

# CRACKING THE CONUNDRUM: TOWARD A RATIONAL FINANCING OF LONG-TERM CARE

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*In this article, Professor Kaplan identifies an issue emerging as one of the major crises in the American health care system: how seniors and their families will finance long-term care. Many individuals neither realize the potential expense of long-term care nor plan for the contingency that they will require such care. Even if an individual is conscientious and attempts to plan for her long-term care, she faces a myriad of uncoordinated options to provide for her care and may easily become confused and frustrated.*

*Professor Kaplan reviews the wide array of long-term care options currently available, including home care, congregate living arrangements, and nursing homes. He then examines the extent of coverage for long-term care provided by the two government programs most older Americans rely upon for long-term care, Medicare and Medicaid. He identifies several coverage gaps in these programs. To fill these gaps, Professor Kaplan proposes that Medicare be amended to cover care provided in nursing homes. In addition, he recommends that long-term care insurance be re-oriented to less intensive care settings, such as assisted living facilities, and that insurance options and features be standardized. Standardization would facilitate easier consumer comparisons and ensure that all insurance options provide a minimal level of coverage.*

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Significant aspects of the American health care system have been the focus of widespread concern in recent years. Early Clinton Administration initiatives addressed, generally, Americans who lack health insurance<sup>1</sup> and

1. See Health Security Act, H.R. 3600, S. 1757, 103d Cong. § 1001 (1993) (discussing universal coverage of health insurance benefits); see also Olveen Carrasquillo et al., *A Reappraisal of Private Employers' Role in Providing Health Insurance*, 340 NEW ENG. J. MED. 109, 109 (1999); Steve A. Schroeder, *The Medically Uninsured—Will They Always Be with Us?*, 334 NEW ENG. J. MED. 1130 (1996). See generally RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* 185–215 (1997) (discussing the failures of the Clinton Health Security Act of 1993); THEDA SKOCPOL, *BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS* (1995) (reviewing the history of the Clinton Health Security Plan of 1993). To address the problem of uninsured Americans,

children's health care.<sup>2</sup> In the last presidential election campaign, the right of patients to sue their health care plans<sup>3</sup> and prescription drug coverage for retirees<sup>4</sup> were prominent issues. An issue of comparable importance, however, has received much less attention, even though it is quickly becoming a major American health care crisis: long-term care for an aging population.<sup>5</sup>

As Americans live longer, they are more likely to develop age-related disabilities that limit their autonomy and ability to live independently.<sup>6</sup> At that point, some type of long-term care becomes necessary, though the specific type of care depends upon the condition of the older person in question.<sup>7</sup> Many issues emerge when the need for long-term care arises,<sup>8</sup> including questions about where such care will be provided and by whom,<sup>9</sup> but an issue that concerns the older person and her family with particular poignancy is who will pay for this care. That issue is the focus of this article.

The article begins by examining the continuum of possibilities that is encompassed by the phrase, "long-term care."<sup>10</sup> This section will show that the traditional nursing home is only one setting in which older people can receive assistance on a chronic or ongoing basis, and newer arrangements

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Congress enacted medical savings accounts in 1996. See I.R.C. § 220 (2000), *added by* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 301(a), 110 Stat. 1936, 2037-48; *see also* Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL. L. REV. 777, 788-90 (discussing Medical Savings Accounts); Gene Steurele, *Medical Savings Accounts: Can One Solve Half a Problem?*, 71 TAX NOTES 537 (1996); Nancy Ann Jeffrey & George Anders, *Not a Cure: 'Medical Savings Accounts' Are Struggling to Catch Fancy of Public*, WALL ST. J., Dec. 12, 1997, at C1, *available at* 1997 WL 14177201. See generally Rhonda L. Rundle & Shailagh Murray, *The Have-Nots*, WALL ST. J., Feb. 21, 2001, at R7, *available at* 2001 WL 2854883.

2. See Children's Health Insurance Program, 42 U.S.C. § 1397aa-jj (2000), *added by* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901-23, 111 Stat. 251.

3. See Adam Cohen, *Are Lawyers Running America?*, TIME, July 17, 2000, at 22; Paula Dwyer, *The Patients' Bill of Rights Is off the Critical List*, BUS. WK., Apr. 3, 2000, at 53; Jim Ritter, *Opponents Differ on Patients' Right to Sue Care Plans*, CHI. SUN-TIMES, Oct. 2, 2000, at 7, *available at* 2000 WL 6697635; *cf.* Jackie Calmes, *Democrats' Dilemma: Is Patients' Rights Bill Best Dead or Alive?*, WALL ST. J., Aug. 29, 2000, at A28, *available at* 2000 WL 3041759; Melinda Henneberger, *Gore Prods Bush and Congress on Patients' Bill of Rights*, N.Y. TIMES, July 20, 2000, at A18.

4. See Jackie Calmes & Laurie McGinley, *Bush Unveils Prescription-Drug Benefit for Medicare as Remedy for Campaign*, WALL ST. J., Sept. 6, 2000, at A28, *available at* 2000 WL 26608604; Shailagh Murray, *A Couple Wonders: Which Drug Plan Will Help Them?*, WALL ST. J., Oct. 27, 2000, at A20, *available at* 2000 WL 26614778; *cf.* Stephen B. Soumerai & Dennis Ross-Degnan, *Inadequate Prescription-Drug Coverage for Medicare Enrollees—A Call to Action*, 340 NEW ENG. J. MED. 722, 724-27 (1999) (discussing congressional proposals for providing drug coverage to the elderly).

5. See generally ROBYN I. STONE, LONG-TERM CARE FOR THE ELDERLY WITH DISABILITIES: CURRENT POLICY, EMERGING TRENDS, AND IMPLICATIONS FOR THE TWENTY-FIRST CENTURY (2000) (discussing the growing demand for long-term care).

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

7. 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).

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

9. 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).

10. See *infra* Part I.

are being developed to accommodate an increasingly diverse group of senior citizens.<sup>11</sup> The article then addresses the disjointed and uncoordinated system that exists today for financing such care, including the government's health care program for retirees (Medicare),<sup>12</sup> the government's health care program for poor people (Medicaid),<sup>13</sup> and private long-term care insurance.<sup>14</sup> After focusing on the various gaps, inconsistencies, and deficiencies in the current system, the article proposes an alternative approach that puts long-term care in the context of health care generally and realigns public policy with appropriate and humane incentives.<sup>15</sup>

## I. THE NATURE OF LONG-TERM 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.<sup>16</sup> This section describes these varied alternatives, beginning with the least disruptive, home care.

### 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.<sup>17</sup> 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.<sup>18</sup> 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.<sup>19</sup> Many of these services are often provided without charge by family members, friends, members of a religious community, or some other affinity group.<sup>20</sup> Some services, including 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.<sup>21</sup> In contrast,

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

12. See *infra* Part II.

13. See *infra* Part III.

14. See *infra* Part IV.

15. See *infra* Part V.

16. See LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 179-82 (2d ed. 1999).

17. See KANE ET AL., *supra* note 7, at 119.

18. *Id.* at 120-21.

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

20. KANE ET AL., *supra* note 7, at 14-15.

21. See NAT'L SENIOR CITIZENS LAW CTR., PLANNING CARE AT HOME 79-83 (2000); UNITED SENIORS HEALTH COUNCIL, LONG TERM CARE PLANNING—A DOLLAR AND SENSE GUIDE 12-14 (rev. ed. 2001).

medically oriented services are usually provided by home health agencies that specialize in these services and have been certified by state and federal regulators.<sup>22</sup> The common thread in all of these arrangements is that they enable the older person to remain in his or her home, to “age in place,” as they are.

Most home care is part-time only, generally provided in segments of eight hours or less per day, and usually not every day. Around-the-clock home care would require three shifts of caregivers every day and would quickly become very expensive.<sup>23</sup> Indeed, the development of nursing homes is partially a response to the prohibitively high cost of providing home care on a constant basis.<sup>24</sup> 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.<sup>25</sup>

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.<sup>26</sup> 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.<sup>27</sup> In-home assessments can also be performed by certain public agencies,<sup>28</sup> particularly for persons who meet those agencies’ financial criteria or otherwise are in their targeted clientele.

A related home care alternative is adult daycare. In this arrangement, an older adult is brought to a special center that offers various services to

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22. FROLIK, *supra* note 11, ¶ 11.04[1][d], at 11-22 to 11-23; NAT’L SENIOR CITIZENS LAW CTR., *supra* note 21, at 89-93.

23. For example, employing nursing aides who earn \$12 per hour would cost \$288 per 24-hour day. Hourly rates at home health agencies are often higher.

24. See FROLIK & KAPLAN, *supra* note 16, at 151. Nursing homes cost an average of \$51,000 per year. See Mary Beth Franklin, *Insuring Against Life’s Frailties*, KIPLINGER’S PERS. FIN., July 1999, at 78, 80. But around-the-clock home care at \$288 per day would cost \$105,120 per year. See *supra* note 23.

25. FROLIK, *supra* note 11, ¶ 12.01, at 12-3.

26. 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*, NAELA Q., Spring 2000, at 25.

27. 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. 1, 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.

28. See UNITED SENIORS HEALTH COUNCIL, *supra* note 21, 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 7, at 143-49.

impaired senior citizens.<sup>29</sup> 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.<sup>30</sup> These centers seek to address the social isolation and loneliness that advanced age can often bring. Adult daycare centers usually operate, however, on a fairly limited schedule. They typically run 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.

As this brief overview suggests, many people may not be appropriate candidates for home care. Individuals who lack support networks, or 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 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.<sup>31</sup> 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.<sup>32</sup>

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.<sup>33</sup> Thus, in the near future, home care may be possible in an increasing array of circumstances.

### B. Congregate Living Arrangements

For older persons whose needs cannot be met by some version of home care, a congregate living arrangement might be appropriate. Such arrangements can be separated into two general categories depending on the extent of the medical services that they provide. Congregate living arrangements where the provision of medical care is the basic orientation are often called "nursing homes" and are considered in the next part of this sec-

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29. See UNITED SENIORS HEALTH COUNCIL, *supra* note 21, at 15.

30. *Id.*

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

32. See FROLIK & KAPLAN, *supra* note 16, at 179 ("Eighty-six percent of older adults want to stay in their current residence as long as possible.").

33. See Sue Shellenbarger, *Taking Care of Parents: New High-Tech Links Can Offer Some Relief*, WALL ST. J., Mar. 8, 2000, at B1, available at 2000 WL 3020866.

tion.<sup>34</sup> The congregate living arrangements considered here provide few, if any, medically oriented services. Instead, they offer different combinations of meals, housing constructed to accommodate specific limitations common to aging individuals, organized recreational and social activities, and certain conveniences that reflect their residents' abilities to live outside a strictly controlled environment. The extent of these services varies considerably from facility to facility, but some generalizations can be made within three, somewhat loosely demarcated categorizations: board and care homes, assisted living facilities, and continuing care retirement communities. All of these arrangements, moreover, are very different from senior-oriented housing that caters to older Americans who are able to function without any assistance.<sup>35</sup> Senior-oriented housing does not usually encompass issues of long-term care and accordingly is not considered in this article.

### 1. Board and Care Homes

The phrase "board and care home" applies to a variety of residential facilities that cater to older people with physical or mental infirmities.<sup>36</sup> Such facilities 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 fairly basic and rarely extends beyond meal preparation or assistance with certain activities of daily living, such as bathing, toileting, and dressing.<sup>37</sup> Assistance with medication may be available, but it is limited to ensuring that residents take the correct dosage at the correct time.<sup>38</sup> Any assistance with medication that requires a nursing professional is usually not offered by these facilities.

Board and care homes have been a fixture in this country for many years. Most of these facilities are relatively small, with twenty-five residents or less. Over fifty thousand such homes are licensed by the various states, and there may be almost as many unlicensed homes.<sup>39</sup> The quality of these homes varies considerably, but most provide a group living environment that meets the needs of certain older residents who can no longer live on their own.

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34. See *infra* Part I.C. See generally FROLIK & KAPLAN, *supra* note 16, at 149-72 (discussing nursing homes).

35. See FROLIK, *supra* note 11, at 2-1 to 3-15. See generally EVELYN HOWARD ET AL., HDR AFFORDABLE SENIORS HOUSING HANDBOOK (1997) (reviewing the variety of housing and service options available to seniors).

36. See generally FROLIK & KAPLAN, *supra* note 16, at 172-76; LEGAL COUNSEL FOR THE ELDERLY, INC., A PRACTICAL GUIDE TO NURSING HOME ADVOCACY 107-13 (1990).

37. See FROLIK & KAPLAN, *supra* note 16, at 172.

38. *Id.* at 173.

39. FROLIK, *supra* note 11, ¶ 9.10, at 9-25.

## 2. *Assisted Living Facilities*

In the 1990s, major corporations began building assisted living facilities (ALF) for older people who require some assistance with daily living, but not the full medical complement of nursing homes.<sup>40</sup> Similar in concept to board and care 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.<sup>41</sup> House-keeping and laundry services are usually provided, sometimes for an additional fee.<sup>42</sup> 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.<sup>43</sup>

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.<sup>44</sup> This distinction is very important, because the monthly fee typically exceeds one thousand dollars and is often much more.<sup>45</sup> 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.<sup>46</sup> Most ALFs have nurses on staff,<sup>47</sup> 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.<sup>48</sup> They can monitor residents' use of prescription drugs and even treat minor health problems.<sup>49</sup> 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.

