

RETIREMENT PLANNING'S GREATEST GAP: FUNDING LONG-TERM CARE

by
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In this Article, Professor Kaplan examines the major missing component of retirement planning: how to finance the potentially explosive cost of long-term care. He reviews the wide array of long-term care options currently available, including home care, assisted living facilities, and nursing homes. Next he examines the coverage for long-term care provided by the government health program for older Americans, Medicare, and private insurance policies that supplement that program. Finding such coverage woefully deficient, Professor Kaplan then considers the governmental health care program for poor people of any age, Medicaid, and assesses that program's coverage of long-term care and its eligibility limitations as tightened by recent legislation. He then turns to private long-term care insurance and analyzes its major components and the various pitfalls that prospective retirees encounter in purchasing such insurance. Finally, Professor Kaplan critiques the federal government's major initiatives to encourage such insurance—namely, the tax deduction of premiums and coordination of certain long-term care insurance policies with the Medicaid program.

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I. INTRODUCTION

Baby Boomers and other prospective retirees are constantly bombarded about how much they need to save for their impending retirement by newspapers, finance magazines, brokerage advertisements, and other sources.¹ These pronouncements range from well-meaning to intentionally spooky and implicitly recognize that this generation is the first to have most of its retirement funding coming from personal savings. In lieu of “traditional” defined benefit pensions that paid a specific amount every month until the retiree and often his spouse passed away, prospective retirees must depend for the most part on various types of individually managed accounts,² be they so-called 401(k) plans (or their cognates for tax-exempt employers, 403(b) and

¹ See, e.g., Jeff Opdyke, *Will You Be Able to Retire?*, WALL ST. J., July 1, 2006, at B1.

² See Richard L. Kaplan, *Enron, Pension Policy, and Social Security Privatization*, 46 ARIZ. L. REV. 53, 58–63 (2004). See generally Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L.J. 451 (2004).

457 plans),³ Individual Retirement Accounts (IRAs),⁴ or other similar arrangements. Accordingly, this generation is largely on its own in terms of financing its retirement needs.⁵

In determining whether these prospective retirees have sufficient retirement resources, various calculations utilize extremely rough estimates of several critical factors. Those factors include expected living expenses after terminating full-time employment, anticipated future investment rates of return, and relevant mortality statistics such as life expectancy. The ensuing extremely hypothetical mélange is then transformed through the apparently precise alchemy of present value computations into the ultimate target number that the Boomers must meet to ensure that their retirement expectations (often described as “dreams”) are attainable. In fact, a newly released popular personal finance book bears the ominous title, *The Number*,⁶ which purports to explain how this critical calculation should be made and its significance for a meaningful life.

In most of these exercises, the cost of future health care is given only cursory attention. For example, Fidelity Investments, to name just one company, notes on its website that prospective retired couples should expect to spend at least \$200,000 on future medical costs. But the company includes an extremely important disclosure that this estimate does not “even factor in the potential costs of spending time in a nursing home or long-term care insurance premiums.”⁷ Instead, prospective retirees are left largely to their own devices to consider this extraordinarily important issue and what to do about it. As a result, the funding of long-term care is the single greatest gap in retirement planning, even though this potential black hole could totally eclipse all of the carefully constructed parameters of pre-retirement calculations.

This Article examines this largely neglected aspect of retirement planning and considers some of the corrective action that should be taken by prospective retirees and their advisors. The Article begins by explaining what the phrase “long-term care” means and its pertinent cost implications.⁸ It then considers the federal government’s health care program for older Americans—namely, Medicare—and explains that this program *does not* cover most long-term care.⁹ Folks who are familiar with the fragmented nature of American health care financing often presume that whatever gaps or holes exist in Medicare’s

³ See generally ALICIA H. MUNNELL & ANNIKA SUNDÉN, COMING UP SHORT: THE CHALLENGE OF 401(K) PLANS (2004).

⁴ See generally Richard L. Kaplan, *Retirement Funding and the Curious Evolution of Individual Retirement Accounts*, 7 ELDER L.J. 283 (1999).

⁵ See generally Patricia E. Dilley, *Hope We Die Before We Get Old: The Attack on Retirement*, 12 ELDER L.J. 245, 250–79 (2004).

⁶ LEE EISENBERG, THE NUMBER: A COMPLETELY DIFFERENT WAY TO THINK ABOUT THE REST OF YOUR LIFE (2006). See also Jeffrey R. Kosnett, *Looking for Your Magic Number*, Kiplinger’s PERS. FIN., Aug. 2006, at 28.

⁷ See Fidelity Investments, Retirement Plan Risks: The Risks of Health Care Costs, http://personal.fidelity.com/planning/retirement/content/health_care_costs.shtml?refpr=h9.

⁸ See *infra* Part II.

⁹ See *infra* Part III.

coverage will be covered by the private supplemental insurance that is often called “Medigap” insurance.¹⁰ But the next section of this Article explains why that is almost never the case with respect to Medicare’s long-term care coverage gaps.¹¹ The Article then examines the government program that actually pays for much of this country’s long-term care needs—namely, Medicaid—and specifically the significant changes that were enacted on February 8, 2006 regarding this program.¹² Finally, the Article analyzes private long-term care insurance—the only alternative that provides any serious planning potential—and considers the obstacles that currently limit its usefulness and appeal.¹³ This section of the Article includes suggestions for Congress and the long-term care industry to implement private long-term care insurance in a way that would avoid some of the obstacles noted.

II. THE NATURE AND COST OF LONG-TERM CARE

As Americans live longer, they are more likely to develop age-related disabilities that limit their autonomy and ability to live independently.¹⁴ At that point, some type of long-term care will become necessary, though the specific type of care depends upon the condition of the older person in question.¹⁵ Many issues emerge when the need for long-term care arises,¹⁶ including questions about where such care will be provided and by whom,¹⁷ but an issue that concerns the older person and her family with particular poignancy is who will pay for this care. Older Americans who can no longer live independently have several options within the rubric of “long-term care,” ranging from assistance in their current residences to a medically-oriented residential institution called a nursing home.¹⁸ This section describes these varied alternatives, beginning with the least disruptive: home care.

¹⁰ See generally LAWRENCE A. FROLIK & RICHARD L. KAPLAN, *ELDER LAW IN A NUTSHELL* 95–103 (Thomson/West 4th ed. 2006).

¹¹ See *infra* Part IV.

¹² See *infra* Part V.

¹³ See *infra* Part VI.

¹⁴ See Lawrence A. Frolik & Alison P. Barnes, *An Aging Population: A Challenge to the Law*, 42 HASTINGS L.J. 683, 694–96 (1991).

¹⁵ See generally ROSALIE A. KANE ET AL., *THE HEART OF LONG-TERM CARE* (1998) (noting the need for long-term care programs that provide consumers with options for individualized treatment).

¹⁶ See ALWAYS ON CALL: WHEN ILLNESS TURNS FAMILIES INTO CAREGIVERS (Carol Levine ed., 2000).

¹⁷ See generally EMILY K. ABEL, *WHO CARES FOR THE ELDERLY?* (1991) (reviewing who provides long-term care and how this care is provided). These issues are often significantly affected by the ethnicity of the older person who requires long-term care. See *ETHNIC ELDERLY AND LONG-TERM CARE* (Charles M. Barresi & Donald E. Stull eds., 1993).

¹⁸ See generally LAWRENCE A. FROLIK, *RESIDENCE OPTIONS FOR OLDER OR DISABLED CLIENTS* (3d ed. 2001) (discussing residential options for senior citizens).

A. *Home Care*

The phrase “home care” applies to an enormous range of accommodations, all of which involve some version of bringing assistance into the residence of an older person.¹⁹ This assistance may consist of home health nurses or aides who administer medications or perform medical procedures, such as injections and insertion of feeding tubes, catheters, or breathing devices.²⁰ On the other hand, home care can also consist of homemaker and personal care services with no medical component at all, such as meal preparation, housekeeping, home maintenance, and simple repairs.²¹ Many of these services are provided without charge by family members, friends, members of a religious community, or some other affinity group.²² Indeed, a report published by the National Alliance for Caregiving estimated that such informal care constitutes almost 80% of all long-term care provided to older Americans.²³

Other services typically entail some out-of-pocket expense. For example, the popular Meals-on-Wheels program and similar efforts are provided at a nominal charge by various public and community-based organizations, such as the local Area Agency on Aging.²⁴ Similarly, adult daycare allows an older adult to be brought to a special center that offers various services to impaired senior citizens.²⁵ Some adult daycare centers provide physical therapy and personal grooming services, in addition to a midday meal, activities appropriate to the elder’s abilities and interests, and the companionship of persons of similar vintage.²⁶ These centers seek to address the social isolation and loneliness that advanced age can often bring. But adult daycare centers usually operate on a fairly limited schedule—typically from early morning to late afternoon—and are not open every day of the week. Thus, adult daycare still requires the older patient to have a supportive network of family and friends to fill in the gaps in the daycare center’s schedule. Finally, medically-oriented services are usually provided by home health agencies that specialize in these services and have been certified by state and federal regulators.²⁷ The common thread in these arrangements is that they enable the older person to remain in his or her home, to “age in place.”

Most home care is part-time only, generally provided in segments of 8 hours or less per day, and usually not every day. Around-the-clock home care would require 3 shifts of caregivers every day and would quickly become very

¹⁹ See KANE ET AL., *supra* note 15, at 119.

²⁰ *Id.* at 120–21.

²¹ FROLIK, *supra* note 18, ¶ 11.04, at 11-19.

²² KANE ET AL., *supra* note 15, at 14–15.

²³ NAT’L ALLIANCE FOR CAREGIVING, CARING TODAY, PLANNING FOR TOMORROW (1999), <http://www.caregiving.org/data/archives/nacguide.pdf>.

²⁴ See NAT’L SENIOR CITIZENS LAW CTR., PLANNING CARE AT HOME 79–80 (2000); UNITED SENIORS HEALTH COUNCIL, LONG TERM CARE PLANNING: A DOLLAR AND SENSE GUIDE 12–14 (rev. ed. 2001).

²⁵ See UNITED SENIORS HEALTH COUNCIL, *supra* note 24, at 15.

²⁶ *Id.*

²⁷ FROLIK, *supra* note 18, ¶ 11.04[1][d], at 11-22 to 11-23; NAT’L SENIOR CITIZENS LAW CTR., *supra* note 24, at 89–93.

expensive. According to the most comprehensive survey of home health costs, the average hourly charge in 2006 for homemaker services was \$17.09 and \$25.32 for home health aides.²⁸ Moreover, “certified” home care providers charge even more—an average of \$36.22 per hour for home health aides.²⁹ In addition, there are significant variations across the various states and within states as well.³⁰ Even using an average rate of \$21 per hour translates into a charge of \$504 per day for around-the-clock care, or almost \$184,000 on an annual basis. Indeed, the development of nursing homes is partly a response to the prohibitively high cost of providing home care on a constant basis.³¹ Thus, home care is an appropriate arrangement for older persons who require assistance with some activities of daily living, but do not require such assistance all day and night. Home care can also be appropriate when family members are willing and able to supplement the services of paid caregivers.³²

A variation on this approach of coordinating paid and unpaid home care is private care management. Under this increasingly popular arrangement, a geriatric care manager assesses what an older person requires to remain at home, provides specific recommendations in accordance with that assessment, and then monitors the actual provision of those services.³³ Geriatric care managers are usually nurses or licensed social workers, and typically work with families who live some distance from the older person in question or who otherwise want a professional to oversee the home care process.³⁴ In-home assessments can also be performed by certain public agencies,³⁵ particularly for persons who meet those agencies’ financial criteria or otherwise are in their targeted clientele.

As this brief overview suggests, many people may not be appropriate candidates for home care. Individuals who lack support networks and persons whose medical needs require more than a few hours of professional intervention per day will find that home care does not work well. Still other older people may

²⁸ GENWORTH FINANCIAL, 2006 COST OF CARE SURVEY (2006).

²⁹ *Id.*

³⁰ *Id.* at 12–30 (detailing regional differences); see also METLIFE MATURE MARKET INST., THE METLIFE MARKET SURVEY OF NURSING HOME & HOME CARE COSTS 12–14 (2005) (same).

³¹ See FROLIK & KAPLAN, *supra* note 10, at 160.

³² FROLIK, *supra* note 18, ¶ 12.01, at 12-3.

³³ See *id.* ¶ 11.04[1], at 11-20 to 11-21; J.C. Conklin, *For Hire: Geriatric-Care Manager (Also Friend, Counselor, Matchmaker)*, WALL ST. J., Apr. 27, 2000, at B1; Mary Lynn Pannen, *A Win-Win Partnership: The Elder Law Attorney & Geriatric Care Manager*, NAT’L ACAD. ELDER L. ATT’YS Q., Spring 2000, at 25.

³⁴ Christine Gorman, *Guardian Angels*, TIME, Mar. 26, 2001, at 75; Georgette Jasen, *When Crisis Strikes: Caring for an Elderly Parent*, WALL ST. J., May 28, 1993, at C1; Tracey Longo, *When Distant Parents Need Your Help*, KIPLINGER’S PERS. FIN., Dec. 1995, at 91. Geriatric care management is also an integral part of employee fringe benefits. See Kelly Greene, *A Renewed Push to Help Workers with Elder Care*, WALL ST. J., Mar. 29, 2000, at B1.

³⁵ See UNITED SENIORS HEALTH COUNCIL, *supra* note 24, at 14–15; see also Andreas E. Stuck et al., *A Trial of Annual In-Home Comprehensive Geriatric Assessments for Elderly People Living in the Community*, 333 NEW ENG. J. MED. 1184 (1995) (discussing the effect of annual in-home comprehensive geriatric assessments). See generally KANE ET AL., *supra* note 15, at 143–49.

resist home care because they do not want strangers coming into their homes, invading their privacy, and making them feel vulnerable. This concern is not trivial. Elder abuse, financial exploitation, and theft of personal assets can flourish in the essentially unsupervised environment of home care.³⁶ Nevertheless, in the right circumstances, home care can enable an older person to remain at home as long as possible, which is the desire of an overwhelming majority of older people.³⁷

Newer technologies are also expanding the population that can be accommodated by home care arrangements. Off-site monitoring of vital signs and other medical indicators, telephonic checks, special alert systems, and even Internet-based services are enabling family members to supervise the care and condition of older relatives who live many miles away.³⁸

B. Assisted Living Facilities

For older persons whose needs cannot be met by some version of home care but who do not require the level of medical attention that a nursing home provides, a mid-level living arrangement called “assisted living” might be appropriate. These planned developments, usually called “assisted living facilities” (ALF) were developed as successors to more traditional “board and care homes” and “continuing care retirement communities” (CCRC). Board and care homes are fairly small, with 25 residents or less, and include foster homes, personal care homes, rest homes, homes for the aged, and similarly denominated institutions. The level of care provided at board and care homes is rather basic and rarely extends beyond meal preparation or assistance with certain activities of daily living, such as bathing, toileting, and dressing.³⁹ Assistance with medication may be available, but it is limited to ensuring that residents take the correct dosage at the correct time.⁴⁰ CCRCs, in contrast, represent combination arrangements that typically have senior-oriented independent living apartments and a nursing home at the same location. Although some CCRCs provide assistance with daily activities, especially meals,⁴¹ any significant nursing assistance is almost always provided in the CCRC’s nursing home.

In the 1990s, major corporations began building assisted living facilities for older people who require some assistance with daily living, but not the full medical complement of nursing homes.⁴² Similar in concept to board and care

³⁶ See FROLIK, *supra* note 18, ¶ 11.04[6], at 11-31 to 11-32. See generally MARTHA D. NATHANSON & CAREL T. HEDLUND, *HOME CARE FRAUD AND ABUSE* (1999) (discussing abuse and fraud in senior home care situations).

³⁷ See FROLIK & KAPLAN, *supra* note 10, at 189 (“According to survey data . . . , 86% of older adults want to stay in their current residence as long as possible.”).

³⁸ See Sue Shellenbarger, *Taking Care of Parents: New High-Tech Links Can Offer Some Relief*, WALL ST. J., Mar. 8, 2000, at B1.

³⁹ See FROLIK & KAPLAN, *supra* note 10, at 182.

⁴⁰ *Id.* at 173.

⁴¹ FROLIK, *supra* note 18, ¶ 8.02[1][b], at 8-4 to 8-5.

