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**FINANCING LONG-TERM CARE IN THE UNITED STATES: WHO SHOULD  
PAY FOR MOM AND DAD?"**

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Abstract:

This article considers the legal framework that applies when older adults need long-term care in the United States. The financial aspects of this phenomenon hit almost all affected families as an unexpected crisis, because long-term care generally falls outside the purview of Medicare, the government's health care program for older Americans. After families discover this reality, they often look to Medicaid, the government's health care program for poor people of any age, but this program has severe problems of access to quality facilities, and its financial eligibility criteria preclude coverage of most elders. The article then analyzes some impediments to obtaining Medicaid coverage of long-term costs, including questions of legal capacity to undertake asset divestment, ineligibility penalties imposed on uncompensated transfers, and mandatory recovery from the estates of Medicaid recipients. The article then turns to private long-term care insurance as a possible response to this dilemma. The article considers recent tax changes that were intended to promote the purchase of this insurance, but finds that these benefits are often illusory and that regulation of such policies is still needed to facilitate informed comparison shopping. Finally, the article examines why the financing of long-term care costs should be a private responsibility at all, especially when the financing of acute care costs has been socialized via the Medicare program.

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## CHAPTER FIVE

RICHARD L. KAPLAN

### FINANCING LONG-TERM CARE IN THE UNITED STATES:

*Who Should Pay for Mom and Dad?*

As the new millennium dawns, the United States approaches the aging of its population amid various dire predictions. All sorts of age-related phenomena are described as being in “crisis,” even though they lack the crucial immediacy or abrupt turning point that the word “crisis” implies. For example, the Medicare system for financing the health care needs of older Americans is projected to go bankrupt – but not until the year 2023. Similarly, the Social Security system that pays monthly stipends to retired American workers and their spouses anticipates running out of money – but not for another four decades (Social Security and Medicare Boards of Trustees 2000). These predictions may be appropriate subjects for policy discussions, but they are not “crises” in any real sense.

One age-related phenomenon that can legitimately be termed a “crisis,” however, is the financing of long-term care. Yet, this situation received almost no attention during the recently concluded Presidential election campaign – unlike the travails predicted for the Medicare and Social Security programs. The reason for this anomaly is that, unlike the impending financial difficulties facing Medicare and Social Security, the financing of long-term care in the United States is a *private*, rather than a public, crisis. That is, if Medicare or Social Security were to run out of money, all of the beneficiaries of these programs would be affected and at the same time – hence, the obvious concern of public officials. In contrast, the need for long-term care is usually faced family-by-family, one older adult at a time, without the kind of nationwide cataclysmic event that captures the attention of the political process. This individualistic focus makes the financing of long-term care a “silent” crisis.

There is nothing silent about this crisis, however, when it hits home. One day, Mom is vibrant, active in community affairs and family events; the next day, she is in a hospital, having survived some neurological event that gave no warning signals.

After she is “stabilized,” she returns not to the lifestyle she had before this “event,” but to a state of dependency that is more or less permanent. Her family must also address these new realities with virtually no advance preparation. To them, and to Mom herself, the onset of long-term care exemplifies the dictionary definition of a “crisis” – namely, “a crucial point or situation in the course of anything: turning point.” Along with the plethora of emotional, physical, and logistical concerns that suddenly confront Mom and her family is one that is often the most traumatic: who will pay for Mom’s long-term care. That question is the focus of this chapter.

### THE MYTH OF MEDICARE

The first shock to almost everyone faced with this situation in the United States is that Medicare, the government’s health care program for retirees, does not cover long-term care as a general matter. Medicare was created in 1965, at a time when acute care – specifically, hospitalization – was the focus of attention. As a result, Medicare covers almost all hospital costs, after a relatively modest deductible, incurred during a patient’s spell of illness (Frolik and Kaplan 1999, 66-7). Indeed, in this context, Medicare’s coverage is really quite good: it applies nationwide, it covers almost all Americans age 65 years and older, it applies to almost any willing health care provider, and it has few limitations in the usual circumstances.

In fact, before the need for long-term care arises, many older patients have experienced Medicare’s coverage of hospital costs and found the results to be very satisfactory. Whether that experience involved themselves or some contemporary, usually a spouse or sibling, they saw Medicare pay most of the bills in question, save for that initial deductible and personal charges like telephone and television. Room costs, nurses’ fees, diagnostic procedures, in-hospital use of pharmaceuticals, and laboratory tests were taken care of, in almost all cases, without any annoying paperwork on the patient’s part or any serious disputes. The hospital billed Medicare directly and that was that.