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40. See ERIC M. CARLSON, LONG-TERM CARE ADVOCACY § 5.07[1] (2002); FROLIK & KAPLAN, *supra* note 16, at 176-78; see also NAT'L CTR. FOR ASSISTED LIVING, FACTS AND TRENDS: THE ASSISTED LIVING SOURCEBOOK (1997); *Can Your Loved Ones Avoid a Nursing Home? The Promise and the Pitfalls of 'Assisted Living'*, 1995 CONSUMER REP., Oct. 1995, at 656.

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

42. KANE ET AL., *supra* note 7, at 177.

43. FROLIK & KAPLAN, *supra* note 16, at 177.

44. See FROLIK, *supra* note 11, ¶ 9.07.

45. CARLSON, *supra* note 40, § 5.09[2][a], at 5-50.

46. See FROLIK, *supra* note 11, ¶ 9.04.

47. *Id.* ¶ 9.06, at 9-11.

48. *Id.* ¶ 9.05[1].

49. *Id.* ¶ 9.05[2].

### 3. *Continuing Care Retirement Communities*

As noted above, if a resident of an ALF requires the medical services of a nursing home, she must, at least temporarily, leave the ALF. In contrast, a resident of a continuing care retirement community (CCRC) who requires nursing home care can generally stay in the CCRC, because a full-service nursing home is part of that institution.<sup>50</sup> Although some CCRCs provide assistance with daily activities, especially meals,<sup>51</sup> any significant nursing assistance is provided in the CCRC's nursing home. This commitment to provide whatever level of care a resident requires, now or in the future, is why CCRCs are often called "life care" facilities<sup>52</sup> and is the major nonfinancial distinction between a CCRC and an ALF.

The major financial distinction between the two types of arrangements is the up-front, or buy-in, fee.<sup>53</sup> The CCRC entry fee, which is in addition to monthly charges, can be in excess of one hundred thousand dollars.<sup>54</sup> There is no such fee at an ALF, although the monthly charges of an ALF often exceed those of a comparable CCRC. In most cases, if a CCRC resident enters the nursing home part of the CCRC, then additional costs are incurred for the duration of that stay.<sup>55</sup> But the point remains that residency in a CCRC represents a significant financial commitment at the outset.<sup>56</sup>

In return for that commitment, a resident of the CCRC has a prior claim to a nursing home bed in the associated nursing home.<sup>57</sup> The nursing home unit of a CCRC, however, is often a free-standing facility that accepts patients from outside the CCRC. Therefore, a potential conflict can arise if the CCRC's nursing home is full at the time a resident of the CCRC needs a bed in its facility.<sup>58</sup> The CCRC agreement, which is a substantial document whose scope and content are regulated by state law,<sup>59</sup> should set forth what rights a CCRC resident has in these circumstances. It might, for example, provide that the CCRC will arrange for the resident to be placed at a comparable facility nearby, and the CCRC may even cover part of the costs related to that placement.<sup>60</sup> In any case, many older people appreciate

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50. See CARLSON, *supra* note 40, § 6.02; FROLIK & KAPLAN, *supra* note 16, at 218. See generally Melynda Dovel Wilcox, *Not a Place to Sit and Watch the Traffic*, KIPLINGER'S PERS. FIN., June 1996, at 62 (describing the establishment and operation of a CCRC in North Carolina).

51. FROLIK, *supra* note 11, ¶ 8.02[1][b], at 8-4 to 8-5.

52. See, e.g., 1 PETER J. STRAUSS ET AL., AGING AND THE LAW ¶ 2230, at 2724 (general ed. 1999).

53. See FROLIK, *supra* note 11, ¶ 8.05[1], at 8-12 to 8-14.

54. See Wilcox, *supra* note 50, at 63.

55. See FROLIK, *supra* note 11, ¶ 8.03, at 8-8 to 8-10.

56. Entry fees are often refundable to some extent during the initial months or years of CCRC residency. See Charles P. Sabatino, *Continuing Care Facilities: Guidelines for Evaluating Contracts*, ELDER-LAW REP., June 1992, at 1, 3.

57. See FROLIK, *supra* note 11, ¶ 8.01, at 8-2.

58. See Michael Moss, *Home, Sweet . . . For Retirees, Moving into 'Continuing Care' Offers No Guarantees*, WALL ST. J., Oct. 8, 1998, at A1, available at 1998 WL 18987392.

59. See FROLIK, *supra* note 11, ¶ 8.09[2], at 8-19 to 8-22; Michael D. Floyd, *Should Government Regulate the Financial Management of Continuing Care Retirement Communities?*, 1 ELDER L.J. 29, 33 (1993).

60. See CARLSON, *supra* note 40, § 6.09[3], at 6-30 to 6-31.

the security of knowing that a nursing home bed will be available when needed, and that is a major reason why they might elect to move into a CCRC.<sup>61</sup>

Another attractive feature of a CCRC is that facility's guarantee that a resident can stay at the CCRC even if she exhausts her financial resources.<sup>62</sup> At an ALF, in contrast, a resident who can no longer afford the monthly charge must leave the facility. The promise of lifetime care is meaningless, of course, if the CCRC goes out of business, so state law imposes various requirements on CCRC operators in regard to financial disclosure, bonding, periodic audits, escrow accounts, and the like.<sup>63</sup> That risk notwithstanding, a CCRC provides a continuum of long-term care within the same basic complex, combined with the promise that a resident cannot outlive his resources and be forced to move elsewhere.

### C. Nursing Homes

Residential facilities that provide long-term care with a substantial medical component are called nursing homes.<sup>64</sup> Some nursing homes offer very sophisticated medical treatment and common recuperative therapies,<sup>65</sup> 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.<sup>66</sup> 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.<sup>67</sup> Nursing personnel are on the premises at all times, although the actual patient care is often assigned to nursing assistants and aides.<sup>68</sup> 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. The average annual cost is \$54,000 per patient,<sup>69</sup> and in some parts of the country, it can be much higher. Nevertheless, these facilities are more cost effective than hospitals,<sup>70</sup> which often are the only realistic alternative. Extensive federal and state regulations cover most aspects

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61. See FROLIK, *supra* note 11, ¶ 8.01, at 8-2; Wilcox, *supra* note 50, at 69.

62. See FROLIK & KAPLAN, *supra* note 16, at 220.

63. CARLSON, *supra* note 40, § 6.08[2][a][ii]; Floyd, *supra* note 59, at 33. See generally FROLIK, *supra* note 11, ¶ 8.10 (discussing the financial stability and soundness of CCRC's).

64. See generally FROLIK & KAPLAN, *supra* note 16, at 149-69 (discussing the functional and financial aspects of nursing homes).

65. See KANE ET AL., *supra* note 7, at 167-69.

66. *Id.* at 169-70; see also J.C. Conklin, *Nursing Homes Add 'Special Care'*, WALL ST. J., Aug. 7, 2000, at B1, available at 2000 WL 3039270 (discussing the trend among nursing homes to add Alzheimer special care units for financial stability).

67. See FROLIK & KAPLAN, *supra* note 16, at 150.

68. See CARLSON, *supra* note 40, § 2.07; KANE ET AL., *supra* note 7, at 165.

69. PHYLLIS R. SHELTON, LONG-TERM CARE PLANNING GUIDE 1 (2000).

70. See FROLIK, *supra* note 11, ¶ 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).

of operating a nursing home, including the size of rooms, nursing credentials and staff, meal hours and intervals, and medical supervision.<sup>71</sup> Because nursing home residents are often unusually vulnerable,<sup>72</sup> a nursing home resident's "bill of rights" was enacted to guarantee certain basic standards.<sup>73</sup> Included are a patient's right to select her own physician,<sup>74</sup> her right to be free of physical and chemical restraints,<sup>75</sup> her right to privacy,<sup>76</sup> confidentiality of clinical records,<sup>77</sup> and visitation by family and friends.<sup>78</sup>

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 fourteen days of admission.<sup>79</sup> The facility must then prepare a written plan for that person's care<sup>80</sup> and it must update this plan at least once a year or whenever a resident's condition changes significantly.<sup>81</sup> Patients must also be under the supervision of a physician or other medical professional<sup>82</sup> in accordance with state law. None of these requirements applies to any of the other long-term care arrangements that were analyzed previously in this article.

## II. MEDICARE

This section examines the financing of long-term care by the government's health care program for older Americans, Medicare.<sup>83</sup> Anyone who is at least sixty-five years old and has met certain work requirements is entitled to benefits under this program.<sup>84</sup> Eligibility is also extended to the spouse of a covered worker and also to a divorced spouse, if their marriage

71. See CARLSON, *supra* note 40, §§ 2.101-.152 (reviewing state regulations of nursing homes); CCH, INC., NURSING HOME REGULATIONS (1995) (reviewing federal regulations of nursing homes); see also Senator 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).

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

73. 42 U.S.C. §§ 1395i-3, 1396r (2000). See generally FROLIK & KAPLAN, *supra* note 16, at 160-69.

74. 42 U.S.C. §§ 1395i-3(c)(1)(A)(i), 1396r(c)(1)(A)(i); 42 C.F.R. § 483.10(d)(1) (2001).

75. 42 U.S.C. §§ 1395i-3(c)(1)(A)(ii), 1396r(c)(1)(A)(ii); 42 C.F.R. § 483.13(a).

76. 42 U.S.C. §§ 1395i-3(c)(1)(A)(iii), 1396r(c)(1)(A)(iii); 42 C.F.R. § 483.10(e)(1).

77. 42 U.S.C. §§ 1395i-3(c)(1)(A)(iv), 1396r(c)(1)(A)(iv); 42 C.F.R. § 483.10(e)(2).

78. 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).

79. 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).

80. 42 U.S.C. §§ 1395i-3(b)(2), 1396r(b)(2); 42 C.F.R. § 483.20(d).

81. 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)(4)(iv)-(v).

82. 42 U.S.C. §§ 1395i-3(b)(6)(A), 1396r(b)(6)(A); 42 C.F.R. § 483.40(a)(1).

83. See 42 U.S.C. §§ 1395-1395ccc. See generally MEDICARE HANDBOOK (Judith A. Stein & Alfred J. Chiplin, Jr. eds., 2000) (discussing Medicare in depth).

84. 42 U.S.C. § 1395c(1). The relevant work requirement is earning at least forty "quarters of coverage" as that phrase is applied to establish eligibility for retirement benefits under Social Security. See FROLIK & KAPLAN, *supra* note 16, at 57-58, 272-78.

lasted at least ten years.<sup>85</sup> As a result, most older Americans are covered by Medicare.<sup>86</sup>

Medicare has two major components that are denominated Part A and Part B.<sup>87</sup> Eligible persons receive Part A at no charge, because Part A is financed by a 2.9% payroll tax on all income from wages, salaries, and self-employment.<sup>88</sup> As long as a retiree worked at least ten years in employment settings that were subject to this payroll tax, that person is entitled to Medicare coverage under Part A.<sup>89</sup> In fact, a person is not required to retire from the compensated workforce to be Medicare-eligible,<sup>90</sup> if he has met that program's length-of-employment requirement.<sup>91</sup> 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 seventy-five percent of the cost associated with this program, and annually adjusted premiums paid by enrollees provide the remaining twenty-five percent.<sup>92</sup> In 2002, this premium was fifty-four dollars per month.<sup>93</sup> Part B covers doctors' bills, ambulance charges, and some home health expenses,<sup>94</sup> 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 visits<sup>95</sup> and "skilled nursing facilities,"<sup>96</sup> commonly called nursing homes. Each of these coverages, moreover, is subject to several significant preconditions and restrictions, which are considered below. But the point is

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85. FROLIK & KAPLAN, *supra* note 16, at 58–59.

86. Medicare also covers individuals who are younger than sixty-five years old if they have received disability benefits from Social Security for at least twenty-four months or have been diagnosed with "end stage renal disease." FROLIK & KAPLAN, *supra* note 16, at 60. But the vast majority of Medicare enrollees are at least sixty-five years old; therefore Medicare will be considered in this article from their perspectives.

87. An additional component, called Part C, provides alternatives to Medicare's traditional benefit package. See 42 U.S.C. § 1395w-21; FROLIK & KAPLAN, *supra* note 16, at 98–99. Because almost all current Medicare enrollees participate in Parts A and B, this article will focus on those components of Medicare.

88. 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.

89. Forty "quarters of coverage" translates into roughly ten years. See *supra* note 84. Persons who have not met this work requirement may purchase Part A for a monthly premium that is adjusted annually. In 2002, this premium was \$319 per month. See <http://www.medicare.gov/Basics/Amounts2002.asp> (last visited May 14, 2002).

90. FROLIK & KAPLAN, *supra* note 16, at 58, 62–63.

91. See *supra* note 84.

92. See 42 U.S.C. § 1395r(a)(1), (3).

93. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., 2002 GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE 6 (2002) [hereinafter MEDICARE & MEDICAID SERVS.]

94. See generally FROLIK & KAPLAN, *supra* note 16, at 74–77 (reviewing coverage under Medicare Part B); MEDICARE HANDBOOK, *supra* note 83, §§ 6.01–.08 (same).