⁴² See ERIC M. CARLSON, *LONG-TERM CARE ADVOCACY* § 5.07[1] (2005); FROLIK & KAPLAN, *supra* note 10, at 185–88; see also NAT’L CTR. FOR ASSISTED LIVING, *FACTS AND*

homes, ALFs are generally larger developments, often housing several hundred residents or more. Restaurant-style dining is the norm, and the individual residential apartments often include small kitchenettes. In addition, ALFs have various safety features that address the needs of older adults, such as pull-cords, grab bars in the bathrooms, and alert systems. Organized social activities, group outings to movies and cultural events, and planned shopping trips are typical as well. Most ALFs offer a range of convenient services on the premises, including a pharmacy, barber and beauty shops, post office, and bank or cash machine.⁴³ Housekeeping and laundry services are usually provided, sometimes for an additional fee.⁴⁴ Although some ALF residents have their own automobiles, many residents rely on the ALF's transportation service to go to houses of worship, doctors' offices, and the like.⁴⁵

ALFs generally have formal admission contracts that set forth the conditions of residency in their facilities. These contracts detail which services are included in the monthly fee and which services bear additional charges.⁴⁶ This distinction is very important, because the monthly fee itself in 2006 averaged \$2,691.20 for a one-bedroom unit, or \$32,294 on an annual basis.⁴⁷ Once again, there are wide national and regional differences.⁴⁸ Some facilities require that residents be able to eat in the dining room, and residents who cannot do so may be asked to leave the ALF. Similarly, ALFs cater to older people without extensive nursing care requirements.⁴⁹ Most ALFs have nurses on staff,⁵⁰ but some utilize an on-call nursing service, which is utilized when the need for nursing assistance arises.

Within these constraints, ALFs provide assistance with personal care needs, bathing, and dressing.⁵¹ They can monitor residents' use of prescription drugs and even treat minor health problems.⁵² For many older Americans, ALFs become their new bases of operations, with occasional stays in a hospital or nursing home as circumstances dictate. In short, ALFs strive to maintain a resident's current functional ability, but they generally do not undertake recuperative or therapeutic measures.

TRENDS: THE ASSISTED LIVING SOURCEBOOK (1997); *Can Your Loved Ones Avoid a Nursing Home? The Promise and the Pitfalls of 'Assisted Living,'* CONSUMER REP., Oct. 1995, at 656.

⁴³ Cf. FROLIK, *supra* note 18, ¶ 9.06, at 9-11.

⁴⁴ KANE ET AL., *supra* note 15, at 177.

⁴⁵ FROLIK & KAPLAN, *supra* note 10, at 187.

⁴⁶ See FROLIK, *supra* note 18, ¶ 9.07.

⁴⁷ GENWORTH FINANCIAL, *supra* note 28, at 2.

⁴⁸ *Id.* at 10-11.

⁴⁹ See FROLIK, *supra* note 18, ¶ 9.04, at 9-5.

⁵⁰ *Id.* ¶ 9.06, at 9-11.

⁵¹ *Id.* ¶ 9.05[1].

⁵² *Id.* ¶ 9.05[2].

C. *Nursing Homes*

Residential facilities that provide long-term care with a substantial medical component are called nursing homes.⁵³ Some nursing homes offer very sophisticated medical treatment and common recuperative therapies,⁵⁴ such as postoperative rehabilitation following hip replacement. Others provide care for chronic conditions, such as Alzheimer's disease, that are not expected to improve over time.⁵⁵ But all nursing homes have medical and nursing care as their primary mission, and provide other services, like meals and housing, incidental to that mission.⁵⁶ Nursing personnel are on the premises at all times, although the actual patient care is often assigned to nursing assistants and aides.⁵⁷ Some nursing homes also provide social programming and group exercise classes geared to the abilities of the residents.

Nursing homes are expensive to operate because they care for very impaired patients. According to the 2006 cost survey cited previously, the average cost of a private room in a nursing home is \$194.28 per day or nearly \$71,000 per year,⁵⁸ and in some parts of the country it can be much higher.⁵⁹ Nevertheless, these facilities are more cost effective than hospitals,⁶⁰ which often are the only realistic alternative. Extensive federal and state regulations cover most aspects of operating a nursing home, including the size of rooms, nursing credentials and staff, meal hours and intervals, and medical supervision.⁶¹ Because nursing home residents are often unusually vulnerable,⁶² a nursing home resident's "bill of rights" was enacted to guarantee certain basic standards.⁶³ Included are a patient's right to select her own physician,⁶⁴ her right to be free of physical and chemical

⁵³ See generally FROLIK & KAPLAN, *supra* note 10, at 158–78 (discussing the functional and financial aspects of nursing homes).

⁵⁴ See KANE ET AL., *supra* note 15, at 167–69.

⁵⁵ *Id.* at 169–70; see also J.C. Conklin, *Nursing Homes Add 'Special Care,'* WALL ST. J., Aug. 7, 2000, at B1 (discussing the trend among nursing homes to add Alzheimer's special care units for financial stability).

⁵⁶ See FROLIK & KAPLAN, *supra* note 10, at 159.

⁵⁷ See CARLSON, *supra* note 42, § 2.07; KANE ET AL., *supra* note 15, at 165.

⁵⁸ GENWORTH FINANCIAL, *supra* note 28, at 2. The average charge for a semi-private room was \$171.32 per day or \$62,532 per year. *Id.*

⁵⁹ See *id.* at 6–7.

⁶⁰ See FROLIK, *supra* note 18, ¶ 12.01, at 12–3 (quoting nursing home rates as high as \$7,000 per month versus hospital rates of \$1,000 or more per day).

⁶¹ See CARLSON, *supra* note 42, §§ 2.101–.152 (reviewing state regulations of nursing homes); CCH, INC., *NURSING HOME REGULATIONS* (1995) (reviewing federal regulations of nursing homes); see also Sen. Charles Grassley, *The Resurrection of Nursing Home Reform: A Historical Account of the Recent Revival of the Quality of Care Standards for Long-Term Care Facilities Established in the Omnibus Reconciliation Act of 1987*, 7 ELDER L.J. 267 (1999) (examining The Omnibus Reconciliation Act of 1987, problems with its enforcement, and nursing home reform efforts).

⁶² Donna Myers Ambrogio, *Legal Issues in Nursing Home Admissions*, 18 L. MED. & HEALTH CARE 254, 255 (1990).

⁶³ 42 U.S.C. §§ 1395i-3, 1396r (2000). See FROLIK & KAPLAN, *supra* note 10, at 169–78.

⁶⁴ 42 U.S.C. §§ 1395i-3(c)(1)(A)(i), 1396r(c)(1)(A)(i) (2000); 42 C.F.R. § 483.10(d)(1) (2005).

restraints,⁶⁵ her right to privacy,⁶⁶ confidentiality of clinical records,⁶⁷ and visitation by family and friends.⁶⁸

In the context of long-term care, nursing homes are first and foremost medical institutions. That fact explains many of the operational requirements that are imposed on nursing homes. For example, a nursing home must assess each new resident's functional abilities and limitations within 14 days of admission.⁶⁹ The facility must then prepare a written plan for that person's care⁷⁰ and it must update this plan at least once a year or whenever a resident's condition changes significantly.⁷¹ Patients must also be under the supervision of a physician or other medical professional⁷² in accordance with state law.

III. MEDICARE

This Part examines the financing of long-term care by the government's health care program for older Americans, Medicare.⁷³ Anyone who is at least 65 years old and meets certain work requirements is entitled to benefits under this program.⁷⁴ Eligibility is also extended to the spouse of a covered worker and to a divorced spouse, if their marriage lasted at least 10 years.⁷⁵ As a result, most older Americans are covered by Medicare.⁷⁶

Medicare has 2 major components that are denominated Part A and Part B.⁷⁷ Eligible persons receive Part A at no charge, because Part A is financed by a 2.9%

⁶⁵ 42 U.S.C. §§ 1395i-3(c)(1)(A)(ii), 1396r(c)(1)(A)(ii); 42 C.F.R. § 483.13(a) (2005).

⁶⁶ 42 U.S.C. §§ 1395i-3(c)(1)(A)(iii), 1396r(c)(1)(A)(iii); 42 C.F.R. § 483.10(e)(1) (2005).

⁶⁷ 42 U.S.C. §§ 1395i-3(c)(1)(A)(iv), 1396r(c)(1)(A)(iv); 42 C.F.R. § 483.10(e)(2) (2005).

⁶⁸ 42 U.S.C. §§ 1395i-3(c)(3)(B)–(C), 1396r(c)(3)(B)–(C); 42 C.F.R. § 483.10(j)(1)(vii)–(viii).

⁶⁹ 42 U.S.C. §§ 1395i-3(b)(3)(A), (C)(i)(I), 1396r(b)(3)(A), (C)(i)(I); 42 C.F.R. § 483.20(b)(2)(i) (2005).

⁷⁰ 42 U.S.C. §§ 1395i-3(b)(2), 1396r(b)(2); 42 C.F.R. § 483.20(d).

⁷¹ 42 U.S.C. §§ 1395i-3(b)(3)(C)(i)(II)–(III), 1396r(b)(3)(C)(i)(II)–(III); 42 C.F.R. § 483.20(b)(2)(ii)–(iii).

⁷² 42 U.S.C. §§ 1395i-3(b)(6)(A), 1396r(b)(6)(A); 42 C.F.R. § 483.40(a)(1) (2005).

⁷³ See 42 U.S.C. § 1395c (2000). See generally 2005–2006 MEDICARE HANDBOOK (Judith A. Stein & Alfred J. Chiplin, Jr. eds., 2006) (discussing Medicare in depth) [hereinafter MEDICARE HANDBOOK].

⁷⁴ 42 U.S.C. § 1395c(1). The relevant work requirement is earning at least 40 “quarters of coverage” as that phrase is applied to establish eligibility for retirement benefits under Social Security. See FROLIK & KAPLAN, *supra* note 10, at 282–88.

⁷⁵ FROLIK & KAPLAN, *supra* note 10, at 57–58.

⁷⁶ Medicare also covers individuals who are younger than 65 years old if they have received disability benefits from Social Security for at least 24 months or have been diagnosed with “end stage renal disease.” FROLIK & KAPLAN, *supra* note 10, at 59. But the vast majority of Medicare enrollees are at least 65 years old; therefore Medicare will be considered in this Article from their perspectives.

⁷⁷ An additional component, called Part C, provides alternatives to Medicare's traditional benefit package. See 42 U.S.C. § 1395w-21 (2000); FROLIK & KAPLAN, *supra* note 10, at 106–07. Because the vast majority of Medicare enrollees participate in Parts A and B, this Article will focus on those components of Medicare.

payroll tax on all income from wages, salaries, and self-employment.⁷⁸ As long as a retiree worked at least 10 years in employment settings that were subject to this payroll tax, that person is entitled to Medicare coverage under Part A.⁷⁹ In fact, a person is not required to retire from the compensated workforce to be Medicare-eligible,⁸⁰ if he has met that program's length-of-employment requirement.⁸¹ As a result, older persons who are still employed may utilize Medicare Part A as their primary health insurance.

Part B is financed very differently. General tax revenues provide 75% of the cost associated with this program, and annually adjusted premiums paid by enrollees provide the remaining 25%.⁸² In 2006, this premium was \$88.50 per month.⁸³ Part B covers doctors' bills, ambulance charges, and some home health expenses,⁸⁴ but the primary payer of long-term care expenses within Medicare is Part A. Even then, Part A's coverage of long-term care is limited to home health visits⁸⁵ and "skilled nursing facilities,"⁸⁶ commonly called nursing homes. Each of these coverages, moreover, is subject to several significant preconditions and restrictions, which are considered below. In other words, Medicare addresses only the 2 extremes in the long-term care continuum, home care and nursing homes, and not assisted living or any other alternatives.

A. Home Care

Medicare provides a range of home health services to enrollees who are confined to their homes.⁸⁷ Eligibility is restricted, however, to persons who require

⁷⁸ I.R.C. §§ 3101(b)(6), 3111(b)(6) (2000). For employees, this payroll tax burden is split between the employee and the employer with each paying 1.45% of the employee's salary.

⁷⁹ Forty (40) "quarters of coverage" translates into roughly 10 years. Persons who have not met this work requirement may purchase Part A for a monthly premium that is adjusted annually. In 2006, this premium was \$393 per month. See DEP'T OF HEALTH & HUMAN SERVS., MEDICARE & YOU 2006, at 6, available at http://www.luc.edu/hr/pdfs/Medicare_&_You_2006.pdf [hereinafter CMS MEDICARE].

⁸⁰ FROLIK & KAPLAN, *supra* note 10, at 57, 62.

⁸¹ See *id.* at 282.

⁸² See 42 U.S.C. § 1395r(a)(1), (3) (2000). Beginning in 2007, however, certain upper-income retirees will pay more than 25% of the Part B costs, with the precise percentage depending upon that retiree's income as reported for federal tax purposes. See Richard L. Kaplan, *Means-Testing Medicare: Retiree Pain for Little Governmental Gain*, J. RETIREMENT PLAN., May-June 2006, at 23.

⁸³ CMS MEDICARE, *supra* note 79, at 8.

⁸⁴ See FROLIK & KAPLAN, *supra* note 10, at 75-78 (reviewing coverage under Medicare Part B); MEDICARE HANDBOOK, *supra* note 73, §§ 6.01-.08 (same).

⁸⁵ See FROLIK & KAPLAN, *supra* note 10, at 71-73 (reviewing Medicare's home health coverage); MEDICARE HANDBOOK, *supra* note 73, §§ 4.01-.08 (describing home health coverage under Medicare).

⁸⁶ See FROLIK & KAPLAN, *supra* note 10, at 68-71 (reviewing coverage for nursing facilities under Medicare Part A); MEDICARE HANDBOOK, *supra* note 73, §§ 3.01-.08 (describing Medicare Part A coverage for nursing facilities).

⁸⁷ 42 U.S.C. §§ 1395f(a)(2)(C), 1395n(a)(2)(A) (2000).

assistance from other people or who need wheelchairs, walkers, or canes to leave their homes.⁸⁸

The covered services include physical and occupational therapy,⁸⁹ medical supplies,⁹⁰ and “part-time or intermittent” nursing care.⁹¹ This last phrase is defined as care of less than 8 hours a day and no more than 28 hours per week.⁹² Thus, Medicare does not cover around-the-clock, or even all-day, in-home care.

For Medicare’s coverage to apply, the nursing care must be provided or supervised by a registered professional nurse.⁹³ The services of home health aides can be covered, as well, if a physician orders services that do not require a licensed nurse’s skills.⁹⁴ In any case, the care must be provided by a Medicare-certified home health agency,⁹⁵ pursuant to a written plan of care established by a physician,⁹⁶ and that physician must review the plan at least once every 60 days.⁹⁷ Thus, informal care giving by friends, relatives, or even paid “helpers” is not covered by Medicare.⁹⁸

In summary, Medicare’s coverage of home health care utilizes a medically oriented approach that only incidentally strives to maintain a senior citizen in his or her home. On average, this coverage is limited to only 4 hours of assistance per day⁹⁹ and requires ongoing coordination with a supervising agency and a physician. This coverage is not what most people think of as home care.

B. Nursing Homes

Medicare covers care in a skilled nursing facility (SNF),¹⁰⁰ but only under 4 conditions, all of which must be met. Even then, Medicare’s coverage is

⁸⁸ 42 U.S.C. §§ 1395f(a)(2)(C), 1395n(a)(2).

⁸⁹ 42 U.S.C. § 1395x(m)(2) (2000).

⁹⁰ 42 U.S.C. § 1395x(m)(5). Included are catheters and colostomy bags. *Id.*

⁹¹ 42 U.S.C. § 1395x(m)(1).

⁹² 42 U.S.C. § 1395x(m) (penultimate sentence).

⁹³ 42 U.S.C. § 1395x(m)(1).

⁹⁴ 42 U.S.C. § 1395x(m)(4). *See also* H. Gilbert Welch et al., *The Use of Medicare Home Health Care Services*, 335 NEW ENG. J. MED. 324, 328 (1996) (noting that home health aides account for almost half of Medicare’s home health care visits).

⁹⁵ 42 U.S.C. § 1395x(m), (o). *See generally* Brian E. Davis, *The Home Health Care Crisis: Medicare’s Fastest Growing Program Legalizes Spiraling Costs*, 6 ELDER L.J. 215, 221–29 (1998).

⁹⁶ 42 U.S.C. § 1395x(m).

⁹⁷ 42 C.F.R. § 484.18(b) (2005).

