent of dollars that are in the private insurance market is helpful, but it is obviously much more important to get things right for the nearly 50 percent of funds from the public Medicaid program (not to mention the 10 percent from
Medicare). At present, although a few states have loosened up the strict service-benefits nature of their programs and allow beneficiaries greater freedom to direct funds to other caregivers (including family members), there still is not much choice. One could (and probably should) try to upgrade the measurement of functional limitation to see if it could serve as a platform for greater reliance on cash benefits. Another problem with this approach for this low-income population is that if severity differs in ways that are not exactly taken into account by the measurement system, some people may receive cash payments that are too low relative to their needs (and others may receive excessive payments).

However, I argue that the choice between insurance types could be better made by altering public financing of long-term care in a more fundamental way, one that I have discussed elsewhere. The notion that I proposed is a subsidy to the purchase of long-term care insurance (private or public), where the subsidy, to be made available to a person with a given set of characteristics and not yet in need of long-term care, would be equal to the expected value of Medicaid benefits that person would receive under the current Medicaid program. Thus, the cost to government would be the same as under the current program, but the person (I argued) might prefer private, stigma-free, and more-flexible insurance. This idea clearly extends to a situation in which the person could use his or her subsidy for the purchase of either service-benefit or cash-benefit long-term care insurance (possibly being charged a higher premium for the latter). Since our interest as altruistic taxpayers is only in seeing that people get long-term care, and not (within broad limits) in the details of which professionals or nonprofessionals provide it in what setting, we should be happy to let our state programs give beneficiaries this kind of choice. A premium-support program makes sense for long-term care even more so than for acute care for the elderly and in the former case is not constrained by the existence of a much-revered program that many want to protect from harm.

To conclude: Anything that will get long-term care insurance out of its current rut is welcome, and the recycling of good old ideas has much to recommend it. The main danger with the disability approach is that it will make transfers to groups not in greatest need (but who are, as in Germany, sometimes politically potent). The main advantage of the approach is that it will transfer power to the most powerless of patients.

NOTES

1. O.D. Dickerson, Health Insurance, 3d ed. (Homewood, Ill.: Richard D. Irwin Inc., 1968), 207.