95. See generally FROLIK & KAPLAN, *supra* note 16, at 70–73 (reviewing Medicare's home health coverage); MEDICARE HANDBOOK, *supra* note 83, §§ 4.01–.08 (describing home health coverage under Medicare).

96. See generally FROLIK & KAPLAN, *supra* note 16, at 68–70 (reviewing coverage for nursing facilities under Medicare Part A); MEDICARE HANDBOOK, *supra* note 83, §§ 3.01–.09 (describing Medicare Part A coverage for nursing facilities).

that Medicare addresses only the two extremes in the long-term care continuum, home care and nursing homes, and not assisted living or other intermediate alternatives.

#### A. Home Care

Medicare provides a range of home health services to enrollees who are confined to their homes.<sup>97</sup> Eligibility is restricted, however, to persons who require assistance from other people or who need wheelchairs, walkers, or canes, to leave their homes.<sup>98</sup>

The covered services include physical and occupational therapy,<sup>99</sup> medical supplies,<sup>100</sup> and “part-time or intermittent” nursing care.<sup>101</sup> This last phrase is defined as care of less than eight hours a day and no more than twenty-eight hours per week.<sup>102</sup> 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.<sup>103</sup> 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.<sup>104</sup> In any case, the care must be provided by a Medicare-certified home health agency,<sup>105</sup> pursuant to a written plan of care established by a physician,<sup>106</sup> and that physician must review the plan at least once every sixty days.<sup>107</sup> Thus, informal care giving by friends, relatives, or even paid “helpers” is not covered by Medicare.<sup>108</sup>

To fill some of Medicare’s gaps and limitations, a private insurance product called “Medigap” has been developed.<sup>109</sup> Medigap policies receive no government funding, and patients bear the entire cost of the premiums. These policies come in twelve different packages, with increasing ranges of

97. 42 U.S.C. §§ 1395f(a)(2)(C), 1395n(a)(2)(A).

98. 42 U.S.C. §§ 1395f(a)(2)(C), 1395n(a)(2).

99. 42 U.S.C. § 1395x(m)(2).

100. 42 U.S.C. § 1395x(m)(5). Included are catheters and ostomy bags. *Id.*

101. 42 U.S.C. § 1395x(m)(1).

102. 42 U.S.C. § 1395x(m) (penultimate sentence).

103. 42 U.S.C. § 1395x(m)(1).

104. 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).

105. 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) (discussing The Home Health Agency).

106. 42 U.S.C. § 1395x(m).

107. 42 C.F.R. § 484.18(b) (2001).

108. Additional limitations under Medicare Part A include a preceding hospital or nursing home stay within fourteen 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); *see also* MEDICARE HANDBOOK, *supra* note 83, § 4.02[B]–[C] (explaining the requirements and limitations of Medicare Part A and Part B).

109. *See generally* FROLIK & KAPLAN, *supra* note 16, at 89–95 (describing private Medigap insurance).

benefits corresponding to increased premium charges.<sup>110</sup> 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.<sup>111</sup> In that circumstance, this benefit includes assistance with activities of daily living, such as dressing, bathing, and personal hygiene, for up to eight weeks, with a dollar limit of \$1,600 per year.<sup>112</sup> Thus, this benefit does not really help with a chronic or ongoing need for in-home care.

### B. Nursing Homes

Medicare covers care in a skilled nursing facility (SNF),<sup>113</sup> but only under certain conditions, all of which must be met.<sup>114</sup> In the context of long-term care, the two most significant required conditions are: (1) a hospital stay of at least three days preceding the SNF admission, and (2) the receipt of “skilled nursing care” while in the SNF.

#### 1. Preceding Hospital Stay

For Medicare to cover a SNF stay, a patient must be admitted to the SNF within thirty days of being discharged from a hospital.<sup>115</sup> 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. This required hospital stay, moreover, must last at least three days,<sup>116</sup> not counting the day of discharge.<sup>117</sup> 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.<sup>118</sup> 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.<sup>119</sup> The

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110. Ten packages, labeled A through J, are available, but plans F and J come in two different versions, one with, and the other without, an annual deductible. Accordingly, a total of twelve different Medigap policies exist. *See id.* at 92–95.

111. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., 2003 GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE 25 (2003), <http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf> (last visited Oct. 7, 2003) [hereinafter 2003 GUIDE].

112. *Id.* at 15. This benefit, moreover, is available only in plans D, G, I, and J.

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

114. *See, e.g.*, FROLIK & KAPLAN, *supra* note 16, at 68 (explaining that the facility in question must be approved for Medicare recipients).

115. 42 U.S.C. § 1395x(i)(A); 42 C.F.R. § 409.30(b)(1) (2001). Admissions to a SNF that occur more than thirty days after discharge from the hospital can be covered if it would not have been “medically appropriate” to begin SNF care during the thirty days immediately following discharge from the hospital. 42 U.S.C. § 1395x(i)(B); 42 C.F.R. § 409.30(b)(2).

116. 42 U.S.C. § 1395x(i).

117. 42 C.F.R. § 409.30(a)(1).

118. *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 two days did not qualify subsequent SNF charges for Medicare coverage).

119. 42 U.S.C. § 1395ww(d). The DRG system establishes a fixed dollar amount that Medicare pays for each of approximately five hundred different diagnoses. *See* EPSTEIN, *supra* note 1, at 159–61. As daily

three-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 three-day standard that Medicare requires for coverage of nursing home costs.

## 2. *Skilled Nursing Care*

A second major limitation on Medicare's coverage of nursing home costs is the requirement that a patient receive "skilled nursing care" that only a SNF can provide.<sup>120</sup> Examples of such care include gastronomy feedings, catheterization, administration of medical gases, injections, and other procedures involving technical and professional personnel.<sup>121</sup> These services must be required on a daily basis<sup>122</sup> to treat a condition that was treated during the preceding hospital stay.<sup>123</sup> 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.<sup>124</sup> This requirement effectively precludes most nursing home residents from Medicare coverage, because their conditions do not necessitate this level of care.<sup>125</sup>

## 3. *Duration-of-Stay Limitation*

Even if a patient otherwise qualifies for Medicare coverage of SNF expenses, a further limitation applies to the length of that person's stay in the SNF. Medicare pays the entire cost of the SNF for only twenty days in a "spell of illness."<sup>126</sup> 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 sixty consecutive days.<sup>127</sup> 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 twenty days.

After these twenty days, Medicare covers the cost of the SNF for the next eighty days, subject to a per-day deductible.<sup>128</sup> This per-day deductible remains the patient's responsibility and is adjusted annually for inflation.

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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 7, at 35.

120. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b)(3).

121. 42 C.F.R. §§ 409.33(a)–(c), 409.31(a)(2).

122. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. §§ 409.31(b), 409.34(a)(1).

123. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b)(2)(ii).

124. 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).

125. See Kaplan, *supra* note 1, at 795.

126. 42 U.S.C. §§ 1395d(a)(2)(A), 1395e(a)(3).

127. 42 U.S.C. § 1395x(a)(2); 42 C.F.R. § 409.60(b).

128. 42 U.S.C. § 1395e(a)(3).

For 2002, this deductible was \$101.50 per day.<sup>129</sup> In other words, if Medicare covers a nursing home stay at all, it pays all costs for the first twenty days and those costs in excess of the per-day deductible for the next eighty days. After the hundredth day, Medicare's coverage ceases.<sup>130</sup>

One of the optional benefits available in the more comprehensive Medigap policies is coverage of the per-day deductible in a SNF for days twenty-one through one hundred.<sup>131</sup> Thus, a patient might be able to insure against this charge. It should be noted, however, that Medigap policies do not change any of the other Medicare SNF requirements, such as a preceding hospital stay or the receipt of "skilled nursing care." Nor do these policies extend beyond day one hundred.<sup>132</sup> Thus, Medigap insurance plays a fairly limited role in the long-term care context—namely, paying the per-day deductible for eighty days in a nursing home stay that otherwise qualifies for Medicare coverage. Beyond that coverage, Medigap policies do not go.

### C. Evaluation

As this section has shown, the principal health care delivery system for older Americans, Medicare, is woefully inadequate in terms of long-term care. It covers only the two extremes of the long-term care continuum, home health care and nursing homes, and does so under significant restrictions. Medicare's coverage of home health care utilizes primarily a medical approach that only incidentally strives to maintain a senior citizen in his or her home. On average, this coverage is limited to only four hours of assistance per day<sup>133</sup> and requires ongoing coordination with a supervising agency and a physician.

Medicare's coverage of nursing homes is also very restricted. Programmatic limitations apply to the level of care needed, the medical condition being treated, and a patient's prior hospitalization. These limitations constrict Medicare's coverage of nursing home costs to an increasingly infrequent paradigm. As a result, Medicare enrollees face substantial financial exposure when they enter a nursing home. This approach, moreover, contrasts rather dramatically with Medicare's coverage of hospital costs,<sup>134</sup> which is much more encompassing and leaves Medicare enrollees with almost no personal financial exposure.

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129. DEP'T OF HEALTH & HUMAN SERVS., MEDICARE AMOUNTS FOR 2002 (2002), <http://web.archive.org/web/20020206061149/http://www.medicare.gov/Basics/Amounts2002.asp>.

130. 42 U.S.C. § 1395d(b)(2).

131. See 2003 GUIDE, *supra* note 111. This option is available in Medigap plans C–J.

132. *Id.*

133. See 42 U.S.C. § 1395x(m) (penultimate sentence) (noting that Medicare generally limits home health services to twenty-eight hours per week, which translates into an average of four hours per day for a seven-day week).

134. See generally FROLIK & KAPLAN, *supra* note 16, at 66–67 (noting the hospital costs covered by Medicare).

For example, when a Medicare enrollee is hospitalized, Medicare covers virtually all costs for treatment, laboratory tests, meals (including special diets), room charges, hospital-based therapies, and pharmaceuticals.<sup>135</sup> This full-cost coverage applies to a patient's first sixty days in the hospital<sup>136</sup> within a "spell of illness"<sup>137</sup> other than a single per-admission deductible.<sup>138</sup> This deductible is adjusted annually for inflation, and in 2002 was \$812.<sup>139</sup> Medicare pays all other charges directly to the hospital and any related service providers. The per-admission deductible, moreover, is covered in every Medigap policy other than the least expensive package,<sup>140</sup> so most Medicare enrollees do not bear this cost directly.<sup>141</sup>

After the first sixty days of hospital care, Medicare covers all costs for an additional thirty days, other than a per-day deductible that is adjusted annually for inflation.<sup>142</sup> In 2002, this deductible for days sixty-one through ninety was \$203.<sup>143</sup> This deductible, however, is one of the "core benefits" that are included in every Medigap policy.<sup>144</sup> Accordingly, it is rarely an important concern, because most Medicare enrollees have Medigap insurance.<sup>145</sup> In any case, the average length of a hospital stay for persons age sixty-five and older is less than seven days.<sup>146</sup> The bottom line is that Medicare plus Medigap provides almost total coverage of most hospital bills, but leaves major gaps in the coverage of nursing home expenses.

Medicare health maintenance organizations (HMOs) really do not help in this context, either. Medicare HMOs offer a variety of benefits, including prescription drugs outside the hospital setting, eyeglasses, hearing aids, and simplified paperwork.<sup>147</sup> These are all major benefits, especially the pharmaceutical coverage.<sup>148</sup> But Medicare HMOs generally do not ex-

135. 42 U.S.C. § 1395x(b)(1)–(3); *see also* 42 C.F.R. §§ 409.10–13 (2001).

136. *See* 42 U.S.C. § 1395e(a)(1)(A); MEDICARE HANDBOOK, *supra* note 83, § 2.04[B].

137. 42 U.S.C. § 1395x(a).

138. 42 U.S.C. § 1395e(a)(1), (b)(1).

139. *See* DEP'T OF HEALTH & HUMAN SERVS., *supra* note 129.

140. *See* 2003 GUIDE, *supra* note 111, at 15, 24.

141. Medicare enrollees bear the cost of this deductible indirectly by paying the additional premium for any Medigap policy other than the basic package (Plan A), which does not cover this expenditure.

142. 42 U.S.C. § 1395e(a)(1)(A). An additional sixty days is available from a lifetime reserve. Once days from this reserve are used, they are not available in the future. 42 U.S.C. § 1395d(a)(1). These days are also subject to a per-day deductible, which was \$406 in 2002. *See supra* note 129.

143. *See* DEP'T OF HEALTH & HUMAN SERVS., *supra* note 129.

144. *See* 2003 GUIDE, *supra* note 111, at 23.

145. Franklin J. Eppig & George S. Chulis, *Trends in Medicare Supplementary Insurance: 1992–96*, 19 HEALTH CARE FIN. REV. 201 (1997). Moreover, all Medigap policies provide an additional 365 days of lifetime hospital coverage. *See* 2003 GUIDE, *supra* note 111, at 23.

146. Margaret J. Hall & Maria F. Owings, *2000 National Hospital Discharge Survey*, ADVANCE DATA, June 19, 2002, at 1, 8, <http://www.cdc.gov/nchs/fastats/pdf/ad329.pdf> (last visited Oct. 7, 2003).

