

A CALL TO ACTION FOR NATIONAL LONG-TERM CARE REFORM: INDIANA'S PRIVATE-PUBLIC COOPERATIVE AS A MODEL

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INTRODUCTION

Your seventy-one-year old widowed grandmother has savings and other financial assets of \$60,000 in addition to a house and one car, which she owns outright. Meager Social Security benefits, interest from savings, and a survivorship benefit from Grandpa's pension plan¹ constitute her total monthly income of \$750. She is in typical health for her age and has Medicare Part B and private medical insurance to supplement acute or catastrophic costs.

The picture just painted might otherwise be a financially rosy one for a person in Grandma's situation. Ironically, she faces a catastrophe that will impair her not only physically, but will also burden her and her family emotionally and financially. As a female over age sixty-five,² and particularly because she has no spouse to care for her,³ Grandma is a likely candidate for some form of extended nursing care. At a national average cost of \$37,000 per year,⁴ Grandma will have exhausted all of her savings and income to pay for nursing home (or even home health) care in just two years. Medicare will pay less than five percent of her long-

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** This Research is dedicated to my late grandmother, Bernice Bechtel, and to all of her care givers and family members who relentlessly tended to her in and out of the nursing home for more than twelve years; and to my grandmother, Frances Jarnagin, with the hope for continued good health and independence.

1. Grandma is one of the lucky few whose spouse elected the survivorship. Before the Retirement Equity Act of 1984 was passed (Pub. L. No. 98-397, 98 Stat. 1426 (codified as amended in scattered sections of 26 and 29 U.S.C.)), workers could—and to obtain higher lifetime payouts often would—decline survivorship benefits without consent of the spouse. JOHN R. WOLFE, *THE COMING HEALTH CRISIS: WHO WILL PAY FOR CARE FOR THE AGED IN THE TWENTY-FIRST CENTURY?* 11 (1993).

2. Half of all women over age 65 will enter a nursing home at least once in their lifetime. Peter Kemper & Christopher M. Murtaugh, *Lifetime Use of Nursing Home Care*, 324 *NEW ENG. J. MED.* 595, 598 (1991). See *infra* note 21 for more complete demographics.

3. Kemper & Murtaugh, *supra* note 2, at 597. Persons living without spouses have more difficulties with Activities of Daily Living (ADLs) and those living with spouses have fewer ADL deficiencies. AGENCY FOR HEALTH CARE POLICY & RESEARCH, U.S. DEP'T OF HEALTH AND HUMAN SERVS., PUB. NO. 90-3462, *FUNCTIONAL STATUS OF THE NONINSTITUTIONALIZED ELDERLY: ESTIMATES OF ADL AND IADL DIFFICULTIES* (1990).

4. JOSHUA M. WIENER ET AL., *SHARING THE BURDEN: STRATEGIES FOR PUBLIC AND PRIVATE LONG-TERM CARE INSURANCE* 1 (1994).

term care costs,⁵ her supplemental medical insurance will pay less than one percent,⁶ and Medicaid will not pay at all unless and until she is impoverished.⁷ Grandma and her family will shoulder about half the burden.⁸

Long-term care (LTC) costs are a significant concern of persons age sixty-five and over—the largest, fastest-growing and wealthiest age group in the United States today.⁹ Yet, while national health care reform has been catapulted to the political forefront, none of the proposals respond adequately¹⁰ to the needs of this politically powerful demographic group.¹¹ Threats of national LTC reform by means of a public program, although silent since the defeat of the Health Security Act,¹² stifled reform developments among the states and in the private insurance market. Although the campaign for public health care reform increased public awareness and debate on financing issues, it hindered the development of solutions by the private sector whose role in the national solution, relative to the public sector's role, is relegated to a residuary and reactionary one.¹³ Is there any relief in sight for our nation's senior citizens and their largest economic concern?

Among several models proposed in recent years, and one in which this Note seeks to revive interest, is a state-endorsed program with an emphasis on private insurance and some expansion of public programs that may serve as a model for, if not a solution to, national senior health care reform. The Indiana Long Term Care Program (ILTCP),¹⁴ one of several state "partnership" programs,¹⁵ encourages Grandma to purchase private LTC insurance for the first few years of extended home or institutional nursing care. In return, when the private insurance proceeds are exhausted, an equivalent amount of Grandma's assets, up to the total amount of LTC insurance dollars paid, are protected from Medicaid "spend down" rules.¹⁶ Eligibility for Medicaid is expanded so she is able to receive public

5. *Id.* at 6. See also WOLFE, *supra* note 1, at 59 (In 1986, Medicare paid for only 1.6% of nursing home expenses in the United States.).

6. WOLFE, *supra* note 1, at 60. See *infra* notes 42-44 and accompanying text.

7. See *infra* text accompanying note 50.

8. See *infra* note 41 and accompanying text.

9. MEREDITH A. COTE, *Collective Political Influence of Those Over Age 65*, in MATURING SOCIETY IN THE MATURING HEALTH CARE SYSTEM: REPORT OF THE SECOND ROSS HEALTH ADMINISTRATION FORUM 29 (1984).

10. See *infra* notes 88-89, 104-110 and accompanying text.

11. COTE, *supra* note 9, at 29.

12. H.R. 3600, 103d Cong., 1st Sess. (1993) (President Clinton's health care reform proposal introduced into the House of Representatives on Nov. 20, 1993). The full text of President Clinton's proposal, prior to its introduction, can be found at 139 CONG. REC. E2571 (daily ed. Oct. 28, 1993) (statement of Rep. Bonior).

13. See *infra* text accompanying notes 88-92.

14. IND. CODE §§ 12-10-9-1 to -11 (1993 & Supp. 1995); IND. CODE §§ 27-8-12-7 to -7.1 (1993 & Supp. 1995); IND. ADMIN. CODE tit. 760, r. 2-20-1 to -43 (Supp. 1995). See *infra* Part III.A-B.

15. See *infra* notes 111-24 and accompanying text.

16. See *infra* Part I.C. on Medicaid spend down.

assistance for LTC. Grandma benefits by obtaining high-quality insurance coverage and by retaining control of her assets for her own use or to pass on through her estate. The state benefits by reducing or at least containing the drain on its Medicaid budget.¹⁷

While ILTCP and four other private-public programs are not designed to protect either the indigent or the individual of substantial means, they do provide relief for a large group of America's seniors who have few alternatives. These few programs, which are in their infancy, stalled because they were seen as threats to the public health care reform proposals. Yet, their developmental history and design may provide a framework for either a national program or federal supervision and coordination of similar systems in all states.

This Note will analyze the development of the ILTCP as an example of other private-public cooperatives, critique its shortcomings, and discuss whether it can serve as a model for national action. It will also compare the most prominent alternatives for national LTC reform and why the private-public cooperative system may or may not improve on them. Part I provides background into the immediacy of the LTC problem and the failings of the current financing system. Part II introduces a measuring stick for LTC proposals with discussion of some advantages and disadvantages of public and private solutions. Part III analyzes the ILTCP and its development, along with a presentation of the popular critiques of and the arguments in support of the program. Part IV explains why the private-public mix presented by ILTCP is an integral part of national LTC reform; however, additional ingredients in the form of public and private enhancements are also vital for an effective and more complete solution and are suggested as necessary complements to the ILTCP model. Finally, Part V concludes that private-public cooperatives like ILTCP are critical for defining not only the private sector's role, but also the public sector's role in LTC financing reform and will lead the charge in the coming months and years toward an equitable and efficient solution to senior health care reform.

I. THE NATIONAL LTC TIME BOMB

A. *Economic Impact of an Aging America*

An aging America¹⁸ is faced with an extraordinary dilemma: seniors no longer fear death, they fear living too long. Although modern medical technology has improved life expectancy,¹⁹ it has also produced substitute evils in the form of

17. See *infra* text accompanying notes 198-202 discussing the debate whether ILTCP-type plans reduce, increase or maintain current Medicaid expenditures.

18. The 65-and-older group, now with 31 million members, is 10 times larger than it was in 1900; the 85-and-older group is the fastest-growing age group, with a 33% growth spurt in the 1980s compared to 10% for the rest of the population. Teri Randall, *Demographers Ponder the Aging of the Aged and Await Unprecedented Looming Elder Boom*, 269 JAMA 2331, 2331-32 (1993) [hereinafter *Elder Boom*].

19. See WOLFE, *supra* note 1, at 15, 23-24 (life expectancy at age 85, at least by some forecast methods, has increased since the 1970s).

chronic and debilitating illnesses and their associated costs.²⁰ Two out of five persons who turned age sixty-five in 1990²¹ will enter a nursing home at least once in their lifetime, and that probability increases with advancing age.²² Of those who will enter institutions, fifty-five percent will have total lifetime nursing home use of at least one year.²³

Baby Boomers, the soon-to-be "Elder Boomers," fear they will out-live their financial assets.²⁴ Besides the deficiencies in their own long-term savings,²⁵ Elder Boomers will also be failed by social support programs: Old-Age and Survivor's Income (OASI, commonly referred to as Social Security) will expire in fifty years and Medicare's hospital insurance will be bankrupt in just five years.²⁶ Compounding this problem is the fact that in the year 2005, the oldest Baby Boomers will only be sixty years old and at the beginning stages of their support needs; in 2030, just thirty-five years away, the Baby Boom population bulge will be out of the work force and into hospitals and nursing homes.²⁷ Consider, too, that some Elder Boomers face the unprecedented likelihood of caring for their frail, very old parents even in their own old age.²⁸ The lack of foresight, and for some individuals the inability, to save for future medical needs, and the meager allocation of scarce public resources on the part of government are evidence that "we, as a society, have not yet made adequate preparation to meet the staggering

20. Even if death is occurring at older ages, that is no indicator that chronic and debilitating illnesses (often referred to as morbidity) are likewise commencing at older ages. Rather, "[i]f the average age at death increases by more than the average age of onset of chronic illness, then the population suffering from chronic illness grows, giving rise to increases in dependency and resource use." *Id.* at 17.

21. Forty-three percent of all persons who turned 65 in 1990 (52% and 33% of older women and men respectively) will enter a nursing home at least once before they die. Kemper & Murtaugh, *supra* note 2, at 597-98 (based on the National Mortality Followback Survey of 1986). Notice that Grandma is among those who turned 65 in 1990.

22. Between ages 65 and 74 there is a 17% chance of nursing home use, 36% from ages 75 to 84. The likelihood jumps to 60% for those over age 85. *Id.* at 596.

23. *Id.* at 597. Additionally, 24% of all persons over age 65 will accumulate up to one year in a nursing home over their lifetime. Nine percent (most of them widowed women) will have total lifetime use of five years or more. *Id.*

24. Jane B. Quinn, *Policies for Old-Age Care*, NEWSWEEK, April 20, 1992, at 62.

25. Baby Boomers' personal savings rate plunged in the 1980s and remains well below the historical standards. WOLFE, *supra* note 1, at 5.

26. U.S. SOCIAL SECURITY BD. OF TRUSTEES OF THE FED. HOSP. INS. TRUST FUND, STATUS OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS: A SUMMARY OF THE 1993 ANNUAL REPORTS (1993); see also WOLFE, *supra* note 1, at 1, 3.

27. WOLFE, *supra* note 1, at 4.

28. *Elder Boom*, *supra* note 18, at 2332. "In 1990, there were nine people aged 85 years and over per 100 persons aged 50 to 64." *Id.* That means, assuming for the moment this figure will not increase, nine percent of Elder Boomers may have to care for their elderly parents even while they prepare for their own retirement.

future needs that we in fact consider probable.”²⁹

B. Current Costs and Financing Alternatives

National expenditures for nursing home and home health care (HHC) costs for 1993 were estimated at more than \$74 billion.³⁰ The average nursing home stay lasts two and one-half years³¹ at an average annual cost of \$37,000. An important caveat to these and all statistical LTC data currently available is that these numbers do not account for many of the nation’s LTC users. Studies have estimated that more than seventy percent of seniors needing LTC receive it informally from unpaid care givers,³² primarily from their spouses or female family members.³³ Further, nursing homes are being used differently today than ever before. Because Medicare forces patients out of the hospital sooner,³⁴ nursing homes are often used for short-term, post-hospital-treatment convalescent stays. These short stays may skew what is otherwise a longer nursing home average stay; thus, the average is understated.³⁵ Absent accurate data on informal care, national LTC consumption statistics reflect primarily nursing home data and, therefore, significantly underestimate costs, levels, and lengths of all other types of LTC provided.

The first payor of nursing home care is often Medicare,³⁶ but it only pays for a maximum of 100 days for skilled nursing care³⁷ in a certified facility and only after a hospital admission of three or more days.³⁸ With these limitations and

29. WOLFE, *supra* note 1, at 1.

30. *Id.* at 6. By the year 2000, nursing home care in the United States will cost \$125 billion. Patrick P. Coll, *Nursing Home Care in 2001*, 36 J. FAM. PRAC. 431, 431 (1993).