Related costs of the hospital experience, such as doctors’ bills and ambulance charges, were handled similarly (Frolik and Kaplan 1999, 74-6). Fees were billed to Medicare, which paid these costs according to its established pricing schedules. Any co-payment obligations of the patient were usually submitted directly to the carrier of the patient’s Medigap insurance, a type of private coverage that most Medicare enrollees have, unless they belong to a managed care plan (Eppig and Chulis 1997). If the Medicare enrollee does belong to a managed care plan, the process is even simpler, because then there is no co-payment obligation (Frolik and Kaplan 1999, 96). In either case, when the dust has settled, most, if not all, of the costs associated with the hospitalization have been covered, with precious little involvement of the patient in the payment process. In effect, the combination of near-universal coverage and relatively seamless payment mechanisms makes the Medicare system, as supplemented by Medigap, the closest U.S. analogy to the national health care system that is found in many other developed countries.

As a result of this hospitalization experience, patients (and their families) are understandably shocked and confused when the need for long-term care arises and Medicare does not play a similar role. After all, they reason, when the patient went to a hospital for medical reasons, Medicare paid the bills. Now that the patient needs long-term care for medical reasons, Medicare will again pay the bills, no? Whether the need for long-term care originated with some physiological event, like a stroke, or some progressively degenerative condition, like Alzheimer's disease, the bottom line is the same: because of *medical* developments, the patient needs care. Why would Medicare not pay for care in this context, when it did so in the hospital setting?

This issue is particularly poignant in light of the effort the government has made in recent years to reduce the length of hospital stays.<sup>1</sup> By refusing to pay for hospital stays beyond certain diagnosis-related limits, Medicare has effectively declared that a less intensive – and expensive – stay in a nursing home would better serve a patient's needs. And if that is the case, one would expect that Medicare will pay for the care that is being substituted for the more expensive hospital stay. Unfortunately, it does not.

When Medicare reduced its coverage of hospital stays, it did not simultaneously expand its coverage of long-term care. That coverage, whether in nursing homes or via home health care agencies, is essentially the same as it was when Medicare was first created. In both settings, Medicare's coverage is severely limited and does not purport to constitute long-term care.

Turning first to nursing homes, Medicare pays for care in a skilled nursing facility (SNF) only under specified conditions, *all* of which must be satisfied (Frolik and Kaplan 1999, 68-70). First, the SNF must submit to Medicare's copious rules and regulations for being designated an "approved provider." Most nursing homes meet this requirement, but some have chosen not to do so, and many Medicare-approved facilities maintain only certain beds on "Medicare-approved" status.

Second, the patient must be admitted into the SNF within 30 days of being discharged from a hospital where the patient stayed at least three days, not counting the date of discharge.<sup>2</sup> This three-day requirement became increasingly significant when Medicare instituted the diagnosis-related maximum permitted stays mentioned previously. These rules translate into generally shorter hospital stays and, as a result, fewer hospital stays last the three days required for SNF coverage. Moreover, many nursing home admissions are not preceded by hospitalizations at all, so these SNF admissions are *never* covered by Medicare.

A final, but extremely important, requirement for Medicare coverage of a SNF stay is that the patient be receiving *skilled* nursing or rehabilitative services that only a SNF can provide. Such services include injections, catheterization, gastrostomy feedings, medical gas administration, and other procedures that require the skills of technical and professional personnel.<sup>3</sup> Furthermore, these services must be needed on a *daily* basis to treat a condition that was treated in the hospital. In other words, Medicare covers only a fairly intensive level of care – not the sort of "intermediate" or "custodial" care that is received by the vast majority of nursing home residents.

Even if *all* of these requirements are met, Medicare's coverage is limited to twenty days at full cost. For the next eighty days of a SNF admission, Medicare covers daily costs in excess of a per-day deductible that is adjusted annually for inflation. In 2001, this per-day deductible is \$99.<sup>4</sup> In other words, for days 21-100, Medicare pays SNF costs only after the patient has paid \$99 per day. And after day 100, Medicare pays nothing!

