Speculating About the Impact of Healthcare Industry Consolidation on Long-Term Services and Supports

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Many aspects of the health care industry in the United States today are caught up in a vigorous “get big or get out”\(^2\) trend characterized by significant consolidation of health care providers and insurers. The current health industry consolidation movement promises to exert an important and powerful array of effects on numerous different population groups seeking or receiving health services in a variety of different health care settings. The other articles in the present Symposium issue of the *Annals of Health Law* address several of those groups and settings.

Particularly regarding the potential impact of health industry consolidation on individuals contemplating, seeking, or obtaining long-term services and supports (LTSS), little is yet known but much may be plausibly speculated. This article joins in that speculation, but attempts to advance the constructive consideration of the topic by offering some suggestions for a research agenda to investigate specific empirical questions about consolidation’s impact on LTSS and thereby generate evidence and knowledge that can be used to either reduce or prevent negative aspects of consolidation for LTSS, on one hand, or foster and facilitate the achievement of positive effects, on the other.

For purposes of the present analysis, LTSS (the modern term that largely has replaced the earlier, more narrowly construed term “long-term care”)\(^3\) refers to ongoing individualized assistance with activities of daily living (ADLs)\(^4\) and instrumental activities of daily living


\(^3\) This change in nomenclature is reflected in both academic literature and government programs. See, e.g., Medicaid.gov, *Long-Term Services and Supports*, at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Long-Term-Services-and-Supports.html.

regardless of the physical location where such assistance is provided. LTSS settings may include, among others, nursing homes, assisted living facilities, continuing care retirement communities, and the private home of the service recipient or that of the recipient’s family member(s) or friends. LTSS may be delivered by many different types of individual, institutional, and agency actors, and LTSS service delivery among multiple actors may occur in either a coordinated or disjointed manner. “About 70 percent of those aged 65 and older are likely to need long-term services and supports at some point in their lives, for an average of 3 years. Twenty percent will need that care for at least 5 years.”

Following this brief introductory section, the article outlines the basic nature and forms of consolidation currently in progress or active discussion among various health care providers and third-party payers, including long-term care insurers. The ensuing section delineates potential general impacts, both detrimental and salutary, of health industry consolidation, with a particular

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focus on application of those potential impacts to LTSS. Section III then identifies specific groups of LTSS consumers according to the most important piece of the story—their primary source of payment for services—and speculates about the ways that individuals within each of those groups may be affected by the health industry consolidation trend. This section also weaves into the discourse a modest health services research agenda to test some of the speculation presented in the previous section about the tangible impact of health industry consolidation on LTSS consumers. The expectation is that the fruits of future investigators pursuing bits and pieces of the suggested research agenda will become a useful part of the continuous information feedback loop helping to reinforce the positive aspects of health industry consolidation and reduce or eliminate the negative aspects.11

I. HEALTH INDUSTRY CONSOLIDATION IN THE UNITED STATES

There is a strong trend in the U.S.12 in the second decade of the third millennium involving the consolidation of key players in the health care industry.13 Problems with maintaining profit

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12 Although this article concentrates on the consolidation trend in the U.S., the U.S. is by no means alone in this trend. See, e.g., Andreas Schmid & Volker Ulrich, *Consolidation and Concentration in the German Hospital Market: The Two Sides of the Coin*, 109 HEALTH POL’Y 301 (2013).

(or excess revenue)\(^{14}\) margins, growing revenue, and meeting the cost of doing business are strong drivers of consolidation, including in the post-acute (shorter-duration, rehabilitation oriented long-term care) and LTSS (longer-duration, maintenance oriented long-term care) space of the health care industry.\(^{15}\) Additionally,

Even if some of these mergers and acquisitions were inevitable, and some of these trends were underway prior to passage of the ACA [Affordable Care Act], that law envisioned that providers would consolidate. The ACA was predicated on the kinds of changes unfolding in the way healthcare is delivered. They are a necessary precursor to many of the ACA’s constructs.\(^{16}\)

Consolidation is taking place in three distinct but intertwined parts of the health care industry: health services providers; health care products producers and sellers; and third party-payers for health services and products. Although there are countless organizational and financial permutations, consolidation among health service providers basically has taken the

\(^{14}\)“Profit” is a term ordinarily applied in the proprietary or for-profit sector, whereas “excess revenues” is the preferred terminology in the not-for-profit universe. See James W. Martin & Nancy Saint-Paul, Terminology, 29 WEST’S LEGAL FORMS, SPECIALIZED FORMS § 25.4 (2014). In the U.S., the majority of LTSS providers are organized as for-profit coporations, but a significant percentage of providers fall into the not-for-profit category. See U.S. DEP’T HEALTH AND HUMAN SERV., LONG-TERM CARE SERV. IN THE UNITED STATES: 2013 OVERVIEW, CDC Vital and Health Statistics Series 3, No. 37 (Dec. 2013), at 12, available at http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf.


\(^{16}\)American Enterprise Institute, Statement before the Comm. on Judiciary, Subcomm. on Regulatory Reform, Commercial and Antitrust Law, Hearing on The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act’s Impact on Competition (Sept. 10, 2015), at 2. But see Thomas L. Greaney, Statement before the Comm. on Judiciary, Subcomm. on Regulatory Reform, Commercial and Antitrust Law, Hearing on The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act’s Impact on Competition (Sept. 10, 2015) (arguing that the ACA was meant to promote competition rather than consolidation).
form of mergers and acquisitions, providers going out of business or amending their business lines, and joint ventures involving multiple providers.

First, we have seen extensive planned or completed consolidation of health service providers nationally, in addition to providers simply closing their doors and walking away. Consolidation has occurred or is being contemplated on both horizontally (one entity owning or controlling multiple similar providers, such as one corporation owning multiple hospitals or multiple physician practices) and vertically (one entity, such as an Accountable Care Organization of the sort encouraged by the Affordable Care Act, owning or controlling

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multiple different kinds of providers, such as a single entity owning or controlling a physician practice, a hospital, a home health agency, a nursing home, and a hospice) integrated levels. As stated by one observer, “Those who follow long-term care closely have been noticing the trend toward convergence for a while. Major nursing home chains have added hospice and home care to their array of services, along with short-term rehabilitation and other types of care.”

Second, planned or completed consolidation has taken place or is likely to take place among producers and sellers of health care products. A number of pharmaceutical companies, retail pharmacy chains, and biotechnology firms have recently explored or contemplated mergers and acquisitions or joint ventures. For instance, in July of 2015 Israeli drug maker Teva

https://www.naacos.com/pdf/NAACOS2014ACOResultsPressRelease082515.pdf (asserting that the large number of ACOs who

will receive no return on their investment [for 2014] … will struggle to stay in the program. We estimate that 40-50 ACOs will leave the program this year [2015]. We understand the ACO program is in its infancy and redesigning healthcare is a long-term commitment that we intend to continue supporting; however, we believe CMS or the Congress needs to take major steps to improve the program.).