31. *Program Overview*, PARTNERSHIP UPDATE (Partnership for Long-Term Care, University of Maryland, Center on Aging, College Park, Md.), Dec. 1994, at 1 [hereinafter PARTNERSHIP UPDATE, Dec. 1994].

32. Teri Randall, *Insurance—Private and Public—a Payment Puzzle*, 269 JAMA 2344, 2345 (1993) [hereinafter *Private-Public Payment Puzzle*]. See also WOLFE, *supra* note 1, at 58 (“[T]hree-fourths of the functionally disabled elderly are helped solely by family members, compared to only about one-fifth who are cared for in nursing homes.”).

33. Nearly 84% of the noninstitutionalized, disabled elderly received assistance from relatives and friends, sometimes supplemented by paid services. WOLFE, *supra* note 1, at 5-6. Non-paid family LTC services were estimated at more than 27 million unpaid days of informal care each week. *Id.* at 6.

34. See *infra* note 77 and accompanying text.

35. Kemper & Murtaugh, *supra* note 2, at 598.

36. Health Insurance for the Aged Act, Pub. L. No. 89-97, 79 Stat. 290 (1965) (codified as amended in scattered sections of 26, 42, and 45 U.S.C.). See *infra* notes 77-79 and accompanying text suggesting that Medicare’s prospective payment system forces it to be a primary payor of the initial LTC burden.

37. 42 C.F.R. § 409.31 (1994) (skilled care requirements). Custodial care is not covered, even though it is the most common type of long-term care provided. 42 U.S.C. § 1395 (1988 & Supp. V 1993).

38. When these criteria are met, Medicare pays 100% of reasonable skilled nursing home

when most nursing home care is provided on a non-skilled level,³⁹ it is easy to understand why Medicare paid less than five percent of the nation's LTC costs in 1991.⁴⁰

If the patient does not meet the above criteria or continues to need care past 100 days, she bears 100 percent of the remaining LTC costs. Forty-six percent of national LTC expenditures are borne by LTC patients and their families from their private assets⁴¹ or, if coverage allows, from private medical or LTC insurance.

Private insurance, including LTC insurance, pays less than one percent of all LTC expenses.⁴² Besides problems with affordability, factors contributing to this low insurance participation include: 1) general attitudes toward insurance; 2) the inadequacies of "first-generation" LTC products such that benefits were inadvertently or even deliberately "designed out" of the policies;⁴³ and 3) confusion in the market as to what role and direction the government will take on this portion of health care reform.⁴⁴ Whether the private sector participation level will improve depends in large part on the public sector's role and the use of incentives to encourage private LTC insurance protection as the primary payor.

costs for the first 20 days, then pays a per diem rate (\$92.00 in 1996) for the next 80 days, with a co-payment by the LTC cohort. 42 C.F.R. § 409.85 (1994); Medicare Program: Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 1996, 60 Fed. Reg. 53,625 (1995) (1996 rates). Medicare also pays for skilled home care in the form of home health aides, physical, occupational and speech therapy, and medical social work. Laurence G. M. Branch et al., *Medicare Home Health: A Description of Total Episodes of Care*, 14 HEALTH CARE FIN. REV. 59 (1993).

39. Alan M. Kunerth, *Timely Medicine for the LTC Crisis*, BEST'S REV.—LIFE-HEALTH INS. EDITION, January 1992, at 34, 35.

40. WIENER ET AL., *supra* note 4, at 6.

41. PAMELA F. SHORT ET AL., NATIONAL MEDICAL EXPENDITURE SURVEY, EXPENDITURES AND SOURCES OF PAYMENT FOR PERSONS IN NURSING AND PERSONAL CARE HOMES 5 (1994); *Private-Public Payment Puzzle*, *supra* note 32, at 2344-45.

42. WOLFE, *supra* note 1, at 59. Private medical insurance, often provided by employers as a retiree benefit, usually does not cover extended nursing care. *Id.* See also Marc A. Cohen et al., *Financing Long-Term Care: A Practical Mix of Public and Private*, 17 J. HEALTH POL. POL'Y 403, 405 (1992).

43. Deficiencies in products as well as marketing abuses have been addressed by the National Association of Insurance Commissioners (NAIC) Long-Term Care Ins. Model Act. See 3 OFFICIAL NAIC MODEL INSURANCE LAWS, REGULATIONS, AND GUIDELINES (Nat'l Ass'n Ins. Comm'rs rev. ed. 1993) [hereinafter NAIC MODEL ACT]; and see the following proposed legislation: Long-Term Care Insurance Consumer Protection Act of 1991 (H.R. 1916, 102d Cong., 1st Sess. (1991)); Consumer Protection Standards for Long-Term Care Insurance Act of 1991 (H.R. 2378, 102d Cong., 1st Sess. (1991)); Long-Term Care Insurance Improvement and Accountability Act of 1992 (H.R. 4848 (Title III), 102d Cong., 2d Sess. (1992)).

For helpful advice on selecting LTC insurance see Alfred Hill, Jr., *Standards for Selecting Long Term Health Care Insurance*, TR. & EST., Apr. 1993, at 41; Douglas Shapiro, *Assisting Older Persons With Long-Term Care Insurance Choices*, 25 CLEARINGHOUSE REV. 679 (1991).

44. Cohen et al., *supra* note 42, at 412.

C. *Saving Up to Spend Down: The Medicaid Anomaly*

After personal assets are depleted or “spent down” on LTC or other health care costs, the private-pay cohort is often converted to a Medicaid cohort. One study found that 12.7 percent of nursing home residents who receive Medicaid assistance were first admitted as private-pay patients—that is, when they entered the facility, they were able to pay for their own LTC costs but soon spent down to Medicaid eligibility.⁴⁵ Data from surveys in Wisconsin and Connecticut, however, indicate higher spend-down rates of thirty-five and fifty percent respectively.⁴⁶ Although it was designed at its inception to be the payor of last resort, Medicaid⁴⁷ now funds forty-five percent of the nation’s LTC burden.⁴⁸ Medicaid accounted for the largest portion of government spending on nursing homes and home care for the elderly in 1993.⁴⁹ Because it is a welfare program, eligibility for Medicaid is limited to those who meet a strict means test: generally, unmarried persons may not own assets (except a home) in excess of \$2,000 and must contribute virtually all of their monthly income to help pay for their care.⁵⁰ In the past, these “asset

45. SHORT ET AL., *supra* note 41, at 12. Paul Cotton, *Must Older Americans Save Up to Spend Down?*, 269 JAMA 2342, 2342 (1993).

46. Cotton, *supra* note 45, at 2342; Greg Arling et al., *Medicaid Spenddown Among Nursing Home Residents in Wisconsin*, 31 GERONTOLOGIST 174 (1991); Korbin Liu & Kenneth Manton, *Nursing Home Length of Stay and Spenddown in Connecticut, 1977-1986*, 31 GERONTOLOGIST 165 (1991). A recent study, which disaggregated spend down components, estimated that one-third of Medicaid enrollees were not eligible when admitted and between 30% and 40% of Medicaid expenditures can be attributed to “spend-downers.” E. Kathleen Adams et al., *Asset Spend-Down in Nursing Homes: Methods and Insights*, 31 MED. CARE 1, 21 (1993).

47. 42 U.S.C. § 1396 (1988 & Supp. V 1993). On average, Medicaid is 69% federally funded and 31% funded by the individual states, although the ratio differs from state to state. Katharine R. Levit et al., *National Health Care Spending, 1989*, HEALTH AFFAIRS, Spring 1991, at 122. Consequently, spend down requirements in each state also differ. *See infra* note 50 for Indiana’s spend down requirements for couples.

48. Adams et al., *supra* note 46, at 17.

49. WIENER ET AL., *supra* note 4, at 6.

50. *Id.* at 7; 42 U.S.C. § 1396a (1988 & Supp. V 1993). For married couples, the spouse remaining in the community has a higher asset and income threshold, allowing the couple to keep some assets while the other spouse is institutionalized and receiving Medicaid assistance. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683 (1988) (codified in scattered sections of 26 and 42 U.S.C.) and Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, 103 Stat. 1979 (codified in scattered sections of 26 and 42 U.S.C.) (spousal impoverishment rules were not repealed). In Indiana, as of January 1, 1996, the in-home spouse may retain up to one-half of the couple’s non-exempt assets up to a maximum of \$76,728 (but not less than \$15,346) and \$1,254 of the total monthly income. INDIANA CLIENT ELIGIBILITY SYSTEM MANUAL ch. 3000, at 4 (1995); *1996 Spousal Impoverishment Limits*, PARTNERS UPDATE (Indiana Long Term Care Program, Family & Social Servs. Admin., Indianapolis, Ind.), Dec. 1995, at 2. The rest must be contributed to pay the LTC spouse’s costs of care.

spend down" guidelines were incentives for some seniors with significant financial resources to transfer assets to family members, trusts or other persons and institutions in order to "look poor"⁵¹ to qualify for Medicaid assistance.⁵² For many though, asset spend down is not just a game or loophole scheme; it is a frightful reality. Asset spend down can be as emotionally devastating as an illness can be physically debilitating.⁵³ "[F]inancial impoverishment, with its attendant restrictions on lifestyle and its dampening of an elder's ability to leave a significant financial inheritance to [his or] her heirs, is perhaps the most feared result of the aging process."⁵⁴

II. PROPOSALS FOR LTC FINANCING REFORM

Before reviewing some current LTC reform proposals, it is necessary to discuss important considerations for resolving LTC's financing problems.⁵⁵ Among these are: 1) educating the public and assuring quality information for decision-makers; 2) defining the scope of LTC; 3) controlling costs; 4) assuring quality of care; and 5) balancing responsibility between the private and public sectors.⁵⁶ These factors are revisited later in order to assess the viability of the private-public cooperative programs.

51. Cotton, *supra* note 45, at 2342 (explaining the anomaly and discussing books on how to exploit loopholes and avoid asset spend down).

52. However, the loopholes have been tightened by the Omnibus Budget Reconciliation Act of 1993 (OBRA-93), which expanded the "look back" period to 36 months for most assets and even longer (60 months) for trusts and other assets. Pub. L. No. 103-66, § 13611(a)(1), 107 Stat. 312, 622 (1993) (amending 42 U.S.C. § 1396p(c)(1) (1988 & Supp. V 1993)); *see also* Patricia Nemore et al., *Just When You Thought You Had Learned the Rules, They Went and Changed Them: OBRA-93 Provisions Concerning Medicaid Transfer of Assets, Treatment of Certain Trusts, and Estate Recoveries*, 27 CLEARINGHOUSE REV. 1199 (1994).

53. "One of the great fears of the elderly is that they will be a burden on their children." Joshua M. Wiener & Raymond J. Hanley, *Long-Term Care Financing: Problems and Progress*, 12 ANN. REV. PUB. HEALTH 67, 70 (1991).

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

55. Kapp suggests that these same considerations, which are about to be discussed, are the reasons why LTC financing has been treated as a public policy "third rail" and has not been squarely addressed. *Id.* at 733. The same sentiment is shared by Mark R. Meiners, Director of the Partnership for LTC, who says LTC has been the "forgotten stepchild in the health care forum debate." *Long-Term Care Tax Provisions in the Contract with America: Hearings on H.R. 8 Before the Subcomm. on Health of the House Comm. on Ways and Means*, 104th Cong., 1st Sess. 6 (1995) (testimony of Mark R. Meiners, Robert Wood Johnson Foundation Partnership for Long-Term Care) [hereinafter Meiners Testimony].