In this context, Medigap insurance does not provide much help either. Such supplementary insurance, which purports to cover the "gaps" in Medicare, does not generally pay for long-term care (Frolik and Kaplan 1999, 93, 95). Even the most comprehensive, and expensive, of Medigap's twelve possible benefit packages pays only the per-day deductible (\$99 in 2001) of days 21-100 for a SNF stay that Medicare is otherwise covering. All of the conditions of Medicare coverage for skilled nursing facilities apply as well to Medigap's coverage. And after day 100, Medigap's coverage ceases.

Ironically, Medicare's coverage of nursing home costs – as limited as it is – may lull some families into thinking that Medicare covers the cost of nursing home care generally. If an older relative was previously admitted into a nursing home under the conditions described above, Medicare covered most of the bills and perhaps Medigap covered the rest – as long as the nursing home stay did not exceed 100 days, of course. Since Medicare covered the cost of that stay, the family might assume that Medicare covers the cost of all such stays. Distinguishing between short-term skilled care and long-term custodial care is not apparent to most people, especially when the facility in question provides both types of care. Yet, this is the distinction that Medicare makes when it covers the former but not the latter.

Turning now to home health care, Medicare's restrictions are severe. First, the Medicare enrollee must be homebound, i.e., unable to leave his or her home, except with assistance from other people or with a wheelchair, walker, or cane. Even then, Medicare covers only physical, occupational, and speech therapy, medical supplies, durable medical equipment, and "part-time or intermittent" nursing care (Frolik and Kaplan 1999, 70-2). Drugs, meal preparation, and homemaker services are not covered. As a result, Medicare's home health services must be supplemented in almost all cases with substantial care from other sources.

#### THE CURIOUS APPEAL OF MEDICAID

Since Medicare does not pay for most long-term care, who does? As Mom and her family discover to their collective horror, *they* do. For wealthy people, this may be an annoyance, but it is not a catastrophe. Nursing home costs average \$54,000 per year, though the charges vary greatly by location and individual facility (Shelton 2000, 1). In some places, the cost may be nearly twice the average. Nevertheless, persons with \$1.5 to \$2 million should be able to finance their nursing home stay, regardless of its length. If their assets are not relatively liquid, they may face some cash flow difficulties, but by borrowing against their equity in these assets, they should be able to finance their long-term care needs.

Interestingly enough, persons at the opposite end of the economic spectrum, the impoverished, also face little economic anxiety in this area, because the government pays for their long-term care needs via a separate health care program called Medicaid (Frolik and Kaplan 1999, 101-16). Medicaid is the health care component of the nation's welfare system, funded jointly by the individual states and the federal government and administered by the state public aid bureaucracies. General eligibility standards are established at the federal level and are then refined within specified parameters by the states. Medicaid is not age-based; in fact, the vast majority of Medicaid claimants are under age 65, although older claimants account for a disproportionately large share of Medicaid's expenditures. As the primary health care system for poor people of all ages, Medicaid's coverage includes long-term care expenses for those claimants needing such care. Many of these claimants have received their health care via Medicaid long before they required long-term care. In effect, Medicaid simply followed these people as they progressed through the continuum of health care needs.

That is not to say that Medicaid is a particularly attractive system, however. Access to health care providers is a chronic problem of Medicaid recipients. Although many health care providers participate in the Medicaid program, many others do not. Nursing homes, in particular, are often not Medicaid providers, because Medicaid's payment schedule is so low. Years of successive budget cuts have resulted in Medicaid rates that are well below current market rates and are often below a facility's actual cost of providing care (United Seniors Health Cooperative 1988, 32). Given these circumstances, some nursing homes have dropped out of the Medicaid program entirely, while others remain in the program but limit sharply the number of Medicaid recipients that they accept. As a result, Medicaid recipients often find themselves shut out of certain nursing homes, especially the more desirable ones (Reschovsky 1996; Buchanan, Madel, and Persons 1991). But if a nursing home resident *is* covered by Medicaid, then Medicaid pays the bills and the resident gets the care he or she needs.

The question thus becomes: What about the people in the middle? That is, what about people who are not wealthy enough to easily pay for long-term care themselves, but who are not poor enough to qualify for Medicaid? These people are the folks who are the most perplexed by the United States' approach to financing long-term care. When they need long-term care, they must utilize their own resources until those resources are virtually exhausted. This process of private pay "spend down" means that these people must draw down their bank accounts and certificates of deposit, sell their stocks, bonds, and mutual funds, cash in their life insurance or access any "accelerated benefits" on such insurance when these policies so provide, and even liquidate their real estate and other investment assets (Frolik and Kaplan 1999, 109-10; Bohlman 1994; Newberry 1999). When almost all of these assets are gone, the formerly self-sufficient middle class person can qualify for Medicaid as one of the impoverished. The awful irony here is that many of these people worked hard all of their lives to avoid accessing the welfare system but end up on that very system when their long-term care needs devastate their financial

assets. In effect, the non-coverage of long-term care expenses operates like a 100 percent estate tax on the middle class!