⁹⁸ Additional limitations under Medicare Part A include a preceding hospital or nursing home stay within 14 days of beginning home health services and a cumulative limit of 100 visits. But if Part A’s requirements are not satisfied, then Medicare Part B will cover the home health services anyway. If the patient in question does not have Medicare Part B, then the services are provided by Part A. *See* 42 U.S.C. § 1395d(a)(3) (2000); *see also* MEDICARE HANDBOOK, *supra* note 73, § 4.02[B]–[C] (explaining the requirements and limitations of Medicare Part A and Part B).

⁹⁹ *See* 42 U.S.C. § 1395x(m) (penultimate sentence) (noting that Medicare generally limits home health services to 28 hours per week, which translates into an average of 4 hours per day for a 7-day week).

¹⁰⁰ *See* 42 U.S.C. § 1395i-3(a) (2000) (defining “skilled nursing facility”).

essentially limited to 100 days. This section will examine first the 4 preconditions for Medicare coverage and then the limitation on duration of stay.

1. *Conditions for Coverage*

First, the specific nursing facility must be approved by Medicare.¹⁰¹ This status means that the facility meets various standards concerning quality of care, staff training, residents' rights, and similar matters. In addition, the facility must agree to accept Medicare's stipulated charges for the services that it provides. Most SNFs are approved by Medicare, so this particular requirement is not terribly restrictive in practice.

Second, a patient must be admitted to the SNF within 30 days of being discharged from a hospital.¹⁰² If a patient goes to a SNF from his or her residence without the prior hospitalization, then Medicare does not pay for the nursing home expenses. In this regard, one commentator noted that "two-thirds of those who enter a nursing home are not coming from a hospital,"¹⁰³ which means that for the majority of nursing home residents, Medicare has no direct financial role.

Third, the required hospital stay must last at least 3 days,¹⁰⁴ not counting the day of discharge.¹⁰⁵ Thus, a trip to a hospital emergency room that does not require further hospital care fails to satisfy this requirement. Likewise, an overnight stay in the hospital for observation does not meet this requirement.¹⁰⁶ In 1983, the federal government instituted a diagnosis-related groupings (DRG) program that effectively reduced the number of hospital days that Medicare would cover for specified medical conditions.¹⁰⁷ The 3-day rule for SNF coverage, however, was not altered at that time to reflect the new DRG rules. Thus, a Medicare enrollee's hospital stay is increasingly likely to not meet the 3-day standard that Medicare requires for coverage of nursing home costs.

Fourth, a patient must require "skilled nursing care" that only a SNF can provide.¹⁰⁸ Examples of such care include gastronomy feedings, catheterization, administration of medical gases, injections, and other procedures involving

¹⁰¹ See FROLIK & KAPLAN, *supra* note 10, at 68.

¹⁰² 42 U.S.C. § 1395x(i)(A); 42 C.F.R. § 409.30(b)(1) (2005). Admissions to a SNF that occur more than 30 days after discharge from the hospital can be covered if it would not have been "medically appropriate" to begin SNF care during the 30 days immediately following discharge from the hospital. 42 U.S.C. § 1395x(i)(B); 42 C.F.R. § 409.30(b)(2) (2005).

¹⁰³ Natalie D. Martin, *Funding Long-Term Care: Some Risk-Spreaders Create More Risks Than They Cure*, 16 J. CONTEMP. HEALTH L. & POL'Y 355, 373 (2000).

¹⁰⁴ 42 U.S.C. § 1395x(i).

¹⁰⁵ 42 C.F.R. § 409.30(a)(1) (2005).

¹⁰⁶ See Soc. Sec. Rul. 69-63, *reprinted in* [Nov. 1969–Dec. 1972 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 26,066 (noting that a hospital stay of 2 days did not qualify subsequent SNF charges for Medicare coverage).

¹⁰⁷ See 42 U.S.C. § 1395ww(d) (2000). The DRG system establishes a fixed dollar amount that Medicare pays for each of approximately 500 different diagnoses. See RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 159–61 (1997). As daily hospital rates rise, the effect of the DRG system is to reduce the number of hospital days that Medicare will cover. See KANE ET AL., *supra* note 15, at 35.

¹⁰⁸ 42 U.S.C. § 1395f(a)(2)(B) (2000); 42 C.F.R. § 409.31(b)(3) (2005).

technical and professional personnel.¹⁰⁹ These services must be needed on a daily basis¹¹⁰ to treat a condition that was treated during the preceding hospital stay.¹¹¹ Thus, even if a resident went to a hospital before going to the SNF, Medicare will cover the costs of the SNF only if that patient receives fairly intensive medical care in the SNF as follow-up to the hospital stay in question.¹¹² This requirement effectively precludes most nursing home residents from Medicare coverage, because their conditions do not necessitate this level of care.¹¹³

2. *Duration-of-Stay Limitation*

Even if a patient otherwise qualifies for Medicare coverage of SNF expenses, that coverage is not unlimited. Medicare pays the entire cost of the SNF for only 20 days in a "spell of illness."¹¹⁴ A "spell of illness" is the period that begins with the patient's admission to the nursing home and ends when the patient has been out of a hospital, SNF, or other rehabilitative facility for 60 consecutive days.¹¹⁵ In the context of long-term care, therefore, an admission into a SNF typically constitutes a single "spell of illness." As a result, Medicare's full coverage of long-term care in a SNF is generally no more than 20 days.

After these 20 days, Medicare covers the cost of the SNF for the next 80 days, subject to a per-day deductible.¹¹⁶ This per-day deductible remains the patient's responsibility and is adjusted annually for inflation. For 2006, this deductible was \$119 per day.¹¹⁷ In other words, if Medicare covers a nursing home stay at all, it pays all costs for the first 20 days and those costs in excess of the per-day deductible for the next 80 days. After the 100th day, Medicare's coverage ceases.¹¹⁸

C. *Medicare Managed Care*

In the context of long-term care, Medicare health maintenance organizations (HMOs) do not really provide any help. Medicare HMOs offer a variety of benefits, including prescription drugs outside the hospital setting, eyeglasses, hearing aids, and simplified paperwork.¹¹⁹ These are all major benefits, although

¹⁰⁹ 42 C.F.R. §§ 409.33(a)–(c), 409.31(a)(2) (2005).

¹¹⁰ 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. §§ 409.31(b), 409.34(a)(1) (2005).

¹¹¹ 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b)(2)(ii).

¹¹² Medicare does, however, cover costs for a condition that first arose in the SNF, if the patient was being treated in the SNF for a condition that arose during a preceding hospital stay. 42 U.S.C. § 1395f(a)(2)(B).

¹¹³ See Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL. L. REV. 777, 795 (1998).

¹¹⁴ 42 U.S.C. §§ 1395d(a)(2)(A), 1395e(a)(3) (2000).

¹¹⁵ 42 U.S.C. § 1395x(a)(2) (2000); 42 C.F.R. § 409.60(b) (2005).

¹¹⁶ 42 U.S.C. § 1395e(a)(3).

¹¹⁷ CMS MEDICARE, *supra* note 79, at 23.

¹¹⁸ 42 U.S.C. § 1395d(b)(2).

¹¹⁹ See FROLIK & KAPLAN, *supra* note 10, at 104; Nancy Ann Jeffrey, *Sign of the Times: Medicare Users Turn to HMOs*, WALL ST. J., Oct. 20, 1995, at C1, available at 1995 WL 9904661; see also Melynda Dovel Wilcox, *Choosing a Medicare HMO*, KIPLINGER'S PERS. FIN., Aug. 1996, at 73, 74.

coverage for pharmaceuticals is now available with traditional Medicare through Medicare Part D, which became available in 2006 for the first time.¹²⁰ But the point is that Medicare HMOs generally do not expand Medicare's constricted coverage of long-term care, regardless of the setting in which that care is provided.

The newest Medicare options are also essentially of no benefit with respect to long-term care, either. Collectively denominated Medicare Part C,¹²¹ these arrangements include variations on Medicare HMOs.¹²² These alternatives have many intriguing and convoluted features,¹²³ but they all represent different approaches to delivering Medicare's traditional package of services¹²⁴ and do not extend Medicare's restricted coverage of long-term care.¹²⁵

IV. SUPPLEMENTAL INSURANCE

To fill some of Medicare's gaps and limitations, a private insurance product called "Medigap" has been developed.¹²⁶ Medigap policies receive no government funding, and patients bear the entire cost of the premiums. These policies come in 14 different packages, with increasing ranges of benefits corresponding to increased premium charges.¹²⁷ But the only Medigap benefit that pertains to home care is restricted to situations in which the patient is already receiving Medicare-covered home health services.¹²⁸ In that circumstance, this benefit includes assistance with activities of daily living, such as dressing, bathing, and personal hygiene, for up to 8 weeks, with a dollar limit of \$1,600 per year.¹²⁹ Thus, this benefit does not really help with a chronic or ongoing need for in-home care.

¹²⁰ See generally Richard L. Kaplan, *The Medicare Drug Benefit: A Prescription for Confusion*, 1 NAT'L ACAD. ELDER L. ATT'YS J. 167 (2005).

¹²¹ See 42 U.S.C. § 1395w-21 (2000).

¹²² See FROLIK & KAPLAN, *supra* note 10, at 106–07.

¹²³ See Karen Visocan, *Recent Changes in Medicare Managed Care: A Step Backwards for Consumers?*, 6 ELDER L.J. 31, 45–48 (1998); see also MEDICARE HANDBOOK, *supra* note 73, Chapter 7 (discussing alternative options for financing Medicare covered services); JOHN J. REGAN ET AL., TAX, ESTATE & FINANCIAL PLANNING FOR THE ELDERLY § 9.16 (2006) (same). See generally DAVID A. PRATT & SEAN K. HORNBECK, SOCIAL SECURITY AND MEDICARE ANSWER BOOK 19-1 to 19-37 (Supp. 2006) (discussing Medicare Part C options, rules, and features).

¹²⁴ 42 U.S.C. § 1395w-22(a)(1)(A) (2000).

¹²⁵ Funds in a "medical savings account" (MSA), however, may be used to pay premiums on a long-term care insurance policy. See I.R.C. §§ 138(c)(1) (2006), 220(d)(2)(B)(ii)(II) (2000), 7702B(b) (2000). But MSA holders face an annual deductible of up to \$6,000 before their medical costs are covered. See 42 U.S.C. § 1395w-28(b)(3)(B) (2000). Accordingly, it is unlikely that a MSA holder would use MSA funds to pay for long-term care insurance when more immediate financial exposure looms in the form of the annual deductible.

¹²⁶ See generally FROLIK & KAPLAN, *supra* note 10, at 95–103 (describing private Medigap insurance).

¹²⁷ 12 packages, labeled A through L, are available, but plans F and J come in 2 different versions, one with, and the other without, an annual deductible. Accordingly, a total of 14 different Medigap policies exist. See DEP'T OF HEALTH & HUMAN SERV., 2006 CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE 42, 47 (2006), <http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf>.

¹²⁸ See *id.* at 47.

¹²⁹ *Id.* This benefit, moreover, is available only in plans D, G, I, and J.

With respect to nursing home care, the only pertinent Medigap benefit is coverage of the per-day deductible in a SNF for days 21 through 100.¹³⁰ This feature is available in the more comprehensive Medigap policies and enables a patient to insure against this expense. It must be noted, however, that Medigap policies do not change any of the other Medicare SNF requirements, such as a preceding hospital stay of at least 3 days or the receipt of “skilled nursing care.” Nor do these policies extend beyond day 100.¹³¹ Thus, Medigap insurance plays a fairly limited role in the long-term care context—namely, paying the per-day deductible for perhaps as many as 80 days in a nursing home stay that otherwise qualifies for Medicare coverage. Beyond that coverage, Medigap policies do not go.

V. MEDICAID

This section examines the financing of long-term care by the government’s health care program for poor people of any age, Medicaid.¹³² Medicaid is funded jointly by the federal government and by state governments, with the federal share ranging from 50% to 76%, depending upon the relative wealth of the particular state.¹³³ Since both levels of government contribute to its financing, Medicaid has federal and state rules establishing what services are covered and who is eligible.¹³⁴ Consequently, there is considerable variation across the country in what Medicaid actually looks like, but some general patterns are fairly consistent.¹³⁵

In the context of long-term care, Medicaid covers home health visits and nursing home stays, as does Medicare, but Medicaid’s coverage is more extensive. For example, Medicaid provides home health care for functionally disabled older citizens and for certain other categories of older people,¹³⁶ even if they are not

¹³⁰ *Id.* at 46. This option is available in Medigap plans C–J. A similar benefit is available in Plans K and L, but it would pay only 50% and 75%, respectively, of the patient’s daily co-payment obligation. *Id.* at 21.

¹³¹ *Id.* at 46.

¹³² 42 U.S.C. § 1396 (2000). See FROLIK & KAPLAN, *supra* note 10, at 109–37 (discussing Medicaid’s history, benefits, and eligibility requirements); REGAN ET AL., *supra* note 123, §§ 10.01–10.17 (same).

¹³³ See LYNDIA FLOWERS ET AL., AARP PUB. POLICY INST., STATE PROFILES 2005: REFORMING THE HEALTH CARE SYSTEM 227 (13th ed. 2005), available at http://assets.aarp.org/rgcenter/health/d18258_reform_05.pdf.

¹³⁴ See also ROBERT B. FLEMING, ELDER LAW ANSWER BOOK 14:3–14:4 (2d ed. 2004) (discussing the operation and administration of Medicaid).

¹³⁵ The analysis that follows concentrates on the federal rules since those rules apply nationwide. For any particular jurisdiction, however, state statutes and public aid manuals remain important sources of the law. See, e.g., ILL. DEP’T OF HUMAN SERVS., DHS CASH, FOOD STAMP, AND MEDICAL MANUAL: POLICY MANUAL, <http://www.dhs.state.il.us/ts/cfsmm/onenet.aspx?item=13473>.

¹³⁶ 42 U.S.C. § 1396t (2000). See generally NAT’L SENIOR CITIZENS LAW CTR., *supra* note 24, at 28–35, 41–43 (discussing Medicaid’s eligible recipients); Ellice Fatoullah, *Mandatory Medicaid Home Care for the Elderly*, ELDER LAW REP., Mar. 1993, at 1 (discussing Medicaid’s eligible recipients).

homebound.¹³⁷ Moreover, this care can include home health aide services,¹³⁸ medical supplies and equipment,¹³⁹ and even some personal care services.¹⁴⁰ In addition, some states cover homemaker services,¹⁴¹ respite care for family caregivers,¹⁴² and adult daycare.¹⁴³

Similarly, Medicaid's coverage of nursing home stays is more extensive than Medicare's coverage, because Medicaid covers chronic conditions, such as Alzheimer's disease, that require a level of assistance that is less than "skilled nursing care."¹⁴⁴ Moreover, since its target clientele consists of poor people with few resources of their own, Medicaid has no duration-of-stay limits or other major restrictions on the scope of its nursing home coverage. As a result, Medicaid is a major source of financing for nursing home care.¹⁴⁵

Medicaid has one overarching limitation, however. It is restricted to people with few assets. The precise amount varies from state to state and depends to a significant extent on whether the Medicaid applicant has a spouse who is living in the community at large, often called a "community spouse."¹⁴⁶ Medicaid's eligibility criteria are examined below.

A. *Unmarried Applicants*

Medicaid applicants without a "community spouse" may own only a few assets to be eligible for the program.¹⁴⁷ Persons with assets in excess of these limits must use up these "excess resources" until their remaining assets fall within Medicaid's eligibility parameters.¹⁴⁸ This so-called "spend down" process seeks to

¹³⁷ See U.S. Dep't of Health & Human Servs., Ctrs. For Medicare & Medicaid Servs., State Medicaid Director Letters, Olmstead Update 3, at attachment 3-9 (July 25, 2000), <http://www.cms.hhs.gov/smdl/downloads/smd072500b.pdf>.

¹³⁸ 42 U.S.C. §§ 1396d(a)(7) (2000), 1396t(a)(1) (2000).

¹³⁹ 42 C.F.R. § 440.70(c) (2006).

¹⁴⁰ 42 U.S.C. § 1396t(a)(3).

¹⁴¹ 42 U.S.C. § 1396t(a)(1).

¹⁴² 42 U.S.C. § 1396t(a)(5).

¹⁴³ 42 U.S.C. § 1396t(a)(7).

¹⁴⁴ 42 U.S.C. § 1396d(a)(4)–(f) (2000).