56. Kapp, *supra* note 54, at 733. For additional, disaggregated criteria, see Cohen et al., *supra* note 42, at 412-15.

A. *Considerations for LTC Financing Proposals*

The first hurdle to clear en route to LTC reform is increasing public awareness about the inadequacy of the current LTC financing system. More importantly, the public must be educated about the probability of needing LTC, its costs and financing mix, and the alternative methods for delivering LTC services. "People seem willing to accept the possibility that they will someday get sick . . . but few people will admit that they face a significant lifetime risk of becoming disabled and using expensive nursing home or home care."⁵⁷ Elderly and non-elderly find, often to their surprise, that neither Medicare nor private medical insurance covers LTC costs.⁵⁸ Although persons may have some LTC experience within their family, few are knowledgeable about the alternatives of in-home and community care; particularly with services that are covered by Medicare.⁵⁹ "The presence of knowledgeable consumers is a necessary condition for the development of an efficient private insurance market."⁶⁰

Not only are individuals misinformed about LTC, but the government and the suppliers of LTC financing also lack accurate data on the actual need for all types and levels of LTC—including informal family-provided home care and the existence of elders who remain at home but do not receive the care they need, formally or informally. Without this information public and private insurers cannot adequately project the use and costs of LTC benefits. For national reform to occur, a new national mindset is needed: the risk of needing LTC is a normal risk of living longer and requires planning on the part of the individual, the community, and the public sector in order to reduce the risk of personal impoverishment.⁶¹

With the expansion and the interchangeability of the types of LTC delivery, it is equally difficult to identify the field of LTC and to define the level of deficiency in basic activities that triggers the payment of benefits.⁶² "It is a daunting task to define the field and determine with the level of specificity demanded by a workable financing scheme what particular services (for example, respite care, adult day care, home personal care attendants) should qualify for

57. Wiener & Hanley, *supra* note 53, at 72.

58. WIENER ET AL., *supra* note 4, at 2.

59. MARGARET STRAW, AMERICAN ASS'N OF RETIRED PERSONS, HOME CARE: ATTITUDES AND KNOWLEDGE OF MIDDLE-AGED AND OLDER AMERICANS 4-6 (1991). While 41% of the respondents age 45 and older had some experience with LTC, only 47% said they were "fairly-" or "well-informed" about HHC. *Id.* See also *Challenge of Providing Long-Term Health Care: Hearings Before the Subcomm. on Medicare and Long-Term Care of the Senate Comm. on Finance*, 102d Cong., 2d Sess 47 (1992) (statement of Paul Willging, Ph.D, Executive Vice President, American Health Care Association) [hereinafter Willging Statement].

60. Cohen et al., *supra* note 42, at 419.

61. Wiener & Hanley, *supra* note 53, at 83.

62. The NAIC Model Act took some measures against this. See NAIC MODEL ACT, *supra* note 43. See also WIENER ET AL., *supra* note 4, at 31-32 & n.5.

inclusion or exclusion."⁶³ It is more manageable to define and include acute care because it is more drastic. The subtler, more intricate services rendered for chronic and debilitating impairments are more difficult to pin down; these services must be better identified and defined if they are to be included in a reformed system.

Cost containment is a chief concern for all Americans, particularly if public entitlement programs like Medicaid or Medicare are expanded to absorb the costs of LTC. When introducing LTC insurance, whether privately⁶⁴ or publicly insured, two phenomena that may drive up costs are adverse selection (those who know they will use LTC will disproportionately buy or use the insurance)⁶⁵ and moral hazard (insureds are not risk averse).⁶⁶ The adverse selection dilemma in private insurance occurs when low-risk individuals choose not to buy the coverage.⁶⁷ In the public sector, adverse selection is inherent in the welfare program because the impoverished or lower-income individuals are often at the greatest risk of poor health and have fewer cost-effective, non-nursing home alternatives. Thus, their higher frequency and longer periods of LTC use adversely skew the public program's risk group.⁶⁸ "The surest way to avoid adverse selection in health-care or long-term-care insurance is to make insurance available to young consumers, before the emergence of most chronic health problems."⁶⁹ The greatest obstacles that prevent the infusion of younger insureds and the normalization of the risk pool are the difficulties: 1) in motivating young, healthy individuals to purchase benefits or participate in public programs, and 2) in projecting thirty or forty years into the future the frequency of LTC use and the effects of inflation on LTC costs.⁷⁰

"Whereas adverse selection is a distortion in the demand for insurance, moral hazard is a distortion in the behavior of those who are already insured, reducing

63. Kapp, *supra* note 54, at 733. To this confusing mix one should add hospice care, therapeutic equipment, community living services and family-provided services.

64. For a more thorough discussion of the economic affects of these phenomena on private insurance, see WOLFE, *supra* note 1, at 68-92.

65. Wiener & Hanley, *supra* note 53, at 73; WOLFE, *supra* note 1, at 68.

66. See *infra* notes 71-73 and accompanying text.

67. WOLFE, *supra* note 1, at 69.

68. SHORT ET AL., *supra* note 41, at 6-7. The study determined that 55.4% of those with family incomes less than \$5000 were institutionalized for the entire year compared with 45.6% of all other income groups; only 3.3% of Medicaid nursing home residents returned to the community and survived there compared to 12.3% of private-pay residents. *Id.*

69. WOLFE, *supra* note 1, at 77 (citing Mark V. Pauly, *What is Adverse About Adverse Selection?*, 6 ADVANCES HEALTH ECON. & HEALTH SERVICES RES. 281-86 (1985)). The earlier insurance is sold, the less chance that young consumers can know their individual chance of illness or disability. Because they cannot know if they are high-risk prospects, they cannot choose to disproportionately buy insurance. Consequently, the risk pool is more normal. *Id.*

70. If actual health care inflation is 2% higher than projected, in 37 years LTC coverage may be grossly underfunded, covering as little as half the actual costs of care. *Id.*

their aversion to losses.”⁷¹ The most common form of moral hazard in the public sector is the “woodwork effect”: those persons who now cope without public assistance would, upon its expanded availability, “‘crawl out of the woodwork’ and suddenly ‘need’ public financial assistance.”⁷² Their expanded use drives up LTC costs. Two forms of moral hazard exist on the private side where insureds who do not pay out-of-pocket: 1) are less likely to prevent and limit their exposure, and 2) are induced to demand “Cadillac care” in the form of excessive, higher-quality, and more expensive services.⁷³ While the first problem is difficult to control, the second may be mitigated with more specific payment guidelines for eligible services.

In addition, costs may be controlled through less expensive delivery systems. New forms of LTC delivery have emerged in recent years in the form of adult day care, respite care, community living and home health care (HHC). Today’s LTC proposals place a great deal of emphasis on HHC and community care services⁷⁴ because they are usually less expensive and, in fact, are preferred by a substantial portion of American seniors.⁷⁵ Government officials and their constituents alike have embraced the idea that “[t]he most important long-term care reform that Congress can enact is to eliminate the nursing home bias.”⁷⁶

One victim of cost containment is quality of patient care, particularly where caps on public programs like Medicare and Medicaid are involved. Medicare’s prospective payment system through diagnosis-related groups (DRGs) results in patients being released from the hospital quicker and sicker,⁷⁷ often to nursing

71. *Id.* at 83.

72. Kapp, *supra* note 54, at 734. Higher quality data on informal LTC use, as discussed above, may help reduce this impact of the moral hazard.

73. WOLFE, *supra* note 1, at 83-84. “Few losses are pure acts of God. In the case of [a privately] insurable medical event, virtually all patients exercise some choice over the care they receive.” *Id.* at 83.

74. *See, e.g.*, H.R. 3600, *supra* note 12; THE PEPPER COMMISSION: U.S. COMM’N ON COMPREHENSIVE HEALTH CARE, A CALL FOR ACTION (1990) (final report) [hereinafter PEPPER REPORT].

75. “Mr. Speaker, if you asked most Americans the best way to live out their last days, they’d say they would like to do it quietly at home. If you asked them the worst way to end their lives, they’d say years of bankruptcy and loneliness in a nursing home.” 138 CONG. REC. E1025 (daily ed. April 9, 1992) (statement of Rep. Waxman regarding The Long-Term Care Family Security Act, H.R. 4848, 102d Cong., 2d Sess. (1992)). *See also* STRAW, *supra* note 59, at 6-10 (44% of respondents preferred home care by family members and 28% preferred professional HHC services; even if round-the-clock care was needed, respondents preferred HHC).

76. *Long-Term Care and Drug Benefits Under Health Care Reform: Hearings Before the Senate Comm. on Finance*, 103d Cong., 2d Sess. 77 (1994) (statement of Richard C. Ladd, Commissioner, Texas Health & Human Services Commission).

77. Coll, *supra* note 30, at 431; Mathy Mezey & Terry Fulmer, *The Future of Nursing Home Care*, 325 NEW ENG. J. MED. 360, 360 (1991). Under Medicare’s Diagnosis-Related Groups (DRGs), payment maximums for medical services are unequivocally stipulated for all diagnoses and treatments. Each specific DRG designates the maximum hospital stay and total fee amounts for

homes for convalescent care. Yet, because Medicare and Medicaid reimbursements do not cover the full cost of care, nursing homes continue to be inadequately staffed.⁷⁸ “Not only does Medicaid require very low levels of income and wealth of its recipients, it also makes its beneficiaries second-class nursing home customers by placing a below-market ceiling on the daily reimbursement rates that it will pay.”⁷⁹ On the contrary, private-pay patients (through personal assets or private insurance) tend to pay full costs and may receive higher quality care. One could conclude that by paying the “full costs,”—that is, elevated rates—private-payors indirectly subsidize public-pay patients. Ideally, any new LTC program would provide equal access to quality services even though the funding mix may differ among patients.

Perhaps the most controversial of all cost issues is the question of how the costs and benefits of a new LTC program will be shared between public and private sources. Underlying the private-public debate, and central to the design of every LTC proposal, is the “Who pays, who benefits?” question which further raises issues of intergenerational inequity⁸⁰ and the political unattractiveness of welfare.⁸¹ At one extreme, a plan adopting universal social LTC insurance, regardless of financial need, reaps the advantages of centralized uniformity and efficiency, but it is also unresponsive to local concerns and too large to adapt to

which hospitals and medical providers will be reimbursed by Medicare. Because hospitals and providers will not be reimbursed for expenses beyond this limit, they discharge the patient sooner even if she has not fully recovered.

78. “Despite a more severely ill population of patients, over the past 10 years such staffing has remained the same or decreased. The average 100-bed nursing home continues to have only 1 registered nurse and 1 ½ licensed practical nurses per shift, and on average each patient receives less than 12 minutes of care from a registered nurse per day.” Mezey & Fulmer, *supra* note 77, at 360. This dilemma is compounded by the scarcity of physicians in nursing homes. *Id.* See also Coll, *supra* note 30, at 433 (discussing the current disincentives for physicians to practice in the nursing home environment).

79. WOLFE, *supra* note 1, at 67. See also WIENER ET AL., *supra* note 4, at 136.

80. Intergenerational equity proponents claim that older persons already consume more than their proportional share of available public resources and to increase programs for their benefit would short-change younger generations. Kapp, *supra* note 54, at 735. For a more detailed explanation and counter arguments to intergenerational inequity see WIENER ET AL., *supra* note 4, at 136-38. See also Robert L. Kane & Rosalie A. Kane, *A Nursing Home in Your Future?*, 324 NEW ENG. J. MED. 627, 628 (1991) (many people are uncomfortable about using public funds in a way that permits the beneficiaries to leave inheritances).

81. According to Wiener, the political downfall of Medicaid is that it is a welfare program. Joshua M. Wiener et al., Comment, *Financing Long-Term Care: How Much Public? How Much Private?*, 17 J. HEALTH POL. POL’Y & L. 425, 430 (1992) [hereinafter *How Much Public?*] (commenting on Cohen et al., *supra* note 42). If both rich and poor were included in a single LTC social program (Wiener supports a primarily social program), the political pull of the group could achieve greater things for the benefit of all its members. The poor would actually benefit from a non-means-tested program. *Id.*

inevitable changes and shifting needs.⁸² Although a new or expanded public program would be administratively efficient, the “woodwork effect” could dramatically increase costs. Depending on the method of financing,⁸³ the cost burden would be shouldered across generations, primarily affecting the young who already contribute to old age programs that may be drained before the young contributors are able to benefit from them.⁸⁴

At the other extreme, the emphasis on a purely private solution, with the government intervening only as a payor of last resort, places responsibility on the patient and her family rather than stretching it across other families and generations. Quality of care improves when the full costs of care are covered, but only those people who can afford to self-insure or pay high LTC insurance premiums can assure themselves the best quality of care. The same people tend to find it politically unpalatable to expand or create another kind of welfare program. In addition, moral hazards are still at work, although in a different form,⁸⁵ driving costs up and leaving more and more people out of the private insurance market. Furthermore, the uninsurable are still “uninsurable,” at least by the private sector, so the burden falls back on the public sector to provide care. The situation, therefore, is no different than the financing system that exists today.

Realistically, the solution will fall somewhere between these polar positions and will include a mix of coordinated public and private efforts.⁸⁶ Once one of the elements in this dynamic relationship becomes known, preferably the public sector

82.

There are several advantages to a national solution. Its policies are uniform and centralized, achieve economies of scale, and sufficiently distribute benefits and burdens among its citizens. . . . [The disadvantages are that they] are not tailored to local concerns and variations, are often dominated by special interest groups, and are paralyzed by the scope and complexity needed to make substantive changes.

Tracy Erwin, Note, *The Oregon Plan: An Ethical Solution to the Health Care Crisis?*, 26 J. HEALTH & HOSP. L. 133, 134 (1993) (citations omitted). See also Greg Arling et al., *The Feasibility of a Public-Private Long-Term Care Financing Plan*, 30 MEDICAL CARE 699, 716 (1992) [hereinafter Arling Simulation] (Medicare traditionally has had much lower administrative costs than the private insurance industry.).