So, what do these people do? The first reaction of many people in these circumstances, most especially the older person's children, is to accelerate Medicaid eligibility by giving away one's assets. This practice of transferring assets to become poor enough for Medicaid is often called "Medicaid planning" or sometimes "Medicaid estate planning." It is extremely controversial and all points of view are advanced with great passion (Broderick 1998; Rein 1996; Moses 1993; Rosenfeld 1998; Soltermann 1993). The adult sons and daughters of the older person who needs long-term care usually cannot understand why Medicare, the government's health care system for older Americans, does not cover this increasingly common consequence of old age. More poignantly, why are hospital costs and acute care covered in full, while long-term care costs are covered only minimally, if at all? This blatant inconsistency strikes them as bizarre, discriminating as it does on the basis of disease: cancer is covered, but Alzheimer's is not. It also strikes them as irredeemably unfair. Cancer patients may have been able to prevent their illness, but Alzheimer's patients could not have done so. And yet, the government pays for treatment of the *preventable* disease. These discrepancies quickly coalesce into genuine panic, a "crisis" in other words, as the adult children see their inheritances threatened by nursing home bills in a way that hospital bills never did. The result: a visceral urge to transfer their parent's assets to themselves and get Mom or Dad on Medicaid as soon as possible.

As understandable as this reaction may be, there are countervailing considerations as well. Medicaid is a poverty program, with perennially shortchanged resources, that struggles in vain to cover the medical needs of the truly poor. Indeed, the originating legislation specifically described Medicaid as applying to those "whose income and resources are insufficient to meet the costs of necessary medical services."<sup>5</sup> To the extent that Medicaid's expenditures care for people who could pay their own way, less remains available to cover the genuinely needy. In effect, middle-class nursing home residents disguised as poor people crowd out those who have no alternative to Medicaid. This philosophical attack on "Medicaid planning" resonates with advocates for the poor, in particular, and others who often analogize this practice to welfare fraud (Quinn 1989; Bates 1992; Crosby and Leff 1994). This view is not shared, obviously, by the anxious heirs who are learning of Medicare's limited coverage of long-term care for the first time, and in rather exigent circumstances to boot. Indeed, they may have difficulty discerning any substantive difference between Medicaid planning on the one hand, and the time-honored and rarely criticized practice of estate tax minimization on the other.

But those inclined to do Medicaid planning face some significant impediments. First, the older person in question might not *want* to transfer all or most of that person's assets to qualify for Medicaid. Medicaid's reputation for restricted access to health care providers is an open secret, and it is clearly easier to get into any particular facility as a "private pay" patient rather than as a Medicaid recipient (Nyman 1989; Reschovsky 1996, 16). And however unappealing the idea of long-

term institutionalization may be, this prospect is even more unappealing if one's choice of facilities is limited by one's status as a Medicaid claimant. Thus, the older person might want to retain his or her assets to maximize the range of facilities from which to choose.

Still other older persons may consider the assets in question as theirs to use as they see fit. Yes, they might like to leave an inheritance to their children, but the money was saved for a "rainy day," and now it is raining. Paying their own way has been a hallmark of their lives, and a subject of considerable personal pride. This accomplishment is especially important to the current generation of older citizens. They never wanted to be a "poverty case," and they will try to forestall becoming one as long as possible (Regan 1995, 1222). The bottom line: they do not want to transfer their assets, because they want to avoid the stigma of being a pauper.

Second, the person in the nursing home might have a spouse at home who needs those assets for her own support. In these circumstances, the institutionalized spouse typically wants to preserve the assets that have been accumulated to ensure an acceptable standard of living for the non-institutionalized spouse. And if the institutionalized spouse were inclined to transfer some of the couple's assets, the spouse at home might forbid such transfers, because the assets in question may be needed for her own expenditures, including future medical costs. Thus, the older person's dependent spouse might prevent asset transfers.