¹⁴⁵ See MICHAEL J. GRAETZ & JERRY L. MASHAW, *TRUE SECURITY: RETHINKING AMERICAN SOCIAL INSURANCE* 137 (1999) (noting that Medicaid pays for 38% of older people's nursing home expenditures). Some states are beginning to cover assisted living facilities or other congregate living arrangements under Medicaid. This development is by no means universal, and the number of available spaces is still very small. See NAT'L CTR. FOR ASSISTED LIVING, *supra* note 42, at 29.

¹⁴⁶ 42 U.S.C. § 1396r-5(h)(2) (2000).

¹⁴⁷ See generally CARLSON, *supra* note 42, § 7.07; FROLIK & KAPLAN, *supra* note 10, at 116–18 (discussing applicants' incomes and resources); REGAN ET AL., *supra* note 123, § 10.07 (same).

¹⁴⁸ Some states employ an alternative approach: if an applicant's monthly income exceeds a specified amount, that person is ineligible for Medicaid. This "income cap" was \$1,809 in 2006, and this approach is followed in approximately 20 states, including Arizona, Florida, and Texas. See REGAN ET AL., *supra* note 123, § 10.07[2][b] (discussing income standards). See generally CARLSON, *supra* note 42, § 7.13[1][d][iv] (discussing the circumstances of income standards through trusts).

limit Medicaid benefits to those persons who were described in the legislation that originally created the program: individuals “whose income and resources are insufficient to meet the costs of necessary medical services.”¹⁴⁹ Thus, to be eligible for Medicaid’s health care benefits, an older person may not have assets that exceed the program’s stipulated allowances.

Those allowances include \$2,000 in cash or market value of all investments.¹⁵⁰ In addition, a Medicaid applicant can have an automobile of any value if he or any member of his household uses it for transportation.¹⁵¹ Further, the value of burial plots¹⁵² and up to \$1,500 designated for burial expenses are “exempt resources” and are excluded from an applicant’s holdings.¹⁵³ Life insurance is exempt as well, but only if the face amount of such insurance does not exceed \$1,500¹⁵⁴—a trifling amount in today’s economy. Finally, the Medicaid applicant may have a residence,¹⁵⁵ with an equity value of as much as \$500,000,¹⁵⁶ but only if that person “expects to return” to it.¹⁵⁷ Many persons requiring long-term care cannot meet that standard. Any assets not described above must be “spent down” before the owner can qualify for Medicaid.

In addition to these limits on an applicant’s assets, Medicaid essentially confiscates that person’s income. That is, if an applicant receives income from Social Security, pension plans, interest income, or dividends, then all of that income must be applied to the applicant’s nursing home expenses.¹⁵⁸ States permit retention of a small monthly allowance for “personal needs,” but this amount is usually \$50 per month or less.¹⁵⁹ When an applicant’s monthly income is insufficient to cover the nursing home charges, Medicaid pays the difference.¹⁶⁰

For example, assume that Eric receives retirement benefits from Social Security of \$1,000 per month, and a private pension of \$930 per month. His income is therefore \$1,930 per month. If the “personal needs allowance” in his state is \$30,¹⁶¹ then he will apply the remaining \$1,900 to his nursing home expenses. Assume further that Medicaid establishes a so-called “reimbursement

¹⁴⁹ 42 U.S.C. § 1396 (2000).

¹⁵⁰ 42 U.S.C. § 1382(a)(3)(B) (2000); 20 C.F.R. § 416.1205(c) (2006).

¹⁵¹ 20 C.F.R. § 416.1218(b)(1) (2006).

¹⁵² 42 U.S.C. § 1382b(a)(2)(B) (2000); 20 C.F.R. § 416.1231(a) (2006). For this purpose, a “burial plot” can include prepaid costs of a casket, headstone, and associated grave opening and closing expenses. FLEMING, *supra* note 134, at 14–32.

¹⁵³ 42 U.S.C. § 1382b(d); 20 C.F.R. § 416.1231(b) (2006).

¹⁵⁴ 42 U.S.C. § 1382b(a) (final sentence); 20 C.F.R. § 416.1230 (2006).

¹⁵⁵ See 42 U.S.C. § 1382b(a)(1).

¹⁵⁶ 42 U.S.C. § 1396p(f)(1)(A) (2000). States may elect to exempt homes with equity of as much as \$750,000. 42 U.S.C. § 1396p(f)(1)(B).

¹⁵⁷ 20 C.F.R. § 416.1212(c) (2006) (first sentence); see also CARLSON, *supra* note 42, § 7.07[2][a].

¹⁵⁸ FLEMING, *supra* note 134, at 14–12; see also FROLIK & KAPLAN, *supra* note 10, at 120.

¹⁵⁹ See CARLSON, *supra* note 42, § 7.401 (listing of personal needs allowances by state).

¹⁶⁰ See 42 U.S.C. § 1396b(f)(4)(C); 42 C.F.R. § 435.725(a) (2005).

¹⁶¹ This amount is the federal minimum. 42 U.S.C. § 1396a(q)(2) (2000).

rate”¹⁶² for that facility of \$100 per day. Eric’s monthly cost for that nursing home room is \$3,000 per month (\$100 per day × 30 days), of which \$1,900 will come from his income, and the remaining \$1,100 will be paid by Medicaid. Thus, Medicaid coverage still requires the applicant (here, Eric) to expend virtually all of his income on nursing home costs.

In this connection, it should be noted that many familiar exclusions and exemptions in tax law have no application to Medicaid. For example, interest on municipal bonds may be exempt from federal income taxation,¹⁶³ but such interest is still countable income for Medicaid purposes.¹⁶⁴ Similarly, individual retirement accounts¹⁶⁵ and other pension-like savings vehicles¹⁶⁶ have no special status in Medicaid.¹⁶⁷ Gifts and inheritances, which are tax-free to the recipients, likewise enjoy no special status.¹⁶⁸ So, if Eric in the above example received \$5,000 when his uncle died, that money is a countable resource that must be “spent down” before Eric is eligible for Medicaid benefits. Its exempt status for tax purposes is irrelevant to Medicaid.¹⁶⁹

B. Applicants with a Community Spouse

A Medicaid applicant with a spouse who is living in the community is treated differently, because that spouse needs some modicum of resources to maintain her own existence.¹⁷⁰ The basic components of the Medicaid system, however, remain the same as described above: assets in excess of stipulated limits must be “spent down” before eligibility is established, an applicant’s income is applied almost entirely to the nursing home’s charges, and tax law exceptions and exclusions are

¹⁶² When Medicaid pays a portion of a person’s nursing home costs, the applicable daily rate is Medicaid’s set rate. See 42 C.F.R. § 431.51(c) (2005). This rate is almost always less than the rate that the nursing home in question charges patients who pay their bills without Medicaid assistance. See Joshua M. Wiener, *Long-Term Care and Devolution, in MEDICAID AND DEVOLUTION: A VIEW FROM THE STATES* 185, 188 (Frank J. Thompson & John J. DiIulio, Jr. eds., 1998).

¹⁶³ I.R.C. § 103(a) (2006).

¹⁶⁴ See 42 U.S.C. § 1382a(b) (2000) (listing income items excluded in Medicaid considerations).

¹⁶⁵ I.R.C. § 408 (2000). See generally DONALD R. LEVY ET AL., *INDIVIDUAL RETIREMENT ACCOUNT ANSWER BOOK* (4th ed. 1998) (reviewing individual retirement accounts).

¹⁶⁶ See I.R.C. §§ 401(k), 403(b), 408(a) (2000); see also FROLIK & KAPLAN, *supra* note 10, at 357–91 (explaining the various forms of pension plans). See generally 403(B) ANSWER BOOK (Donald R. Levy ed., 2000) (explaining 403(b) pension plans); STEVEN J. FRANZ ET AL., 401(K) ANSWER BOOK (1999); GARY S. LESSER ET AL., *ROTH IRA ANSWER BOOK* (1999) (explaining Roth individual retirement accounts).

¹⁶⁷ FLEMING, *supra* note 134, at 14–30.

¹⁶⁸ I.R.C. § 102(a) (2006).

¹⁶⁹ Similarly, once a personal residence is sold, the proceeds from that sale receive no Medicaid exemption, unlike the \$250,000 income tax exclusion that applies to gains from such sales. See I.R.C. § 121(a) (2000). See generally FROLIK & KAPLAN, *supra* note 10, at 198–204 (describing the taxation of gains on residences).

¹⁷⁰ See H.R. REP. NO. 100-105, pt. 2, at 65 (1988), as reprinted in 1988 U.S.C.A.N. 857, 888 (explaining the purpose of the Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683).

not relevant in this context. Some protections exist, however, to avoid impoverishing the “community spouse.”¹⁷¹

A community spouse may retain a residence,¹⁷² regardless of its value,¹⁷³ and an automobile, also without regard to its value.¹⁷⁴ A burial plot and burial expense arrangement similar to that allowed to a Medicaid applicant are allowed to the community spouse as well.¹⁷⁵ In addition, a community spouse can retain cash, bonds, stocks, mutual funds, and other investments up to an amount set by the Medicaid applicant’s state of residence.¹⁷⁶ This amount is called the “community spouse resource allowance,”¹⁷⁷ (CSRA) and must fall within a range established by the Medicaid statute.¹⁷⁸ This range is adjusted annually for inflation¹⁷⁹ and in 2006 was \$19,908 to \$99,540.¹⁸⁰ Many states employ the low-point of this range; several states use the high-point; and other states apply formulas or figures between these 2 points.¹⁸¹ Thus, Medicaid allows the community spouse to retain a significant amount of assets, especially if the residence has substantial value, but the amount of unrestricted resources is limited by the applicable state’s CSRA.

With regard to the community spouse’s income, such as Social Security benefits and pension plan payouts, the picture is more complex. Generally, states allow a community spouse to keep whatever income is in his or her name.¹⁸² If the amount of that income is below certain standards, moreover, Medicaid allows some of the applicant’s income to be transferred to the community spouse for her support.¹⁸³ This transfer leaves less of the Medicaid applicant’s income available

¹⁷¹ The term “community spouse” applies only to a person of the opposite sex of the Medicaid applicant because a federal statute known as the “Defense of Marriage Act” applies to all federal programs, including Medicaid. *See* Pub. L. No. 104-199, § 3(a), 110 Stat. 2419 (1996) (amending 1 U.S.C. § 7).

¹⁷² 42 U.S.C. §§ 1396r-5(c)(5)(A) (2000), 1382b(a)(1) (2000); 20 C.F.R. § 416.1212(c) (2005).

¹⁷³ 42 U.S.C. § 1396p(f)(2)(A); *see also* 20 C.F.R. § 416.1212(b) (2006).

¹⁷⁴ 42 U.S.C. §§ 1382b(a)(2)(A) (2000), 1396r-5(c)(5)(B) (2000).

¹⁷⁵ 42 U.S.C. §§ 1382b(a)(2)(B), (d)(1), 1396r-5(c)(5)(A) (2000).

¹⁷⁶ 42 U.S.C. § 1396r-5(c)(1)(A), (f)(1).

¹⁷⁷ 42 U.S.C. § 1396r-5(f)(2).

¹⁷⁸ 42 U.S.C. § 1396r-5(f)(2)(A)(i)–(ii).

¹⁷⁹ 42 U.S.C. § 1396r-5(g).

¹⁸⁰ *See* U.S. Dep’t of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Spousal Impoverishment, http://www.cms.hhs.gov/MedicaidEligibility/09_SpousalImpoverishment.asp.

¹⁸¹ FROLIK & KAPLAN, *supra* note 10, at 126; *see also* CARLSON, *supra* note 42, § 7.401 (listing of CSRA limits by state). Additional amounts may be retained by the community spouse upon specific application through a “fair hearing” procedure. *See* 42 U.S.C. § 1396r-5(e)(2)(A)(v), (C); *see also* CARLSON, *supra* note 42, § 7.10[3][a]; H. Kennard Bennett, *Fair Hearings: What They Are and How to Handle Them*, NAELA Q., Spring 1996, at 11; Ezra Huber, *Hearings & Appeals: A Primer for the Elder Law Attorney*, SHEPARD’S ELDERCARE/L. NEWSL., Apr. 1994, at 1; Ron M. Landsman, *Going to Court to Improve Spousal Benefits*, ELDERLAW REP., Sept. 1998, at 1.

¹⁸² 42 U.S.C. § 1396r-5(b)(1), (2)(A)(i).

¹⁸³ 42 U.S.C. § 1396r-5(d)(1)(B)(2), (5). For an example of how this income supplement is calculated, *see* CARLSON, *supra* note 42, § 7.11[5].

to the nursing home,¹⁸⁴ in which case Medicaid pays a larger proportion of the applicant's nursing home expenses. This minimum income standard,¹⁸⁵ much like the CSRA, is set by the applicable state from within a specified range.¹⁸⁶ This range is adjusted annually for inflation¹⁸⁷ and in 2006 was \$1,650 to \$2,489 per month.¹⁸⁸ Once again, some states utilize the low-point of this range, others use the high-point, and other states employ formulas that result in some mid-range figure.¹⁸⁹

C. Other Restrictions

Medicaid has 2 major features that further limit its appeal as a funding source for long-term care expenses. First, it penalizes would-be applicants who transfer assets to family members and friends to accelerate their eligibility under Medicaid's resource limitations. Second, Medicaid recovers benefits it pays on behalf of its beneficiaries from the beneficiaries' estates after they die.

1. Transfer Penalties

Potential Medicaid applicants and their families are often horrified by Medicaid's severe asset limitations and their corresponding "spend down" requirements, especially if the applicant does not have a community spouse. In response, some people try to transfer their "excess" resources to adult children or grandchildren to reduce the amount of their assets before seeking Medicaid benefits. But if an older person transfers his or her assets, Medicaid imposes a transfer penalty that makes the transferor ineligible for Medicaid benefits for a certain period of time.¹⁹⁰ This transfer penalty is calculated by dividing the amount of any uncompensated transfers by the monthly cost of providing care,¹⁹¹ which is usually a county or state average.¹⁹² Whatever figure is employed, the result is the number of months that the older person is disqualified from receiving Medicaid benefits.¹⁹³ Moreover, the Deficit Reduction Act that was enacted on

¹⁸⁴ CARLSON, *supra* note 42, § 7.10[3][c], at 7-40.

¹⁸⁵ See 42 U.S.C. § 1396r-5(d)(2) (defining the "community spouse monthly income allowance").

¹⁸⁶ 42 U.S.C. §§ 1396r-5(d)(3)(A), (B)(iii), (C), 1396r-5(d)(4) (2000).

¹⁸⁷ 42 U.S.C. § 1396r-5(g).

¹⁸⁸ U.S. Dep't of Health & Human Servs., *supra* note 180.

¹⁸⁹ See CARLSON, *supra* note 42, § 7.401 (listing monthly income allowances by state). These allowances can be augmented by special application through the "fair hearing" procedure. 42 U.S.C. § 1396r-5(e)(2)(A)(i), (B).

¹⁹⁰ 42 U.S.C. § 1396p(c)(1)(A) (2000). Certain asset transfers are not subject to penalties. A transfer of the applicant's home to her spouse, minor child, a sibling who shares ownership of the home, and the like are excluded from the penalty provision. See 42 U.S.C. § 1396p(c)(2)(A)(i)-(iv). See generally CARLSON, *supra* note 42, § 7.12[6][c]-[e]; FLEMING, *supra* note 134, at 14-53 to 14-54.

¹⁹¹ 42 U.S.C. § 1396p(c)(1)(E)(i).

¹⁹² 42 U.S.C. § 1396p(c)(1)(E)(i)(II). Some states utilize the private pay rate at the specific facility in which the Medicaid applicant is residing. See CARLSON, *supra* note 42, § 7.401 (listing of applicable monthly rates by state); FLEMING, *supra* note 134, at 14-99 to 14-101 (same).

¹⁹³ 42 U.S.C. § 1396p(c)(1)(D).

February 8, 2006 mandated that the starting date of this penalty period is when the Medicaid applicant would otherwise be eligible for Medicaid.¹⁹⁴

To illustrate, assume that Aunt Sharon transfers bank certificates of deposit worth \$200,000 to her various nieces and nephews, and that the average cost of care in her county of residence is \$4,000 per month. The resulting penalty period is 50 months (\$200,000 ÷ \$4,000 per month), so Sharon is ineligible for Medicaid benefits for 50 months (more than 4 years!) starting when she has run through her resources and would otherwise be eligible for Medicaid benefits.