83. Affirmative taxes on income, like those imposed for OASI (Social Security), OASDI and SMI (Medicare Part A), fuel the intergenerational inequity argument because they are applied across generations. Increased inheritance taxes, while arguably also an intergenerational tax, at least satisfy the “family obligation” concerns because they affect primarily the recipient’s family. This death tax to recoup public LTC expenditures, even though distributed across income groups, seems to be politically tolerable for LTC costs. Kapp, *supra* note 54, at 742-43. See also Kane & Kane, *supra* note 80, at 628.

84. See *supra* note 26 and accompanying text.

85. See *supra* notes 71-73 and accompanying text.

86. The coordination of public and private already exists in acute care for the elderly, handled jointly by Medicare and Medicare supplement insurance policies, and in disability and retirement income, covered by Social Security (OASDI and OASI) and private insurance and retirement instruments.

element, it will influence and shape the developments in the other sector.⁸⁷

B. Public-Private Sector Dynamics

The developments in 1993 and 1994 demonstrate the degree to which the actions of one sector influence and shape the actions of the other. President Clinton's Health Security Act,⁸⁸ and other nearly universal LTC insurance proposals that called for funding by new public programs or an expansion of existing ones,⁸⁹ put an interested but skeptical nation at a standstill while it waited to see what role the federal government would eventually take in the LTC solution. Probably on the expectancy that some public LTC reform would emerge from these suggested solutions, and fearing any measures outside the reform package might enlarge Medicaid exposure, Congress inserted a provision in the Omnibus Budget Reconciliation Act of 1993 (OBRA-93)⁹⁰ which essentially put a moratorium on state LTC initiatives that worked in conjunction with expanded Medicaid eligibility.⁹¹ Hence, private LTC insurance has not been able to realize its full potential.

While the number of individuals insured by private insurance companies will continue to grow, the proportion of the population covered by private insurance is likely to remain far below the percentage that could afford to pay for insurance. . . . Unless and until the government clearly defines its own role in this area, most consumers will be reluctant to purchase private insurance.⁹²

1. *Public and Public-Private Options.*—Public LTC strategies take many forms along the public-private continuum, from a nearly universal public approach with some incentives for private insurance for those who can afford it,⁹³ to a more balanced system providing public insurance for either front-end⁹⁴ or back-end,

87. Cohen et al., *supra* note 42, at 406-08.

88. H.R. 3600, *supra* note 12.

89. Among proposals calling for major public financing are The Brookings-ICF Institute Model (Brookings-ICF Model) (*see* WIENER ET AL., *supra* note 4, at 7), the PEPPER REPORT (*supra* note 74; *see also* Kapp, *supra* note 54, at 737-38), and the American Medical Association (*see* Charlene Harrington et al., *A National Long-term Care Program for the United States: A Caring Vision*, 266 JAMA 3023 (1991)).

90. Pub. L. No. 103-66, §§ 13611-12, 107 Stat. 312, 622-29 (1993) (amending scattered sections of 42 U.S.C.). *See infra* notes 125-130. *See also* Nemore et al., *supra* note 52, at 1199.

91. Even in light of OBRA-93's restrictions on asset disregard benefits, two states, Maryland and Illinois, went forward with partnership programs similar to ILTCP. Telephone Interview with Hunter McKay, Deputy Director of The Partnership for Long-Term Care (Jan. 4, 1995) [hereinafter McKay Interview]. *See infra* note 113.

92. Cohen et al., *supra* note 42, at 412.

93. *See, e.g.*, H.R. 3600, *supra* note 12; Brookings-ICF Model, *supra* note 89; PEPPER REPORT, *supra* note 74.

94. *See, e.g.*, PEPPER REPORT, *supra* note 74.

catastrophic costs with private funds covering the rest,⁹⁵ to a public subsidy system to help certain individuals pay private LTC insurance premiums.⁹⁶ None of the forms are exclusive and combinations of several public initiatives are common.

An example of a primarily public proposal is the Brookings-ICF Institute Model (Brookings-ICF Model)⁹⁷ which calls for a social LTC insurance program, most likely through expansion of the Medicare program, that provides universal or near-universal coverage on a non-means-tested basis.⁹⁸ In addition, the model liberalizes the financial eligibility requirements for Medicaid “so that it does not require total impoverishment” and, like most of the current proposals,⁹⁹ emphasizes a more balanced delivery system with expanded HHC and community care services.¹⁰⁰

The rationales for the Brookings-ICF Model and other social insurance strategies are: 1) universal coverage normalizes the risk pool and can be accomplished sooner and more efficiently through a public system;¹⁰¹ 2) because social insurance programs benefit everyone, they enjoy broad public and political support;¹⁰² and 3) a social program would improve access and quality and “would

95. A prior version of Senator Mitchell’s Life Care Bill called for universal HHC coverage, with a modest deductible and co-insurance for an unlimited period of time, and public nursing home insurance coverage only after a two-year “deductible” period in which the individual would self-insure or buy private insurance to cover LTC costs. Wiener & Hanley, *supra* note 53, at 79.

96. See, e.g., S. 1600, 103d Cong., 1st Sess., 139 CONG. REC. S14,629-30 (daily ed. Oct. 28, 1993) (statements of Sen. Packwood and Sen. Dole) (Secure Choice Long-Term Care Bill). See also 139 CONG. REC. S16,285 (daily ed. Nov. 19, 1993) (statement of Sen. Simpson). The subsidy targets individuals between 100% and 300% of the federal poverty level (FPL).

97. WIENER ET AL., *supra* note 4, app. A at 191-219; Wiener & Hanley, *supra* note 53, at 69.

98. The Brookings-ICF Model is “in line with, but [is] far more reaching than, the proposals put forth by President Clinton [in the Health Security Act of 1993].” WIENER ET AL., *supra* note 4, at 27.

99. See, e.g., H.R. 3600, *supra* note 12; WIENER ET AL., *supra* note 4; S. 1833, 103d Cong., 2d Sess., 140 CONG. REC. S1318-19 (daily ed. Feb. 10, 1994) (statement of Sen. Wofford) (Life Care Act).

100. WIENER ET AL., *supra* note 4, at 7. According to Wiener, in a time of limited resources, a new program should focus new spending on people receiving LTC at home or who have a chance to return home from the nursing facility. Wiener & Hanley, *supra* note 53, at 79. “In our view, protecting the assets of those who will die in a nursing home deserves a lower priority.” WIENER ET AL., *supra* note 4, at 28.

101. WIENER ET AL., *supra* note 4, at 132. Reliance on private insurance is a long-range strategy because its purchasers are typically younger, insurable persons whose need for LTC is not likely to occur for many years down the road. In addition, private insurance will never guarantee universal coverage because some people are simply “uninsurable.” *Id.*

102. *Id.* at 132-34 & n.11. A February, 1993 Gallup survey showed strong support for government spending on LTC, even if it meant more taxes. *Id.* at 134 n.11. See also Willging Statement, *supra* note 59.

reduce the preference [that] providers tend to give to private-pay patients."¹⁰³

For a variety of reasons, it is improbable that broad-scale federal LTC insurance, like the example above, will come to fruition. First, there is a lack of consensus on what the goals of a LTC system should be.¹⁰⁴ Decision-makers are torn between holding individuals and their families responsible for LTC and the popular support for a social LTC program. They cannot decide, even among initiatives in which public and private insurance coordinate to cover front- and back-end LTC coverage, how to apportion the responsibility. Perhaps this explains why LTC has been treated as the "third rail"¹⁰⁵ or "forgotten step-child"¹⁰⁶ of health care reform. Second, other important issues, such as child welfare and protection for the uninsured, are at the top of the public policy agenda and compete against LTC reform for scarce public resources.¹⁰⁷ Third, as a tradeoff for being more efficient and cost effective, government-based insurance lacks the flexibility to adapt in a rapidly changing world and it eliminates consumer choice in the types of cost-sharing packages that are available.¹⁰⁸ Fourth, the major drawback of a public program is its cost and, by implication, the taxes and other funding mechanisms needed to pay for it.¹⁰⁹ Finally, and perhaps as a result of the aforementioned factors, there is "a growing perception that a regulated private insurance industry can play an important role in addressing the LTC financing problem for middle-income elders."¹¹⁰

This author proposes that an equitable balance and a more efficient LTC system calls for the private sector to play the major role. However, for the private sector to become more involved, the public sector must develop mechanisms that will elevate private insurance to a lead role and expand Medicare and Medicaid financing for LTC services. The following section outlines the mechanism, a partnership of front-end private insurance and back-end public catastrophic coverage, by which this LTC reform can be accomplished.

2. *Private-Public Cooperatives.*¹¹¹—Developed primarily on the state level,

103. WIENER ET AL., *supra* note 4, at 134. However, a leveling in the quality of care has its price: high-quality, high-cost providers would migrate toward "average," thereby reducing their once-higher standards and eliminating consumer choice. *Id.* at 135.

104. Marc A. Cohen et al., *New Perspectives on the Affordability of Long-term Care Insurance and Potential Market Size*, 33 GERONTOLOGIST 105, 105 (1993) [hereinafter *New Perspectives on Affordability*].

105. Kapp, *supra* note 54, at 733; see also *supra* note 55.

106. Meiners Testimony, *supra* note 55.

107. *New Perspectives on Affordability*, *supra* note 104, at 105. See also WIENER ET AL., *supra* note 4, at 139-40 ("The Greater Importance of Health Care for the Uninsured").

108. WIENER ET AL., *supra* note 4, at 139. See also Wiener & Hanley, *supra* note 53, at 79.

109. Wiener & Hanley, *supra* note 53, at 79.

110. *New Perspectives on Affordability*, *supra* note 104, at 105.

111. While some literature broadly categorize these as public-private plans, this author chooses to define them as *private-public* cooperatives or partnerships because, in actuality, the order of payment is no different than the current situation: *private* dollars are exhausted first and then *public* dollars are contributed. The only difference in this new private-public mix is that

private-public cooperatives encourage the individual to purchase LTC insurance to cover the earlier years of LTC needs while public assistance funds catastrophic care—that is, the “longest-term” care—on the back end. Largely through the support and work of the Robert Wood Johnson Foundation (RWJF), a national health care philanthropy that funds The Partnership For Long-Term Care,¹¹² several states have pursued interests in various forms of private-public cooperatives.¹¹³ Among them, Connecticut, Indiana, New York, and California, the initial participants in the national Partnership for LTC,¹¹⁴ have succeeded in bringing their plans to fruition. Ten other states have passed enabling legislation;¹¹⁵ of those ten, Illinois,¹¹⁶ Iowa,¹¹⁷ Maryland,¹¹⁸ and

insurers pay the private dollars (after the insured pays the premium, of course) instead of the LTC user and her family. Because these private-public cooperative programs are widely known as partnership programs, this Note will hereafter refer to them and to the policies approved by them as “partnership” or “qualified” plans or policies. *See infra* notes 163-64 regarding “qualified.”

112. The national program office is located at the University of Maryland, Center on Aging, HHP Building, Room 1240, College Park, MD, 20742-2611, (301) 405-2544.

113. According to the national office of the Partnership for Long-Term Care, nearly 20 states had initiated enabling legislation of some form of partnership plans before mid-1993. McKay Interview, *supra* note 91. The effect of OBRA-93's estate recovery requirement, which nullifies much of the asset protection awarded these plans, stalled most states' interests in these programs (*see infra* notes 125-130 and accompanying text); however, several states continued to enact and propose enabling legislation. *See, e.g.*, Kansas H.R. 2324, 75th Leg., 1st Sess. (1993) (proposal by Representatives Wells and Lane). Maryland and Illinois, despite the restriction, went forward with their programs, approved state amendment plans and promulgated regulations for program and policy development. McKay Interview, *supra* note 91.

114. PARTNERSHIP FOR LONG-TERM CARE, PROGRAM DESCRIPTION (University of Maryland, Center on Aging ed. 1993). Iowa joined the list in 1993 with a program designed like the ILTCP. McKay Interview, *supra* note 91; WIENER ET AL., *supra* note 4, at 88-89. Massachusetts, New Jersey, Oregon, and Wisconsin were initially involved in implementing similar RWJF programs. MARK R. MEINERS, ADMINISTRATION ON AGING RESEARCH, SUPPORT OF STATE LONG-TERM CARE INS. PARTNERSHIP DEV. PROGRAMS vii (1991). However, these states were not able to fully implement their programs when they were stifled by Clinton's and other public reform proposals and by OBRA-93. McKay Interview, *supra* note 91.