Even if the older person is willing to transfer these assets, that person may no longer be able to do so. That is, if the reason they need long-term care relates to their deteriorating mental condition, they may no longer have sufficient "mental competence" or "legal capacity" to transfer assets or engage in other financial transactions (Frolik and Kaplan 1999, 12-5; Walsh et al. 1994). Legal capacity is rarely an all-or-nothing phenomenon, to be sure. It may exist in the morning, or when certain medications have not been combined, or in familiar surroundings, or for some types of transactions and not for others. But at some point, the question must come up whether the older person understands what he or she is being asked to do. If not, the assets cannot legally be transferred, unless some sort of substituted judgment mechanism (i.e., guardianship, conservatorship, financial power of attorney, revocable trusts) is already in place (Frolik and Kaplan 1999, 224-66).

Finally, even if the older person is willing and able to do Medicaid planning, the Medicaid statute itself erects some significant obstacles. If assets are transferred during the 36 months that precede an application for Medicaid benefits, those transfers must be disclosed to the Medicaid authorities. Failure to do so is Medicaid fraud, plain and simple. Disclosed transfers subject the older person to a "transfer penalty," a period during which Medicaid benefits will not be paid.<sup>6</sup> This period is determined by dividing the amount transferred by the monthly cost of providing care. Most states employ county-wide or state-wide averages of the cost of care, while some other states use the cost in the facility in question. In either case, transferring assets makes the transferor ineligible for Medicaid for a specified period of time.

The mechanics can be illustrated as follows. Assume that Joseph transfers stocks and bonds worth \$300,000 within three years of applying for Medicaid, and that the state's average cost of care is \$4,000 per month when the transfer is made. The resulting penalty period is seventy-five months ( $\$300,000 \div \$4,000$ ), meaning that Medicaid will not cover Joseph until six years and three months *after* the date these assets were transferred. As this example illustrates, asset transfers are not the easy escape hatch that the putative heirs might imagine.

On the other hand, if Joseph in this example had transferred his \$300,000 *more* than three years before he applied for Medicaid benefits, that transfer would not be disclosed or penalized. Thus, the lesson seems to be: transfer the assets at least three years in advance. But this approach has two very significant drawbacks. First, as a practical matter, one rarely knows 36 months in advance that long-term care will be needed. Thirty-six *hours* is more typical. Thirty-six months ago Mom was living on her own, with no apparent necessity to transfer anything to anybody for any reason.

Second, the rules may change. The 36-months rule is not carved in stone. Indeed, this transfer penalty or "lookback" rule began its statutory life as a 24 month period, and over the years, it was increased first to 30 months, and now 36 months (Broderick 1998, 264-71; Frolik and Kaplan 1999, 125-7). There is no reason to think that 36 months will be the rule forever. In fact, transfers involving trusts currently employ a 60 months lookback period. Moreover, there is no "grandfathering" of prior transfers. That is, assume that Joseph makes the transfer described previously when the lookback period is 36 months. He then waits 37 months and applies for Medicaid benefits, thinking that he will not need to disclose the asset transfer and face a penalty period. Assume further that last year, Congress changed the lookback period to 48 months. When Joseph applies for Medicaid, his transfer of 37 months ago falls *within* the newly lengthened lookback period of 48 months, and it must be disclosed. Accordingly, a penalty period will be imposed on what Joseph thought would be an exempted transfer. The point here is that the relevant lookback period is determined when the Medicaid application is *filed* – not when the assets are transferred. As a result, even long-range Medicaid planning can be quite problematic.

And if the preceding caveats about Medicaid planning were not sufficiently discouraging, Medicaid sports one additional disincentive: mandatory estate recovery. That is, the state is required to recover its Medicaid expenditures from the assets the Medicaid recipient owns at death (Frolik and Kaplan 1999, 127-8; Rein 1996, 223-7; Wilcox 1998). Such assets consist of two basic types. First, a Medicaid recipient is often allowed to retain a car and a home if he or she "intends" to return home, however remote that possibility might be. Second, after a Medicaid application has been approved, a Medicaid recipient might inherit assets from his or her spouse or sibling. In any case, when the Medicaid recipient dies, that person's assets are subject to a lien filed to reimburse Medicaid for the amount it expended on that person's behalf. In effect, estate recovery provisions transform Medicaid into a loan-like program, unlike any other poverty-based or "means-tested" program, and

unlike Medicare, which makes no such claims, regardless of how wealthy a former enrollee may be.