Pharmaceuticals Industries LTD. agreed to buy the generic drug manufacturer Allergan Pic for approximately $40.5 billion in cash and stocks.\textsuperscript{27}

Third, there has been consolidation in the third-party payer marketplace. Not only have general health insurers been active in mergers and acquisitions, such as the 2015 purchase of Cigna Corp. by previous rival Anthem Inc.\textsuperscript{28} and Aetna’s acquisition of previous competitor Humana.\textsuperscript{29} As summarized by one analyst, “Deals among the nation’s largest health insurers in recent weeks have been almost head-spinning. But whatever the details, if the combinations are finalized, the result will be an industry dominated by three colossal insurers.”\textsuperscript{30}

The “head-spinning” pace of health insurer consolidations has been explained by one set of commentators in the following terms:

There are good reasons why these consolidation moves are happening now. Five years after the passage of the Affordable Care Act, and in the wake of the Supreme Court’s recent decision to uphold the use of federal tax credits to subsidize the health insurance costs of poorer Americans [in \textit{King v. Burwell}, -- 576 U.S.—(2015)], uncertainty about the implications of the new law is dissipating. Companies now know the basic outlines of the future health insurance marketplace, and they are looking to position themselves competitively in the fast-evolving health care ecosystem. What’s more, easy access to cheap debt and high market valuations make the prospect of deals financially attractive to buyers and sellers alike. These trends are exacerbated by the shared fear that if

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\textsuperscript{27} Chitra Somayaji & David Wainer, \textit{Teva to Buy Allergan’s Generics Unit for $40.5 Billion}, BNA HEALTH CARE DAILY REPT. (July 27, 2015), at www.bna.com/health-care-daily/.


any particular company doesn’t move fast enough, it risks being left without a “dance partner.”

Private LTSS insurers marketing individual policies directly to consumers have been energetically involved in similar consolidation activity. Moreover, the LTSS insurance industry has seen several important industry actors exit the marketplace or restrict their business activities in this arena. In addition, certain LTSS providers are beginning to consolidate the provider and insurer roles, eliminating the need for separate insurance companies. One of the nation’s largest nursing home companies has recently become a “provider-sponsored organization,” or a provider group that accepts full financial risk for its consumers’ care in exchange for a fixed monthly payment.

II. GENERAL POTENTIAL EXPECTATIONS OF CONSOLIDATION

This section sets out, in very barebones fashion, the most salient general potential expectations of consolidation in the health care industry. Consolidation may produce either

32 Shakeout Continues in the Individual Long-Term Care Market, SCI. LETTER (Apr. 26, 2005), at http://go.galegroup.com/ps/i.do?id=GALE%7CA267769613&v=2.1&u=tall85761&it=r&p=AO NE&sw=w&asid=88ef9f9f3ca28c7daabb4aa709fb6fd5.
35 Obviously, the present discussion neither aspires nor pretends to substitute for a comprehensive economics text. For a concise summary of basic concepts in economics, see TODD G. BUCHHOLZ, FROM HERE TO ECONOMY: A SHORTCUT TO ECONOMIC LITERACY (1995).
positive or negative effects, and the specifics of both types are exceedingly difficult to predict accurately. In Section III, I will apply these general potential expectations, both positive and negative, to specific groups of LTSS consumers, laying the groundwork for proposed research agenda elements.

A. Negative Potential Impacts

Supply-side consolidation in any industry ordinarily generates expectations of reduced competition in the marketplace of goods and services available for consumers. A reduced number of competitors vying for the business of consumers—approaching or reaching monopoly or oligarchy conditions—generally translates into less or non-existent choice for those consumers, both as a result of the unavailability of alternative providers of goods and services and the likelihood of organizations steering consumers toward particular service or


37 Regarding a research agenda, see also H. Stephen Kaye & Charlene Harrington, Long-Term Services and Supports in the Community: Toward a Research Agenda, 8 DISABILITY & HEALTH J. 3 (2015).

38 “A monopoly exists when one firm is the only seller of a good or service.” BUCHHOLZ, supra n. 35 at 80. A monopoly is the reverse of a monopsony, which is a market situation in which the product or service of several sellers is sought by only one buyer.

product providers in whom the steering organization itself has a financial or other type of
interest.\textsuperscript{40}

In turn, constricted consumer choice usually produces a regime of higher prices and
lower quality. Regarding the former, “Monopolies tend to keep their prices and profits high by
restricting the supply of a good.”\textsuperscript{41} For instance, consumer advocates have voiced concerns that
consolidation among health insurers will result in higher premiums charged to consumers.\textsuperscript{42} The
American Hospital Association recently warned Congress:

The market concentration threatened by the pending insurance deals is large and
durable, and consumers and providers are at risk if the deals are allowed to move
forward. The two deals [Anthem/Cigna and Aetna/Humana] promise fewer
choices for consumers for commercial insurance and Medicare Advantage (MA)
plans, narrower networks of providers in what few choices remain, and higher
premiums and/or out-of-pocket costs, among other things. Even if these insurers
make good on their promise to reduce costs if they are permitted to consolidate,
insurers have a dismal track record of passing any of those benefits on to
consumers…\textsuperscript{43}

Along with these apprehensions about insurer consolidation, a study conducted in the
first part of 2015 found that the cheapest provider-owned health plans sold on ACA marketplaces

\textsuperscript{40} The practice of organizational steering of consumers toward particular providers may raise
serious antitrust concerns, but analysis of those issues is beyond the scope of this article. See
John J. Miles, \textit{Diversification and Section 2 of the Sherman Act—Steering as Predatory Conduct},

\textsuperscript{41} \textit{Buchholz, supra} n. 35, at 80. \textit{See also Richard A. Epstein, Overdose: How Excessive
economic theory, the single monopolist raises price and cuts output in order to maximize his
private gains; in so doing he reduces overall social welfare.”).

\textsuperscript{42} Abelson, \textit{supra} n. 30.