These transfer penalties are imposed, moreover, on transfers made during the 60 months prior to the transferor applying for Medicaid.¹⁹⁵ Transfers made more than 60 months prior to applying for Medicaid benefits are generally not subject to a transfer penalty, but most people do not know that they will require such care 5 years ahead of time. In any case, the law may change after the transfer is made; after all, this so-called “look-back” period was only 24 months when the transfer penalty rule was first enacted,¹⁹⁶ and it was only 36 months before the law was amended in the recently enacted Deficit Reduction Act.¹⁹⁷ In fact, a transfer that was not subject to a transfer penalty when it was made might become subject to such a penalty, if the change in the look-back period is not made prospective. This eventuality occurred when the look-back period was last altered in 1993,¹⁹⁸ though the most recent amendment was not made applicable to pre-enactment transfers.¹⁹⁹

Notwithstanding that particular bit of legislative grace, planning for Medicaid eligibility by transferring assets is problematic for at least 2 additional reasons. First, the Medicaid applicant may not be able to execute the transfer due to diminished capacity.²⁰⁰ That is, if a client needs long-term care because of her deteriorating mental condition, there is a strong possibility that she lacks sufficient legal capacity to transfer property.

Second, even if a person can legally transfer her assets, she may be unwilling to do so out of a sense of vulnerability.²⁰¹ It is an open secret that many long-term care facilities limit the number of Medicaid recipients that they will accept,²⁰² and some institutions do not participate in the program at all.²⁰³ Recent trends towards

¹⁹⁴ 42 U.S.C. § 1396p(c)(1)(D)(ii).

¹⁹⁵ 42 U.S.C. § 1396p(c)(1)(B)(i).

¹⁹⁶ See 3 A. KIMBERLEY DAYTON ET AL., ADVISING THE ELDERLY CLIENT § 29.84 (2005).

¹⁹⁷ See 42 U.S.C. § 1396p(c)(1)(B)(i), (ii)(I).

¹⁹⁸ See Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13611(e)(2)(A), 107 Stat. 312, 627 (codified as amended at 42 U.S.C. § 1396p(c)).

¹⁹⁹ See 42 U.S.C. § 1396p(c)(1)(B)(i).

²⁰⁰ See FROLIK & KAPLAN, *supra* note 10, at 12–17.

²⁰¹ See Marshall B. Kapp, *Options for Long-Term Care Financing: A Look to the Future*, 42 HASTINGS L.J. 719, 743 (1991).

²⁰² John A. Nyman, *The Private Demand for Nursing Home Care*, 8 J. HEALTH ECON. 209, 210 (1989); James D. Reschovsky, *Demand for and Access to Institutional Long-Term Care: The Role of Medicaid in Nursing Home Markets*, 33 INQUIRY 15, 16 (1996); Wiener, *supra* note 162, at 203.

²⁰³ See 42 U.S.C. § 1396r(c)(2)(F)(i)(I)–(II) (2000) (noting that Medicaid recipients residing in a nursing home which withdraws from Medicaid may not be discharged from that

ever-lower Medicaid rates paid by the government reduce further the number of places available to Medicaid recipients.²⁰⁴ Thus, not only does one's status as a Medicaid recipient limit his initial choice of nursing facilities, but if the quality of care deteriorates at his facility, being a Medicaid recipient might affect that person's ability to move elsewhere.

2. *Estate Recovery*

A second feature that makes Medicaid unappealing is mandatory estate recovery. States are required to recover Medicaid expenditures from whatever assets a Medicaid recipient owns at his or her death.²⁰⁵ Thus, even if a Medicaid applicant retains, for example, a residence to which he "intends to return,"²⁰⁶ Medicaid will recover the long-term care expenses it paid on his behalf from the value of that residence.²⁰⁷ Similarly, assets owned by a Medicaid recipient's community spouse will be subject to Medicaid's estate recovery provisions when that spouse dies.²⁰⁸ In addition, any assets acquired by inheritance or gift, for instance antique furniture bequeathed by a Medicaid recipient's older sibling, would be subject to estate recovery.²⁰⁹ In this respect, Medicaid is rather unique: no other health insurance policy, or other welfare program for that matter, customarily demands repayment of benefits previously provided.²¹⁰ Nor is there any *de minimis* level of assets that is beyond the scope of Medicaid's estate recovery provisions.²¹¹ As a result, Medicaid's mandatory estate recovery provision converts what would otherwise be an entitlement program into a loan arrangement, whereby the Medicaid applicant eventually pays the cost of the care she received from whatever assets remain at her death. The bottom line is that for

home); see also 42 U.S.C. § 1396r(c)(2)(F)(i)(III)–(ii) (requiring notice that a nursing home does not participate in the Medicaid program).

²⁰⁴ See Wiener, *supra* note 162, at 203.

²⁰⁵ 42 U.S.C. § 1396p(b)(1) (2000); see also CARLSON, *supra* note 42, § 7.14; REGAN ET AL., *supra* note 123, § 10.08[5]. See generally Naomi Karp et al., Medicaid Estate Recovery: A 2004 Survey of State Programs and Practices 1 (2005), http://assets.aarp.org/rgcenter/il/2005_06_recovery.pdf (describing state programs that attempt to recover Medicaid expenditures from the recipient's estate); U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAID ESTATE RECOVERY COLLECTIONS (2005), <http://www.aspe.hhs.gov/daltcp/reports/estreccol.pdf>.

²⁰⁶ Such a residence is an exempt resource for Medicaid purposes, as long as its equity value does not exceed \$500,000 (or \$750,000 in certain states). See 20 C.F.R. § 416.1212(b) (2006).

²⁰⁷ See 42 U.S.C. § 1396p(a)(1)(B)(i) (authorizing real estate liens on the residences of Medicaid patients who are living in nursing homes).

²⁰⁸ 42 U.S.C. § 1396p(b)(2); see *id.* for exceptions that apply to certain immediate family members in specific circumstances: a minor child of the Medicaid recipient or a sibling who co-owned the Medicaid recipient's residence.

²⁰⁹ For this purpose, a person's "estate" is defined by state probate law and includes personal and real property. 42 U.S.C. § 1396p(b)(4)(A). States may expand their probate law definitions for this specific purpose by including property held in a joint tenancy, life estate, living trust, or "other arrangement." 42 U.S.C. § 1396p(b)(4)(B); see also Karp, *supra* note 205, at 19–23 (survey of state practices).

²¹⁰ See Charles P. Sabatino & Roger A. Schwartz, *Medicaid Estate Recovery Law and Practice: Picking the Bones of the Poor*, in NAT'L ACAD. ELDER L. ATT'YS, INST. MANUAL 10 (1994).

²¹¹ Cf. I.R.C. § 2010(c) (2000) (exemption from the federal estate tax of \$2,000,000).

the most part, Medicaid long-term care benefits require the applicant to exhaust that person's financial resources.

VI. LONG-TERM CARE INSURANCE

As this Article has shown thus far, the coverage of long-term care under Medicare and Medicare supplemental insurance is quite limited, and the much more extensive coverage that is available under Medicaid imposes an enormous antecedent cost in terms of financial asset utilization. Consequently, prospective retirees who are looking to fund possible long-term care costs must plan to pay for most of their care out of their own savings or perhaps shift the risk of such expenditures via private long-term care insurance. This Part considers the latter alternative.

Long-term care insurance is a product of relatively recent vintage that is designed specifically to provide for long-term care needs.²¹² Typically, such insurance began as nursing home insurance,²¹³ but soon included optional riders to cover the cost of less intensive care settings such as in-home health care and even assisted living facilities.²¹⁴ This Part begins by providing a brief overview of the major components of long-term care insurance, followed by an in-depth financial analysis that might be undertaken by a prospective retiree who is considering this product. This Part next examines some of the pitfalls that retirees face when considering the purchase of long-term care insurance. Finally, this Part examines what Congress has done to stimulate the purchase of such insurance through tax deductibility of premiums and coordination of such insurance with Medicaid eligibility.

A. *Major Components*

Long-term care insurance is essentially a product of the private marketplace and accordingly has almost infinite variations, but there are 3 major parameters to every policy—namely, daily insured amount, length of coverage, and the elimination period. In addition, of the various policy options that are available, the 2 most expensive and critical additions are coverage of home care and inflation protection. This section now considers these 5 critical components of long-term care insurance.

1. *Daily Insured Amount*

Long-term care insurance is typically calibrated in terms of the amount that it will pay per day for covered services.²¹⁵ If the care costs less than this amount, the policy will pay the actual cost of the care that it provided. For that reason, the

²¹² See generally FROLIK & KAPLAN, *supra* note 10, at 138–53 (discussing policy provisions of long-term care insurance).

²¹³ See ALBERT NORMAN ET AL., LONG TERM CARE INSURANCE: A PROFESSIONAL'S GUIDE TO SELECTING POLICIES 44 (3d ed. 1995).

²¹⁴ FLEMING, *supra* note 134, at 12–21.

²¹⁵ NAT'L ASS'N INS. COMM'RS, A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE 16 (1999) [hereinafter NAIC GUIDE].

daily insured amount is really a maximum benefit. The specific amount secured depends upon what amounts are available from a particular insurer and how much the prospective insured is willing to pay, because the higher the benefit obtained, the higher will be the insurance premium charged. For that reason, most people face a trade-off between what they think their care will actually cost and what they are willing and/or able to pay in insurance premiums. As a result, most policies involve some element of co-insurance. That is, if Janice expects that care will cost \$125 per day, she may purchase long-term care insurance with a daily benefit of \$100 per day and simply expect to pay the remaining \$25 per day as her “share” of the cost.

2. *Length of Coverage*

The second major component of long-term care insurance is the length of the period during which benefits will be paid.²¹⁶ Once again, this variable depends upon the options that a particular insurer makes available and what the prospective insured is willing to pay, because the longer the benefit period, the higher will be the insurance premium charged. Accordingly, a second element of co-insurance arises whereby Janice might buy four years of coverage and expect to use her own resources should she need care after that period has run. Some companies offer lifetime coverage, but that option is obviously more expensive than a time-limited coverage period and in some cases may be unavailable to any particular person. That is, after a prospective insured reaches a certain age, some companies simply do not offer lifetime benefits.

An increasingly popular variation on this theme provides that an insured has a “pool of funds” available equal to the maximum insured benefit and that specific usage will depend upon the cost of care provided in a particular circumstance.²¹⁷ For example, a policy with a nursing home benefit of \$100 per day for 2 years would provide a “pool of funds” of \$73,000 (2 years × 365 days × \$100 per day) that can be used however the policyholder decides. Thus, benefits used in a less expensive care setting, such as adult daycare or assisted living, would effectively extend the policy’s benefit period.

3. *Elimination Period*

The final essential component of long-term care insurance is the “elimination” or “waiting” period. This period is the number of days during which the insured would qualify for the policy’s benefits but during which the insured will cover her own expenses.²¹⁸ In other words, the elimination period works much like a deductible in more conventional insurance settings, with the first number of days not covered by the policy. Once again, this factor introduces an element of co-insurance whereby the insured agrees to cover the cost of her care during the specified period with the resulting premium lower than would otherwise be charged. Moreover, the standard insurance trade-off applies here as well—namely, the shorter the elimination period, the greater the risk to the insurance carrier, and accordingly the higher the premium will be.

²¹⁶ *Id.* at 15.

²¹⁷ *Id.* at 13; *How to Judge a Policy*, CONSUMER REP., Oct. 1997, at 40–41.

²¹⁸ NAIC GUIDE, *supra* note 215, at 18.

4. *Home Care Coverage*

As an option, most long-term care insurance policies now offer coverage outside of nursing homes, including in-home care and often assisted living facilities as well.²¹⁹ This rider is fairly expensive because most people would prefer to receive long-term care in their own home if that is at all feasible, or if not, then in an assisted living facility. But the typical home health care benefit is only one-half of the policy's nursing home benefit.²²⁰ Thus, if a long-term care insurance policy pays \$100 per day toward nursing home costs, its home health care benefit will pay only \$50 per day. While some policies offer home care benefits equal to the policy's nursing home benefit, this coverage necessarily increases the cost of this specific rider. Although a daily home care benefit of \$100 per day would cover most of the cost of an assisted living facility, it would not come close to covering the cost of around-the-clock care in a policyholder's residence.²²¹ Accordingly, the prospective insured must have access to a dependable network of family, friends, and others to supplement the home care provider if she expects to use the policy's benefits for home care.

5. *Inflation Protection*

As noted above, long-term care insurance benefits are calibrated in terms of a specified sum per day. And as with all insurance, coverage must be obtained before the insured event takes place. In the case of long-term care insurance, policies are usually purchased years and sometimes decades in advance of needing long-term care. Even if the level of coverage was adequate at the time it was obtained, the erosive effect of inflation may take its toll over time. Thus, a policy that provided \$100 per day might have constituted close to full coverage when it was purchased but may be more like 50% coverage when its benefits are actually claimed. One alternative is for the insured to simply self-insure for the impact of inflation. In other words, the policyholder may decide to bear the cost of whatever inflation in long-term care costs occurs and invest her other assets to meet that risk.

A different plan is to obtain some sort of inflation protection when the policy is first obtained.²²² This option is also an expensive rider but one that becomes increasingly more significant when prospective buyers are in their 50s and 60s, because the need for long-term care is likely to be many years in the future. Accordingly, prospective retirees need to pay particular attention to the contours of this option.

The 2 most common variations increase the daily insured amount by 5% of the original amount per year or by 5% compounded annually.²²³ The second version is more expensive but more closely tracks the actual effect of inflation.

²¹⁹ *Id.* at 14.

²²⁰ *How to Judge a Policy*, *supra* note 217, at 40; see also NAT'L ASS'N INS. COMM'RS, LONG-TERM CARE INSURANCE MODEL REGULATION § 10B (1995) [hereinafter MODEL REGULATION] (discussing minimum standards for home health care components).

²²¹ PHYLLIS R. SHELTON, LONG-TERM CARE PLANNING GUIDE: THE CONSUMER RESOURCE FOR LONG-TERM FINANCING 17 (2000).

²²² NAIC GUIDE, *supra* note 215, at 18–20.

²²³ *Id.* at 19.

The following table²²⁴ shows the different impact of these 2 alternatives on a \$100 daily benefit for certain periods of time.

<u>Length in Years</u>	<u>Annual</u>	<u>Compounded</u>
5	\$125	\$128
10	\$150	\$163
15	\$175	\$208
20	\$200	\$265
25	\$225	\$339

Clearly, the longer the period in which a policy is in force before its benefits become payable, the greater the significance of having some sort of inflation protection and the greater the benefit under the annual compounding formulation.

B. Financial Analysis Example

As the previous discussion has shown, each of the 5 major components of long-term care insurance requires the prospective policyholder to make choices about how much coverage she wants and to what extent she is willing to self-insure for these costs. That is, the more risk that the insured seeks to transfer to the insurance company, the higher the premium will be. The following chart²²⁵ demonstrates how these major components fit in actual long-term care insurance policies offered by one of the major carriers in this particular market:

²²⁴ Derived by author using LAWRENCE A. CUNNINGHAM, *INTRODUCTORY ACCOUNTING, FINANCE AND AUDITING FOR LAWYERS* 241 (2004).

²²⁵ Slightly adapted by author from Nancy Ann Jeffrey, *Your Needs, Plus Your Budget, Equals What to Pay on Long-Term Care Policy*, WALL ST. J., Mar. 21, 1997, at C1 (rates shown for policies issued by John Hancock Life Insurance Co.).

ANNUAL COST OF AN INDIVIDUAL POLICY

Age at Issue	55	65	75
\$100 daily benefit for nursing-home, home-health coverage; 4 years coverage; 100-day deductible period	\$510	\$990	\$2,830
Shorter coverage period: 2 years	\$380	\$720	\$2,010
Lower home-health-care benefit: \$50 daily	\$410	\$810	\$2,350
Shorter deductible period: 20 days	\$643	\$1,247	\$3,566
Richer benefits: \$200 daily for nursing home and home-health care	\$1,020	\$1,980	\$5,660
Inflation-indexed benefits: annual increases at 5% compounded rate	\$1,090	\$1,740	\$4,230

From examining this chart, it is clear that the age at which the policy is first obtained is a major determinant of the price charged. That is, the younger a buyer is, the lower that person's premium will be.²²⁶ Moreover, the price increases rather dramatically as an insured's age rises. Thus, the increase in premium from age 65 to age 75 is much greater than the increase from age 55 to age 65, regardless of the specific composition of the insurance package being considered. The unmistakable message for buyers is that they should consider obtaining long-term care insurance earlier rather than later, and especially before reaching one's 65th birthday. In other words, if a prospective retiree plans to fund his or her long-term care needs through the mechanism of long-term care insurance, that person should seriously consider purchasing such insurance as part of his pre-retirement planning.