To summarize, Medicaid does pay for long-term care but at rates that effectively limit the providers that one may choose. Eligibility is restricted to poor people, and persons who seek to artificially establish Medicaid eligibility face potential problems of legal incapacity and daunting penalty periods. Finally, estate recovery provisions require that benefits be paid back after the recipient dies – unlike any other health insurance program.

### PRIVATE LONG-TERM CARE INSURANCE

Some people facing the prospect of long-term care look to private insurance to solve the financing problem (Gordon 1994, 163-96; Center for Long-Term Care Financing 1999; Barreira 1995; Hayes 1999). Such insurance can cover the entire panoply of long-term care, from in-home care to assisted living to nursing homes. These policies employ various approaches to benefit payouts, some using daily maximums while others offer a “pool of dollars” that can be accessed in different ways (Frolik and Kaplan 1999, 131-43). In 1996, Congress gave private long-term care insurance a modicum of official imprimatur by mandating certain contract features and by authorizing the deduction of premiums for such insurance policies as medical expenses.<sup>7</sup> Since that time, long-term care insurance has been increasingly touted as the best answer for financing long-term care but, to date, such insurance pays for less than 1 percent of long-term care expenditures in the United States (Graetz and Mashaw 1999, 136).

Why that is so has many causes. First, most older people think that Medicare will cover the cost of their long-term care, so they see no need to buy private insurance that would simply duplicate Medicare’s coverage (Center for Long-Term Care Financing 1999, 55). That is not the case, of course, but Medicare’s deficiencies with respect to long-term care are not well understood by most people, including most older people. In contrast, most retirees do understand that Medicare has an array of deductibles, co-payments, and other limitations, such as no coverage outside the United States and no coverage of prescription drugs. Consequently, most older Americans buy Medigap insurance or join a Medicare health maintenance organization to address these deficiencies, but less than 10 percent of senior citizens currently have long-term care insurance (Wiener, Tilly, and Goldenson 2000, 60).

Second, long-term care insurance is very expensive, especially if it is acquired later in life. By then, the risk of the insured event happening is much greater, and the premiums reflect this reality. As an example, a policy providing four years of coverage at \$100 per day of either nursing home or home care coverage, with a 100-day elimination period (comparable to a deductible) costs \$2,830 per year if acquired when one is 75 years old, but only \$990 if one is 65 years old, and only \$510 if one is 55 years old (Jeffrey 1997).

Although these policies may be costly, their cost pales by comparison to the event that they insure. At a monthly outlay of \$3,000 per month (\$100 per day x

thirty days), the annual premium paid by a 75-year old is recovered in the first month that it pays benefits. Indeed, the financial exposure of the insurance company on this policy – namely \$146,000 (\$100 per day x 365 days per year x four years) – suggests that the premium charged might actually be too low! That possibility brings up another concern of would-be buyers of long-term care insurance: What if the policies *are* priced too low, and the insurance company goes bankrupt once claims are made? Long-term care insurance policies are simply too new to provide any comforting financial history, making this concern a troubling aspect of the private insurance approach. Nor is there any federal insurance that would back-up the financial stability of long-term care insurance companies. State-run guaranty funds do exist, but their protections are limited and largely untested (*Gotcha!* 1991, 432-3).

In any case, the cost of private long-term care insurance seems high, especially when there is no guarantee that it will be needed. To be sure, some 43% of persons age 65 and over will spend some time in a nursing home, but many of those stays are relatively short-term, i.e., less than 120 days. Between Medicare's coverage of short-term skilled care and the typical insurance policy's elimination period, few of these costs would be covered by long-term care insurance. On the other hand, the average nursing home stay is two and one-half years, and there is a 10% chance that the stay will exceed four years (*How to judge* 1997). In other words, there is a relatively small risk of a very large expense – the classic scenario that insurance is designed to handle.

A similar situation confronts buyers of fire insurance for their home. If a homeowner does not smoke, the likelihood of a major home fire is very small. Nevertheless, nearly all homeowners – including nonsmokers – carry fire insurance on their homes. Such insurance is required when a homeowner obtains a mortgage loan to purchase or improve the residence. In effect, the lender forces the homeowner to purchase this insurance. Of course, when a home mortgage is obtained, the size of the potential loss from a fire dwarfs the typical homeowner's equity in the home, as well as that person's other financial resources, so this insurance is a prudent investment. But even in later years, when the loan has been paid off, the homeowner usually maintains the fire insurance, despite the lack of any contractual obligation. The result is that homeowners pay premiums throughout the period of their homeownership for fire insurance policies that they will almost never need, and few find anything objectionable in this situation.