115. Enabling legislation has passed in Colorado, Illinois, Iowa, Maryland, Massachusetts, Missouri, North Dakota, Ohio, Rhode Island, and Washington. *Replication Activity*, PARTNERSHIP UPDATE (Partnership for Long-Term Care, University of Maryland, Center on Aging, College Park, Md.), July 1995, at 3 [hereinafter PARTNERSHIP UPDATE, July 1995]. Six other states have either passed study legislation or currently have enabling legislation pending: Kansas, Michigan, Minnesota, Pennsylvania, Tennessee, Virginia. *Id.*

116. ILL. ANN. STAT. ch. 320, paras. 35/1 to /60 (Smith-Hurd 1993 & Supp. 1995). Illinois has one insurer which has filed its product for certification. McKay Interview, *supra* note 91.

117. IOWA CODE ANN. §§ 249G.1-249G.4 (West 1994) (Long-Term Care Asset Preservation Program); IOWA CODE ANN. §§ 514G.1-514G.10 (West 1988 & Supp. 1995) (Long-Term Care Insurance).

118. MD. CODE ANN., HEALTH-GEN. §§ 15-401 to -407 (1994).

Massachusetts,¹¹⁹ have also approved state amendment plans and submitted proposed rules and regulations for the implementation of their programs.¹²⁰

The advantages to private-public cooperatives are that they: 1) offer high quality LTC insurance coverage which is subject to stricter standards in a way that is more affordable than before; 2) help contain state medical assistance expenditures; 3) prevent personal impoverishment; and 4) eliminate incentives for asset transfer.¹²¹ These advantages are discussed in greater detail below in the ILTCP example.

The mechanism primarily used in these programs is an amended state plan that allows the state to disregard the assets or resources of an individual on the condition of purchasing an approved LTC insurance policy. Most plans follow a "dollar-for-dollar" model,¹²² while New York follows a "total asset protection" model¹²³ and Massachusetts limits its asset disregard to the home.¹²⁴

In whatever form, it was this device—access to a means-tested welfare program to protect assets of middle- and upper-middle-income elderly, allowing them to leave inheritances with Medicaid dollars—that was the target of Congress's hostility during the thrust for public reform. In a last-ditch effort to quash the growing interest in the partnership programs and the accompanying expansion of Medicaid eligibility, Representative Henry A. Waxman inserted an

119. MASS. GEN. L. ANN. ch. 118E, § 25 (West 1994).

120. McKay Interview, *supra* note 91.

121. IND. CODE § 12-10-9-5 (1993 & Supp. 1995); IOWA CODE ANN. § 249G.1 (West 1994).

122. CONN. GEN. STAT. ANN. § 17-12q (1992 & Supp. 1995) (to be codified at § 17b-252); IND. CODE §§ 12-10-9-1 to -11 (1993 & Supp. 1995); IND. CODE §§ 27-8-12-7 to -7.1 (1993 & Supp. 1995); CAL. WELF. & INST. CODE §§ 22000-22013 (West 1991 & Supp. 1995); IOWA CODE ANN. §§ 249G.1-249G.4 (West 1994); IOWA CODE ANN. §§ 514G.1-514G.10 (West 1988 & Supp. 1995).

123. The New York State (NYS) Partnership for LTC allows a person to protect all remaining assets once that person has purchased a certified partnership policy. The certified policy must cover a minimum of either three years of nursing home care or six years of HHC or a combination of the two, with a minimum daily benefit of \$105 for 1994 and \$110 for 1995. N.Y. COMP. CODES R. & REGS. tit. 11, § 39 (1992). See NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE, QUARTERLY UPDATE (1995) [hereinafter NEW YORK QUARTERLY UPDATE, FIRST QUARTER 1995]. "New York's target population is different" from the other states. McKay Interview, *supra* note 91. Because it has a population with one of the highest disposable income levels, New York is interested in reaching those people who can afford to buy insurance but until now have resorted to transferring assets in order to become Medicaid eligible. *Id.* See also WIENER ET AL., *supra* note 4, at 88-89 & n.f.

124. Prior to its partnership program, Massachusetts was one of several states which, under 42 U.S.C. § 1396p(a) (1988 & Supp. V 1993) (Medicaid lien), was permitted to put a lien on the LTC user's home against the amount of public dollars spent for LTC services. McKay Interview, *supra* note 91. The new program disregards the home, and only the home, and forgoes the Medicaid lien when the individual purchases a qualified LTC policy covering a minimum daily benefit. MASS. GEN. L. ANN. ch. 118E, § 25 (West 1994).

OBRA-93 provision¹²⁵ that specifically reneged the asset disregard feature conferred by private-public cooperatives. Prior to OBRA-93, states were permitted, but not required, to use estate recovery programs to recoup Medicaid benefits that paid for LTC services.¹²⁶ Estate recovery is now mandatory in all states¹²⁷ for certain situations, and specifically for individuals who received Medicaid by having their assets and resources disregarded in connection with the receipt of benefits under a LTC insurance policy,¹²⁸ in other words, the beneficiaries of partnership policies. In the case of partnership beneficiaries, the state must seek estate recovery for Medicaid benefits paid for nursing facility and "other [LTC] services,"¹²⁹ effectively reversing, post-mortem, any expansion of Medicaid benefits derived during the partnership beneficiary's lifetime. Grandfathered from this restriction are partnership participants in California, Connecticut, Indiana, Iowa, Massachusetts, and New York whose state amendment plans were approved prior to OBRA-93's May 14, 1993 deadline.¹³⁰

Since the demise of the Health Security Act and other public LTC insurance proposals, there is a revived interest in the state private-public cooperatives and a partnership program on a national level.¹³¹ The Secure Choice Long-Term Care Bill¹³² called for a premium subsidy for persons whose income is between the federal poverty level (FPL) and 300 percent of the FPL, and would provide this

125. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13612(a), 107 Stat. 312, 627 (amending 42 U.S.C. § 1396p(b)(1) (1988 & Supp. V 1993)).

126. 42 U.S.C. § 1396p(b)(1) (1988 & Supp. V 1993). Recovery was limited, among other ways, in that it could only recoup nursing home benefits or benefits paid to persons who were 65 or older when they received Medicaid, and could only occur after the death of a surviving spouse so long as there were no surviving dependent children. *Id.* See also Nemore et al., *supra* note 52, at 1205.

127. See Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13612(a), 107 Stat. 312, 627 (1993).

128. *Id.* In addition, states are required to recover from: 1) individuals in nursing homes or other facilities who pay a share of the cost as a condition of receiving Medicaid and who cannot be reasonably expected, ever, to be discharged and returned home, and 2) individuals who were age 55 and over when they received Medicaid payments for nursing home care, HHC, and community-based services and related hospital and prescription drug services. *Id.* These provisions apply to Medicaid payments made on or after October 1, 1993. *Id.* § 13612(d)(1)(A), 107 Stat. at 628. See also Nemore et al., *supra* note 52, at 1205.

129. Nemore et al., *supra* note 52, at 1205. Because the reference to HHC and community-based care is not limited to "waiver" services, states might have to try to recover for state-provided services that go beyond federal Medicaid costs. *Id.* See *infra* notes 138-39 and accompanying text regarding state Medicaid waivers.

130. Nemore et al., *supra* note 52, at 1205; McKay Interview, *supra* note 91 (Iowa's program director got wind of Representative Waxman's draft and pushed its state plan amendment through in two weeks to meet the deadline).

131. See Willging Statement, *supra* note 59 (praising the Life Care Act's proposal for federal participation in such a plan).

132. S. 1600, *supra* note 96.

target group "enhanced asset protection above that permitted under [current Medicaid rules]."¹³³ The Life Care Act¹³⁴ would allow individuals to purchase \$30,000, \$60,000, or \$90,000 in LTC benefits from a qualified policy with an equal level of asset protection. According to its co-sponsor, Senator Wofford, the Life Care Act is a better solution than universal public insurance: "Even the Health Security Act, which I have cosponsored, does not go far enough. . . . [It] does not fully address the cruel way we now pay for long-term nursing home care, which force[s] [individuals] to spend themselves onto welfare."¹³⁵ An explanation of the design, development, and implementation of private-public cooperatives through the ILTCP example will provide a framework for analysis for either a national partnership or for coordination of similar partnership systems in all states with some federal intervention.

III. THE INDIANA LONG TERM CARE PROGRAM (ILTCP)¹³⁶

A. Legislative Development

The enabling legislation for ILTCP,¹³⁷ the first of its kind in the nation in 1987, directed the Indiana Department of Public Welfare to apply to the Department of Health and Human Services (DHHS) Health Care Financing Administration (HCFA) for a Medicaid waiver.¹³⁸ The waiver¹³⁹ allows the state to provide certain community and in-home services not covered in the state Medicaid plan in order to encourage the use of these less costly alternatives and to avoid or delay institutionalization of patients whenever possible. In December 1991, HCFA approved Indiana's state plan amendment¹⁴⁰ authorizing an asset disregard¹⁴¹ under section 1902(r)(2) of the Social Security Act.¹⁴² The

133. 139 CONG. REC. S14,629, S14,630 (daily ed. Oct. 28, 1993) (statement of Senator Packwood).

134. S. 1833, *supra* note 99.

135. 140 CONG. REC. S1318, S1319 (daily ed. Feb. 10, 1994) (statement of Senator Wofford).

136. IND. ADMIN. CODE tit. 760, r. 2-20-1 to -43 (Supp. 1995) (authorized by IND. CODE §§ 12-10-9-1 to -11 (1993 & Supp. 1995); IND. CODE §§ 27-8-12-7 to -7.1 (1993 & Supp. 1995)).

137. Act of May 6, 1987, No. 42, § 11, 1987 Ind. Acts 1242, 1252-46 (codified as amended at IND. CODE. § 12-10-9-5 (Supp. 1995)).

138. 42 U.S.C. § 1396n(b)-(d) (1988 & Supp. V 1993). The Secretary is authorized to waive certain requirements to promote cost effectiveness and efficiency in the delivery of health care. *Id.*

139. IND. ADMIN. CODE tit. 760, r. 2-20-24 (Supp. 1995). Indiana's Medicaid waiver services include case management, homemaker services, respite care, attendant care, adult day care, and "other services which . . . are essential to prevent institutionalization." *Id.*

140. INDIANA LONG TERM CARE PROGRAM, FAMILY & SOCIAL SERV. ADMIN., INDIANA LONG TERM CARE PROGRAM: INSURER PARTICIPATION REQUIREMENTS A-3 to A-4 (1993) [hereinafter ILTCP INSURER PARTICIPATION REQUIREMENTS].

141. *See infra* notes 162-68 and accompanying text explaining asset disregard.

142. 42 U.S.C. § 1396a(r)(2) (1988 & Supp. V 1993).

amendment allows individuals to receive Medicaid assistance by having their assets disregarded from spend-down requirements in connection with the purchase of and the benefits received from an approved LTC insurance policy. The ILTCP is administered by the Indiana Family and Social Services Administration and its implementation is shared with the Department of Insurance. Indiana's program was introduced on May 18, 1993, with qualified policies offered from eight different insurers.¹⁴³

The ILTCP was developed with the following objectives: 1) to stimulate individuals to insure for their LTC needs; 2) to provide a mechanism for qualifying for Medicaid LTC assistance without first being required to exhaust all their resources; 3) to provide high quality, accessible and affordable LTC insurance; 4) to improve public understanding of LTC financing and provide counseling services to individuals in planning for their LTC needs; and 5) to alleviate the financial burden on the state's medical assistance budget by encouraging private initiatives.¹⁴⁴ Toward the goal of high-quality insurance coverage, the program holds insurers to stricter standards than the NAIC Model Act¹⁴⁵ by imposing heavy reporting requirements,¹⁴⁶ marketing and agent licensing standards,¹⁴⁷ and the following minimum benefit standards:

- (1) Minimum daily nursing home benefit of seventy-five percent of the state's average daily private-pay rate, which is re-calculated every calendar year.¹⁴⁸
- (2) Maximum policy benefits must be stated in lump sum dollar terms, not in days or years of care,¹⁴⁹ and must offer a minimum plan designed to cover one year of nursing home costs.¹⁵⁰
- (3) Mandatory inflation protection, which increases both the daily benefit and the maximum policy benefit annually without additional

143. INDIANA LONG TERM CARE PROGRAM, FAMILY & SOCIAL SERVS. ADMIN., INDIANA LONG TERM PROGRAM: LONG TERM CARE INS. UNIFORM DATA SET REPORTING 2 (1993) [hereinafter ILTCP UNIFORM DATA, THIRD QUARTER 1993]. There are currently ten approved insurers. PARTNERS (Indiana Long Term Care Program, Family & Social Servs. Admin., Indianapolis, Ind.), Winter 1995, at 1 (right-hand column).

144. IND. CODE § 12-10-9-5 (Supp. 1995).

145. See NAIC MODEL ACT, *supra* note 43.

146. IND. ADMIN. CODE tit. 760, r. 2-20-37 to -40 (Supp. 1995).

147. *Id.* r. 2-20-34.