1. Impact of Inflation

On the other hand, the earlier one obtains long-term care insurance, the greater the possible erosion due to inflation because the likely period before benefits will be needed is longer. In that circumstance, choosing the inflation rider becomes even more incumbent. But as noted previously, inflation protection is an expensive addition and increases the cost significantly. According to the preceding chart,²²⁷ simply adding the 5% compounded inflation rider (the bottom line) to the package on the first line increases the annual cost for a 55-year-old purchaser from

²²⁶ See also NAIC GUIDE, *supra* note 215, at 23 (discussing the correlation between age and cost of long-term care insurance).

²²⁷ See *supra* note 225.

\$510 to \$1,090, more than doubling its cost. Indeed, choosing the package without inflation protection but with twice the offered benefits—namely, the next-to-last line—is actually cheaper!

And while the premium increase for the inflation rider is significant at all age levels, it is most significant as a percentage of the premium at lower ages. That is, the increase noted above for a 55-year-old purchaser is \$580 (\$1,090 less \$510) or 114% of the cost of the package without inflation, while the comparable figure for the 75-year-old purchaser is \$1,400 (\$4,230 less \$2,830) or 49% of the no-inflation premium. Of course, the need for inflation protection is far greater for the 55-year-old purchaser than for the 75-year-old purchaser, but the point remains that the addition of inflation protection palpably reduces the premium advantage that a younger purchaser would otherwise enjoy.

Furthermore, the younger purchaser will be paying more years of annual premiums than will someone who purchases long-term care insurance later in life. That is, the 55-year-old purchaser will have paid 20 years of premiums, or \$10,200 (\$510 annual premium \times 20 years) for the no-inflation policy before the 75-year-old even acquires her policy. A countervailing consideration that cannot be easily dismissed, however, is that during this 20-year period, the 55-year-old purchaser has had coverage for long-term care, which the 75-year-old has not. While it is true that the risk of needing long-term care at younger ages is much less than at older ages,²²⁸ it still exists and what really counts is the risk of a *particular individual* for needing such care, which is largely unknowable. Accordingly, the increased premiums paid by the younger purchaser do more than simply lock in lower rates for the future.²²⁹ They also provide coverage for long-term care costs during that interim period, however low the risk of needing this care might be.

This analysis, in fact, brings up an independent reason for considering long-term care insurance early in one's retirement planning—namely, the risk of developing serious medical conditions.²³⁰ That is, some medical conditions arise later in life that may limit the amount of coverage that one can buy.²³¹ For some conditions, any particular insurer might limit how much coverage the prospective policyholder can obtain, usually in terms of the length of the coverage period, or might charge a significantly higher premium for the coverage that it does provide. Alternatively, the insurer might issue the policy with a "pre-existing condition" provision that excludes coverage for long-term care that is attributable to the medical conditions that existed when the policy was obtained.²³² This exclusion

²²⁸ See Marc A. Cohen et al., *Inflation Protection and Long-Term Care Insurance: Finding the Gold Standard of Adequacy* 18 (2002), http://assets.aarp.org/rgcenter/health/2002_09_inflation.pdf (finding that "the expected age at which half of all policyholders use [long-term care] services is 82").

²²⁹ See *id.* at 4–5 (reporting that 59% of new long-term care insurance buyers aged 55–64 years purchased inflation protection versus only 41% of buyers of all ages).

²³⁰ See FROLIK & KAPLAN, *supra* note 10, at 144–45; SHELTON, *supra* note 221, at 35–36.

²³¹ See, e.g., BENJAMIN LIPSON, J.K. LASSER'S CHOOSING THE RIGHT LONG-TERM CARE INSURANCE 241–52 (2002) (reproducing UnumProvident's Underwriting Guide of Medical Risks with 6 different categories).

²³² NAIC GUIDE, *supra* note 215, at 23.

might apply for a specified period of time or even forever, depending upon the language of the pre-existing condition provision in question. And for people with certain conditions, no long-term care insurance policy may be issued at all. Indeed, current medical underwriting practices would reject almost a quarter of all Americans aged 65 years if they applied for this insurance.²³³

In short, long-term care insurance is not like Medicare, which accepts all enrollees who meet its age and work experience requirements.²³⁴ Instead, long-term care insurance is a private market product and therefore subject to whatever medical underwriting criteria that a private insurer wishes to employ to limit its cost exposure. Accordingly, prospective retirees may want to obtain long-term care insurance earlier than their own financial analysis might otherwise suggest to avoid being disqualified from obtaining coverage later because of intervening medical conditions.

2. *The Investment Alternative*

Faced with the situation delineated above, a prospective retiree might be inclined to simply save enough dedicated assets to cover the anticipated cost of long-term care. Returning to the insurance price chart set forth previously,²³⁵ consider the policy that pays \$100 per day for 4 years, with benefits increased by 5% compounded annually. The premium for this policy is \$1,740 per year if the purchaser is 65 years old at the time the policy is first obtained.²³⁶ In 15 years, the amount of the daily benefit will be \$208 due to the inflation rider.²³⁷ To pay \$208 per day, or \$6,240 for a 30-day month, for a period of 4 years, requires a lump sum of \$265,699.²³⁸ To accumulate this sum, the 15 annual investments between age 65 and age 80 of \$1,740 would need to earn 28.9% each year.²³⁹

This result, moreover, must be attained after payment of long-term capital gains taxes at 15%,²⁴⁰ ordinary income tax at, for example, 28%,²⁴¹ and whatever state income tax rate applies to investment income. Assuming that the blended impact of these taxes is an effective tax rate of 25%, the required investment

²³³ Christopher M. Murtaugh et al., *Risky Business: Long-Term Care Insurance Underwriting*, 32 INQUIRY 271, 277 (1995). A 2006 survey of 27 long-term care insurance companies found that only 36.5% of applicants were rated in the most favorable classification according to their medical profiles. See Claude Thau et al., *Eighth Annual Long-Term Care Insurance Survey*, reprinted in BROKER WORLD MAG., July 2006, at 6.

²³⁴ See *supra* note 74.

²³⁵ See *supra* note 225.

²³⁶ *Id.*

²³⁷ SHELTON, *supra* note 221, at 28.

²³⁸ The present value of \$1 received at the end of each month for 4 years, at an assumed interest rate of 6%, is \$42.58. MICHAEL SHERMAN, COMPREHENSIVE COMPOUND INTEREST TABLES 192 (2d ed. 1986). This factor (\$42.58) is then multiplied by the monthly benefit (here, \$6,240) to derive the value of the lump sum needed to generate these monthly benefits—namely, \$265,699.

²³⁹ Computation performed by author.

²⁴⁰ I.R.C. § 1(h)(1)(C) (2006).

²⁴¹ REGAN ET AL., *supra* note 123, § 6.04, at 6–16.

return before taxes is 38.5%.²⁴² That investment return, it should be noted, must be earned not once or twice, but 15 years in a row! Of course, this exercise assumed that our 65-year-old retiree did not require any long-term care throughout the 15-year period during which his investments were accumulating. On the other hand, this exercise also assumed that the insurance company did not raise its rates on existing policies, an issue that will be examined in the next section of this Part.

C. *Pitfalls of the Purchasing Dilemma*

As the preceding analysis has shown, considering long-term care insurance is not an easy process. One must make decisions at the outset about the daily insured amount, the length of coverage, the elimination period, whether to include home care coverage, and whether to have the benefit amounts increased to counter the effects of inflation over time. And that, of course, is assuming that the prospective purchaser would rather not simply invest his assets on his own to cover these possible costs. Were that these considerations were the only pitfalls of the purchasing dilemma! No such luck, as this section now explores.

1. *Buyer Resistance*

At the outset, it should be noted that long-term care insurance is one tough product to buy. Unlike other aspects of retirement planning that portray unstructured relaxation on distant exotic shores, the image of long-term care is, quite frankly, depressing. Whether the context is home care or the widely dreaded nursing home, long-term care implies a certain level of dependency on others for daily life functioning. This reality may be a part of one's future, but it is not pleasant to contemplate.²⁴³

Moreover, it might never happen. According to a rigorous new study, approximately 69% of Americans who turned 65 years old in 2005 will eventually require some type of long-term care, although there is a significant gender difference.²⁴⁴ The percentages of those who are likely to need such care are 58% for men and 79% for women.²⁴⁵ Much of this care will be provided at home, often by family members on a gratis basis, but 37% of current 65-year-olds will need

²⁴² An effective tax rate of 25% means that the investor keeps 75% of the pre-tax investment return. Thus, the after-tax rate of return of 28.9% must be divided by .75 to derive the required pre-tax rate of return of 38.5%. If the investments in question were held in a tax-deferred account, then the proceeds would be taxed upon their withdrawal at ordinary income rates. I.R.C. § 408(d)(1) (2006). The absence of a lower capital gains tax rate means that the blended tax rate in that circumstance would be higher, probably closer to 30%. In that circumstance, the after-tax retention would be 70%, and the pre-tax rate of return needed to produce an after-tax rate of return of 28.9% would be 41.3% (28.9% ÷ .7).

²⁴³ Cf. KANE ET AL., *supra* note 15, at 164 (stating that 30% of "seriously ill hospitalized elderly patients" would prefer to die rather than live in a nursing home).

²⁴⁴ Peter Kemper et al., *Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?*, 42 INQUIRY 335, 342 (2005/2006), available at <http://www.allhealth.org/briefingmaterials/Long-TermCareOveranUncertainFuture-WhatCanCurrentRetireesExpect-461.pdf>.

²⁴⁵ *Id.*

care in an assisted living facility or a nursing home.²⁴⁶ To be sure, 15% will stay less than 1 year,²⁴⁷ not counting the sort of short-term post-hospital nursing home stays that Medicare typically covers.²⁴⁸ But 5% will spend more than 5 years in a nursing home.²⁴⁹ Thus, the overall chance of a lengthy nursing home stay is relatively small but still very significant for those who happen to be that particular group.

Of course, that is precisely the purpose of insurance: to protect against unlikely but unpleasant events.²⁵⁰ For example, life insurance pays benefits upon the death of the insured,²⁵¹ clearly a distasteful occurrence. Death, however, is inevitable; disability is not. For that reason, long-term care insurance is fundamentally different than life insurance, and as a result, there is some basis for generalized denial on the part of prospective insurance purchasers.

2. *Confusing Policy Options*

Once a prospective buyer has surmounted the considerable hurdle of contemplating his or her own chronic dependency, that person must confront the obstacles of the purchasing decision itself. This process is made far more difficult than it needs to be by the lack of industry standardization regarding the basic components of long-term care insurance policies. For example, some policies pay benefits for 3, 5, or 7 years, while others cover 2, 4, or 6 years.²⁵² Some policies offer lifetime coverage, while others do not.²⁵³ Similarly, the daily benefit options from one insurance company might range from \$100 to \$200 in \$10 increments, while another company might start lower, extend higher, or offer \$25 or \$50 increments.²⁵⁴ The “elimination period” may be 30, 60, or 90 days at one company, but 50, 75, or 100 days at another.²⁵⁵ Moreover, some companies aggregate time in separate nursing home stays toward satisfying their “elimination period” requirement, while other companies count only days spent consecutively

²⁴⁶ *Id.*

²⁴⁷ *Id.*

²⁴⁸ *Id.* at 340.

²⁴⁹ *Id.* at 342.

²⁵⁰ *See id.* at 346 (“... LTC [long-term care] need appears to be the archetypal insurable risk that could be spread by insurance, public or private.”).

²⁵¹ *See* BEN G. BALDWIN, *THE LAWYER’S GUIDE TO INSURANCE* 153 (1999).

²⁵² *See, e.g.*, NORTHWESTERN LONG TERM CARE INS. CO., *QUIETCARE* 7 (2005) (noting policy options for 3 years, 6 years, or life); PHYSICIANS MUTUAL INS. CO., *VISTA CARE* 8 (2002) (noting policy options for 2 years to 5 years, or life); Jeffrey, *supra* note 225 (noting policy options for 2 years or 4 years).

²⁵³ *See, e.g.*, Jeffrey, *supra* note 225.

²⁵⁴ *See, e.g., id.* (noting policy options for \$100 and \$200 daily rates); *see also* NORTHWESTERN LONG TERM CARE INS. CO., *supra* note 252, at 6 (noting that Northwestern’s range is \$50 to \$300 per day); PHYSICIANS MUTUAL INS. CO., *supra* note 252, at 2 (noting that Physicians Mutual’s range is \$30 to \$300).

²⁵⁵ *See* Jeffrey, *supra* note 225 (noting policy options for elimination periods of 20 or 100 days); PHYSICIANS MUTUAL INS. CO., *supra* note 252, at 2 (noting policy options for elimination periods of 0, 30, 60, 90, 180, or 365 days); NORTHWESTERN LONG TERM CARE INS. CO., *supra* note 252, at 6 (noting policy options for elimination periods of 45, 90, or 180 days); *see also* GE CAPITAL ASSURANCE, *PRIVILEGED CARE SELECT* 2 (1996) (0, 50, or 100 days).

during a single stay.²⁵⁶ Home care benefits may be half of the daily nursing home benefit in some policies, but equal to that benefit in others.²⁵⁷

And if all of this variety were not enough, additional options are available in some policies, but not in all. As noted previously, many policies offer inflation protection riders that automatically increase the amount of the daily benefit every year.²⁵⁸ Some riders add a specified percentage of the original benefit amount each year, whereas others apply a specified percentage to the current benefit amount and compound the increase year after year.²⁵⁹

And there is more. Some policies waive the premium once a policyholder begins receiving benefits under the policy.²⁶⁰ Other policies refund part of the premiums paid, either to the policyholder or to her heirs, if no claim is made for long-term care benefits.²⁶¹ Still other policies provide that a lower daily benefit will be paid should the policyholder discontinue premium payments, if the policy's premiums were paid for a specified number of years.²⁶² Other policies may maintain the same level of benefits but for a reduced period of time.²⁶³

The inevitable result of all these choices and alternatives is consumer confusion and frustration. The range of options²⁶⁴ discourages cost comparisons between policies and shrouds the insurance buying process with an unfortunate air of mystery.²⁶⁵ It does not help matters that almost none of the major insurance companies have interactive websites that allow prospective customers to alter benefit packages and see the impact of their selections on the resulting premiums. Instead, prospective customers are directed to insurance agents for quotations and information, a process that is at once the most expensive means of distribution and also the most intrusive.²⁶⁶

²⁵⁶ NORMAN ET AL., *supra* note 213, at 61–62; SHELTON, *supra* note 221, at 25–26.

²⁵⁷ *See supra* note 254; *see also* GE CAPITAL ASSURANCE, *supra* note 255 (80% option for home care).

²⁵⁸ NAIC GUIDE, *supra* note 215, at 18–19.

²⁵⁹ *Id.* at 19; *see also* NORMAN ET AL., *supra* note 213, at 77–80 (discussing inflation protection). An alternative allows policyholders to purchase additional insurance without medical underwriting. *See id.* at 80, 82–84.

²⁶⁰ NAIC GUIDE, *supra* note 215, at 20.

²⁶¹ SHELTON, *supra* note 221, at 36.

²⁶² *Id.*

²⁶³ NAIC GUIDE, *supra* note 215, at 21; SHELTON, *supra* note 221, at 37.

²⁶⁴ Additional options include worldwide coverage, medical alert systems, and medical equipment. SHELTON, *supra* note 221, at 45.

²⁶⁵ *See* Ellen Graham, *Weighing the Benefits of Buying Insurance for Extended Elder Care*, WALL ST. J., Mar. 31, 1999, at B1 (noting the “baffling array of variables” that affect premiums for long-term care insurance).

²⁶⁶ *See* AMERICA’S HEALTH INSURANCE PLANS, LONG-TERM CARE INSURANCE IN 2002, at 20 (2004), http://www.ahipresearch.org/pdfs/18_LTC2002.pdf (finding that “79% of long-term care insurance policies ever issued had been sold directly to individuals”). Some employers offer long-term care insurance to their employees at favorable group rates, thereby lowering distribution expenses and related premium costs. *See* NORMAN ET AL., *supra* note 213, at 102–09; SHELTON, *supra* note 221, at 51–54. In addition, certain professional associations and other affinity groups offer group policies. NAIC GUIDE, *supra* note 215, at 11.