In contrast, long-term care insurance is widely regarded as a “bad investment.” Better to keep the money and pray that one never needs long-term care. The extent of this denial is the key to the entire long-term care financing dilemma (Mezzullo and Woolpert 1992, §24.18 at 23-5). No one wants to imagine himself or herself as disabled and requiring full-time assistance with the basic activities of daily living. It is simply too painful. To be sure, most people do not enjoy imagining themselves dead either, but life insurance is seen as a different sort of purchase. Similarly, estate planning seminars and lectures are always eagerly attended, even though the central event being planned around is the attendee's demise. Death, of course, is a verity; it

happens to everyone. Thus, the imperative to plan is obvious. Long-term care does *not* happen to everyone; hence, the imperative to plan is much, much weaker.

What might be done to alter this situation? Clearly, better education of all involved is essential. People need to know how much long-term care costs, the realistic likelihood of needing such care, and the general non-coverage of such costs by Medicare. They also need to understand how significantly the premium for long-term care insurance is affected by a person's age when such insurance is first obtained. As the data presented previously demonstrates, buying a long-term care insurance policy early in life is cheaper – not just on an annual basis, but over time as well – despite the likelihood that the younger buyer will make more annual premium payments. For example, a 55-year old who pays \$510 per year for thirty years (*i.e.*, until age 85) is out of pocket \$15,300, while a 75-year old who pays \$2,830 per year for ten years is out of pocket \$28,300. Even considering the “time value of money,” namely the opportunity cost of the funds tied up in this fashion, the younger buyer usually comes out ahead.

Moreover, the younger buyer is more likely to be able to buy long-term care insurance in the first place (Gordon 1994, 192; Frolik and Kaplan 1999, 137-8; Bonahoom 1993). That a person's insurability declines as he or she ages is a point that many people understandably fail to appreciate. After all, Medicare accepts everyone who is at least 65 years old, regardless of health status. Even Medigap insurers may not refuse to issue a policy to someone who applies within the first six months of that person's Medicare coverage.<sup>8</sup> But long-term care insurance is different. There is *no* guarantee that an applicant can obtain the type or amount of long-term care insurance that he or she may want. In fact, there is no guarantee that a long-term care insurance policy will be issued at all! Younger buyers, however, are more likely to obtain long-term care insurance, because many disqualifying medical conditions are either age-related or do not typically become part of one's medical profile until later in life. Thus, the ability to qualify for insurance is a substantial incentive to buy such insurance earlier rather than later, quite apart from the financial considerations involved (Hayes, Boyd, and Hollman 1999, 23-4).

On the other hand, purchasing long-term care insurance well before it is needed exposes the insured to significant inflation risk. A policy that pays benefits of, say, \$100 per day may be very appropriate when taken out by a 55-year old today. But in twenty years or so, the nursing home daily rate may be two or three times today's charge (or more), leaving the policyholder seriously underinsured. Accordingly, there is a natural tendency to delay purchasing long-term care insurance until the applicable daily rate is closer at hand and therefore easier to predict. To counter this tendency, long-term care insurance policies offer inflation protection riders that increase the daily benefit amount by some factor – usually 5% per year – on either a simple or compounded basis (Frolik and Kaplan 1999, 135-6). Adding this rider to a long-term care insurance policy, however, increases its cost rather dramatically. In the earlier example, the annual premium for a 55-year old was \$510, but if a 5% annual compounding rider is added, that policy's premium rises to \$1,090 per year –

a 113% increase! And for younger purchasers, adding this rider can increase the policy's premium by a factor of four or more.<sup>9</sup>

Quite apart from considerations of cost, there is much about long-term care insurance as it currently exists that is seriously off-putting. Simply trying to purchase such insurance is a maddening process that frustrates any serious attempt at comparison shopping. Some companies quote "elimination" or "waiting" periods of 30, 60, or 90 days; others offer 20, 50, or 100 days. Some policies last two, four, or seven years; others go out three or five years, or life. Comparing the resulting premiums requires some fairly intricate calculations. The obvious solution is to replicate what the federal government did for Medigap insurance nearly a decade ago: standardize insurance options and packages (Frolik and Kaplan 1999, 90-1). Consumers understand price, so there is no need to regulate prices, if policies can be made comparable to one another. But the existing almost infinite universe of possible combinations and permutations serves only to discourage would-be buyers of long-term care insurance.