\textsuperscript{43} Am. Hosp. Ass’n, Statement before the Comm. on Judiciary, Subcomm. on Regulatory
Reform, Commercial and Antitrust Law, Hearing on \textit{The State of Competition in the Health Care
Marketplace: The Patient Protection and Affordable Care Act’s Impact on Competition} (Sept.
10, 2015), at 2. \textit{But see America’s Health Insurance Plans, Statement before the Comm. on
Judiciary, Subcomm. on Regulatory Reform, Commercial and Antitrust Law, Hearing on \textit{The
State of Competition in the Health Care Marketplace: The Patient Protection and Affordable
Care Act’s Impact on Competition} (Sept. 10, 2015), at 6-8 (contending that consolidation of
health insurers may foster pro-competitive effects).
were 12% more expensive than the cheapest plans not owned by providers.\textsuperscript{44} Other studies of health organizational consolidation\textsuperscript{45} and physician practice competition\textsuperscript{46} appear to support the hypothesis that connects reduced competition among providers to higher prices and expenditures. Regarding the quality issue, “Understanding the relation between competition and quality is a central issue in economics generally. Economists are interested in understanding the optimal level of competition in a market. Moreover, the link between competition and quality is central in designing antitrust and other regulatory policies.”\textsuperscript{47} Surgeon and health policy essayist Atul Gawande opines:

I think there are actually two major concerns—one is that monopolies raise prices, and the second is that monopoly means you also lose the pressure on quality of care. When patients don’t have elsewhere to go, the pressure on the system to ensure they have quality is also just as affected as the prices.\textsuperscript{48}

Some economists remain skeptical about the degree to which increased competition brings about the optimal level of quality in health services delivery in the first place.\textsuperscript{49} Certainly, reliable empirical research findings on the competition-quality relationship in the LTSS arena


\textsuperscript{46} Laurence C. Baker et al., \textit{Physician Practice Competition and Prices Paid by Private Insurers for Office Visits}, 312 JAMA 1653 (2014).

\textsuperscript{47} Gautam Gowrisankaran, \textit{Competition, Information Provision, and Hospital Quality}, in \textit{INCENTIVES AND CHOICES IN HEALTH CARE} (Frank A. Sloan & Hirschel Kasper, eds.) 319-352, 343 (2008).


specifically are quite sparse, as most of the limited research in this arena has concentrated on hospitals. Moreover, usefully evaluating the quality of LTSS is a complicated proposition.\(^5^0\)

Besides measuring descriptive performance,

\[\text{w}e\text{ should find ways to measure and systematically collect information on adequacy and appropriateness of care and the consumers’ level of integration, control, participation, and general well-being.}^{**5**}\text{It is essential that we also assess the impact of LTSS on ‘quality of life’ (e.g., comfort, meaningful activity, relationships, enjoyment, dignity, autonomy, privacy, individuality, spiritual well-being, and functional competence) as well as its ability to promote a sense of safety, security, and order.}^{5^1}\]

Another aspect of quality of care concerns continuity, a matter of particular importance to those many LTSS consumers who use the services of multiple providers in multiple care settings. The American Academy of Family Physicians predicts that consolidation, especially among health insurers, may create “mass disruptions in continuity of care due to changing and narrowing networks of” providers.\(^5^2\) Narrow provider networks may be problematic for consumers for a large number of reasons.\(^5^3\)

\[\text{B. Positive Potential Impacts}\]

\(^{50}\text{Cf. Gary Claxton et al.,} \text{Insight Brief: Measuring the Quality of Healthcare in the U.S., PETERSON-KAISER HEALTH SYSTEM TRACKER (Sept. 9, 2015), at }\text{http://www.healthsystemtracker.org/insight/measuring-the-quality-of-healthcare-in-the-u-s/?utm_campaign=Peterso}\text{nt&utm_source=hs_email&utm_medium=email&utm_content=21924623&hsenc=p2ANqtz--745cqfSoYXILhLYEKZUKHZqz--xuAfWLB0wLNo0VDz6dLnb}_{\text{kjmBmY3sAoQCc5rLQtIsq6YVv6wK1XpYhHEcTRVQ&hsmi=21924623.}}^{51}\text{Kali S. Thomas & Robert Applebaum, Long-Term Services and Supports (LTSS): A Growing Challenge for an Aging America, 25 PUB.’LY & AGING REP’T 56, 60 (2015).}^{52}\text{Blackwelder 1 and 2, supra n. 38.}^{53}\text{Valarie Blake, Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform, 16 MINN. J.L. SCI. & TECH. 63 (2015).}
By contrast, it is arguable that increased coordination among LTSS providers and insurers may result in greater systemic efficiency; according to this view, it “will make possible the elimination of considerable administrative costs, as new combinations render current systems and operations redundant.” Enhanced operational efficiency should, in theory, lead to lower prices and better coordination and continuity of care, the lack of which has been described as what “may very well be the missing link of the healthcare delivery chain” and which often is a very serious problem for contemporary LTSS consumers. Operational efficiencies that ultimately will benefit consumers, as well as employers who subsidize health insurance for those consumers, are enthusiastically predicted by health providers and insurers participating in consolidation activities in their arguments against vigorous government antitrust scrutiny.

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55 Kaplan, *supra* n. 31.
56 Lower prices should result from insurers’ stronger bargaining power to negotiate lower payment rates with providers and insurers’ increased ability to positively impact clinical management. *Id.* However, “health insurance mergers also may contribute to increased hospital consolidation because of hospitals looking to gain greater leverage in negotiating with a dwindling number of health plans.” James Swann, *Insurance Industry Consolidation Could Mean Higher Premiums*, BLOOMBERG BNA 24 HLR 1065 (July 29, 2015).
There are a few factors that might even support the claim that consolidation in the LTSS industry actually will contribute to an enhanced quality of service. Fear of exposure to potential direct (corporate)60 and/or vicarious liability61 (under either an apparent agency62 or a non-delegable duty63 theory) claims, plus the need to compete against other, fewer but still competitive, surviving providers for consumers’ lucrative business, should encourage LTSS entities to exercise greater oversight and control regarding the quality of services being offered and delivered by the various providers who make up the larger enterprise. In addition, recent changes in regulations implementing Affordable Care Act (ACA)64 provisions regarding Medicare reimbursement give hospitals a strong (and perhaps even an excessively strong)65 financial incentive to avoid too-fast hospital readmissions after discharge; thus, hospitals have a strong financial incentive to do better discharge planning and followup, including selecting and carrying on business with high quality LTSS providers who are more likely to provide higher quality care that is less likely to result in a quick hospital readmission. Furthermore, consolidation among disparate providers, each of whom is involved at some point in the care of

61 Foster, supra n. 60, at 328-330.
the consumer, may facilitate better sharing of that consumer’s pertinent health and social information within the single parent service delivery entity. Such sharing of information, in turn, is expected to enhance consumer care.66 Presumably (albeit not guaranteedly),67 the problems with failure of interoperability of electronic health record (EHR) programs that have impeded timely, efficient, and accurate record sharing among disparate providers thus far68 would be eliminated when all parts of the single parent provider entity are using the same program.69

III. EFFECTS OF LTSS CONSOLIDATION ON PARTICULAR POPULATION GROUPS

The preceding section set out, at an exceedingly broad and general level, some of the main expectations that might be reasonably foreseen as natural results of consolidation within the health care industry. In this section, I try to apply these general possibilities to particular distinguishable categories of people who might comprise the current universe of LTSS consumers in the U.S. Also in this section, I tentatively suggest a smattering of research questions that could be pursued to test the speculative possibilities identified here concerning the

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69 See Deth Sao et al., Interoperable Electronic Health Care Record: A Case for Adoption of a National Standard to Stem the Ongoing Health Care Crisis, 34 J. LEGAL MED. 55 (2013).
consolidation-LTSS relationship. The results of some the suggested empirical investigations should importantly inform the ongoing development of LTSS practice and policy.