148. *Id.* r. 2-20-36.1(3). See also *id.* r. 2-20-36.2, -36.3 (regarding nursing-home-only policies and qualified riders, respectively).

149. *Id.* r. 2-20-34.

150. *Id.* r. 2-20-36.1(1)-(2). At a minimum, policies must contain and offer a "maximum benefit amount option equivalent to [365] times the minimum daily nursing facility benefit." *Id.* r. 2-20-35(2), -35(3).

proof of insurability.¹⁵¹

- (4) ILTCP now allows participants to select approved policies covering only nursing home care.¹⁵² If HHC coverage is purchased—either initially with nursing home coverage (integrated policy)¹⁵³ or added later as a rider—the policy must pay daily benefits for HHC, respite and community care benefits of at least fifty percent of, but not more than, the purchased nursing home maximum daily benefit.¹⁵⁴
- (5) Specific “benefit triggers” which require policy benefits to be paid¹⁵⁵ upon a showing that the individual has either:
 - a) a deficiency in two or more of the following uniform Activities of Daily Living (ADLs): eating, transferring (or mobility), dressing, bathing, and toileting;¹⁵⁶ or
 - b) a cognitive impairment, including Alzheimer’s disease and similar forms of senility or irreversible dementia;¹⁵⁷ or
 - c) a complex, unstable medical condition which requires round-the-clock assistance of professional nursing observation or intervention more than once a day.¹⁵⁸
- (6) Protection against lapse by requiring the insurer to a) notify an authorized designee, usually a family member of the insured, that the policy is about to lapse and b) provide a minimum ninety-day guaranteed reinstatement period for a policyholder who, due to a cognitive impairment, has forgotten to pay her premium.¹⁵⁹
- (7) Mandatory offer to reduce coverage to a lower premium if the policy becomes too expensive to maintain at its current level.¹⁶⁰

Moreover, toward the goal of educating the public on LTC alternatives and financing arrangements, the Department of Insurance created the Senior Health

151. *Id.* r. 2-20-35(2), -35(3).

152. IND. CODE § 12-10-9-7.5(b) (Supp. 1995); PARTNERSHIP UPDATE, Dec. 1994, *supra* note 31, at 3.

153. IND. ADMIN. CODE tit. 760, r. 2-20-21.1 (Supp. 1995).

154. *Id.* r. 2-20-36.1(3)(B).

155. *Id.* r. 2-20-21 (“insured event” defined).

156. *Id.* r. 2-20-4.

157. *Id.* r. 2-20-14.

158. *Id.* r. 2-20-15.

159. *Id.* r. 2-20-36(6), -36(7).

160. *Id.* r. 2-20-36(5). This reduced benefit amount offer cannot dip below the minimum benefit required for qualification and the insurer is only required to allow this offer to be exercised once. *Id.* r. 2-20-36(5), -36(6).

Insurance Information Program (SHIIP).¹⁶¹ The SHIIP enlists trained senior volunteers to counsel interested persons concerning questions about ILTCP as well as Medicare and Medicaid rights and filing procedures.

B. Design of the Program

Indiana's program is a true private-public cooperative in which senior citizens are encouraged to purchase private insurance to cover front-end costs while the state's medical assistance program, primarily Medicaid, picks up the back-end, catastrophic costs. Like its counterparts in Connecticut, California, and Iowa,¹⁶² ILTCP works as follows: for every dollar of LTC benefits paid by a qualified LTC policy,¹⁶³ a dollar of the qualified insured's¹⁶⁴ assets¹⁶⁵ is protected from Medicaid spend down rules.¹⁶⁶ The individual's income, however, is not protected from Medicaid and must still be contributed to LTC expenditures. In the earlier example, Grandma would purchase a qualified LTC policy in the amount of the total assets she wishes to protect, presumably the full \$60,000.¹⁶⁷ When her need for LTC arises, the insurance policy will pay first until all policy benefits are exhausted. Then Grandma will apply for Medicaid and will receive assistance for LTC costs to the extent they exceed her monthly income.

Grandma keeps control of her assets and does not have to spend them down or transfer them to become eligible for Medicaid. The insurance dollars substitute

161. ILTCP INSURER PARTICIPATION REQUIREMENTS, *supra* note 140, at A-4. The free counseling services are accessible through a network of statewide offices and a toll-free number, 1 (800) 452-4800.

162. *See supra* notes 114 and 122. *See also supra* notes 123-24 and accompanying text discussing how New York's and Massachusetts' programs differ.

163. Only those policies which meet the strict coverage and reporting requirements of IND. CODE §§ 27-8-12-7 to -7.1 (1993 & Supp. 1995) and IND. ADMIN. CODE tit. 760, r. 2-20-37 to -40 (Supp. 1995) for the purpose of participating in ILTCP are eligible for asset disregard and asset protection. IND. ADMIN. CODE tit. 760, r. 2-20-30 (Supp. 1995).

164. A "qualified insured" is a "beneficiary of a qualified long term care policy" or is otherwise enrolled in a health maintenance organization (HMO) that covers LTC services. IND. ADMIN. CODE tit. 760, r. 2-20-29 (Supp. 1995); IND. CODE § 12-10-9-7 (Supp. 1995).

165. The term "assets," as opposed to "resources," limits the protection to particular tangible and intangible assets. "Resources" encompasses income and rights to income which ILTCP does not protect.

166. Asset disregard operates to increase the Medicaid eligibility threshold: "'asset disregard' means a one dollar (\$1) increase in the amount of assets [a qualified insured] may retain under [Indiana Code section] 12-15-3 for each one dollar of benefit paid out [by the qualified policy] for long term care services." IND. CODE § 12-10-9-8(a) (Supp. 1995).

167. There is no limit to the amount of assets she can protect. She could, in order to reduce premiums or for any other reason, choose to insure an amount less than her asset total, say \$40,000. In that case, after the policy benefits are paid on eligible services, she must deplete her excess assets (\$20,000 in this example) down to the protected level of \$40,000 before Medicaid will pay for her LTC needs.

for her own assets; therefore, although Grandma becomes eligible for Medicaid, she does so no sooner by "spending down" insurance dollars for LTC than by spending her own dollars. Further, because she does not become dependent on Medicaid any sooner with partnership insurance than with the current system, the state's medical expenditures, all else being equal,¹⁶⁸ do not increase. Because Grandma still has assets producing income, she can still contribute that income to her LTC costs and possibly reduce the dollars that Medicaid would otherwise have paid. Moreover, the state pays only for the back-end or catastrophic coverage and, because the majority of individuals use LTC for less than twenty-four months, the likelihood for long-term Medicaid dependence may be reduced.

C. How ILTCP Measures Up

Several considerations for national LTC reform were presented in Part II A that provide a yardstick to measure ILTCP's solution. This section revisits those factors and offers additional considerations specific to the design of the private-public cooperatives which either support or hinder the proposition that ILTCP is a model for national LTC reform.

1. *Public Awareness.*—Whenever a new state program is introduced it raises eyebrows, either from skepticism or from genuine interest. The ILTCP, launched amidst the national health care reform thrust, has raised, through media coverage, literature and television advertisements, public awareness of the potential for, costs of, and alternative options to LTC.¹⁶⁹ To further disseminate information and educate the public, ILTCP put mechanisms in place like SHIP whereby interested persons may receive one-on-one counseling from disinterested state volunteers regarding ILTCP and LTC insurance in general, and advice on Medicare and Medicaid rights and filing procedures. Likewise, program marketing efforts and SHIP services have elevated awareness and discussion of alternative delivery systems, such as HHC and community care, that are available and may already be covered by Medicare.¹⁷⁰ After an individual purchases a qualified insurance plan, and once the need for LTC develops, mandatory case management services¹⁷¹ continue to direct the insured to various service and payment alternatives. The ILTCP goes a long way toward producing more knowledgeable consumers who, in turn, make better decisions about their LTC planning.

State and national decision-makers, providers and private insurers also benefit from the improved quality of information resulting from insurer reporting

168. See *infra* notes 198-201 and accompanying text explaining how inflation and increased use resulting from moral hazard affect public expenditures with the private-public cooperative system.

169. In January 1995, ILTCP spent \$40,000 on television spots to "mak[e] the public aware of the program and get[] them to make the first step of calling [SHIP's toll-free number] for more information." Memorandum from Jim Leich, Director, Indiana Long Term Care Program, to Agent Partners (January 5, 1995) (on file with the author).

170. See Branch et al., *supra* note 38.

171. IND. ADMIN. CODE tit. 760, r. 2-20-9 to -10 (Supp. 1995).

requirements. Participating insurers must maintain and submit quarterly data on individuals who purchased qualified plans,¹⁷² changed or dropped their coverage,¹⁷³ were denied coverage, and why they were denied.¹⁷⁴ Additional data is submitted as to age, sex, marital status of ILTCP buyers, and whether they purchased individual or group policies. Furthermore, partnership programs report the types of benefits (nursing home care or HHC) insurance dollars pay for¹⁷⁵ and the insured's progress in qualifying for asset protection.¹⁷⁶ The data from all of the state partnership plans are given to the national office¹⁷⁷ and will be used for the benefit of program directors, interested states, and the private insurance industry.

Achieving quality information on non-partnership insureds, however, is difficult because insurance companies are reluctant to publish their market share information and to incur the additional costs involved in collecting the data.¹⁷⁸ The Medicare Current Beneficiary Survey (MCBS) is a continuous survey of a representative sample of the Medicare population that grew out of the need to provide valid estimates of different types of health care spending.¹⁷⁹ Although its information draws from a broader sample—Medicare enrollees who may or may not be receiving LTC services—MCBS is a multi-purpose system¹⁸⁰ and is not focused on identifying the actual types of LTC needed or used. Thus, improved information-gathering mechanisms on state and national levels are still needed in order to obtain the full LTC picture on the larger sample of American seniors.

2. *Defining the Scope of LTC.*—Even with the NAIC's standards, confusing variations exist in today's ordinary LTC policies. A policy's "insured event," which triggers payment of benefits, may require deficiencies in one, two or three out of a list of five or six ADLs or may be complicated further by including instrumental ADLs (IADLs) in the mix.¹⁸¹ Such ADL or IADL deficiencies may or may not need a physician's certification before benefits are paid. Options for inflation protection range from simple to compound annual increases that continue for either a limited period, such as fifteen years or to age eighty, or for life. Policies also differ on the extent and types of HHC and community-based care that are included. While most policies do not reimburse for home care provided by family members, a diligent LTC shopper will find a few policies that will pay for

172. *Id.* r. 2-20-37(1).

173. *Id.* r. 2-20-37(2), -37(3).

174. *Id.* r. 2-20-37(4).

175. *Id.* r. 2-20-37(5) to -37(7).

176. *Id.* r. 2-20-39.

177. PARTNERSHIP UPDATE, Dec. 1994, *supra* note 31, at 4.

178. McKay Interview, *supra* note 91.

179. Gerald S. Adler, *A Profile of the Medicare Current Beneficiary Survey*, 15 HEALTH CARE FINANCING 153, 153 (1994).

180. *Id.*

181. "Instrumental activities of daily living,' or IADLs, capture a more complex range of activities necessary for independent living in the community, including handling personal finances, preparing meals, shopping, traveling, doing housework, using the telephone, and taking medications." WIENER ET AL., *supra* note 4, at 164.

such costs. The myriad of options makes it difficult for most LTC insurance prospects to compare products and to make a confident decision on LTC protection.

The ILTCP and its counterparts eliminate the confusion by setting specific, uniform ADL definitions and defined benefit triggers for all qualified policies.¹⁸² Home health care and community care coverage is no longer required on each policy; however, when these coverages are purchased, the policy must pay at least half the daily nursing home benefit that was purchased.¹⁸³ Inflation protection is mandatory for ILTCP policies either through automatic annual increases in the daily benefit (and the unused benefits) or by tying the policy benefit to at least seventy-five percent of the State's average daily private-pay rate.¹⁸⁴ Without stifling the creative options and competitive forces needed in the marketplace, ILTCP reduces the noise and confusion of policy provisions thereby enabling its insured participants to make educated choices.