3. Rate Stability

A further difficulty in this regard is that premiums on existing long-term care insurance policies might be increased in the future. Although such premiums cannot be increased for specific individuals, they can be raised for an entire "class" of policies, such as those issued within a particular state.²⁶⁷ While some insurance companies have not raised their rates, others have done so with apparent abandon, causing their premiums to double or even triple over a period of 10 years, or so.²⁶⁸ As a result, a long-term care insurance policy that was affordable when it was first obtained may become unaffordable as premiums increase beyond what a policyholder is able to pay.²⁶⁹ The unfortunate consequence in these situations is that some policyholders may not renew their policies,²⁷⁰ thereby forfeiting the benefit of the premiums paid in previous years and losing their insurance coverage when it is most likely to be needed.²⁷¹ Accordingly, post-issuance premium increases discourage would-be insurance buyers who must confront the prospect of future unaffordability on existing policies.

In response to the phenomenon of significant rate increases on existing policies, the National Association of Insurance Commissioners (NAIC) amended the model long-term care insurance regulation to require disclosure of past rate increases²⁷² and to require that the prospective policyholder acknowledge that future rate increases are possible.²⁷³ In addition, the regulation provides that an insured who receives a "substantial premium increase" must be offered several options, one of which would maintain her current premium schedule but with reduced benefits.²⁷⁴ In effect, the insured is subject to a retroactive decrease in

²⁶⁷ CARLSON, *supra* note 42, § 9.05[2]; NAIC GUIDE, *supra* note 215, at 23; *see, e.g.*, ME. REV. STAT. ANN. tit. 24-A, § 2413(1)(G)(1)(b) (stating that rates on a policy that is "guaranteed renewable" may be "revised by the insurer on a class basis"); *cf.* I.R.C. § 7702B(b)(1)(C) (2006) (noting that long-term care insurance policies must be "guaranteed renewable"); I.R.C. § 7702B(g)(1)(A), (2)(A)(i)(I), (B)(i) (incorporating the MODEL REGULATION provision on guaranteed renewability).

²⁶⁸ Ann Davis, *Shaky Policy Unexpected Rate Rises Jolt Elders Insured for Long-Term Care*, WALL ST. J., June 22, 2000, at A1; Jane Bryant Quinn, *Long-Term Care Can Become a Dirty Game*, CHI. TRIB., Sept. 12, 1999, at 3.

²⁶⁹ *See* NORMAN ET AL., *supra* note 213, at 94; *see also* NAIC GUIDE, *supra* note 215, at 24.

²⁷⁰ *See Long-Term Care Insurance: Testimony Before the United States Senate Special Comm. on Aging*, 106th Cong. (2000) (statement of Allan Kanner, Allan Kanner & Associates, P.C.) (following a 7-fold increase in premiums over 7 years, most of his clients did not renew their policies); *see also* *Hanson v. Acceleration Life Ins. Co.*, No. CIV.A3-97-152, 1999 WL 33283345 (D.N.D. Mar. 16, 1999). *See generally* Allan Kanner, *The Filed Rate Doctrine and Insurance Fraud Litigation*, 76 N.D.L. REV. 1 (2000).

²⁷¹ An important study of policy lapses found that only 23.2% of persons who had long-term care insurance in 1996 maintained their coverage through 2000. Paul E. McNamara & Nayoung Lee, *Long-term Care Insurance Policy Dropping in the U.S. from 1996 to 2000: Evidence and Implications for Long-term Care Financing*, 29 GENEVA PAPERS ON RISK & INS. 640, 646 (2004).

²⁷² MODEL REGULATION § 9.B.

²⁷³ *Id.* § 9.C.

²⁷⁴ *Id.* § 26.D(3), (4)(a).

anticipated benefits.²⁷⁵ In any case, this amendment is prospective so it applies only to those long-term care insurance policies that are issued *after* this amendment has been adopted in the relevant state.²⁷⁶ And the most recent tally of adopting states shows that only 21 states have adopted this particular amendment.²⁷⁷

4. *Security of Benefits*

The issue of unanticipated rate increases is symptomatic of a more general concern with the companies that are issuing these policies. Companies that seek these rate increases often claim that these increases are needed to forestall corporate bankruptcy, which raises the question of these benefits' fundamental dependability. That is, long-term care insurance is often purchased years, and sometimes decades, in advance of the benefits becoming payable. At that point in time, will the company be there to provide the promised benefits? Although many states administer so-called "guaranty funds" for such a contingency, these funds typically impose caps of \$100,000 on total benefits paid and are often restricted to policyholders who reside in their state.²⁷⁸

In this context, recent history has not been terribly reassuring. For example, Fidelity Investments terminated its co-marketing arrangement with a major long-term care insurance carrier without even notifying existing policyholders. Even more ominously, a study released in May 2006 by the AARP, the senior citizens advocacy group, reported that "nine of the top-selling companies" have terminated their long-term care insurance business entirely in recent years.²⁷⁹ With respect to one of those departing insurers, TIAA-CREF, a revealing article this past spring in the *Wall Street Journal* described this change as follows:

In 2003, [the company] sold off one such business: insurance for long-term care, as in nursing homes. This sort of insurance has been a tricky

²⁷⁵ An even worse alternative allows a policyholder to receive a policy that provides benefits equal to the premium amounts paid thus far. *Id.* §§ 26.D(4)(b), 26.E(3). Using the example in the text accompanying notes 223–227, the insured would be eligible to receive a policy that paid long-term care benefits of only \$26,100 (annual premiums of \$1,740 × 15 years), rather than the \$303,680 (daily benefit of \$208 × 365 days × 4 years) that the policy claimed to provide—an effective reduction in coverage of more than 91%! *See also* Mary Beth Franklin, *Costs Up, Benefits Down*, KIPPLINGER'S PERS. FIN., Oct. 2004, at 93 (describing a situation with a 95.2% reduction in benefits).

²⁷⁶ *See* Terri Cullen, *As Fee Increases Hit Holders of Insurance for Long-Term Care, Is It Safe to Buy?*, WALL ST. J., Mar. 2, 2005, at D1 (reporting in 2005 that "some policyholders who purchased their coverage years ago have seen their premiums increase sharply in the past year . . ."). At least one actuary contends that significant post-issuance rate increases are unlikely on newly issued policies, because insurance companies are assuming investment returns (i.e., interest rates) and lapse rates than are closer to actual experience. Claude Thau, *LTCI's Toughest Questions Answered*, LTC BULLETS, Aug. 16, 2006, at 4, <http://www.centerlrc.com/bullets/archives2006/650.htm>.

²⁷⁷ *See* Mila Kofman & Lee Thompson, Long-Term Care Financing Project, Consumer Protection and Long-Term Care Insurance: Predictability of Premiums 6 (Mar. 2004), <http://lrc.georgetown.edu/pdfs/consumer.pdf>.

²⁷⁸ *An Empty Promise to the Elderly?*, CONSUMER REP., June 1991, 425.

²⁷⁹ Bonnie Burns, Comparing Long-Term Care Insurance Policies: Bewildering Choices for Consumers 13 (2006), http://assets.aarp.org/rgcenter/il/2006_13_lrci.pdf.

area for consumers, *who worry that an insurer might nickel-and-dime them later when they're old and vulnerable*. In this respect, TIAA-CREF's good-guy reputation as a nonprofit was a selling point.

But the sale of its existing long-term-care policies to a for-profit insurer has upset some clients. "They betrayed me," says Jeremy Stone, former head of the Federation of American Scientists and a TIAA-CREF client since 1964. With a long-term care policy, "you have to trust the organization to follow through," he says.²⁸⁰

The highlighted passage in the above quotation refers to another common feature in long-term care insurance policies that can be very problematic, especially if the insurer is experiencing financial difficulty when the time to pay a policyholder's benefits arrives: gatekeeper provisions. That is, most consumers do not realize that they cannot simply access their long-term care insurance benefits whenever they choose to do so. Instead, they must apply for such benefits from the insurance company, and that company will decide whether they qualify for payment of benefits.²⁸¹

These "gatekeeper" provisions respond to what economists commonly call "moral hazard" or "induced demand."²⁸² This phrase refers to the tendency of insured people to claim benefits under insurance policies even when they may not, in fact, require the services that such benefits provide.²⁸³ In the context of long-term care, "moral hazard" implies that policyholders—or perhaps their families—might try to obtain assistance when other accommodations could be made simply because their insurance would cover the cost of such assistance.²⁸⁴ To guard against this possibility, gatekeeper provisions require that a case manager determine whether the insurance company must pay for the long-term care being claimed.²⁸⁵ But if the case manager is not independent of the insurance company in question, that manager might be inclined to deny claims to save the insurance company the cost of paying for long-term care.²⁸⁶

To the extent that a gatekeeper frustrates a policyholder's expectations at the time the policy was first obtained, these provisions call into question the basic value of the insurance policy itself.²⁸⁷ After all, if an insurance company can unilaterally determine its financial exposure by asserting that long-term care is not

²⁸⁰ Tom Lauricella, *College Try: A Wall Streeter Aims to Revive Handler of University Pensions*, WALL ST. J., Apr. 24, 2006, at A1 (emphasis added).

²⁸¹ *An Empty Promise to the Elderly?*, *supra* note 278; *see also* NORMAN ET AL., *supra* note 213, at 58–59.

²⁸² *See* Kapp, *supra* note 201, at 734.

²⁸³ ALICE M. RIVLIN & JOSHUA M. WIENER, *CARING FOR THE DISABLED ELDERLY: WHO WILL PAY?* 66 (1988).

²⁸⁴ *See* Kapp, *supra* note 201, at 734.

²⁸⁵ NORMAN ET AL., *supra* note 213, at 58.

²⁸⁶ *See id.* at 58–59.

²⁸⁷ *See An Empty Promise to the Elderly?*, *supra* note 278; *cf.* I.R.C. § 7702B(c)(2)(A), (4) (2006) (stating that a person is "chronically ill" for purposes of receiving long-term care services if that person has been certified by *any* "licensed health care practitioner" as requiring "substantial assistance" in order to perform at least 2 "activities of daily living," or requiring "substantial supervision" because of "severe cognitive impairment").

really necessary, what did the policyholder really get when he acquired the policy? In other words, do such gatekeeper provisions undercut the “peace of mind”²⁸⁸ that long-term care insurance is supposed to convey?

D. Federal Government Encouragement of Long-Term Care Insurance

According to well-regarded estimates, less than 10% of older Americans have long-term care insurance.²⁸⁹ Toward a general goal of increasing this number, the federal government²⁹⁰ has undertaken 2 very different strategies: first, providing tax incentives, principally the deductibility of long-term care insurance premiums; and second, encouraging state-level “partnerships” that allow a Medicaid applicant to retain assets equal to the long-term care insurance benefits that have been paid for that person.

1. Tax Incentives

With an explicit objective of encouraging people to buy long-term care insurance,²⁹¹ Congress amended the tax law in 1996 to make premiums for such insurance tax-deductible.²⁹² This effort has not been terribly successful because the touted tax benefits are often illusory and thus incapable of motivating would-be insurance buyers.²⁹³ For instance, the tax amendment treats long-term care insurance premiums as “medical expenses,”²⁹⁴ thereby subjecting those expenses to the tax code’s floor for such expenses—namely, 7.5% of a taxpayer’s “adjusted gross income” (AGI).²⁹⁵ Moreover, medical expenses are an “itemized

²⁸⁸ See Debra C. Newman, *Long-Term Care Insurance Provides Peace of Mind in Retirement*, J. RETIREMENT PLAN., Nov.–Dec. 1998, at 24.

²⁸⁹ Gen. Accounting Off., Long-Term Care Insurance: Better Information Critical to Prospective Purchasers 3 (2000), <http://www.gao.gov/archive/2000/he00196t.pdf>; see also Mary Beth Franklin, *Medicaid Gets Tough*, KIPLINGER’S PERS. FIN., May 2006, at 89 (“In most states, less than 10% of the 50-and-older population has coverage.”).

²⁹⁰ Some state governments have created special programs to encourage the purchase of long-term care insurance, but those programs are outside the scope of this Article. See generally Joshua M. Wiener et al., *Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance*, 8 ELDER L.J. 57, 67–70, 76–83 (2000). For a recent compilation of state incentives, see American Council of Life Insurance, *State Tax Incentives for Long-Term Care Insurance* (2004), <http://www.ltcconsultants.com/general/news/StateTax05.pdf>.

²⁹¹ See H.R. REP. NO. 104-496, at 115 (1996), as reprinted in 1996 U.S.C.A.N. 1865, 1916.

²⁹² I.R.C. § 213(a), (d)(1)(D) (2000). To qualify for this deduction, a long-term care insurance policy must satisfy the requirements of I.R.C. § 7702B(b), (g). See generally FROLIK & KAPLAN, *supra* note 10, at 150–51 (discussing tax qualified policies); NAIC GUIDE, *supra* note 215, at 8–10 (stating that long-term care insurance premiums are tax deductible as of 1997, but older policies may be grandfathered allowing the same tax advantages as policies taken out after July 1, 1997).

²⁹³ See Wiener et al., *supra* note 290, at 96.

²⁹⁴ I.R.C. § 213(d)(1)(D).

²⁹⁵ I.R.C. § 213(a). The phrase “adjusted gross income” (AGI) refers to a person’s total income minus the deductions listed in I.R.C. § 62(a)(1)–(17) (2006). See generally BORIS I. BITTKER ET AL., *FEDERAL INCOME TAXATION OF INDIVIDUALS* ¶ 2.01[3] (3d ed. 2002).

deduction,”²⁹⁶ so nearly 2 out of 3 taxpayers receive no tax benefit from this provision because they do not itemize their deductions.²⁹⁷ In addition, Congress added age-specific limits on the amount of long-term care insurance premiums that can be deducted,²⁹⁸ and any premiums in excess of these limits provide no tax benefit whatsoever. These limits are adjusted annually for inflation,²⁹⁹ but they cap the amount that can be deducted nonetheless. In 2006, those limits were as follows:

<u>Age of Insured</u>	<u>Annual Premium</u>
Under 41	\$280
41–50	\$530
51–60	\$1,060
61–70	\$2,830
Over 70	\$3,530

To illustrate the interaction of these various restrictions, assume that Deborah is 65 years old and pays \$3,500 per year for long-term care insurance, \$1,062 for the enrollee’s portion of Medicare Part B coverage (\$88.50 per month³⁰⁰ × 12 months), and \$800 for Medigap insurance. The limit on deductible long-term care insurance premiums for someone ages 61–70 and over in 2006 was \$2,830.³⁰¹ Thus, the other \$670 (\$3,500 less \$2,830) of Deborah’s long-term care insurance premium is ignored for tax purposes. If Deborah’s AGI³⁰² in 2006 was \$50,000, her medical expense deduction would be computed as follows:

Long-term care insurance	\$2,830	(limit)
Medicare Part B premium	1,062	
Medigap insurance	<u>800</u>	
	\$4,692	
7.5% of AGI (\$50,000)		
	<u>\$(3,750)</u>	
Deduction allowed	<u>\$942</u>	

Thus, of the \$3,500 that Deborah paid for long-term care insurance, she can deduct only \$942. And since most older Americans do not itemize their

²⁹⁶ See I.R.C. §§ 63(d)(1) (2006), 62(a)(1)–(17), 213(a); see also BITTKER ET AL., *supra* note 295, ¶ 26.01.

²⁹⁷ Sixty-four percent (64%) of taxpayers did not itemize deductions. See Brian Balkovic, Individual Income Tax Returns, Preliminary Data, 2004, at 6, <http://www.irs.gov/pub/irs-soi/04inplim.pdf>.

²⁹⁸ I.R.C. § 213(d)(10)(A).

²⁹⁹ *Id.* § 213(d)(10)(B).

³⁰⁰ CMS MEDICARE, *supra* note 79, at 8.

³⁰¹ Rev. Proc. 2005-70, 2005-47 C.B. 979, 984.

³⁰² See *supra* note 295 and accompanying text.

deductions,³⁰³ Deborah will probably not deduct even this \$942 on her tax return. But if she does itemize her deductions, this deduction of \$942 will reduce her taxes by \$141 or \$236, depending upon whether she is married or single.³⁰⁴ This paltry benefit can hardly motivate Deborah to pay \$3,500 for long-term care insurance if she is not already so inclined. In recognition of this reality, various proposals have been made to increase the tax incentives to buy long-term care insurance,³⁰⁵ though none have been enacted thus far.