A. Completely Self-Pay Population

Most Americans do a rather poor job of estimating, and planning effectively for, their future health care expenditures.\(^70\) Nonetheless, some individuals pay entirely for their own LTSS out of their own pockets, either using personal pensions, savings, investments, and reverse mortgages\(^71\) or by relying on family members who voluntarily or involuntarily\(^72\) support them financially. People who fit within this category are true consumers, the beneficiaries of economic empowerment that both permits and compels them to exercise choice and control over the who, what, where, when, and how details of their own LTSS plan. The power of the purse allows the consumer (or a surrogate who is making decisions on behalf of a decisionally impaired individual)\(^73\) to hire, fire, and direct the actions of their LTSS providers. Sometimes, particularly when there is significant geographical distance between the LTSS consumer and the consumer’s family and the consumer has serious cognitive impairment, a private professional care manager is paid to assist in arranging and monitoring the LTSS planning and implementation details.\(^74\)


\(^74\) Aging Life Care Association (formerly National Association of Professional Geriatric Care Managers), at http://www.aginglifecare.org/ALCA/About_Aging_Life_Care/Find_an_Aging_Life_Care_Exper
For LTSS consumers in the self-pay, consumer-direction category, health care industry consolidation may exert a fairly limited impact. Many self-pay LTSS consumers are able to remain in home environments ("age in place") by purchasing full- or part-time health care, companion, or homemaker services provided by individual, independent, self-employed private caregivers or by relying on care from family members whom the consumer agrees to monetarily compensate or who provide those services without any material compensation ("informal caregiving"), or a combination of private, paid caregivers and family caregivers. The health care industry consolidation trend examined in this article is unlikely to substantially affect the availability, affordability, or quality of private, independent, self-employed LTSS caregivers whom consumers seek to hire with their own funds, although certainly there will be...


76 Companion care services fall under the broader employment categories of “home health aides” and “personal and home care aides.” See Jeffrey A. Eisenach & Kevin W. Caves, Economic and Legal Aspects of FLSA Exemptions: A Case Study of Companion Care, 63 LABOR L.J. 174 (2012).


79 “According to the Bureau of Labor Statistics (BLS) estimates, nearly a quarter of personal and home care aides in 2008 were self-employed. This figure is undoubtedly an underestimate because national databases do not adequately capture this segment of the market.” Robyn I. Stone & Natasha S. Bryant, Educating Direct Care Workers on Transitions of Care, 31 ANNUAL REV. GERONT. & GERIATR. 167, 169 (2011).
other challenges to the retention and expansion of an adequate number of unaffiliated direct-care workers.80

Similarly, consolidation should have little impact on paid or informal family caregiving for consumers who need LTSS at home, neither lightening nor worsening the availability of family caregivers to LTSS consumers.81 Confronting the LTSS system’s extremely extensive dependence on informal caregiving is a matter of grave and immediate public policy concern.82

It is estimated that informal caregivers voluntarily provide three quarters of all long-term care to elderly friends and family members. In 2009, the unpaid care that was provided by 42 million family caregivers was valued at approximately $450 billion dollars. However, the configuration of the modern family has made caregiving an ever more challenging activity. In addition, family caregivers are no longer solely assisting in instrumental activities of daily living (preparing meals and paying bills) and activities of daily living (helping to bathe and feed); rather, many are providing complex medical care to their older loved ones.83

The adverse effects of family (and even more pointedly, female)84 caregiver burden (physical, mental, and financial) must be addressed on an urgent basis.85 Caregiver stress is an established

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81 Cf. A.E. Benjamin et al., Retention of Paid Related Caregivers: Who Stays and Who Leaves Home Care Careers?, 48 (Suppl. 1) GERONTOLOGIST 104 (2008) (reporting on a study of the caregiving careers of “related workers” (families and friends of the LTSS consumer)).
84 See Mercedes Martinez-Marcos & Carmen De la Cuesta-Benjumea, How Women Caregivers Deal with Their Own Long-Term Illness: A Qualitative Study, 70 J. ADVANCED NURS. 1825 (2014).
predictor of nursing home placement and an independent risk factor for the caregiver’s morbidity and mortality. However, health industry consolidation by itself is unlikely to exacerbate or mitigate the policy challenges surrounding caregiver burden, unless consolidation results in reduced or total unavailability of formal, professional LTSS providers in a particular geographic location.

To the extent that self-pay consumers need or choose to use institutional or agency LTSS providers in whole or part for companion care or specific services requiring specialized training and licensure, the effects of current consolidation in the health care industry may be positive or negative. On the positive side, greater efficiency (if indeed facilitated by consolidation of providers) could result in better coordination and continuity of care for self-pay consumers who employ multiple institutional or agency LTSS providers; that development should then translate into enhanced quality of care. On the negative side, if consolidation means a smaller number of institutional and agency LTSS providers are vying for each consumer’s business, that may mean less consumer choice and hence less incentive on the providers’ part to compete on the basis of price or quality. Self-pay consumers, whose interests are not represented by a government agency or private insurer, are left to their own bargaining power and acumen in negotiating deals with providers for their care, potentially placing them at a disadvantage. By the same token, because LTSS providers may perceive self-pay consumers as affluent, and therefore desirable, they may be more flexible in negotiating the terms of a relationship with such consumers than


Thomas & Appelbaum, supra n. 51, at 59.
they would be in negotiating service or compensation details with insured consumers or their third-party payers.

The surmises presented here are, to some degree, susceptible to either empirical verification or disproof. A health services research agenda concerned with LTSS could investigate the impact, if any, of health industry consolidation on the availability of unaffiliated direct-care workers and institutional and agency services for self-pay consumers, as well as changes in the price and quality of LTSS available to and received by those consumers.