3. *Cost Containment.*—Issues of cost containment include costs to the consumer in addition to concerns for controlling public program expenditures.

a. *Consumer affordability.*—Opponents contend that the affordability of LTC insurance is prohibitive for most seniors¹⁸⁵ and ILTCP only benefits the persons who could afford the insurance in the first place. Thus, so the argument goes, the partnership programs do not improve on today's situation; indeed, they only benefit those who could buy insurance anyway by allowing them to use public dollars to the detriment of public programs designed for the needy. These arguments fail to acknowledge that

[t]he problem with the current system is that an individual who buys a policy covering, for example, two years of [LTC] but who ends up needing care for five years can still lose all his or her assets. These Medicaid initiatives thus make it possible to obtain lifetime asset protection without having to buy an insurance policy that pays lifetime benefits.¹⁸⁶

Without the ILTCP option, to absolutely protect her assets from spend down Grandma would have to purchase a lifetime coverage policy, costing approximately \$3,686 per year.¹⁸⁷ Under ILTCP she receives the same "lifetime"

182. IND. ADMIN. CODE tit. 760, r. 2-20-4, -14, -15, -21 (Supp. 1995). See *supra* notes 155-58 and accompanying text.

183. IND. ADMIN. CODE tit. 760, r. 2-20-36.1(3)(B)-(C) (Supp. 1995). See *supra* notes 152-54 and accompanying text.

184. IND. ADMIN. CODE tit. 760, r. 2-20-35(2), -35(3) (Supp. 1995). See *supra* note 148 and accompanying text.

185. Some studies indicate LTC insurance is within the reach of only 20% of today's elderly. Cohen et al., *supra* note 42, at 408. See also *How Much Public?*, *supra* note 81, at 427.

186. WIENER ET AL., *supra* note 4, at 89.

187. Rates for Bankers United Life Assurance Company's GoldenCare Plus policy, based on \$80 per day nursing home benefit, with lifetime nursing home and HHC benefits (\$40 per day), inflation protection, and a 20-day deductible period.

asset protection by purchasing \$60,000 in LTC benefits for an annual premium of \$2,662.¹⁸⁸ “Smaller” policies¹⁸⁹ mean smaller premiums for ILTCP’s target market and, consequently, a greater inducement to seek out private insurance.

Affordable policies provide additional advantages for this target group. First, the alternative to Medicaid eligibility—asset transfer to “look poor”—is less attractive. “[A]necdotal evidence suggests that at least some older people divest their assets to become Medicaid eligible under the current financing system.”¹⁹⁰ The asset protection of ILTCP would obviate this need, reducing the total spend down by expanding the eligibility threshold.¹⁹¹ Second, reduced premiums for lifetime asset protection will induce low-risk consumers to buy,¹⁹² which eventually may reduce overall premiums by normalizing the risk pool.

Another significant rebuttal to the unaffordability argument is that demand for LTC cannot be measured wholly by the consumer’s “ability to pay.” “[A]s with other products, people base their purchase of [LTC] insurance on its perceived value relative to cost. If [LTC] insurance is perceived as a good buy, then more people will purchase policies. . . . [B]eing able to afford something and deciding to purchase it are two distinctly different concepts.”¹⁹³ At a forty-three percent chance of entering a nursing home¹⁹⁴ and, consequently, the great potential for spend down, the costs are high. The perceived value of LTC protection relative to its cost will be very high for most people.

The end result of asset depletion has been tested by computer simulation.¹⁹⁵ Three possible financing structures were used: 1) no private insurance but the existing Medicaid system remains in place (public model); 2) private LTC insurance coverage for everyone and the existing Medicaid system remains in place (private model); and 3) a private-public cooperative system like ILTCP.¹⁹⁶ The ILTCP analogue had the intended effect of reducing asset depletion; it showed, not surprisingly, a substantial improvement over the public model and beat the private model by more than three to one.¹⁹⁷ If reducing personal impoverishment is a goal of a reformed LTC system, and it should be, ILTCP and its counterparts are the best solution.

188. *Id.* ILTCP GoldenCare Plus rates based on \$80 per day nursing home care, \$40 per day HHC, inflation protection, 20-day deductible period, and \$60,000 worth of benefits.

189. Recall that under ILTCP benefits are measured in lump sum dollar amounts rather than months or years of coverage, (IND. ADMIN. CODE tit. 760, r. 2-20-35(1) (Supp. 1995)) so “smaller” rather than shorter coverage is the appropriate term.

190. Arling Simulation, *supra* 82, at 716.

191. *Id.*

192. Recall that adverse selection in private insurance means persons who know they are high-risk already have an incentive to buy. *See supra* notes 65, 67-70 and accompanying text.

193. Cohen et al., *supra* note 42, at 408.

194. Kemper & Murtaugh, *supra* note 2, at 597-98.

195. Arling Simulation, *supra* note 82.

196. *Id.*

197. Personal assets used for LTC costs under the public model were \$48.7 million, the private model, \$36.0 million, and the ILTCP analogue model, \$10.7 million. *Id.* at 709.

b. Controlling public expenditures.—The effects of any private insurance proposal on the public purse will not be known for a decade or two.¹⁹⁸ In theory, under ILTCP Medicaid expenditures will not increase because individuals will become eligible no sooner than under the current financing system. This theory was tested and proved accurate when costs and use of LTC services remain level.¹⁹⁹ The more likely scenario is that LTC costs will increase in the future. Moreover, use will increase: “a new financing plan may bring about changes in LTC use, either through adverse selection or insurance induced demand [moral hazard].”²⁰⁰ When LTC inflation and increased use of LTC services are factored into the simulation, Medicaid absorbs most of the cost increases under all three financing arrangements.²⁰¹ However, the ILTCP model still shows less increase in Medicaid expenditures than the public model.²⁰²

Moral hazard occurs with either privately- or publicly-insured LTC programs. As originally designed, ILTCP would have tempered the moral hazard effect, particularly the “Cadillac care” effect, because asset protection only applied to those payments that covered “Medicaid-eligible [LTC] services.”²⁰³ Hence, although Grandma’s policy would pay \$60,000 in benefits, she might have had to spend down her own assets to a lower threshold (less than \$60,000) if the policy paid for non-Medicaid-eligible services. ILTCP no longer conditions asset protection on Medicaid eligible services; rather, a qualified insured shields a dollar of her own assets for each dollar of policy benefits paid for any long term care services.²⁰⁴ Although this control against moral hazard has been removed, other safeguards remain. For instance, case management services are required with all HHC and community care services to assess, coordinate and monitor such services.²⁰⁵ Mandatory case management helps assure appropriate, cost-effective LTC services are utilized.

Another advantage of ILTCP which offsets the impact of increased LTC use on public expenditures is that participants are allowed to keep their assets. Grandma earns interest income on her \$60,000 of assets. Partnership plans only protect assets, not income, from Medicaid spend down.²⁰⁶ The ILTCP system allows her to retain those assets and, consequently, a higher income from which

198. WIENER ET AL., *supra* note 4, at 90. Because most policies will be purchased by younger, more insurable seniors, their use of policy benefits and then Medicaid dollars is delayed for many years. *Id.*

199. Arling Simulation, *supra* note 82, at 709. Medicaid funding under the ILTCP analogue totaled \$67.1 million compared to \$71.5 million for the public model. The entirely private model, for obvious reasons, had the lowest Medicaid funding at \$41.8 million. *Id.*

200. *Id.* at 715.

201. *Id.* at 712-13.

202. *Id.* (\$117 million compared to \$121 million for the public model).

203. IND. CODE. § 12-10-9-8(a) (1993).

204. *Id.* § 12-10-9-8(a) (Supp. 1995). See also IND. ADMIN. CODE tit. 760, r. 2-20-18.1 (Supp. 1995) (“Eligible long term care services” defined).

205. IND. ADMIN. CODE tit. 760, r. 2-20-36.1 to -36.3 (Supp. 1995).

206. See *supra* notes 163-66 and accompanying text.

she must contribute to her own LTC costs, relieving the state Medicaid budget of at least some of the burden. The state (and the federal government), therefore, retains a taxpayer who can continue to contribute to her own LTC cause. This feature, largely overlooked in the public cost control debate, improves on the current structure in which an impoverished individual has no assets, and thus no income from assets to help pay for LTC services. Because ILTCP's target market is individuals with assets between \$50,000 and \$300,000, interest income earned on those assets and the income taxes paid at the state and federal level are significant factors offsetting the potential increases in public spending that cannot be overlooked.

4. *Quality of Care Received.*—Most health care providers are business organizations; thus, they undertake their endeavors with the hope of doing so profitably or, at least, not at a loss. Nursing facilities and HHC agencies are not required to accept Medicaid patients, but most do if they have available beds.²⁰⁷ Given two patient populations, one paying full costs of care and the other covering only about sixty to seventy percent of costs, astute business managers will allocate a greater portion of their scarce resources (primarily human resources in this field) to the hand that feeds them and fewer resources to the hand that seeks handouts. It is precisely this scenario which explains why Medicaid patients are often relegated to “second-class nursing home residents.”²⁰⁸ A primary goal of ILTCP is to eliminate this dual-treatment practice.

Quality of care is best when private dollars pay—when patients are able to pay, whether with their own assets or with insurance dollars, the full costs of their care. When a LTC financing system works to improve the private-/public-pay ratio, everyone benefits: the private-pay patient receives more attentive care; the provider can cover costs of more or higher-skilled staff; and the Medicaid patient indirectly benefits from the improved quality of care.

Oponents of ILTCP argue that it does nothing to change the private-/public-pay ratio because its participants eventually turn to Medicaid and because the same percentage of people will start out on Medicaid as would without the program. This attack does little to offer a solution; rather it drains alternative public proposals of their strength. It also ignores the corollary benefits of marketing the partnership plans: the simultaneous increase in non-partnership plan sales.²⁰⁹ “An analysis of sales in Indiana indicates that total sales of *all* [LTC] policies by participating insurers increased by 27% during the six months following the

207. Fortunately, Indiana's vacancy rate is higher than many states. “Indiana ranked first in the country in nursing home beds per capita in 1992.” *Did You Know?*, PARTNERS (Indiana Long Term Care Program, Family & Social Servs. Admin., Indianapolis, Ind.), Autumn 1994, at 2 [hereinafter PARTNERS, Autumn 1994]. In some states with lower vacancy, finding a “Medicaid bed” is difficult and is another reason persons who need care just cannot get it.

208. WOLFE, *supra* note 1, at 83-84. See also WIENER ET AL., *supra* note 4, at 136.

209. The impression at the national Partnership for LTC office, although hard data are difficult to obtain from non-partnership insurers, is that LTC sales in partnership states are up for both partnership and non-partnership policies. McKay Interview, *supra* note 91.

initiation of the program."²¹⁰ Therefore, at least some of the qualified policy plans are not displacing regular LTC insurance sales.²¹¹ Indeed, the increased awareness and improved product quality that accompany the partnership programs have, no doubt, induced demand for all LTC policies. Another factor which may explain the overall increase in LTC insurance sales is that, out of the full sample of all persons who investigate the program, a significant number discover that eventual Medicaid dependence is not desirable and that lifetime coverage under a regular policy is a better solution. Those persons who purchase non-qualified LTC insurance do even more to improve the public expenditure outlook: private-pay patients are in the system longer because, after insurance benefits are paid out, they must use personal assets for LTC before Medicaid steps in.

Not all ILTCP participants are bound for Medicaid as the program's opponents claim. A significant portion of ILTCP purchasers have chosen lifetime coverage.²¹² In Indiana, forty-one ILTCP buyers purchased lifetime coverage, compared with eight in Connecticut and four in New York.²¹³ Most remarkable is the New York figure because participants automatically receive lifetime "total asset protection" by purchasing just three years of nursing home care and six years of HHC benefits.²¹⁴ The purchase of lifetime coverage by the New York residents²¹⁵ indicates that expanded eligibility for Medicaid is not the only major feature that drives sales. Many buyers prefer a high quality LTC insurance

210. PARTNERSHIP UPDATE, Dec. 1994, *supra* note 31, at 3 (emphasis added).

211. Few people are replacing their current policies to purchase the asset protection plans. For the period ending September 30, 1993, 71% of ILTCP sales were by first-time purchasers with only 29% replacements, which is comparable with Connecticut, 74% versus 26%, and New York, 76% first-time versus 24% replacement purchases. See ILTCP UNIFORM DATA, THIRD QUARTER 1993, *supra* note 143, at 3; Memorandum from the Connecticut Partnership for Long-Term Care to the National Partnership for Long Term Care 3 (Dec. 15, 1993) (on file with author) [hereinafter Connecticut Quarterly Figures, Third Quarter 1993]; NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE, QUARTERLY UPDATE 3 (1993) [hereinafter NEW YORK QUARTERLY UPDATE, THIRD QUARTER 1993].

212. ILTCP UNIFORM DATA, THIRD QUARTER 1993, *supra* note 143, at 3. The 41 sales in Indiana accounted for 18% of all ILTCP sales in the first two quarters of the program. By the first quarter of 1995, 14% of the cumulative total of ILTCP purchasers chose lifetime coverage. INDIANA LONG TERM CARE PROGRAM, FAMILY & SOCIAL SERVS. ADMIN., INDIANA LONG TERM PROGRAM: LONG TERM CARE INS. UNIFORM DATA SET REPORTING STATISTICS 5 (1995) [hereinafter ILTCP UNIFORM DATA, FIRST QUARTER 1995].