2. Medicaid-Insurance Partnerships

In the same 2006 legislation that restricted eligibility to Medicaid, Congress authorized state governments to create so-called “Long-Term Care Partnerships.”³⁰⁶ The thrust of these arrangements is that people who own specially designated long-term care insurance policies would be eligible for Medicaid payment of their long-term care expenses after they exhaust their insurance benefits.³⁰⁷ In effect, the policyholder who uses all of her long-term care insurance benefits would be allowed to retain assets equal to those benefits and still qualify for Medicaid. In addition, assets remaining at the person’s death are exempt from Medicaid’s estate recovery provisions to the extent of the long-term care insurance benefits that she received.³⁰⁸

For example, assume that Linda has \$125,000 of countable resources under Medicaid’s definition and has a qualifying long-term care insurance policy that will pay \$100 per day for 2 years. If this policy has the “pool of benefits” feature, it will pay long-term care expenses—whether in a nursing home or in some less costly setting—of \$73,000 (\$100 per day × 365 days per year × 2 years). Should Linda utilize all of these benefits, her policy will enable her to keep \$73,000 of her countable resources while still qualifying for Medicaid. Her remaining \$52,000 (\$125,000–\$73,000) of assets, however, would need to be “spent down” since those assets represent an excess over the

³⁰³ See Wiener et al., *supra* note 290, at 96 (noting that half of older Americans have no tax liability); *supra* note 297 and accompanying text.

³⁰⁴ A married person with AGI of \$50,000 would probably be in the 15% tax bracket, because taxable income was AGI minus itemized deductions and personal exemptions of \$3,300 per person in 2006. See Rev. Proc. 2005-70, 2005-47 C.B. 979, 983. If so, a deduction of \$942 would provide a tax benefit of \$141 (\$942 × 15%). A single person with the same AGI would probably be in the 25% tax bracket, and a \$942 deduction would lower that person’s taxes by \$236 (\$942 × 25%). See *id.* § 3.01.

³⁰⁵ See, e.g., Long-Term Care and Retirement Security Act of 2005, S. 1244, 109th Cong. § 2(a) (2005) (proposing that premiums for long-term care insurance be deductible in deriving AGI, so that *all* taxpayers—not just those who itemize their deductions—can deduct these premiums); Long-Term Care Support and Incentive Act of 2005, H.R. 2935, 109th Cong. § 2(a) (2005) (same); Improving Long-Term Care Choices Act of 2005, S. 1602, 109th Cong. § 121(a) (2005) (same). But see Karin C. Ottens, Note, *Using Tax Incentives to Solve the Long-Term Care Crisis: Ineffective and Inefficient*, 22 VA. TAX REV. 747 (2003) (suggesting that government should look at nontax approaches to solve the long-term care crisis).

³⁰⁶ Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6021(a)(1), 120 Stat. 4, 68 (2006), *amending* 42 U.S.C. § 1396p(b)(1)(C).

³⁰⁷ See § 6021, 120 Stat. at 68 (codified at 42 U.S.C. § 1396p(b)(1)(C)(iii)).

³⁰⁸ 42 U.S.C. § 1396p(b)(1)(C)(ii) (2000), *amended by* § 6021, 120 Stat. at 68.

insurance benefits paid. Had Linda's policy paid for 4 years, she would have been able to keep all \$125,000 of her assets.³⁰⁹

a. Qualifying Insurance

To qualify for this treatment, a long-term care insurance policy must contain the consumer protections that are required to ensure that its premiums are eligible for tax deductibility;³¹⁰ but most policies sold currently qualify.³¹¹ Those consumer protections³¹² incorporate various model provisions established by the National Association of Insurance Commissioners (NAIC)³¹³ regarding guaranteed renewability³¹⁴ and mandatory disclosures.³¹⁵ Other key protections involve no prior hospitalization³¹⁶ and specific procedures to prevent policies from lapsing unintentionally if the insured fails to pay renewal premiums when they become due.³¹⁷ Indeed, no fewer than 9 sections of NAIC's model act³¹⁸ and 19 sections of NAIC's model regulation³¹⁹ are specifically incorporated as required provisions of "partnership" policies.³²⁰

"Partnership" policies differ from "tax-qualified" policies, however, in one important respect: inflation protection. "Tax-qualified" policies must make such protection available, but "partnership" policies must *include* inflation protection if the policyholder is under age 76 when the policy is first obtained.³²¹ Moreover, if the insured is under age 61 when he or she first purchases the policy, it must include "compound annual inflation protection."³²² And if the insured is 61 through 75 years old when the policy is purchased, it must include "some level of inflation protection" but not necessarily compound annual protection.³²³

b. Evaluation

The ultimate question, of course, is whether coordinating long-term care insurance with Medicaid makes such insurance more attractive than it would be

³⁰⁹ Four years = 1,460 days × \$100 of daily benefits = \$146,000, which is more than her assets of \$125,000.

³¹⁰ § 6021, 120 Stat. at 68 (adding 42 U.S.C. § 1396p(b)(1)(C)(iii)(II)).

³¹¹ See AMERICA'S HEALTH INSURANCE PLANS, *supra* note 266, at 25 (noting that 90% of long-term care insurance policies sold in 2002 were "tax-qualified"); Thau et al., *supra* note 233, at 11 ("[m]ore than 98%" of policies were so qualified).

³¹² See I.R.C. § 7702B(b) (2000).

³¹³ 42 U.S.C. § 1396p(b)(5)(B)(i) (incorporating provisions adopted as of October 2000). Any subsequent revisions of the model act and model regulation will be reviewed by the federal government to determine whether those revisions should be incorporated. See § 6021, 120 Stat. at 71-72 (codified at 42 U.S.C. § 1396p(b)(5)(C)).

³¹⁴ § 6021, 120 Stat. at 69 (codified at § 1396p(b)(5)(A)(i)(I)).

³¹⁵ § 6021, 120 Stat. at 70 (codified at § 1396p(b)(5)(A)(i)(VII), (VIII)).

³¹⁶ § 6021, 120 Stat. at 70 (codified at § 1396p(b)(5)(A)(ii)(II)).

³¹⁷ § 6021, 120 Stat. at 69 (codified at § 1396p(b)(5)(A)(i)(VI)).

³¹⁸ § 6021, 120 Stat. at 70 (codified at § 1396p(b)(5)(A)(ii)).

³¹⁹ § 6021, 120 Stat. at 69 (codified at § 1396p(b)(5)(A)(i)).

³²⁰ § 6021, 120 Stat. at 68 (codified at § 1396p(b)(1)(C)(iii)(III)).

³²¹ § 6021, 120 Stat. at 68 (codified at § 1396p(b)(1)(C)(iii)(IV)(cc)).

³²² § 6021, 120 Stat. at 68 (codified at § 1396p(b)(1)(C)(iii)(IV)(aa)).

³²³ § 6021, 120 Stat. at 68 (codified at 42 U.S.C. § 1396p(b)(1)(C)(iii)(IV)(bb)).

otherwise. As the “partnership” program is constituted, long-term care insurance serves primarily to preserve a specified amount of assets from the ravages of long-term care costs. Any assets in excess of insurance benefits received, however, must be depleted before Medicaid can be accessed.³²⁴ And in an explanation to state Medicaid directors dated July 27, 2006, the federal agency that administers Medicaid noted that a person with home equity in excess of the statutory limit created by the Deficit Reduction Act (generally \$500,000)³²⁵ remains ineligible for Medicaid even if she has a qualifying “partnership” insurance policy.³²⁶ Thus, the partnership program’s utility as an asset protection device is rather circumscribed.

To be sure, a prospective retiree can protect additional assets by purchasing a long-term care insurance policy with greater benefits. But that option already exists outside the “partnership” program. In fact, some people who can afford to pay their own long-term care costs might prefer to insure against those costs in order to preserve their accumulated wealth for specific family or charitable purposes. Long-term care insurance can be especially valuable in this context if a person’s financial holdings are largely illiquid, such as real estate or stock in a closely held corporation. That is, long-term care insurance enables a policyholder to pay for long-term care expenses without needing to sell those assets at a time that might be inopportune from an investment perspective.³²⁷

Be that as it may, the question remains whether the “partnership” arrangement creates any significant *additional* incentive to buy long-term care insurance. In this context, it is worth examining the experience of comparable programs in California, Connecticut, and to a lesser extent Indiana that predated the Deficit Reduction Act’s authorization of “partnership” programs by more than a decade.³²⁸ Sales of long-term care insurance in those states have

³²⁴ See § 6021, 120 Stat. at 68 (codified at 42 U.S.C. § 1396p(b)(1)(C)(iii) (providing that a Medicaid applicant’s assets may be ignored “in an amount equal to the insurance benefits payments”)).

³²⁵ § 6014(a), 120 Stat. at 64–65 (codified at 42 U.S.C. § 1396p(f)(1)(A)). States may elect to exempt homes with equity of as much as \$750,000. § 6014(a), 120 Stat. at 65 (codified at 42 U.S.C. § 1396p(f)(1)(B)).

³²⁶ CENTER FOR MEDICAID & STATE OPERATIONS, CENTERS FOR MEDICARE & MEDICAID SERVICES, ENCLOSURE: QUALIFIED LONG-TERM CARE PARTNERSHIPS UNDER THE DEFICIT REDUCTION ACT OF 2005, at 3 (2006), <http://www.cms.hhs.gov/smdl/downloads/LTCEnclosure.pdf>.

³²⁷ At the Lewis & Clark Law School Forum, Professor Stephen Kanter suggested that a prospective retiree might prefer to use her accumulated assets to pay for long-term care costs and obtain term life insurance to fulfill her testamentary objectives, be they charitable or familial. This strategy has considerable appeal, in part, because it avoids the need to satisfy a long-term care insurance policy’s gatekeeper provisions, which might be problematic in certain circumstances. See *supra* text accompanying notes 281–87. But some retirees may be unable to obtain term life insurance due to medical conditions that nevertheless do not preclude obtaining long-term care insurance, albeit at higher-than-standard rates. Regarding the use of life insurance to fund long-term care, see FROLIK & KAPLAN, *supra* note 10, at 155–57.

³²⁸ See H.R. REP. NO. 109-362, at 286 (2005) as reprinted in 2006 U.S.C.C.A.N. 3, 104. New York has a similar program, but it is distinctly more generous by allowing

been characterized as “disappointingly small,”³²⁹ though slightly better than in some other states.³³⁰ Many of the usual impediments, including the cost of insurance premiums, were at work, but in addition, the explicit tie-in of Medicaid to long-term care insurance apparently did not enhance the appeal of such insurance. As the distinguished analyst Dr. Joshua Wiener reported, “[o]ne survey of overall insurance purchasers found that 91 percent of respondents reported that avoiding Medicaid was an ‘important’ or ‘very important’ reason for buying a policy.”³³¹ Furthermore, he notes that “the primary message that insurance agents use to sell long term care insurance [is that] Medicaid is a ‘terrible’ program, with inferior access to poorer quality facilities.”³³² If that is the case, then the “partnership” program, which explicitly offers *easier* eligibility for Medicaid, seems ill-conceived. In adopting the Deficit Reduction Act, Congress apparently believed that any incentive—even an ill-conceived one—is better than none. The accuracy of that assessment remains to be seen.

VII. CONCLUSION

When doing the financial planning for retirement, most Americans ignore the potentially devastating impact that long-term care needs might make on their situation. In fact, a retirement risk survey undertaken by the prestigious Society of Actuaries found that even though 74% of prospective retirees believe it is at least “somewhat likely that the average person [aged 65 years] will spend [some] time in a nursing home,”³³³ only 44% expect to be in that group themselves and only 12% think such a possibility is “very likely.”³³⁴ Moreover, a major survey of Americans age 45 and older done by the AARP revealed that 55% of respondents

policyholders to access Medicaid eligibility without regard to the coverage limits of their qualifying policy. *Id.* For the particular parameters of these state programs, see Nelda McCall & Jodi Korb, *What Have We Learned from the Partnership for Long Term Care? in WHO WILL PAY FOR LONG TERM CARE? INSIGHTS FROM THE PARTNERSHIP PROGRAMS* 153–58 (Nelda McCall ed., 2001) [hereinafter *WHO WILL PAY*].

³²⁹ Nelda McCall et al., *The Partnership for Long-Term Care: Who Are the Partnership Policy Purchasers?*, 54 MED. CARE RES. & REV. 472, 487 (1997). *See also id.* at 485 (noting that nearly 70% of such purchasers “definitely” or “probably” would have purchased long-term care insurance without the “partnership” program).

³³⁰ *See* Eileen Tell, *Index of the Long-Term Care Uninsured*, LTC BULLETS, Jan. 6, 2006, at 4, <http://www.centerlrc.com/members/lcbbullets/599.htm> (observing that 3 of the 18 states with “above average” market penetration for long-term care insurance were “partnership” program states); *see also* McCall & Korb, *supra* note 328, at 179 (noting that “the Partnership may be having its desired effect of attracting middle-income and -asset consumers.”).

³³¹ Joshua M. Wiener, *The Limits of the Partnership for Long Term Care*, in *WHO WILL PAY*, *supra* note 328, at 249.

³³² *Id.*

³³³ SOCIETY OF ACTUARIES, 2001 RETIREMENT RISK SURVEY: KEY FINDINGS AND ISSUES 5 (2001).

³³⁴ *Id.*

thought that Medicare covered long-term nursing home costs³³⁵ and that 41% thought that Medicare covered assisted living facility expenses.³³⁶ As this Article has shown, Medicare's coverage of nursing home costs is severely restricted, and its coverage of assisted living facility expenses is nonexistent. Elsewhere, I have suggested that nursing home care should be included in Medicare's package of benefits to recognize the increasingly medical role that nursing homes play in our modern health care system.³³⁷ But political realities suggest that Medicare will not be extended in this fashion, especially after that program was recently expanded to cover outpatient prescription drugs.³³⁸

Accordingly, most Americans will continue to depend on family resources for informal care until their care needs escalate. They will then expend their own funds until they are essentially destitute and can access benefits under the government's health care program for poor people, Medicaid. Recent Congressional action, however, has made accessing Medicaid even more problematic than in the past, sending the rather clear message that long-term care is fundamentally a private responsibility. As a consequence, prospective retirees need to consider this important issue in making their retirement-based financial arrangements.

For some people, the need to fund long-term care will mean simply accumulating more assets than would otherwise be required before they retire. But others will want to shift the risk of these costs through the mechanism of private long-term care insurance. Unfortunately, doing so is a forbidding process, plagued by a lack of readily obtainable information, troubling policy limitations, and a dizzying array of possible optional features. It is in the nature of a private market to develop ever-newer coverage combinations and permutations,³³⁹ but in this case, more is clearly less.

For long-term care insurance to play an important role, government needs to foster genuine price competition and better informed consumers. At a minimum, contract features should be standardized to facilitate cost comparisons,³⁴⁰ as is the

³³⁵ AM. ASS'N OF RETIRED PERSONS, THE COSTS OF LONG-TERM CARE: PUBLIC PERCEPTIONS VERSUS REALITY 26 (2001), http://assets.aarp.org/rgcenter/health/ltr_costs.pdf.

³³⁶ *Id.* at 36.

³³⁷ Richard L. Kaplan, *Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, 2004 U. ILL. L. REV. 47, 82–85 (2004).

³³⁸ See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101(a)(2), 117 Stat. 2066, 2071–2075 (codified at 42 U.S.C. § 1395w-101).

³³⁹ See, e.g., Jeff D. Opdyke, *Insurers Push Policies For Long-Term Care*, WALL ST. J., Dec. 27, 2005, at D1 (reporting Genworth Financial's creation of a new "product that marries a long-term-care contract with an annuity").

³⁴⁰ See CONG. BUDGET OFF., FINANCING LONG-TERM CARE FOR THE ELDERLY 27 (2004), <http://www.cbo.gov/ftpdocs/54xx/doc5400/04-26-LongTermCare.pdf> ("standardiz[ing] the variety of LTC insurance policies now being sold would make it easier for consumers to compare premiums, might lead to more competition among insurers, and could make policies generally more understandable.").

case currently with Medigap insurance policies.³⁴¹ For example, long-term care insurance could be offered for only certain specific periods, such as 3 years, 6 years, or life. Other key policy variables such as daily amounts and elimination periods should be simplified as well. In addition, consumers must be protected from large premium increases after a policy is issued, so that policyholders are not compelled to abandon their policies when they are most likely to need them. Finally, policyholders must have some mechanism by which to appeal claims that are denied by an insurance company's gatekeeper. Otherwise, the benefits these policies offer may be as illusory as the current law's purported tax benefits. Until then, the harrowing prospect of funding long-term care will remain retirement planning's greatest gap.

³⁴¹ See DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., 2006 CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE 20–21 (2006), <http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf>.