B. Consumers Paying for LTSS Through Private Health Insurance Policies

A second category of consumers consists of people who need LTSS such as inpatient or outpatient rehabilitative care or medication or equipment management for a short period of time following an acute illness or procedure. Such care is not intended to be custodial or maintenance, but rather is intensive enough that it is expected to get the consumer to a point at which hospital readmission and further LTSS are unnecessary. Unsurprisingly, people with no insurance coverage often experience significant barriers in accessing post-acute care, but many people in the paradoxically-named short-term LTSS category have health insurance policies

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87 “Post-acute care (PAC) includes rehabilitation or palliative services that beneficiaries receive after, or in some cases instead of, a stay in an acute care hospital. Depending on the intensity of care the patient requires, treatment may include a stay in a facility, ongoing outpatient therapy, or care provided at home.” MedPac, Post-Acute Care, at http://medpac.gov/-research-areas/-post-acute-care.
obtained through present or past employment or individual purchase that will pay for all or part of those prescribed short-term LTSS that are consented to by the consumer.

The various general possible impacts of health industry consolidation outlined in Section II, supra, are possible for this consumer population. Additionally, as health insurers consolidate into a smaller number of competitors, researchers should particularly investigate whether those insurers begin to reduce their benefits for short-term LTSS by refusing to cover previously covered services, reimbursing providers at lower rates, and/or shifting more of the associated costs to the consumer through increased deductibles or co-insurance contractual obligations. If such changes in health insurance coverage for post-acute care occur widely, the role of those involved in hospital discharge planning will become even more central for consumers.

C. Consumers Paying for LTSS Through Private Long-Term Care Insurance

A number of people in the U.S. purchase private insurance that specifically covers all or part of the costs of specified LTSS, although the potential market for this form of insurance is much larger than the actual market saturation achieved so far. The contractual terms of these

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91 Coinsurance is defined as “[y]our share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service.” Coinsurance, at https://www.healthcare.gov/glossary/co-insurance/.


93 See, e.g., Peter Kyle, Confronting the Elder Care Crisis: The Private Long-Term Care Insurance Market and the Utility of Hybrid Products, 15 MARQUETTE ELDER’S ADVISOR 101 (2013). Compare Enrique Zamora et al., Long-Term Care Insurance: A Life Raft for Baby Boomers, 26 ST. THOMAS L. REV. 79, 102 (2013) (describing LTCI as “a viable option”) with Judy Feder, The Challenge of Financing Long-Term Care, 8 ST. LOUIS U. J. HEALTH L. & POL’Y 47, 47 (2014) (criticizing private long-term care insurance because it “typically costs a lot, offers limited value, and is subject to premium increases that can cause purchasers to lose coverage they have paid into for years”).
insurance products, which usually are lumped together under the heading of “long-term care insurance (LTCI),” may vary substantially in the details of coverage, eligibility, qualifying conditions for payment, deductibles and co-insurance requirements, inflation protection for benefits, and premium prices, all depending upon the particular policy purchased. As a general matter:

Long-Term Care Insurance is privately contracted health insurance for long-term care expenses. The coverage is generally activated when the insured needs assistance with certain activities of daily living as defined by the terms of the policy. A long-term care policy generally will provide coverage for: home health care (beyond that covered by Medicare); care offered where one resides in assisted living, memory care, or personal care facilities; and nursing home care. Additionally, a policy may provide coverage benefits for adult day care, respite care, and hospice care (beyond that covered by Medicare).94

Traditional claims-based coverage directly reimburses providers for rendered services. By contrast, indemnity-based (“cash-based”) long-term care insurance provides the insured with a check that represents the maximum allowable daily benefit amount stipulated in the policy. The latter form is more consistent with consumer-directed LTSS.95

Private long-term care insurance companies have encountered substantial barriers to selling their product to potential purchasers. “Although long-term care (LTC) is one of the biggest financial risks facing the elderly today, very few—13% of current 65 year olds—are insured against this risk.”96 Most prominent among these impediments is widespread

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94 Eileen Walsh & Whitney Wilson, An Introduction to Funding Long-Term Care Without Medicaid, 35 BIFOCAL 17, 19 (Sept.-Oct. 2013).
psychological denial by middle-aged, middle-class people (precisely the group that could benefit the most by having insurance that protects their assets from being dissipated in the event that LTSS are later needed) that they could ever become so disabled that LTSS might be necessary for them. That denial means that too many people wait until they are old and frail, and therefore likely to file claims for coverage within a short period of time, before trying to purchase long-term care insurance, in other words, a perfect storm of adverse selection.\footnote{Kyle, supra n. 93, at 112-113.} When the only people buying the insurance product are those who are most likely to use it quickly, insurers can only remain financially viable\footnote{Nimmi Cleve, \textit{Long-Term Care Insurance: An Endangered Species}, 22 ANNALS HEALTH L. ADVANCE DIRECTIVE 182, 192 (2013) (“The current problem that the LTCI universe faces is precisely this: expenditures are far exceeding funding. Therefore, the LTCI model is not financially viable in its current avatar.”).} and meet state minimum solvency (reserve) requirements\footnote{\textit{E.g.}, N. MEX. STAT. ANN. § 59A-23A-6.D.} by vigorously screening potential purchasers and excluding many of them\footnote{“As these policies are medically underwritten, the older an individual becomes, the more likely they are to suffer medical conditions, which could lead to the insurance company declining the applicant.” Zamora et al., supra n. 93, at 100.} and by charging very high premiums to those purchasers who qualify for coverage. Those high prices, in turn, make private long-term care insurance unaffordable for many people who otherwise might be interested.

The other main barrier to the sale of private long-term care insurance policies is the crowding out effect of the Medicaid program.\footnote{Regarding Medicaid funding of LTSS, see Section III. E, infra.} Because many people incorrectly perceive that Medicare will pay for their eventual LTSS,\footnote{Regarding Medicare funding of LTSS, see Section III. D, infra.} but correctly perceive that Medicaid ultimately will be available to them as a safety net payment program for LTSS if they fail to save or expend their financial assets, they feel no strong imperative to devote their own current dollars to
insurance premium payments for protection they may never use or will use only in the future.\textsuperscript{103} As one set of commentators has aptly summarized the situation, “Unfortunately, because the majority of middle-class Americans have failed to plan for their future long-term care needs, Medicaid has in effect become the primary financier rather than a means of last resort for the indigent.”\textsuperscript{104}

Besides difficulties in selling policies, “[t]he [long-term care insurance] industry has two [other] fundamental problems. A long-standing one—buyers are dropping coverage less often than the industry predicted. And a more serious new one—historically low interest rates are sucking the profit out of the business.”\textsuperscript{105} As a consequence of this multifactorial economic dynamic, the number of companies offering private long-term care insurance policies for sale to the public has constricted significantly in the last several years.\textsuperscript{106} Some of these companies have ceased doing business altogether, some have stayed and continue marketing their other products but have discontinued their long-term care insurance lines, and some companies have participated in mergers and acquisitions.\textsuperscript{107}

\textsuperscript{103} Kyle, supra n. 93 at 113-114; Andrew M. Hyer et al., Paying for Long-Term Care in the Gem State: A Survey of the Federal and State Laws Influencing How Long-Term Care Services for Idaho’s Growing Aged and Disabled Populations Are—and Will Be—Funded, 48 IDAHO L. REV. 351 (2012).