213. ILTCP UNIFORM DATA, THIRD QUARTER 1993, *supra* note 143, at 3; Connecticut Quarterly Figures, Third Quarter 1993, *supra* note 211, at 2; NEW YORK QUARTERLY UPDATE, THIRD QUARTER 1993, *supra* note 211, at 2.

214. N.Y. COMP. CODES R. & REGS. tit. 11, § 39 (1992). See *supra* note 123 and accompanying text.

215. In addition to those who purchased lifetime coverage, ten New York participants bought policies with five years of nursing home and ten years of HHC benefits, another five persons bought policies with six years of nursing home and twelve years of HHC coverage. NEW YORK QUARTERLY UPDATE, THIRD QUARTER 1993, *supra* note 211.

product that has passed strict state scrutiny even when Medicaid spend-down is not an issue.

The ratio of LTC insureds to non-insureds is improving either because of or in spite of programs like ILTCP. Hence the stream of private-pay patients and the access to quality care is likely to increase under this system because the incentive for private initiatives is in place.

5. *Problems with Design.*—Although each partnership program has idiosyncratic quirks and flaws, the major shortcoming of these plans is that the asset protection feature is not portable. Like all LTC policies, benefits are paid no matter where in the United States the insured receives care.²¹⁶ A person who purchases regular LTC insurance in Montana or Kentucky or in any state may retire to the Sun Belt without fear of losing policy benefits, although he or she may be underinsured if the benefit purchased is less than the average daily costs of care in the new state. For obvious reasons, a state like Florida or Arizona or South Carolina, which is stumbling under its own Medicaid burdens, will not honor a transient LTC user's asset protection program. Even those states participating in RWJF programs like ILTCP do not reciprocate asset protection because of the differences in: 1) regional fluctuations in the average cost of care; 2) state regulations regarding standards and requirements of LTC insurance coverage; and 3) state Medicaid budgets and the way Medicaid is administered in each state.²¹⁷ If Grandma buys an ILTCP policy she may move to another state and will still be insured, but if she wants to preserve her asset protection, she must return to an Indiana facility (or receive HHC in an Indiana residence) before the policy benefits are exhausted.²¹⁸

Lack of reciprocity and portability is a major factor preventing a nationwide system of state partnership programs. The federal Medicaid program, or similar public fund, would have to intervene, possibly making state reimbursements with regional cost factors similar to the current Medicare system. Otherwise a national partnership program, affecting the federal portion of Medicaid expenditures rather than state Medicaid budgets, may be needed to assure portability. This is particularly important if the goal is to encourage younger persons to purchase LTC insurance as they are apt to be more mobile before they retire or need LTC. Some tradeoffs are necessary in any LTC solution and it appears that for the partnership programs, at least for now, portability is being traded for the desired benefits of high quality, affordable insurance, state Medicaid cost containment and the prevention of personal impoverishment.²¹⁹

216. *Questions & Answers*, PARTNERS (Indiana Long Term Care Program, Family & Social Servs. Admin., Indianapolis, Ind.), Summer 1995, at 4 [hereinafter PARTNERS, Summer 1995].

217. McKay Interview, *supra* note 91; *Spreading the Partnership*, PARTNERS (Indiana Long Term Care Program, Family & Social Servs. Admin., Indianapolis, Ind.), Autumn 1995, at 2.

218. PARTNERS, Summer 1995, *supra* note 216, at 4.

219. McKay Interview, *supra* note 91.

IV. RECOMMENDATIONS

As discussed earlier, no single private or public solution exists. ILTCP fits somewhere toward the "private" end of the continuum and is only part of the solution. The possibility of private-public mixes is endless and a survey of all the possible combinations and their projected effects on public costs is beyond the scope of this Note. However, this author recommends the following public sector complements to ILTCP as one possibility for a more complete package and comprehensive solution: 1) increased public education and pursuit of better data on national LTC use; 2) tax incentives for employers who provide cost-effective group LTC coverage; 3) federal mechanisms that promote portability of the asset protection feature; and 4) small increases in affirmative taxes to pay for inevitable public spending increases, preferably in a limited estate recovery system and with limited additional regressive taxes.

A. Educating the Public and Generating Quality Information

Notwithstanding the heightened media and consumer attention on health care reform, the myth that LTC costs are covered by Medicare still exists. People needing extended care are not aware that options for HHC and community programs exist,²²⁰ and in many areas of the country these alternatives are undeveloped. The government's strongest contribution would be to dispel these mistaken beliefs and to remove the nursing home bias inherent in the current Medicare and Medicaid systems. In addition, for national programs and the private insurance industry to anticipate the risks and costs of their respective programs, they must have better information on the actual needs among senior Americans for all types of LTC. It is essential that studies and feedback on Medicare and Medicaid not only track nursing home use obtained on known users, but they should also track data on the informal care provided by family members as well as care that some people forego because it is unaffordable or because they do not want to go to a nursing home. A more informed public and government will be better prepared to plan for the risks, develop solutions to LTC financing, and adapt to changes in LTC use.

B. Financial Incentives

For national LTC reform to succeed, ILTCP and its counterparts need assistance from national public mechanisms that provide additional incentives for private responsibility. The asset protection feature of private-public cooperatives encourages elderly people who are closest to the risk of using LTC to buy insurance. However, this feature is limited by state lines and it does not provide incentives for younger persons to obtain protection. A discriminatory tax incentive in favor of younger purchasers is likely to meet with constitutionality challenges. Moreover, tax incentives are likely to benefit only the higher income groups, leaving out a significant portion of the partnerships' target market.

220. See *supra* notes 58-59 and accompanying text.

A more effective approach is to award tax credits to employers who sponsor, in whole or in part, their employees' participation in more cost-effective group LTC insurance plans. This will work to encourage and infuse younger, healthier people into the insurance system, normalizing the risk pool. Because nearly one-third of all its partnership sales are group- or employer-sponsored purchases, Connecticut's partnership program enjoys the lowest average age of partnership buyers at fifty-nine years old.²²¹ Meanwhile, the average age of an ILTCP participant is sixty-nine years old because until very recently ILTCP had no group ILTCP policies approved.²²²

Due to administrative economies, group plans are more cost effective and premiums, whether paid entirely by the employer or shared with the employee, are lower. In addition, group plans encourage purchases by younger individuals.²²³ When insureds purchase at younger ages, adverse selection costs are reduced and more people are insured. When more people are insured, more private dollars fund the full costs of LTC, making it more affordable to improve the quality of care by hiring more or better-skilled caregivers. Thus, employer- and group-sponsored plans are crucial to the success of LTC reform because they boost the participation of private-payors and help normalize the risk pool with younger, healthier insureds. To that end, several recent bills²²⁴ have called for tax clarifications where LTC insurance would be treated like medical insurance for both employers and employees. Therefore, the premiums individuals pay would be included in the present medical expense exemption, and employer-paid premiums would be deductible expenses.²²⁵

221. Memorandum from the Connecticut Partnership for Long-Term Care to the National Partnership for Long Term Care 5 (May 10, 1995) (on file with author) [hereinafter Connecticut Quarterly Figures, First Quarter 1995]. Cumulative statistics show 32% of Connecticut's purchasers were *under* the age of 65. *Id.* New York's purchasers averaged 68 years of age, 40% of them were under age 65, with only 6% of purchases in the first quarter of 1995 coming from group or organization sales. NEW YORK QUARTERLY UPDATE, FIRST QUARTER 1995, *supra* note 123, at 5. California's program, aside from sales by the California Public Employees' Retirement System, has not approved group policies. According to cumulative statistics (7/94 to 3/31/95), the average age of their partnership buyer was 68, with only 27% of those under the age of 65. CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE, QUARTERLY REPORT 3 (1995).

222. ILTCP UNIFORM DATA, THIRD QUARTER 1993, *supra* note 143. Group policies were not available until the fourth quarter of 1994. *Id.* See also PARTNERS, Autumn 1994, *supra* note 207, at 2. Group sales represented 2% and 7% of all partnership sales for the fourth quarter 1994 and first quarter 1995 respectively. With the advent of group sales, about 33% of ILTCP's buyers were under age 65. ILTCP UNIFORM DATA, FIRST QUARTER 1995, *supra* note 212, at 4.

223. The average age of partnership beneficiaries in group sales in Connecticut, Indiana, and New York were 59, not reported, and 62, respectively, compared to the average age for individual purchasers of 64, 69, and 68, respectively. Connecticut Quarterly Figures, First Quarter 1995, *supra* note 221, at 2; ILTCP UNIFORM DATA, FIRST QUARTER 1995, *supra* note 212, at 4; NEW YORK QUARTERLY UPDATE, FIRST QUARTER 1995, *supra* note 123.

224. See, e.g., H.R. 8, 104th Cong., 1st Sess. (1995).

225. *Id.*

C. Portability of Asset Protection as Additional Incentive

Younger consumers, who will not face the potential for long term care for another twenty, thirty or more years, and who are more likely to be mobile, will have a greater incentive to purchase a portable partnership policy. Support for a national federal partnership program has been rejuvenated by the Life Care Act, which would honor the asset protection feature in any state the insured receives care. Short of this national partnership for LTC, reciprocity of the asset protection feature could be achieved through federal reimbursement mechanisms that are rated for regional differences in cost of care.²²⁶ A mechanism such as this could eliminate the portability problem with a nationwide system of state private-public cooperatives.

Alternatively, the federal government could enact standards on insurance companies by which a partnership purchaser in one state must be allowed to transfer his or her policy to another state's approved insurer without having to prove insurability and at premiums based on the age attained at the original purchase date. The insured may be required to purchase additional coverage if the average daily cost of care in the transferee state exceeds his or her maximum daily benefit. Government intervention through mechanisms such as these are costly, both in reimbursements and in administration. Moreover, an intervention such as this may appear to virtually federalize the insurance industry which is currently under state control. However, drastic measures similar to these may be necessary to induce younger individuals to purchase partnership policies and, thus, achieve a much larger and more diversified pool of insured LTC users.

D. Affirmative Taxes to Fund Public Costs

Because the costs and use of LTC are likely to increase in the future, public expenditures are equally likely to increase. Public dollars are necessary to cover LTC costs for the indigent and uninsurable. Funding the public portion of LTC expense with compulsory payroll taxes, like those which pay for Social Security (OASI) and Medicare (SMI), is less politically palatable than increasing inheritance taxes. In a nationwide system of state partnership programs, states could increase their inheritance tax, which currently is negligible or nonexistent in some states, to fund care for the indigent and uninsurable. If, instead, a national partnership for LTC were to develop, an increase in federal estate tax could offset much of the increase from the "woodwork" effect and moral hazard. These death taxes, however, are inherently progressive and characteristically welfare-type taxes, which are politically unappealing.

An alternative inheritance tax that may be more acceptable is an estate recovery tax similar to the OBRA-93 requirement. With estate recovery, the "tax"

226. Medicare uses similar mechanisms for physician and medical facility reimbursement. See, e.g., Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 1995 Rates; Correction, 59 Fed. Reg. 64,153 (1994) (to be codified at 42 C.F.R. §§ 412-13).

is limited to the LTC user and his or her family rather than distributed across generations and income groups. However, the current OBRA-93 requirements function to reverse the very carrot which creates incentives to purchase these LTC policies—the asset protection feature. It has discouraged several states from participating in partnership programs and would likely discourage consumers from purchasing these policies. The estate recovery tax would be easier to swallow, both by interested states and their consumer constituents, if it recovered only the most catastrophic public expenditures—nursing home costs. Additionally, such limitation on estate recovery would encourage consumers to choose HHC and community care whenever possible, reducing unnecessary institutionalization costs and keeping public expenditures as low as possible.

CONCLUSION

Private-public cooperatives are a vital part of America's LTC reform and go the longest yard in putting this solution within manageable reach. Programs like ILTCP do not answer the needs of the indigent. Medicaid still remains a necessary and important financier of LTC for poor families, which is its intended purpose. Nor do the partnership programs protect the upper-middle and upper class citizens who can self-insure or pay for lifetime LTC private insurance. The partnerships do, however, provide a significant remedy for a large window of America's elderly who have few legitimate alternatives, and encourage them to plan now to take responsibility for their own LTC needs.

The solution for national LTC reform is within our grasp: “[a]lthough long-term care financing has been viewed as an insolvable problem, it is actually one of the more tractable social issues facing the United States. . . . [T]his issue has a range of known and feasible solutions.”²²⁷ The trick is choosing a solution with which American citizens can live. ILTCP is such a solution. When coordinated with public initiatives for a better-informed public and government, tax clarifications and other incentives for purchase, and increases in affirmative taxes to fund increasing public costs, ILTCP and its counterparts set forth an equitable, efficient and politically acceptable answer to the impending LTC crisis.

227. Wiener & Hanley, *supra* note 53, at 83.