147. *See* FROLIK & KAPLAN, *supra* note 16, at 96–97; 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; Melynda Dovel Wilcox, *Choosing a Medicare HMO*, KIPLINGER'S PERS. FIN., Aug. 1, 1996, at 73, 74.

148. *See* Nancy Ann Jeffrey, *Seniors in Medicare HMOs Should Know the Drugs That Prescription Plans Cover*, WALL ST. J., May 16, 1997, at C1, available at 1997 WL 2420897 (describing the coverage of prescription medications as "a magnet that has helped membership in Medicare managed-care plans explode in recent years"); *see also* Margaret Davis et al., *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, HEALTH AFF., Jan.–Feb. 1999, at 231, 231 (ninety-five percent of Medi-

pand Medicare's constricted coverage of long-term care, regardless of the setting in which that care is provided.

Finally, the newest Medicare options are also essentially of no benefit with respect to long-term care. Collectively denominated Medicare Part C,<sup>149</sup> these arrangements include variations on Medicare HMOs and a consumer-controlled cash fund called a "medical savings account."<sup>150</sup> These alternatives have many intriguing and convoluted features,<sup>151</sup> but they all represent different approaches to delivering Medicare's traditional package of services<sup>152</sup> and do not extend Medicare's restricted coverage of long-term care.<sup>153</sup>

### III. MEDICAID

This section examines the financing of long-term care by the government's health care program for poor people of any age, Medicaid.<sup>154</sup> Medicaid is funded jointly by the federal government and by state governments, with the federal share ranging from fifty to eighty-three percent, depending upon the relative wealth of the particular state.<sup>155</sup> Since both levels of government contribute to its financing, Medicaid has federal and state rules establishing what services are covered and who is eligible.<sup>156</sup> Consequently, there is considerable variation across the country in what Medicaid actually looks like, but some general patterns are fairly consistent.<sup>157</sup>

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

care HMOs cover drugs); Laurie McGinley & Jacob M. Schlesinger, *Clinton Drug-Benefit Plan Recasts Medicare Debate*, WALL ST. J., June 28, 1999, at A28, available at 1999 WL 5458173.

149. See 42 U.S.C. § 1395w-21 (2000).

150. See FROLIK & KAPLAN, *supra* note 16, at 98-100.

151. 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 83, § 7.06 (discussing alternative options for financing Medicare covered services); JOHN J. REGAN ET AL., TAX ESTATE & FINANCIAL PLANNING FOR THE ELDERLY § 9.17 (2002) (same). See generally DAVID A. PRATT & SEAN K. HORNBECK, SOCIAL SECURITY AND MEDICARE ANSWER BOOK 19-1 to 19-34 (2d ed. 2000) (discussing Medicare Part C options, rules, and features).

152. 42 U.S.C. § 1395w-22(a)(1)(A).

153. 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), 220(d)(2)(B)(ii)(II), 7702B(b) (2000). On the other hand, 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). Accordingly, it is unlikely that an 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.

154. 42 U.S.C. § 1396, added by Pub. L. No. 89-97, § 121(a), 79 Stat. 343 (1965). See generally FROLIK & KAPLAN, *supra* note 16, at 101-30 (discussing Medicaid's history, benefits, and eligibility requirements); REGAN ET AL., *supra* note 151, §§ 10.01-17 (same).

155. John K. Iglehart, *The American Health Care System: Medicaid*, 340 NEW ENG. J. MED. 403, 403 (1999).

156. *Id.*; see also ROBERT B. FLEMING, ELDER LAW ANSWER BOOK 14-3 (2000) (discussing the operation and administration of Medicaid).

157. 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 PUB. AID, POLICY MANUAL (1999).

extensive. For example, Medicaid provides home health care for functionally disabled older citizens and for certain other categories of older people,<sup>158</sup> even if they are not homebound.<sup>159</sup> Moreover, this care can include home health aide services,<sup>160</sup> medical supplies and equipment,<sup>161</sup> and even some personal care services.<sup>162</sup> In addition, some states cover homemaker services,<sup>163</sup> respite care for family caregivers,<sup>164</sup> and adult daycare.<sup>165</sup>

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."<sup>166</sup> 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.<sup>167</sup>

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."<sup>168</sup> The program'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.<sup>169</sup> Persons with assets in excess of these limits must use up these "excess resources" until their remaining assets fall within Medicaid's eligibility parameters.<sup>170</sup> This so-called "spend

158. 42 U.S.C. § 1396t. See generally NAT'L SENIOR CITIZENS LAW CTR., *supra* note 21, at 28–35, 41–43 (discussing Medicaid's eligible recipients); Ellice Fatoullah, *Mandatory Medicaid Home Care for the Elderly*, ELDERLAW REP., Mar. 1993, at 1 (same).

159. See HCFA Update No. 3, Attachment 3-g, July 25, 2000, available at <http://www.cms.hhs.gov/states/letters/smd725a0.asp> (last visited Oct. 6, 2003).

160. 42 U.S.C. §§ 1396d(a)(7), 1396t(a)(1) (2000).

161. 42 C.F.R. § 440.70 (2001).

162. 42 U.S.C. § 1396t(a)(3).

163. 42 U.S.C. § 1396t(a)(1).

164. 42 U.S.C. § 1396t(a)(5).

165. 42 U.S.C. § 1396t(a)(7).

166. 42 U.S.C. § 1396d(a)(4)–(f).

167. See MICHAEL J. GRAETZ & JERRY L. MASHAW, *TRUE SECURITY: RETHINKING AMERICAN SOCIAL INSURANCE* 137 (1999) (noting that Medicaid pays for thirty-eight percent 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 40, at 29.

168. 42 U.S.C. § 1396r-5(h)(2).

169. See generally CARLSON, *supra* note 40, § 7.07; FROLIK & KAPLAN, *supra* note 16, at 109–10 (discussing applicants' incomes and resources); REGAN ET AL., *supra* note 151, § 10.07 (same).

170. 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 \$1,590 in 2001, and this approach is followed in approximately twenty states, including Arizona, Florida, and Texas. See REGAN ET AL., *supra* note 151, § 10.07[2][b] (discussing income standards). See generally CARLSON, *supra* note 40, § 7.13[1][d][iv] (discussing the circumstances of income standards through trusts).

down” process seeks to 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.”<sup>171</sup> 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.<sup>172</sup> In addition, a Medicaid applicant can have an automobile that is worth no more than \$4,500, unless it is needed for medical treatment.<sup>173</sup> Further, the value of burial plots<sup>174</sup> and up to \$1,500 designated for burial expenses are “exempt resources” and are excluded from an applicant’s holdings.<sup>175</sup> Life insurance is exempt as well, but only if the face amount of such insurance does not exceed \$1,500<sup>176</sup>—a trifling amount in today’s economy. Finally, the Medicaid applicant may have a residence,<sup>177</sup> regardless of its value,<sup>178</sup> but only if that person “expects to return” to it.<sup>179</sup> 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.<sup>180</sup> States permit retention of a small monthly allowance for “personal needs,” but this amount is usually fifty dollars per month or less.<sup>181</sup> When an applicant’s monthly income is insufficient to cover the nursing home charges, Medicaid pays the difference.<sup>182</sup>

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,<sup>183</sup> then he will apply the remaining \$1,900 to his nursing home expenses. Assume further that Medicaid establishes a so-

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171. 42 U.S.C. § 1396.

172. 42 U.S.C. § 1382(a)(3)(B); 20 C.F.R. § 416.1205(c).

173. 42 U.S.C. § 1382b(a)(2)(A); 20 C.F.R. § 416.1218(b).

174. 42 U.S.C. § 1382b(a)(2)(B); 20 C.F.R. § 416.1231(a). For this purpose, a “burial plot” can include prepaid costs of a casket, headstone, and associated grave opening and closing expenses. FLEMING, *supra* note 156, at 14–18.

175. 42 U.S.C. § 1382b(d); 20 C.F.R. § 416.1231(b).

176. 42 U.S.C. § 1382b(a) (final sentence); 20 C.F.R. § 416.1230.

177. *See* 42 U.S.C. § 1382b(a)(1).

178. 20 C.F.R. § 416.1212(b).

179. 20 C.F.R. § 416.1212(c) (first sentence); *see also* CARLSON, *supra* note 40, § 7.07[2][a].

180. FLEMING, *supra* note 156, at 14–6, -11; *see also* FROLIK & KAPLAN, *supra* note 16, at 112.

181. *See* CARLSON, *supra* note 40, § 7.401 (listing of personal needs allowances by state).

182. *See* 42 U.S.C. § 1396b(f)(4)(C); 42 C.F.R. § 435.725(a) (2001).

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

called “reimbursement rate”<sup>184</sup> for that facility of \$100 per day. Eric’s monthly charge for that nursing home is \$3,000 per month (\$100 day x 30 days), \$1,900 of which 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,<sup>185</sup> but such interest is still countable income for Medicaid purposes.<sup>186</sup> Similarly, individual retirement accounts<sup>187</sup> and other pension-like savings vehicles<sup>188</sup> have no special status in Medicaid.<sup>189</sup> Gifts and inheritances, which are tax-free to the recipients, likewise enjoy no special status.<sup>190</sup> 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.<sup>191</sup>

### 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.<sup>192</sup> 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 not relevant in this context.

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184. 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). 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* 185, 188 (Frank J. Thompson & John J. DiIulio, Jr. eds., 1998).

185. I.R.C. § 103(a) (2000).

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

187. I.R.C. § 408; see also Richard L. Kaplan, *Retirement Funding and the Curious Evolution of Individual Retirement Accounts*, 7 *ELDER L.J.* 283 (1999). See generally DONALD R. LEVY ET AL., *INDIVIDUAL RETIREMENT ACCOUNT ANSWER BOOK* (4th ed. 1998) (reviewing individual retirement accounts).

188. See I.R.C. §§ 401(k), 403(b), 408(a); see also FROLIK & KAPLAN, *supra* note 16, at 344–78 (explaining the various forms of pension plans). See generally 403(B) ANSWER BOOK (Donald R. Levy ed., 2000) (explaining 403(b) pension plans); EMJAY CORP., 401(K) ANSWER BOOK (2000); GARY S. LESSER ET AL., *ROTH IRA ANSWER BOOK* (1999) (explaining Roth individual retirement accounts).

189. FLEMING, *supra* note 156, at 14-17.

190. I.R.C. § 102(a).

191. 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). See generally FROLIK & KAPLAN, *supra* note 16, at 188–94 (describing the taxation of gains on residences).

192. See H.R. REP. NO. 100-105, pt. 2, at 65 (1988), 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).

Some protections exist, however, to avoid impoverishing the “community spouse.”<sup>193</sup>

A community spouse may retain a residence,<sup>194</sup> regardless of its value,<sup>195</sup> and an automobile, also without regard to its value.<sup>196</sup> A burial plot and burial expense arrangement similar to that allowed to a Medicaid applicant are allowed to the community spouse as well.<sup>197</sup> 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.<sup>198</sup> This amount is called the “community spouse resource allowance,”<sup>199</sup> (CSRA) and must fall within a range established by the Medicaid statute.<sup>200</sup> This range is adjusted annually for inflation<sup>201</sup> and in 2002 was \$17,856 to \$89,280.<sup>202</sup> Many states employ the low-point of this range; several states use the high-point; and other states apply formulas or figures between these two points.<sup>203</sup> 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 her own name.<sup>204</sup> 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.<sup>205</sup> This transfer leaves less of the Medicaid applicant’s income available to the nursing home,<sup>206</sup> in which case Medicaid pays a larger proportion of the applicant’s nursing

193. 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 1 U.S.C. § 7 (2000), *added* by Pub. L. No. 104-199, § 3(a), 110 Stat. 2419 (1996).

194. 42 U.S.C. §§ 1396r-5(c)(5)(A), 1382b(a)(1) (2000); 20 C.F.R. § 416.1212(c) (2001).

195. 20 C.F.R. § 416.1212(b).

196. 42 U.S.C. §§ 1382b(a)(2)(A), 1396r-5(c)(5)(B).

197. 42 U.S.C. §§ 1382b(a)(2)(B), (d)(1), 1396r-5(c)(5)(A).

198. 42 U.S.C. § 1396r-5(c)(1)(A), (f)(1).

199. 42 U.S.C. § 1396r-5(f)(2).

200. 42 U.S.C. § 1396r-5(f)(2)(A)(i)–(ii).

201. 42 U.S.C. § 1396r-5(g).

202. See *2002 Medicaid and Medicare Adjustments*, ELDERLAW REP., Dec. 2001, at 3; see also *New Minimum Needs Allowance Set*, ELDERLAW REP., July–Aug. 2002, at 5 (discussing 2002 minimum needs allowance).

203. FROLIK & KAPLAN, *supra* note 16, at 118–19; see also CARLSON, *supra* note 40, § 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 40, § 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/LAW NEWSL., Apr. 1994, at 1; Ron M. Landsman, *Going to Court to Improve Spousal Benefits*, ELDERLAW REP., Sept. 1998, at 1.

204. 42 U.S.C. § 1396r-5(b)(1), (2)(A)(i).

205. 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 40, § 7.11[5].

206. CARLSON, *supra* note 40, § 7.10[3][c], at 7–40.

home expenses. This minimum income standard,<sup>207</sup> much like the CSRA, is set by the applicable state from within a specified range.<sup>208</sup> This range is adjusted annually for inflation<sup>209</sup> and in 2002 was \$1,493 to \$2,232.<sup>210</sup> 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.<sup>211</sup>

### C. Other Restrictions

Medicaid has two 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.