\textsuperscript{104} Zamora et al., supra n. 93, at 100; Sean R. Bleck et al., Preserving Wealth and Inheritance Through Medicaid Planning for Long-Term Care, 17 MICH. ST. U. J. MED. & L. 153 (2013).


The consequences of exit and consolidation in the long-term care insurance industry for present or future middle-class consumers of LTSS probably are mainly negative. As competition in the long-term care insurance industry is diminished, the cost of those policies still being sold can be expected to rise substantially. As a further attempt at achieving financial stability, insurers may simultaneously or at different intervals tighten up on various aspects of coverage provided in their policies. Consumers who already own long-term care insurance policies, but whose insurers decide to discontinue this product line, may now find themselves medically rejected when they apply for policies with the fewer, more selective remaining companies or will be forced to pay substantially more in premiums for the same or lesser coverage. All of these expected impacts are subject to careful empirical study, although early observations appear so far to confirm the negative hypotheses.

D. Consumers Paying for LTSS Through Medicare

Contrary to popular belief, Part A (Hospital Insurance) of Original Medicare does not provide an open-ended entitlement to payment for all LTSS for eligible Medicare beneficiaries. Rather, Medicare coverage for LTSS is quite limited, not to mention


Medicare Part A covers (with a non-trivial co-insurance requirement after the first 20 days) up to 100 days per spell of illness (benefit period) in a skilled nursing facility (SNF) for needed skilled nursing services (not custodial care), but only if admission to the SNF is post-acute, that is, immediately following a hospital admission that lasted for at least three consecutive days. Part A also pays for certain home health care for homebound individuals; these services must be provided by a Medicare-certified agency and may include medically necessary, physician ordered, part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy. Medicare Part B also covers medically necessary home health services delivered by Part B providers.

Medicare-eligible individuals may choose, on an annual basis, to opt out of Original Part A and Part B (Supplementary Medical Insurance) Medicare and instead enroll in a Medicare Advantage Plan (MAP) under Medicare Part C. The Medicare Advantage option has been growing in popularity in various parts of the U.S., despite the overt antagonism of the Obama

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administration toward this private sector approach, as reflected in the ACA.\textsuperscript{118} When an individual selects this option, the Medicare program pays a periodic fee to one of the managed care (Health Maintenance Organization or Preferred Provider Organization) or private Fee-for-Service plans operating in the Medicare enrollee’s geographical area, and in consideration of that periodic fee the Plan agrees to provide the enrollee or be responsible for the provision of, at the least, all of the services that would have been covered under Original Medicare.\textsuperscript{119} This includes the LTSS that Original Medicare covers. Different MAPs, for marketing reasons, offer different service coverage packages over and above the basics required to match Original Medicare (for example including vision, hearing, and dental care coverage), and similarly may differ regarding deductibles, co-pays, and co-insurance imposed on the consumer.\textsuperscript{120} A MAP could offer LTSS benefits beyond those contained in Original Medicare, but such coverage expansion is not common.

Continued consolidation of health insurers is likely to affect the Medicare Advantage program by reducing the number of competing MAPs available to any particular Medicare-eligible consumer considering this option. Some parts of the U.S. already experience an absence

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\textsuperscript{118} See Richard L. Kaplan, \textit{Reflections on Medicare at 50: Breaking the Chains of Path Dependency for a New Era}, 23 \textit{ELDER L.J.} 1, 24-26 (2015); Gretchen Jacobson et al., \textit{Medicare Advantage 2015 Spotlight: Enrollment Market Update}, \textit{KAISER FAMILY FOUNDATION ISSUE BRIEF} at 1 (June 2015) (“Despite concerns that reductions in payments to Medicare Advantage plans enacted in the Affordable Care Act of 2010 (ACA) would lead to reductions in Medicare Advantage enrollment, the number and share of Medicare beneficiaries enrolling in Medicare Advantage plans has continued to climb.”).

\textsuperscript{119} See supra n. 103-104.

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or dearth of MAPs available for selection by local Medicare enrollees, and consolidation can only make that circumstance worse. MAP enrollment already is concentrated among a handful of large insurers; for instance, together, Humana and UnitedHealth provide coverage for nearly 40% of all people enrolled in MAPs. Some parts of the country that now have one or a few MAPs available may, following mergers and consolidations, have even fewer or no competing MAPs. Those Plans that continue to offer products for Medicare enrollees in a particular area may be able as a business practice, because of lessened competition for consumers, to provide more restrictive provider networks while raising the size of the consumer’s financial contribution to care (through imposition of increased premium amount, deductible, co-pay, and co-insurance requirements). Because MAPs today rarely offer LTSS coverage beyond that required to match Original Medicare, the hypothesized effects of consolidation on Medicare Advantage should be minimally felt in the LTSS arena. Nevertheless, investigation of consolidation’s impact on the availability, affordability, and content of MAP generally, and on LTSS for Medicare beneficiaries specifically, should be placed solidly on the health services research agenda.

E. Consumers Paying for LTSS Through Medicaid

The Medicaid program\textsuperscript{125} is the primary public payer for both nursing home care and home- and community based LTSS.\textsuperscript{126} “Medicaid is the largest single purchaser of LTSS in the United States, with cumulative spending of more than $130 billion annually on behalf of more than four million individuals. This spending surpasses both Medicare and commercial insurance spending combined.”\textsuperscript{127}

Historically, with the notable exception of the Department of Veterans Affairs’ Aid and Attendance and Housebound program,\textsuperscript{128} individuals who were dependent on public funding for their LTSS were subject to important choices about the who, what, when, where, and how details of their service plan being determined and directed by the funding agency (usually the state’s designated Medicaid agency).\textsuperscript{129} Institutional (mainly nursing home) services were favored for many years under the terms of the Medicaid statute, but in the last couple of decades an array of home- and community-based (HCB) alternatives have become increasingly available to

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\textsuperscript{125} Title 19 of the Social Security Act, codified at 42 U.S.C. § 1396 et seq. See generally Laura Snyder & Robin Rudowitz, Medicaid Financing: How Does It Work and What Are the Implications?, KAISER FAMILY FOUNDATION ISSUE BRIEF (May 20, 2015).