#### I. 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 so transfers his or her assets, Medicaid imposes a transfer penalty that makes the transferor ineligible for Medicaid benefits for a certain period of time.<sup>212</sup> This transfer penalty is calculated by dividing the amount of any uncompensated transfers by the monthly cost of providing care,<sup>213</sup> which is usually a county or state average.<sup>214</sup> Whatever figure is employed, the result is the number of months

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

208. 42 U.S.C. § 1396r-5(d)(3)(A), (B)(iii), (C), r-5(d)(4).

209. 42 U.S.C. § 1396r-5(g).

210. See 2002 Medicaid and Medicare Adjustments, *supra* note 202; see also *New Minimum Needs Allowance Set*, *supra* note 202.

211. See CARLSON, *supra* note 40, § 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). For an illustration of how additional assets might be retained to generate a community spouse's monthly needs allowance, see CARLSON, *supra* note 40, § 7.10[3][a][ii].

212. 42 U.S.C. § 1396p(c)(1)(A). 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 40, § 7.12[6][c]-[e] (discussing the transfer of Medicaid benefits); FLEMING, *supra* note 156, at 14-33.

213. 42 U.S.C. § 1396p(c)(1)(E)(i).

214. 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 40, § 7.401 (listing of applicable monthly rates by state); FLEMING, *supra* note 156, at 14-30 to 14-32 (same).

from the date of the transfer in question that the older person is disqualified from receiving Medicaid benefits.<sup>215</sup>

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 fifty months (\$200,000 divided by \$4,000 per month), so Sharon is ineligible for Medicaid benefits for fifty months (more than four years!) starting with the date on which she transferred these assets.

These transfer penalties are imposed, moreover, on transfers made during the thirty-six months prior to the transferor applying for Medicaid.<sup>216</sup> Transfers made more than thirty-six months prior to applying for Medicaid benefits are generally not subject to a transfer penalty,<sup>217</sup> but most people do not know that they will require such care three years ahead of time. In any case, the law may change in this area; for example, this so-called “look-back” period was only twenty-four months when the transfer penalty rule was first enacted.<sup>218</sup> As a consequence, a transfer that was not subject to a transfer penalty when it was made could become subject to such a penalty, because the look-back period has been increased between the date the transfer occurred and the date on which the transferor applied for Medicaid benefits.<sup>219</sup> Thus, planning for Medicaid eligibility by transferring assets can be very problematic.

## 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.<sup>220</sup> Thus, even if a Medicaid applicant retains, for example, a residence to which he “intends to return,”<sup>221</sup> Medicaid will recover the long-term care expenses it paid on his behalf from the value of that residence.<sup>222</sup> Similarly, assets owned by a Medicaid recipient’s community spouse will be subject to

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215. 42 U.S.C. § 1396p(c)(1)(D).

216. 42 U.S.C. § 1396p(c)(1)(B)(i), (ii)(I).

217. For transfers involving trusts, however, the applicable period is sixty months. 42 U.S.C. § 1396p(c)(1)(B)(i).

218. See 2 LOUIS A. MEZZULLO & MARK WOOLPERT, *ADVISING THE ELDERLY CLIENT* § 29.84 (2002).

219. When the look-back period is changed, the change is typically effective upon enactment with no protection of transfers made prior to that date. See, e.g., 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) (2000)).

220. 42 U.S.C. § 1396p(b)(1); see also CARLSON, *supra* note 40, § 7.14; REGAN ET AL., *supra* note 151, § 10.08[5]. See generally CHARLES P. SABATINO & ERICA WOOD, *MEDICAID ESTATE RECOVERY: A SURVEY OF STATE PROGRAMS AND PRACTICES* (1996) (describing state programs that attempt to recover Medicaid expenditures from the recipient’s estate); Melynda Dovel Wilcox, *Will Nursing-Home Bills Haunt Your Estate?*, *KIPLINGER’S PERS. FIN.*, Apr. 1, 1998, at 115.

221. Such a residence is an exempt resource for Medicaid purposes. 20 C.F.R. § 416.1212(b) (2001).

222. 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).

Medicaid's estate recovery provisions when that spouse dies.<sup>223</sup> 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.<sup>224</sup> 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.<sup>225</sup> Nor is there any de minimis level of assets that is beyond the scope of Medicaid's estate recovery provisions.<sup>226</sup>

#### D. Evaluation

As this section has shown, Medicaid covers a range of long-term care services, including custodial care in a nursing home. To receive Medicaid benefits, however, an older person must first deplete most of his or her financial assets. Severe penalties are imposed on persons who give away their assets to accelerate their eligibility for Medicaid benefits, and the program's estate recovery provisions seek reimbursement from whatever assets the recipient owns when he or she dies. Each of these features constitutes a marked difference between Medicare and Medicaid.

These differences are particularly apparent when long-term care is compared to acute care in a hospital setting. When an older person enters a hospital for medical reasons, the government (through Medicare) pays almost all of the bills,<sup>227</sup> without inquiry into the beneficiary's financial resources or marital status. But when that same person goes into a nursing home for medical reasons, the government (through Medicaid) demands impoverishment as the price for covering that person's expenditures. Even though some assets may be retained by the older person's community spouse, those assets are limited to specific categories and the applicable limits vary considerably from state to state.<sup>228</sup> In any case, it seems more than strange that Medicare, the government's health care plan for older Americans, does not cover the increasingly common medical exigency of nursing home institutionalization.

This lack of Medicare coverage for nursing home costs changes from merely strange to cruel when one contemplates the full consequences of accessing Medicaid. Medicaid is a poverty program, intended for people with

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223. 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.

224. 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 SABATINO & WOOD, *supra* note 220, at 14–17 (survey of state practices).

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

226. Cf. I.R.C. § 2010(c) (West Supp. 2002) (exemption from federal estate and gift taxes of \$1,000,000).

227. See *supra* text accompanying notes 135–46.

228. See *supra* text accompanying notes 194–203.

very limited means.<sup>229</sup> Most older people, however, are not poor, and they take considerable pride in providing for themselves without needing to access any “welfare” program.<sup>230</sup> But to obtain Medicaid coverage of their long-term care costs, they must liquidate a lifetime’s accumulation of assets, either through payment of long-term care expenses or as gifts to relatives. Such gifts, however, can subject the older person to penalty periods during which they are ineligible for Medicaid benefits.<sup>231</sup> In any case, parting with one’s financial resources can leave an older person feeling very vulnerable,<sup>232</sup> and the resulting despondency can only worsen that person’s already weakened condition.

Becoming a Medicaid recipient is, after all, not without its consequences. It is an open secret that many long-term care facilities limit the number of Medicaid recipients that they will accept,<sup>233</sup> and some institutions do not participate in the program at all.<sup>234</sup> Recent trends towards ever-lower Medicaid rates paid by the government reduce further the number of places available to Medicaid recipients.<sup>235</sup> 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.

In addition, the impoverishment that Medicaid demands can affect relations with an older person’s family members. A Medicaid recipient’s ability to give money and property to favored relatives or on special occasions is significantly curtailed,<sup>236</sup> and such gifting activity is often an important source of family pride and self-esteem. Furthermore, the prospect of lost inheritances can motivate family members to consider various strategies that typically diminish an elder’s financial independence.<sup>237</sup> The point is

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229. Medicaid is the health care component of the government’s anti-poverty safety net, and the vast majority of its recipients are not older people. See Frank J. Thompson, *The Faces of Devolution*, in *MEDICAID AND DEVOLUTION*, *supra* note 184, at 14, 23 (noting that only twelve percent of Medicaid recipients are aged sixty-five years or older). Many aspects of Medicaid discussed in this article pertain only to Medicaid’s long-term care program. See generally REGAN, *supra* note 151, §§ 10.05–06.

230. See WILLIAM H. CROWN ET AL., *PUB. POLICY INST., AN ANALYSIS OF ASSET TESTING FOR NURSING HOME BENEFITS 9–11* (1994); HARLEY GORDON, *HOW TO PROTECT YOUR LIFE SAVINGS FROM CATASTROPHIC ILLNESS AND NURSING HOMES 13* (3d ed. 1994).

231. See *supra* text accompanying notes 212–19.

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

233. 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 184, at 203.

234. See 42 U.S.C. § 1396r(c)(2)(F)(i)(I)–(II) (2000), added by Nursing Home Resident Protection Amendments of 1999, Pub. L. No. 106-4, 113 Stat. 7 (noting that Medicaid recipients residing in a nursing home which withdraws from Medicaid may not be discharged from that 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).

235. See Wiener, *supra* note 184, at 203.

236. See *supra* text accompanying notes 212–19.

237. See Joel C. Dobris, *Medicaid Asset Planning by the Elderly: A Policy View of Expectations, Entitlement and Inheritance*, 24 *REAL PROP. PROB. & TR. J.* 1, 7–8 (1989); David M. Rosenfeld, *Whose Decision Is It Anyway?: Identifying the Medicaid Planning Client*, 6 *ELDER L.J.* 383, 389 (1998); see also Donald P.

that an older person's need for some financial independence is no less critical when that person requires long-term care, and qualifying for Medicaid benefits can drastically erode that independence.<sup>238</sup>

#### IV. LONG-TERM CARE INSURANCE

This section examines private long-term care insurance, a product of relatively recent vintage that is designed specifically to provide for long-term care needs.<sup>239</sup> Such insurance began as nursing home insurance,<sup>240</sup> but soon included optional riders to cover the cost of in-home health care.<sup>241</sup> The typical home health care benefit, however, is one-half of the policy's nursing home benefit.<sup>242</sup> For example, if a long-term care insurance policy pays \$100 per day toward nursing home costs, its home health care benefit will pay \$50 per day. This rider, in other words, can provide some in-home assistance with the activities of daily living, but it does not purport to pay for around-the-clock care in a policyholder's residence.<sup>243</sup>

More recently, long-term care insurance policies have started to cover assisted living facilities, adult daycare centers, and other alternatives to nursing homes.<sup>244</sup> Much of the appeal of these policies, in fact, is that they provide a source of funds that a policyholder can use to secure long-term care in whatever setting he or she chooses. Indeed, some policies reinforce this concept by providing a so-called "pool of funds," which is an amount equal to the policy's daily nursing home benefit times the number of days of coverage.<sup>245</sup> 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 x 365 days x \$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, effectively extend the policy's benefit period.

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Baker, *Medicaid's Financially Healthy Users: Hiding of Assets Adds to Soaring Cost of Care for Elderly*, WASH. POST, Feb. 24, 1992, at A1 (discussing means by which elder's children can protect their inheritances); Andrew Bates, *Golden Girls*, NEW REPUBLIC, Feb. 3, 1992, at 17, 18 (same); Jane Bryant Quinn, *Do Only the Suckers Pay?*, NEWSWEEK, Dec. 18, 1989, at 52 (same).

238. Korbin Liu & Kenneth G. Manton, *The Effect of Nursing Home Use on Medicaid Eligibility*, 29 GERONTOLOGIST 59 (1989); Joshua M. Wiener et al., *Letters to the Editor: Nursing Home Care: Still a Routine Catastrophe*, 30 GERONTOLOGIST 417 (1990). *Contra* Stephen A. Moses, *The Fallacy of Impoverishment*, 30 GERONTOLOGIST 21 (1990) (arguing that Medicaid recipients can effectively retain control of their assets by transferring their assets to a trusted relative).

239. See generally FROLIK & KAPLAN, *supra* note 16, at 131-46 (discussing policy provisions of long-term care insurance).

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

241. FLEMING, *supra* note 156, at 12-14 to 12-15.

242. *How to Judge a Policy*, CONSUMER REP., Oct. 1997, at 40, 40; see also NAT'L ASS'N INS. COMM'RS, *LONG-TERM CARE INSURANCE MODEL REGULATION § 10B* (1995) (discussing minimum standards for home health care components).

243. SHELTON, *supra* note 69, at 17.

244. See NORMAN ET AL., *supra* note 240, at 55-57; SHELTON, *supra* note 69, at 19-20; see also NAT'L ASS'N INS. COMM'RS, *A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE* 14 (1999) [hereinafter NAIC GUIDE].

245. NAIC GUIDE, *supra* note 244, at 13; *How to Judge a Policy*, *supra* note 242, at 41.

Long-term care insurance policies are primarily purchased as individual policies, which is the most expensive means of distribution.<sup>246</sup> Some employers offer long-term care insurance to their employees at favorable group rates, thereby lowering distribution expenses and related premium costs.<sup>247</sup> Certain professional associations and other affinity groups offer similar group policies.<sup>248</sup> These group policies, moreover, guarantee acceptance for any member of the applicable group.<sup>249</sup> This is an extremely important feature because there is no guarantee outside the group insurance context that a prospective policyholder will be able to obtain a long-term care insurance policy. Depending upon a person's medical profile, an older person might be rejected by the companies offering such policies or face prohibitive premium charges, unpalatable policy restrictions, and pre-existing condition exceptions.<sup>250</sup>

### A. Tax Incentives

To encourage more people to buy long-term care insurance,<sup>251</sup> Congress amended the tax law in 1996 to make premiums for such insurance tax-deductible.<sup>252</sup> This effort has not been terribly successful because the touted tax benefits are often illusory and thus incapable of motivating would-be insurance buyers.<sup>253</sup> For instance, the tax amendment treats long-term care insurance premiums as "medical expenses,"<sup>254</sup> thereby subjecting those expenses to the tax code's floor for such expenses—namely, 7.5% of a taxpayer's "adjusted gross income." (AGI)<sup>255</sup> Moreover, medical expenses are an "itemized deduction,"<sup>256</sup> so the seven out of ten taxpayers who do

246. Joshua M. Wiener & Laurel Hixon Illston, *How to Share the Burden, Long-Term Care in the 1990s*, BROOKINGS REV., Spring 1994, at 17, 18 (stating that ninety percent of long-term care insurance policies are sold to individuals).

247. See NORMAN ET AL., *supra* note 240, at 102–09; SHELTON, *supra* note 69, at 51–54.

248. NAIC GUIDE, *supra* note 244, at 11.

249. NORMAN ET AL., *supra* note 240, at 104; SHELTON, *supra* note 69, at 53.

250. See FROLIK & KAPLAN, *supra* note 16, at 137–38; SHELTON, *supra* note 69, at 35–36; see also CNA, RATES AND UNDERWRITING GUIDE 5–11 (1994) (listing alphabetically medical conditions that disqualify a person from obtaining long-term care insurance or require some modification of the standard insurance policy).

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

252. I.R.C. § 213(a), (d)(1)(D) (2000), *added by* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, 2008. 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 16, at 143–44 (discussing tax qualified policies); NAIC GUIDE, *supra* note 244, 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).

253. See 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, 96 (2000).

254. I.R.C. § 213(d)(1)(D).

255. 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). See generally BORIS I. BITTKER & MARTIN J. MCMAHON, JR., *FEDERAL INCOME TAXATION OF INDIVIDUALS* ¶ 2.1[3] (2d ed. 1995).

256. See I.R.C. §§ 63(d)(1), 62(a)(1)–(17), 213(a); see also BITTKER & MCMAHON, *supra* note 255, ¶ 26.1.

not itemize their deductions<sup>257</sup> receive no tax benefit from this provision. In addition, Congress added age-specific limits on the amount of long-term care insurance premiums that can be deducted,<sup>258</sup> and any premiums in excess of these limits provide no tax benefit whatsoever. These limits are adjusted annually for inflation,<sup>259</sup> but they cap the amount that can be deducted nonetheless.

To illustrate the interaction of these various restrictions, assume that Deborah is seventy-five years old and pays \$3,600 per year for long-term care insurance, \$648 for the enrollee's portion of Medicare Part B coverage (\$54 per month<sup>260</sup> x 12 months), and \$800 for Medigap insurance. The limit on deductible long-term care insurance premiums for someone age seventy and over in 2002 was \$2,990.<sup>261</sup> Thus, the other \$610 (\$3,600-\$2,990) of Deborah's long-term care insurance premium is ignored for tax purposes. If Deborah's AGI<sup>262</sup> in 2002 was \$50,000, her medical expense deduction would be computed as follows:

Long-term care insurance	\$2,990 (limit)
Medicare Part B premium	648
Medigap insurance	<u>800</u>
	\$4,438
7.5% of AGI (\$50,000)	<u>(3,750)</u>
Deduction allowed	<u>\$ 688</u>

Thus, of the \$3,600 that Deborah paid for long-term care insurance, she can deduct only \$688. And since most older Americans do not itemize their deductions,<sup>263</sup> Deborah will probably not deduct even this \$688 on her tax return. But if she does itemize her deductions, this deduction of \$688 will reduce her taxes by \$103 or \$186, depending upon whether she is married or single.<sup>264</sup> This paltry benefit can hardly motivate Deborah to pay \$3,600 for long-term care insurance if she is not already so inclined.<sup>265</sup>

257. See Scott M. Hollenbeck & Maureen Keenan Kahr, *Individual Income Tax Returns, 1997: Early Tax Estimates*, STAT. INCOME BULL., Winter 1998-99, at 132, 145-46.

258. I.R.C. § 213(d)(10)(A).

259. I.R.C. § 213(d)(10)(B).

260. MEDICARE & MEDICAID SERVS., *supra* note 93.

261. Rev. Proc. 2001-59, § 3.12, 2001-52 I.R.B. 623.

262. See *supra* note 255 and accompanying text.

263. See Wiener et al., *supra* note 253, at 96 (noting that half of older Americans have no tax liability); *supra* note 257 and accompanying text.

264. A married person with AGI of \$50,000 would probably be in the fifteen percent tax bracket, because taxable income was AGI minus itemized deductions and personal exemptions of \$3,000 per person in 2002. See Rev. Proc. 2001-59, 2001-52 I.R.B. 623. If so, a deduction of \$688 would provide a tax benefit of \$103 (\$688 x 15%). A single person with the same AGI would probably be in the twenty-seven percent tax bracket, and a \$688 deduction would lower that person's taxes by \$186 (\$688 x 27%). See *id.*

265. In this connection, see Long-Term Care and Retirement Security Act of 2001, S. 627, 107th Cong. § 2(c)(1) (2001) (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). See also H.R. 831, 107th Cong. § 2(c)(1) (2001) (same).

### B. Major Obstacles

A would-be purchaser of long-term care insurance must also contend with at least three major obstacles: the cost of premiums, variegated policy terms and features, and internal gatekeeper provisions.

#### 1. The Cost of Premiums

As the preceding example with Deborah illustrated, the cost of long-term care insurance can be quite high. The benefits obtained from a policy paying one hundred dollars per day can recoup the annual premium within a few months,<sup>266</sup> but the premium is a major expense nonetheless.<sup>267</sup> And if a policy is acquired later in life, then the cost is higher still, because long-term care insurance premiums vary considerably depending upon the age of the applicant when the policy is first obtained.<sup>268</sup> For example, the annual premium for a long-term care insurance policy that costs \$510 if the insured is fifty-five years old, is \$990 if the insured is sixty-five years old and \$2,830 if the insured is seventy-five years old.<sup>269</sup> The older insurance buyer, moreover, is less likely to be accepted by insurance companies because many disqualifying medical conditions are either age-related or become more problematic as a person ages.<sup>270</sup> But the point remains that long-term care insurance is a major expenditure by the time that most people seriously consider its acquisition.

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.<sup>271</sup> 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 ten years or so.<sup>272</sup> 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 policy-

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266. Benefits of \$100 per day for a thirty-day month equal \$3,000. The average annual premium for long-term care insurance is \$2,305 for a policy purchased at age sixty-five, and \$7,022 at age seventy-nine. See Wiener et al., *supra* note 253, at 60.

267. *Id.* at 60-61.

268. *Id.* at 60; see also NAIC GUIDE, *supra* note 244, at 22-23 (discussing the correlation between cost and age for long-term care insurance); Franklin, *supra* note 24, at 78, 81 (same).

269. 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, available at 1997 WL 2413961.

270. SHELTON, *supra* note 69, at 36; Franklin, *supra* note 24, at 81.

271. CARLSON, *supra* note 40, § 9.05[2]; NAIC GUIDE, *supra* note 244, at 23; see also NAT'L ASS'N INS. COMM'RS, *supra* note 242, § 6A(2) (1995) (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) (2000) (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).

272. Ann Davis, *Shaky Policy Unexpected Rate Rises Jolt Elders Insured for Long-Term Care*, WALL ST. J., June 22, 2000, at A1, available at 2000 WL 3033960; Jane Bryant Quinn, *Long-Term Care Can Become a Dirty Game*, CHI. TRIB., Sept. 12, 1999, at 3, available at 1999 WL 2911300.

holder is able to pay.<sup>273</sup> The unfortunate consequence in these situations is that older policyholders will probably not renew their policies,<sup>274</sup> thereby forfeiting the benefit of the premiums paid in previous years and losing their insurance coverage when it is most likely to be needed. Accordingly, postissuance premium increases discourage would-be insurance buyers who must confront the prospect of future unaffordability on existing policies.

## 2. Policy Options and Features

Unlike the Medigap insurance policies described previously,<sup>275</sup> long-term care insurance policies have no fixed packages of benefits or standardized policy options. For example, some policies pay benefits for three, five, or seven years, while others cover two, four, or six years.<sup>276</sup> Some policies offer lifetime coverage, while others do not.<sup>277</sup> 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.<sup>278</sup> The “elimination period,” which acts like a deductible by requiring a set time period of long-term care treatment before a policy’s coverage begins, may be thirty, sixty, or ninety days at one company, but fifty, seventy-five, or one hundred days at another.<sup>279</sup> In this connection, moreover, some companies aggregate time in separate nursing home stays toward satisfying their “elimination period” requirement, while other companies count only days spent consecutively during a single stay.<sup>280</sup> Home care benefits may be half of the daily nursing home benefit in some policies, but equal to that benefit in others.<sup>281</sup>

And if all of this variety were not enough, additional options are available in some policies, but not in all. For example, many policies offer infla-

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273. See NORMAN ET AL., *supra* note 240, at 94; see also NAIC GUIDE, *supra* note 244, at 24.

274. 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 seven-fold increase in premiums over seven years, ninety percent of policyholders 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) (examining the inherent conflict in applying the filed rate doctrine to fraud-based insurance claims).

275. See *supra* text accompanying notes 109–10.

276. See, e.g., NORTHWESTERN LONG-TERM CARE INS. CO., NORTHWESTERN MUTUAL LIFE, QUIETCARE 9 (1999) (three years, six years, or life); TIAA CREF, TEACHERS SELECTCARE LONG-TERM CARE INSURANCE 11 (1999) (three years, five years, or seven years); Jeffrey, *supra* note 269 (two years or four years).

277. See, e.g., Jeffrey, *supra* note 269.

278. See, e.g., *id.* (\$100 and \$200 daily rates); see also NORTHWESTERN LONG-TERM CARE INS. CO., *supra* note 276, at 9 (noting that Northwestern’s range is \$50 to \$250 per day); TIAA CREF, *supra* note 276 (noting that TIAA CREF’s range is \$40 to \$300).

279. See *supra* note 278 (John Hancock: 20 or 100 days; TIAA CREF: 30, 60, or 90 days; Northwestern: 90 or 180 days); see also GE CAPITAL ASSURANCE, PRIVILEGED CARE SELECT (1996) (0, 50, or 100 days).

280. NORMAN ET AL., *supra* note 240, at 61–62; SHELTON, *supra* note 69, at 25–26.

281. See *supra* note 276; see also GE CAPITAL ASSURANCE, *supra* note 279 (eighty percent option for home care).

tion protection riders that automatically increase the amount of the daily benefit every year.<sup>282</sup> 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.<sup>283</sup> The difference can be substantial: a benefit of \$100 per day that is increased five percent per year becomes \$220 per day after twenty-five years, while a five percent compounded increase makes the benefit amount \$323 per day after the same period.<sup>284</sup>

And there is more. Some policies waive the premium once a policyholder begins receiving benefits under the policy.<sup>285</sup> 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.<sup>286</sup> 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.<sup>287</sup> Alternatively, the level of benefits are maintained, but for a shorter period.<sup>288</sup>

The inevitable result of all these choices and alternatives is consumer confusion and frustration. The range of options<sup>289</sup> discourages cost comparisons between policies and shrouds the insurance buying process with an unfortunate air of mystery.<sup>290</sup> All too often, prospective policyholders simply turn away from the entire enterprise in disgust.

### 3. *Gatekeeper Provisions*

Most long-term care insurance policies have some mechanism to determine whether a policyholder who seeks benefits under the policy requires long-term care.<sup>291</sup> These so-called "gatekeeper" provisions respond to what economists commonly call "moral hazard" or "induced demand."<sup>292</sup> 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

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282. NAIC GUIDE, *supra* note 244, at 18–19.

283. *Id.* at 19; *see also* NORMAN ET AL., *supra* note 240, at 77–80 (discussing inflation protection). An alternative allows policyholders to purchase additional insurance without medical underwriting. *See id.* at 80, 82–84.

284. SHELTON, *supra* note 69, at 28 (discussing inflation protection).

285. NAIC GUIDE, *supra* note 244, at 20.

286. SHELTON, *supra* note 69, at 36.

287. *Id.*

288. NAIC GUIDE, *supra* note 244, at 21; SHELTON, *supra* note 69, at 37.

289. Additional options include worldwide coverage, medical alert systems, and medical equipment. SHELTON, *supra* note 69, at 45.

290. *See* Ellen Graham, *Weighing the Benefits of Buying Insurance for Extended Elder Care*, WALL ST. J., Mar. 31, 1999, at B1, available at 1999 WL 5446593 (noting the "baffling array of variables" that affect premiums for long-term care insurance).

291. *Gotcha! The Traps in Long Term Care Insurance*, CONSUMER REP., June 1991, at 425, 426, 429; *see also* NORMAN ET AL., *supra* note 240, at 58–59.