\textsuperscript{126} KAISER COMM’N ON MEDICAID AND THE UNINSURED, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS 5 (May 2015).


\textsuperscript{129} See Karen Tritz, LONG-TERM CARE: CONSUMER-DIRECTED SERVICES UNDER MEDICAID. Cong. Rsrch Serv. Rep’t (Aug. 31, 2006) at Table 1, available at http://congressionalresearch.com/RL32219/document.php (comparing agency-directed versus consumer-directed LTSS in terms of program structures and policies); Mary J. Clark et al., A Longitudinal Comparison of Consumer-Directed and Agency-Directed Personal Assistance Service Programs Among Persons With Physical Disabilities, 30 DISABILITY & REHAB. 689, 689 (2008) (“Agency-directed models offer few choices over who is hired, daily scheduling, the types of services to be performed, or how the services are performed.”).
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consumers on Medicaid through a slew of state-specific waiver programs. Although originally the HCB alternatives were built around an agency-directed model, more recently a variety of opportunities for consumer-directed LTSS have been opened up for Medicaid-dependent people, by moving from an indemnity model of payment by the government agency to a disability model of empowering the consumer to purchase, pay for, and arrange the specific logistical details of desired services directly. The consumer-directed model is supportive of consumer autonomy, although this model is not without some feminist critics.

Most state Medicaid programs are in a transition period involving a move from the traditional fee-for-service provider payment model to various incarnations of managed care, under which Medicaid beneficiaries participate in private health plans run by insurers. This transition may be understood as follows:

Managed care differs from the fee-for-service system because the MCO [managed care organization] assumes either full or partial financial risk. Under the

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134 See Pear, supra n. 117.
traditional fee-for-service system, medical providers issue a fee for each service they provide and are reimbursed by the state’s Medicaid program. Fee-for-service providers are only responsible for the specific service they provide.***However, under the risk-based approach to managed long-term care, the state’s Medicaid program arranges to have a single MCO, also known as a contractor, [or several competing MCOs] provide a package of long-term care benefits. The MCO then contracts with medical providers to render medical services to the beneficiaries within their program. When choosing which medical providers to contract with, the MCO may seek providers known to be cost-effective or it may choose to pay providers a capitated per patient fee.135

Under traditional fee-for-service Medicaid, the state must permit consumers to obtain services from any provider who is willing to accept the state’s unilaterally dictated Medicaid reimbursement as payment in full for the particular service(s) rendered. However, when a state enters into a contract with one or more private MCOs to serve the state’s Medicaid population, the state may obtain a federal waiver136 or may amend its State Medicaid Plan137 to mandate that individual consumers make the shift to managed care from fee-for-service. Importantly, though, states ordinarily may not require consumers who are dually eligible for both Medicare and Medicaid to enroll in managed care138 unless a waiver has been obtained by the state from the federal Department of Health and Human Services.139 There is continuing litigation in Florida challenging that part of the state’s Medicaid managed care LTSS waiver that mandates consumer participation, on the grounds that forcing Medicaid LTSS consumers, who are virtually by definition disabled, into this arrangement violates their rights against discrimination under the Americans With Disabilities Act.140

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135 Jenna Steffy, Medicaid Managed Long-Term Care: Will It Solve Medicaid’s Financial Crisis?, 21 ANNALS HEALTH L. ADVANCE DIRECTIVE 72, 76 (2011).
136 42 U.S.C. §§ 1396n (b)(2) & 1315(a).
The contracts that individual states are in the process of negotiating with MCOs typically include LTSS as part of the comprehensive package of benefits the MCO agrees to provide to Medicaid-eligible consumers. Most of these contracts also include provisions for some form of mandatory care coordination in order to promote the policy objectives of improved continuity and coherence of services, and hence, enhanced quality, expanded access to services, and more effective cost containment.

At this relatively early stage in the evolution of managed LTSS, it is difficult to predict how, or whether, this managed care transformation, and particularly the care coordination element, will impact consumer direction in this arena. “A majority of [current managed care contracts with state Medicaid programs] require that all members receive, or at least be offered, care coordination,” which may range in extent from an annual contact for consumers in low risk groups to more frequent contacts for consumers at higher risk. “Although contracts emphasize consumer choice and preferences in the service planning process, most [thus far] do not address various groups of people for whom enrollment in the Medicaid managed care program is voluntary).

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142 Kimberly A. Opsahl, Using Integrated Care to Meet the Challenge of the ADA’s Integration Mandate: Is Managed Long-Term Care the Key to Addressing Access to Services?, 10 IND. HEALTH L. REV. 211 (2013); Mary Crossley, Giving Meaning to “Meaningful Access” in Medicaid Managed Care, 102 KY. L.J. 255 (2013-2014).


144 Id. at 9-10.
whether members can opt out of care coordination altogether.”

For many consumers, maintaining elements of consumer choice and self-direction of services is of paramount concern.

It is unclear how, and whether, consolidation in the health care industry will affect people who receive LTSS under the different forms of Medicaid. For consumers whose LTSS are subsidized by Medicaid under a traditional agency-directed model, researchers will need to examine the impact on the access to, and quality of, services available to consumers. We will need to collect and analyze data concerning consolidation’s impact on the number of providers of different types of LTSS and particularly on whether a reduced number of providers in different categories really means more limited choices for consumers. We will need to investigate whether fewer providers for coordinating agencies to employ will lead to states choosing to increase their Medicaid reimbursement rates or, instead, result in states keeping their reimbursement rates constant and either cutting back on quantity or timeliness of services made available to consumers or employing lower quality providers who agree to work more cheaply.

In the dwindling number of states still operating Medicaid LTSS programs on a non-managed care basis, Medicaid-dependent consumers participating in a consumer-directed option probably will be affected by health industry consolidation in much the same way that consolidation may impact consumers who pay out-of-pocket for their true consumer-directed LTSS. The key difference for self-pay consumers, though, is that, depending on their

145 Id. at 10.
146 Susan C. Reinhard, What Do Older Adults Want from Integrated Care?, 37 GENERATIONS 68, 70 (2013).
147 See n. 121, supra, and accompanying text.
149 See Section III.A., supra.
particular financial capabilities, they may be able to offer potential providers more from their own pockets than they could pay them if limited by a Medicaid program voucher or other cash equivalent. Thus, the self-pay consumer may end up paying more for LTSS, but be able to select and hire providers out of a larger pool of willing competitors. Because the Medicaid-dependent but self-directed consumer may, due to financial constraints, have access to a smaller pool of willing competitors from whom to choose LTSS providers, that consumer also may be more constrained than a self-pay counterpart in firing unsatisfactory providers or supervising them too closely for fear of alienating them. Researchers should examine empirically whether these surmised scenarios materialize.