292. *See* Kapp, *supra* note 232, at 734.

such benefits provide.<sup>293</sup> In the context of long-term care, “moral hazard” implies that policyholders—or perhaps their families—may try to obtain assistance when other accommodations could be made since their insurance will cover the cost of such assistance.<sup>294</sup> However real this concern may be, the upshot of these gatekeeper provisions is that some case manager determines whether the insurance company must pay for the long-term care being claimed.<sup>295</sup>

From the perspective of the policyholder, a gatekeeper provision can be somewhat problematic. That is, if the case manager is not independent of the insurance company in question, then that manager might be inclined to deny claims to save the insurance company the cost of paying for long-term care.<sup>296</sup> 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.<sup>297</sup> After all, if an insurance company can unilaterally determine its financial exposure by asserting that long-term care is not really necessary, then what did the policyholder really get when he or she acquired the policy?

Similar concerns plague managed care plans generally. Indeed, much of the disenchantment with managed care<sup>298</sup> and the varied proposals for a “patients’ bill of rights”<sup>299</sup> can be attributed to the inherent conflict of interest that exists when an insurance company determines the scope of its financial liability. The problem is essentially the same in the context of long-term care insurance: do gatekeeper provisions undercut the “peace of mind”<sup>300</sup> that such policies are supposed to convey?

### C. Evaluation

Given Medicare’s minimal coverage of long-term care costs and Medicaid’s unappealing requirements for impoverishment, long-term care insurance should be popular. But as this section has shown, such insurance is expensive, confusing, and of uncertain reliability. The range of complicated options and the absence of price stability guarantees discourage most

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

294. See Kapp, *supra* note 232, at 734.

295. NORMAN ET AL., *supra* note 240, at 58.

296. See *id.* at 58–59.

297. See *Goicha! The Traps in Long Term Care Insurance*, *supra* note 291; cf. I.R.C. § 7702B(c)(2)(A), (4) (2000) (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 two “activities of daily living,” or requiring “substantial supervision” because of “severe cognitive impairment”).

298. See R. Adams Dudley & Harold S. Luft, *Managed Care in Transition*, 344 *NEW ENG. J. MED.* 1087, 1087 (2001); see also EPSTEIN, *supra* note 1, at 420–29 (discussing the effect that managed care has on the traditional doctor-patient relationship).

299. See *supra* note 3 and accompanying text.

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

older people from financing their long-term care expenses through this mechanism. Thus, it is not surprising that fewer than ten percent of older Americans have long-term care insurance.<sup>301</sup>

Existing tax incentives purport to encourage people to buy these policies, but the tax benefits offered are uncertain and often negligible.<sup>302</sup> In any case, tax incentives cannot change the product's most fundamental problem: it pays for care that people hope and pray they will never need.<sup>303</sup>

Of course, insurance typically provides protection against unpleasant events. For example, life insurance pays benefits upon the death of the insured,<sup>304</sup> clearly a distasteful occurrence. Death, however, is inevitable; disability is not. According to current estimates, about half of women and one-third of men over the age of sixty-five will spend some time in a nursing home.<sup>305</sup> The key word there is "some." Half of these stays will be relatively short-term,<sup>306</sup> involving recuperative care for hip fractures, for example, and other hospital-centered events. These nursing home stays will probably satisfy Medicare's coverage criteria<sup>307</sup> and will therefore not expose the patient to significant financial liability. Moreover, these stays would probably fall within the "elimination period" of many long-term care insurance policies,<sup>308</sup> so those policies would not cover the related expenses in any case.

But the point is that the long-term nursing home situation is much less frequent an occurrence. The probability that an older person will require a nursing home for more than three years is twelve percent.<sup>309</sup> Thus, most elders will not face lengthy institutionalization. On the other hand, of those who were in a nursing home more than three years, five out of nine were there for more than five years.<sup>310</sup> Thus, there is a small chance of an extended nursing home stay, but such stays can be quite lengthy when they do occur.

Some people rationalize their decision not to purchase long-term insurance by saving for the cost of long-term care through their other investments. Such a program, however, requires fairly amazing investment prowess to succeed. Consider, for instance, a policy offered by a major long-term care insurance company that pays \$100 per day for up to four years, with the benefits increased by five percent compounded annually. The premium for this policy is \$1,740 per year if the purchaser is sixty-five

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301. GEN. ACCOUNTING OFFICE, GAO/T-HEHS-00-196, LONG-TERM CARE INSURANCE: BETTER INFORMATION CRITICAL TO PROSPECTIVE PURCHASERS 3 (2000).

302. See *supra* text accompanying notes 254-64.

303. Cf. KANE ET AL., *supra* note 7, at 164 (stating that thirty percent of "seriously ill hospitalized elderly patients" would prefer to die rather than live in a nursing home).

304. See BEN G. BALDWIN, THE LAWYER'S GUIDE TO INSURANCE 153 (1999).

305. Kapp, *supra* note 232, at 721.

306. NORMAN ET AL., *supra* note 240, at 8.

307. See *supra* text accompanying notes 113-30.

308. See *supra* text accompanying note 279.

309. NORMAN ET AL., *supra* note 240, at 9.

310. Computations done by author on data presented in *id.*

years old<sup>311</sup>—and meets the company's medical underwriting criteria, of course. In fifteen years, the amount of the daily benefit will be \$208 due to the inflation rider.<sup>312</sup> To pay \$208 per day, or \$6,240 for a thirty-day month, for four years requires a lump sum of \$265,699.<sup>313</sup> To accumulate this sum, the fifteen annual investments between age sixty-five and age eighty of \$1,740 would need to earn 28.9% each year.<sup>314</sup> This result, moreover, must be attained after payment of long-term capital gains taxes at twenty percent,<sup>315</sup> ordinary income tax at, say 27%,<sup>316</sup> 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 return before taxes is 38.5%.<sup>317</sup> That investment return, it should be noted, must be earned not once or twice, but fifteen years in a row! At this point, denial has transmogrified into delusion.

Faced with this situation, most older Americans wait until a long-term care crisis develops. By then, of course, it is too late to purchase long-term care insurance or do any anticipatory Medicaid planning, even if they were so inclined. Instead, they depend upon family caregivers and friends, especially their spouses, daughters, or daughters-in-law.<sup>318</sup> Most long-term care, in fact, is provided by such persons without charge.<sup>319</sup>

But these traditional sources of long-term care may be less available in the future. Families are now more geographically dispersed than in previous generations, and many adult children live too far away to effectively assume these responsibilities.<sup>320</sup> Moreover, these people are increasingly preoccupied with responsibilities to their own families, including the caring of young children. Sometimes, they make the requisite sacrifices, including reduced hours at work,<sup>321</sup> declined overtime and promotions, and the like.<sup>322</sup>

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311. See Jeffrey, *supra* note 269.

312. SHELTON, *supra* note 69, at 28.

313. The present value of one dollar received at the end of each month for four years, at an assumed interest rate of six percent, 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.

314. Computation performed by author.

315. I.R.C. § 1(h)(1)(C) (2000).

316. REGAN ET AL., *supra* note 151, § 6.04, at 6-16.

317. 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). 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% divided by .7).

318. See generally EMILY K. ABEL, WHO CARES FOR THE ELDERLY? PUBLIC POLICY AND THE EXPERIENCES OF ADULT DAUGHTERS (1991) (discussing the family's role in caring for the elderly).

319. KANE ET AL., *supra* note 7, at 14-15; STONE, *supra* note 5, at 11; see also Peter S. Arno et al., *The Economic Value of Informal Caregiving*, HEALTH AFF., Mar.-Apr. 1999, at 182, 182.

320. Frolik & Barnes, *supra* note 6, at 703; Jasen, *supra* note 27; see also Longo, *supra* note 27, at 91 (discussing long-distance care).

321. Richard W. Johnson & Anthony T. Lo Sasso, *Parental Care at Midlife: Balancing Work and Family Responsibilities near Retirement*, URB. INST. RETIREMENT PROJECT BRIEF SERIES, Mar. 2000, at 5 (not-

In this context, long-term care insurance could fund supplemental long-term care, whether it consists of home care, adult daycare, assisted living facilities, or other arrangements that cost less than nursing home care. Such insurance, however, is burdened by the need to fund expensive nursing home care. As a result, long-term care insurance is a costly and confusing product.

## V. A COMPREHENSIVE APPROACH TO FINANCING LONG-TERM CARE

Given the deficiencies and inconsistencies examined above, this article proposes that the United States' approach to financing long-term care be restructured to recognize the fundamental difference between medically oriented services and more residential and social settings for such care. Under this restructuring, the Medicare program should cover all care provided in nursing homes, but long-term care provided in other settings should remain a private responsibility. To help meet that private responsibility, long-term care insurance should be improved to make it a more appealing and effective option.

### A. *Expanding Medicare*

Medicare's coverage of nursing home stays should be expanded in three major ways. First, the requirement that a hospital stay precede a nursing home admission<sup>323</sup> should be eliminated entirely. Second, the limitation that Medicare covers only "skilled nursing care"<sup>324</sup> should be eliminated. Third, the limit on the length of a nursing home stay<sup>325</sup> should be changed. This section considers the rationale for these three recommendations and their implications.

#### 1. *Eliminating the Need for a Preceding Hospital Stay*

Many older Americans are admitted to nursing homes directly from their personal residences. Often, a visiting relative or friend notices that the older person is no longer able to live independently or is endangering her health in some way. For example, the older person may be skipping meals, leaving stoves or irons turned on, or otherwise engaging in potentially dangerous activities. In such circumstances, a nursing home placement may be appropriate, even though there was no need to go to a hospital.

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ing that women who were caring for elderly parents reduced their hours of paid work by forty-three percent, men by twenty-eight percent).

322. See Raymond L. Rigoglioso, *Your Money or Your Life: The Financial Burden of Caregiving*, in ALWAYS ON CALL, *supra* note 8, at 113, 119-23; see also Gail Gibson Hunt, *Caregiving and the Workplace*, *in id.* at 101, 102-07 (discussing sacrifices that families make when providing informal care).

323. 42 U.S.C. § 1395x(i)(A) (2000); see *supra* text accompanying notes 115-19.

324. 42 U.S.C. § 1395f(a)(2)(B); see *supra* text accompanying notes 120-25.

325. 42 U.S.C. §§ 1395d(a)(2), 1395e(a)(3).

At other times, an older person might go to a nursing home after a hospital stay, but that stay did not meet the three-day requirement that Medicare demands.<sup>326</sup> Indeed, the ratcheting down of approved hospital stays by the Diagnostic Range Groupings (DRG) program makes this situation increasingly likely.<sup>327</sup> A fairly typical example of this situation might involve an older person who suffers a bad fall and is rushed to the emergency room of a nearby hospital. While there, x-rays are taken and various diagnostic tests are run, but the results show that no bones were fractured. The older person is then released and sent home, or kept overnight for observation and sent home the following morning. In either circumstance, the older person may be experiencing considerable pain and cannot cope on her own. She will probably require a nursing home or other convalescent facility for recuperative therapy and treatment. Nevertheless, her failure to meet Medicare's three-day hospital stay requirement precludes coverage of these nursing home expenditures.

Eliminating the preceding hospital stay requirement would provide Medicare coverage for the older person's nursing home costs in each of the scenarios set forth above. Moreover, this change recognizes that nursing home stays are increasingly used as substitutes for hospital stays, because medical care that previously could be provided only in a hospital can now be delivered in a nursing home. Extending Medicare's coverage to nursing homes, therefore, simply reflects recent developments in postoperative care and related aspects of medicine. In fact, some nursing home stays are a direct result of Medicare's budget-oriented DRG policy, which discharges hospital patients "quicker-and-sicker."<sup>328</sup> When patients are released before they can cope at home, they often enter nursing homes to receive the care that they would have received in a hospital.<sup>329</sup> Accordingly, Medicare has a moral imperative to pay for nursing home stays that result from DRG-shortened hospital stays.

Be that as it may, the bottom line is that the existing requirement of a prior hospital stay for Medicare nursing home coverage should be discontinued. People enter nursing homes primarily for medical reasons, and there is no sound basis on which to discriminate between hospital coverage and nursing home coverage. The requirement of a preceding hospital stay is increasingly a relic of the mid-1960s that no longer makes sense.

## 2. *Eliminating the Skilled Care Limitation*

Nursing homes today care for an increasing number of Americans whose cognitive skills have deteriorated. Indeed, some homes have special units called "Alzheimer's Centers," which provide a wide range of services

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326. 42 U.S.C. § 1395x(i).

327. See *supra* note 119.

328. KANE ET AL., *supra* note 7, at 35.

329. See *id.*

to maximize the cognitive capabilities of patients who are suffering from this disease and whose condition is not expected to improve.<sup>330</sup> In some nursing homes, such care is the predominant service provided, especially for patients who are in these facilities for more than one year.<sup>331</sup> Almost none of this care is covered by Medicare because such care does not meet Medicare's requirement of "skilled nursing care."<sup>332</sup> The result of this limitation is that Medicare discriminates on the basis of disease: care required by a physical disability may be provided in a hospital or "skilled" nursing unit, the costs of which Medicare will cover, but care required by a mental or cognitive impairment may be provided in a nursing home, and Medicare does not cover those costs.

This distinction between skilled care and nonskilled care is a trap for the unwary that most nonmedical people find difficult to fathom and impossible to justify.<sup>333</sup> Consider the reaction when the family of Aunt Florence learns that Medicare will not pay to care for her Alzheimer's, while Medicare covers her friend's care for emphysema. The stench of arbitrariness is further aggravated when one considers causation and personal responsibility. That is, there are no agreed-upon lifestyle factors, such as smoking, that might have precipitated Florence's cognitive impairment, in contrast to her friend's emphysema. In other words, Medicare pays for conditions that might have been prevented, but does not pay for conditions over which the patient has no control. The policy rationale for this dichotomy eludes most people.