Health industry consolidation’s impact on Medicaid LTSS managed care consumers could take interesting forms. Even apart from the consolidation effect, one set of commentators examining the shift to Medicaid managed care in Illinois cautions, “[F]ewer providers may participate in the managed care plans than are currently participating in [the traditional fee-for-service] Medicaid program. Fewer hospitals are participating in the managed care plans than are currently participating in Medicaid.”150 With the advent of health industry consolidation and fewer separate providers with whom an MCO may contract for LTSS, the provider network from whom a Medicaid LTSS consumer may receive services may shrink even further. Such an effect should be quantified by health services researchers.151

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151 This task is part of a program evaluation contract awarded in 2015 to the Florida State University Dep’t of Behavioral Sciences and Social Medicine by the Florida Agency for Healthcare Administration [hereinafter Evaluation Contract].
The ramifications of state Medicaid managed care programs on the quality of care available to consumers is a topic of considerable debate.\textsuperscript{152} It is particularly difficult to predict the effect of health industry consolidation on quality in Medicaid managed LTSS programs. On one hand, because of the enormous size and reach of their Medicaid programs,\textsuperscript{153} states exercise near-monopsony, \textit{de facto} single-payer\textsuperscript{154} purchasing power for LTSS. Thus, a provider who wants to become or remain part of the managed Medicaid LTSS network (low reimbursement being better than zero market share) in some states with multiple competing providers may have an incentive—bordering on coercion\textsuperscript{155}—to be attractive to the state by achieving and maintaining positive ratings and reputation for quality and consumer satisfaction.\textsuperscript{156} On the other hand, despite their near-monopsony power, some states may have so few LTSS providers


\textsuperscript{155} Cf. Nat’l Fed’n Indep. Bus. V. Sebelius, 132 S.Ct. 2566, 2604-2605 (2012) (plurality holding that Medicaid is such a large portion of state budgets that the federal government’s threat to withhold Medicaid funds from a state amounts to unconstitutional coercion).

\textsuperscript{156} See \textit{FLA. STAT.} § 409.982(1) (“Managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.”).
competing to be included in their inadequately compensated managed Medicaid LTSS provider networks that those states find it necessary to tolerate the inclusion of providers exhibiting somewhat less than a stellar quality of care record. Researchers should investigate which of these hypotheses ultimately gets borne out by the evidence.\footnote{See Evaluation Contract, supra n. 151.}

F. Consumers Receiving LTSS Through Membership in a Continuing Care Retirement Community

A significant number of individuals needing LTSS receive them through membership in a Continuing Care Retirement Community (CCRC). By definition, CCRCs are generally residential facilities established in a campus-like setting that provide access for older Americans to three levels of housing and care: independent homes or apartments where residents live much as they did in their own homes; assisted living, which provides help with the daily tasks of living; and skilled nursing care for those with greater physical needs. Most residents must be able to live independently when they enter into a contract with a CCRC, with the intent of moving through the three levels of care as their needs change.\footnote{U.S. Gov’t Accountability Off., Older Americans: Continuing Care Retirement Communities Can Provide Benefits, But Not Without Some Risk 3, GAO-10-611 (2010).}

There are several general types of contracts that a CCRC might offer to a prospective resident, each varying in terms of required entrance fee and monthly payments.\footnote{Id. at 5-6.} In Type A (often labeled extensive or Life Care arrangements), in return for a substantial entrance fee and reasonably stable monthly payments, a resident is entitled to housing, residential services, amenities, and unlimited health services. The CCRC accepts the financial risk that a resident’s need for services, and the resource cost to satisfy that need, will increase over time. In Type B (a modified contract), the initial monthly payment is less for the same housing and residential...
amenities, but only certain health services are included, with the resident paying out of pocket for assisted living or skilled nursing services that exceed the modified contract’s coverage limits. In fee-for-service (Type C) contracts, the resident’s lower entrance and monthly fees cover independent living, but the resident is at risk to pay market rates for all health-related services needed. A Type D (rental) contract involves no entrance fee but provides the resident with guaranteed access to CCRC residential and health services, for which the resident pays a monthly fee the amount of which depends on the living space and services needed.

CCRCs have been experiencing many of the same kinds of financial risks in the past few years that have incentivized other types of health care providers to engage in consolidation activities, as well as risks more unique to this sector of the health industry. Notable bankruptcies and restructurings have characterized the CCRC industry over the past decade. Most “successful CCRCs have a mission-based sponsor that also is well-heeled and capitalized. Whether it be a faith-based or a fraternal organization or the beneficiary of some other sponsor, it appears that staying power in the CCRC industry resides with those who independently have the money to continue to support the difficult margins that are being experienced…”

Consolidation in the CCRC business place might impact actual or potential consumers in a number of ways. The consumer’s choice of CCRC would be impinged by a smaller number of these providers competing for the consumer’s business, and access to any CCRC in a particular geographic area might be negatively affected by voluntary or involuntary closings that diminish the total number of spaces available. Scarcer available spaces could lead to less attractive

\[160\] Id. at 8-11.
\[162\] Brandt & Troop, supra n. 2, at 69.
contractual terms (for example, higher entrance fees and monthly payments, or less coverage) for consumers *qua* purchasers who are forced to compete for those finite but desirable spaces. At the same time, if consolidation puts remaining CCRCs on firmer financial footing and accordingly prevents closings and bankruptcies, the financial interests of consumers who have invested an entrance fee in a CCRC would be better protected.

IV. CONCLUSION

The current, and probably continuing, consolidation of health services providers, producers and sellers of health care products, and third-party payers for health services and products inevitably will exert a variety of impacts on health care consumers generally and within specific contexts. Actual and potential consumers of LTSS, as well as their families, are likely to be affected in unique ways, differing to a large extent depending on the way that respective groups of consumers now finance their own LTSS. Sparse significant data are available yet regarding such effects, but speculation nonetheless abounds. This article joins in this basically uninformed but plausible speculation exercise but, I hope, adds constructively to the discussion by suggesting the rudiments of a health services research agenda that leads eventually to evidence-informed public policy making and private sector conduct that optimizes consolidation’s impact on consumers’ interests in access to, affordability of, and quality received in the realm of LTSS.