Medicare essentially socializes the risk of enormous medical expenses in the hospital context, and it should do so in the nursing home context as well. There is no reason to condition a person's exposure to the financially ruinous costs of medical care on the specific setting in which that care is administered. Accordingly, the skilled care limitation should be repealed, and Medicare should cover the cost of nursing home care, regardless of the level of care that a patient requires.

### 3. *Changing the Duration-of-Stay Limitation*

In the context of long-term care, Medicare's current limit on the length of a nursing home stay cannot stand. A total of twenty days at full coverage and eighty additional days at partial coverage is inadequate for chronic care.<sup>334</sup> Precisely where the new limit should be is unclear. Three-quarters of older people's nursing home stays are less than three years,<sup>335</sup>

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330. See Conklin, *supra* note 66.

331. See *id.*

332. 42 C.F.R. § 409.33(a)–(c) (2001). Moreover, Medicare does not pay for "custodial" care. 42 U.S.C. § 1395y(a)(9) (2000); 42 C.F.R. § 411.15(g).

333. See CARLSON, *supra* note 40, § 8.05[3][a][i], at 8-16 (2002) ("The average resident or family member understandably believes that every resident of a nursing facility receives 'skilled' care . . .").

334. 42 U.S.C. §§ 1395d(a)(2)(A), 1395e(a)(3). These limits pertain to a "spell of illness." See *supra* text accompanying notes 126–30.

335. Computation by author based on data in NORMAN ET AL., *supra* note 240, at 9.

but the longer stays are obviously the most expensive. Perhaps the best approach is to replicate Medicare's coverage of hospital stays—namely, a limit that covers almost all stays, with a significant co-payment requirement for the latter portion of that limit.<sup>336</sup> Medigap insurance could then cover the required co-payment and even provide additional nursing home days as it does currently in the context of hospital care.<sup>337</sup> In any case, the length of a nursing home stay that Medicare covers must be changed to reflect the realities of long-term care.

#### 4. *Other Long-Term Care Settings*

For several reasons, Medicare should probably not be extended to long-term care settings other than nursing homes. First, there is the significant problem of induced demand called moral hazard or the “woodwork effect.”<sup>338</sup> This concern suggests that if a third-party payer, like Medicare, covers a service that was previously not covered, then potential claimants will come out of the woodwork, and the program will collapse from its own weight. With respect to nursing homes, there might be some increased demand if Medicare covered the cost of these facilities, but the overall impact will probably be limited.<sup>339</sup> After all, the decision to place a loved one in a nursing home is usually very traumatic without regard to financial considerations.<sup>340</sup>

Long-term care settings other than nursing homes, however, are seen as more appealing, and the possibility of induced demand would therefore be much more significant. In fact, when Medicare's standards for covering home health care were made less restrictive by the 1988 decision in *Duggan v. Bowen*,<sup>341</sup> the demand for home health care rose dramatically.<sup>342</sup> Moreover, many elders and their families are genuinely attracted to assisted living facilities (ALF) and continuing care retirement communities (CCRC).<sup>343</sup> These facilities offer companionship, entertainment opportunities, and convenience, all in relatively modern settings. The image they

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336. See *supra* text accompanying notes 136–43. The National Academy of Elder Law Attorneys has recommended a long-term care benefit that consists of an inflation-indexed number of dollars, which would be subject to a deductible of \$10,000 and a twenty percent co-payment requirement. NAT'L ACAD. OF ELDER LAW ATTORNEYS, WHITE PAPER ON REFORMING THE DELIVERY, ACCESSIBILITY AND FINANCING OF LONG-TERM CARE IN THE UNITED STATES 21 (2000).

337. See *supra* text accompanying note 144.

338. Kapp, *supra* note 232, at 734.

339. See *id.* at 734 n.109.

340. See CARLSON, *supra* note 40, § 3.02[1]; see also KANE ET AL., *supra* note 7, at 164–65 (noting that nursing homes often involve “sharing rooms with successions of not necessarily compatible strangers, crowded conditions, rigid routines, patronizing attitudes, healthful but unappetizing meals presented unattractively”); STRAUSS ET AL., *supra* note 52, ¶ 2409, at 3007 (1999) (discussing the emotional difficulty of placing a loved one in a nursing home).

341. 691 F. Supp. 1487 (D.D.C. 1988).

342. See Davis, *supra* note 105, at 230–32.

343. Wilcox, *supra* note 50, at 62, 63.

convey is of “places to live,”<sup>344</sup> drawing an implicit—if somewhat unfavorable—distinction with nursing homes. As a result, if Medicare covered ALFs or CCRCs, then the increased demand might be overwhelming.

Second, arranging for long-term care in settings other than nursing homes is usually done with considerable care and planning. Typically, there is a lengthy process of interviews, references checks, site inspections, and cost comparisons to determine the best environment for the particular elder. In contrast, a nursing home admission is often arranged at the behest of a hospital discharge planner with only a few days warning, if that.<sup>345</sup> Thus, there is less need for Medicare to relieve the anxiety of sudden and unanticipated expenditures in the context of long-term care settings other than nursing homes.

Finally, Medicare has no current involvement with congregate living arrangements,<sup>346</sup> other than the nursing care units within continuing care retirement communities.<sup>347</sup> These arrangements, after all, are primarily residential and social facilities with much less attention to medical matters than nursing homes.<sup>348</sup> While these facilities are subject to various state statutes,<sup>349</sup> state provisions focus on the financial aspects of congregate living arrangements, consumer protection, and the like.<sup>350</sup> Extending Medicare coverage to these facilities, therefore, would require new federal regulations appropriate to the particular features of these facilities.

All of these considerations underscore the key role of nursing homes in this country’s health care system and suggest why they are fundamentally different from other long-term care settings. In brief, nursing home care often substitutes for hospital care, but other long-term care settings typically take the place of family-provided care. Accordingly, Medicare should cover the cost of nursing homes, but leave the responsibility for other long-term care arrangements with the families of the older persons involved.

### B. *Improving Long-Term Care Insurance*

If Medicare coverage is extended to nursing homes, what then is the role of long-term care insurance? One possibility is that such insurance might help finance long-term care in settings *other than* nursing homes. In

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344. See, e.g., Aida Rogers, *Continuing Care Retirement Communities: “You’re not going there to die; you’re going there to live,”* SHEPARD’S ELDER CARE/LAW NEWSL., Dec. 1991, at 7; Wilcox, *supra* note 50, at 68–69.

345. See CARLSON, *supra* note 40, § 3.02[1], at 3–7.

346. FROLIK, *supra* note 11, ¶¶ 8.09[1], 9.08[2].

347. See 42 U.S.C. §§ 1395i-3, 1396r (2000), *added by* Nursing Home Reform Law, Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, §§ 4201–4218, 101 Stat. 1330, 1330-160 to 1330-221; *see also* 42 C.F.R. §§ 483.5–.75 (2001) (discussing the requirements for long-term care facilities). *See generally* 1–6 Medicare and Medicaid Guide (CCH).

348. *See generally supra* text accompanying notes 36–63.

349. CARLSON, *supra* note 40, §§ 5.101–.152 (addressing state statutes on assisted living facilities), 6.101–.152 (addressing state statutes on continuing care retirement communities).

350. *See* Floyd, *supra* note 59, at 33.

so doing, long-term care insurance could overcome one of its biggest impediments—namely, that it provides coverage for what people dread, an extended stay in a nursing home. Instead, long-term care insurance would pay for long-term care in settings that older people find much more acceptable.

This change would also address another major obstacle that currently plagues long-term care insurance: the high cost of premiums. Because this insurance would no longer need to cover the high cost of nursing homes, premiums could be lowered dramatically, thereby making this insurance more affordable and less distasteful to prospective buyers.

By focusing on long-term care settings other than nursing homes, moreover, long-term care insurance could be made less confusing. For example, insurance geared to ALFs, CCRCs, and other long-term arrangements would no longer need “elimination periods” and other concepts that make sense only in the episodic context of nursing home stays. Similarly, benefit payouts could be based on monthly charges, rather than daily rates.

Furthermore, changing the nature of long-term care insurance could serve as an occasion to improve the product more generally. For example, contract features should be standardized to facilitate cost comparisons, as is the case currently with Medigap insurance policies.<sup>351</sup> Instead of the existing multiplicity of options, long-term care insurance could be offered for only certain specific periods, such as three years, six years, or life. In addition, consumers should 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.<sup>352</sup> 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 become illusory. If these improvements are made, then long-term care insurance would become an effective mechanism by which older

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351. See 2003 GUIDE, *supra* note 111, at 10.

352. In 2000, the National Association of Insurance Commissioners amended the model long-term care insurance act requiring the policyholder to acknowledge that future rate increases are possible. See NAIC News Release, June 2000, available at <http://www.naic.org/pressroom/naicnews/news2000/NNewsJune2000.pdf> (last visited Feb. 1, 2004).

An amendment to the model long-term care insurance regulation purports to deal with the problem of subsequent premium increases, but its remedies fall short of most consumers’ expectations. This amendment provides that an insured who receives a premium increase may opt to maintain her current premium schedule, but must accept *reduced* benefits that such premiums would now purchase. In other words, the insured is subject to a retroactive decrease in anticipated benefits. And if the increases exceed a specified cap, which depends upon an insured’s age when the policy was issued, that person may receive instead a policy providing benefits equal to the premium amounts paid thus far. See Long-Term Care Insurance Model Reg., app. F (2002), available at [http://www.naic.org/models\\_papers/models/docs/lcreg1.doc](http://www.naic.org/models_papers/models/docs/lcreg1.doc) (last visited Feb. 1, 2004).

Using the example set forth in the text accompanying *supra* notes 311–14, assume that the insured has received notice of a premium increase that exceeds the specified cap. In that case, the insured may receive a policy providing benefits equal to only \$26,100 (annual premiums of \$1,740 for fifteen years) rather than the \$303,680 (daily benefit of \$208 for four years) that the policy claimed to provide—an effective reduction in coverage of more than ninety-one percent!

people shift the financial risk of long-term care in settings that they find more appealing.

### C. *Financing Implications of These Proposals*

If Medicare's obligations are extended to cover nursing homes, then the resources of that program will obviously require augmentation. Rather than simply increase Medicare's existing payroll tax,<sup>353</sup> this programmatic expansion could serve as an occasion to fundamentally reexamine Medicare's financing structure. Looking at this issue afresh, there is no reason to fund Medicare by a tax that applies only to income from labor. Medicare benefits received are a function of an enrollee's health and not that person's payroll tax contributions—unlike Social Security, where the benefits received are correlated with the earnings that have been subjected to the program's payroll tax.<sup>354</sup> The entire Medicare program, therefore, should be funded in the same manner as Medicare Part B: general tax revenues plus premiums paid by enrollees.<sup>355</sup> The precise ratio of these two sources is certainly debatable, but the point remains that whatever revenue sources fund government operations generally should fund at least part of Medicare's expenditures. Accordingly, the Medicare payroll tax should be repealed.

A reappraisal of current law is also in order with respect to long-term care insurance premiums. As reconstituted under the proposal set forth above, long-term care insurance would cover the cost of care in settings where the delivery of health care is incidental or only minimally involved. Accordingly, this insurance would no longer be analogous to health insurance, and premiums for such insurance should therefore not be classified as a medical expense for tax purposes. The present classification has resulted in few benefits to taxpayers and serves primarily as a marketing ploy.<sup>356</sup> Consequently, classifying these premiums as nondeductible expenses would impact few current or potential policyholders and would signal that long-term care insurance is an investment product, rather than a health care financing mechanism.

## VI. CONCLUSION

The provision of long-term care is an increasingly important societal concern as more Americans live long enough to require assistance with their daily routines. The current system of financing such care is a poorly designed hodge-podge with no underlying rationale. It offers no security to

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353. I.R.C. §§ 3101(b) (employees), 3111(b) (employers) (2000).

354. See FROLIK & KAPLAN, *supra* note 16, at 282–87 (explaining how Social Security benefits are derived from a worker's lifetime earnings).

355. 42 U.S.C. § 1395r(a)(1), (3) (2000); see also NAT'L ACAD. OF SOC. INS., FINANCING MEDICARE'S FUTURE 29 (2000) (discussing how Medicare Part B is funded).

356. See *supra* text accompanying notes 254–64.

afflicted senior citizens or their families and inflicts major financial burdens in an essentially random fashion.

Instead of the current system, this article proposes that all nursing home costs be covered by Medicare, the government's health care system for older Americans, rather than demanding that older people satisfy the impoverishment requirements of Medicaid, the government's health system for poor people. By treating these costs as it does hospital expenses, Medicare could spread the risk of substantial medical expense and fulfill retirees' reasonable expectations that their health care expenses will be covered. Care in nonmedically oriented settings would remain a private responsibility, but long-term care insurance—improved as this article suggests—could be purchased to shift the financial burden of such care. By allocating the responsibility for long-term care in this fashion, families could protect themselves as they see fit without facing the cruel prospect of destitution when a loved one enters a nursing home.