Other improvements should be made as well. Most long-term care insurance policies contain gatekeeper provisions that determine whether long-term care is needed when a claim is filed (Frolik and Kaplan 1999, 138-9). These provisions often do not operate independently of the issuing company. That situation must change, and some sort of expedited review of negative coverage determinations should be added as well. Otherwise, consumers face the same situation that has caused so much consternation recently in the area of managed care – namely, the insurance companies that pay for care determine the level of care that they claim the patients need, and there is little opportunity to challenge these decisions with someone who does not have a clear conflict of financial interest in the outcome.

In addition, policyholders should be protected from future premium increases. At present, long-term care insurance carriers may increase a policyholder's premium only by doing so for the entire "class" of policies sold in a particular state. While the major insurance companies have generally not raised premiums on long-term care insurance policies once they have been issued, some insurers have done so, in some cases *tripling* the cost of their policies over a period of ten to twelve years (Davis 2000; Quinn 1999). As a consequence, the affected policyowners often must drop their insurance coverage precisely when they are most likely to need it. This practice of large post-issuance premium increases seriously undermines the confidence of would-be insurance buyers and should cease immediately.

Thus far, the long-term care insurance industry has resisted efforts to regularize these policies and make their purchase more understandable. Instead, it has introduced ever more policy options and lobbied Congress to make premiums tax deductible. These new policy options, however, are mainly a marketing device. For example, when assisted living facilities first began to develop, long-term care insurers promoted the availability of insurance benefits to pay for such arrangements, but they typically offered nothing to existing policyholders whose policies were issued before these facilities became common. Coverage was not

extended to these facilities, nor were low cost riders made available – hardly the way to boost consumer confidence.

Even the tax deductibility of long-term care insurance premiums is more a marketing angle than a financial benefit (Wiener, Tilly, and Goldenson 2000). The deduction of these premiums is subject to stipulated age-delineated caps, and any premium paid in excess of these limits is nondeductible.<sup>10</sup> Furthermore, the amount that is deductible is treated as a “medical expense” – certainly a logical classification, but one that limits the actual deduction to the excess of these expenses over 7.5% of a taxpayer’s “adjusted gross income.”<sup>11</sup> Since this limit applies to the aggregate of a taxpayer’s out-of-pocket medical expenses, it is often very difficult in advance to determine the extent to which long-term care insurance premiums will lower that person’s taxes.

For example, assume that Janice is 75 years old, pays \$3,400 per year for long-term care insurance, \$600 for the enrollee’s portion of Medicare, \$900 for Medigap insurance, and \$700 for prescription drugs. The cap in 2001 for deducting long-term care insurance for someone over age 70 is \$2,860, so this is her maximum deduction.<sup>12</sup> The other \$540 (\$3,400 – \$2,860) of her long-term care insurance premium is nondeductible. If Janice’s adjusted gross income is \$50,000, her medical expense deduction is computed as follows:

Long-term care insurance	2,860
Medicare enrollee portion	600
Medigap insurance	900
Prescription drugs	<u>700</u>
	\$5,060
7.5% of AGI (\$50,000)	<u>(3,750)</u>
Deduction allowed	<u>\$1,310</u>

Thus, a long-term care insurance premium of \$3,400 becomes a medical expense deduction of \$1,310 in this example. Even then, medical expenses are an “itemized deduction,” which effectively means that these costs will not be deducted at all by the nearly 72% of taxpayers who do not “itemize” deductions on their tax returns (Hollenbeck and Kahr 1998-99). If Janice in this example were among those taxpayers who did “itemize” deductions, this \$1,310 deduction would lower her taxes by \$197 or \$360, depending upon her marital status. Thus, the actual tax benefit produced by the “deductibility” of long-term care insurance premiums will usually be much less than most policyholders anticipate.

#### ALLOCATING THE RESPONSIBILITY FOR FINANCING LONG-TERM CARE

The final question is whether long-term care insurance is the best way of financing long-term care, even if the problems highlighted above could be remedied. That is, even if prospective purchasers were made aware of the medical and financial advantages of early purchase of insurance, and the policy terms were standardized into comparable packages, and premiums were not increased on existing policies,

and the determination of need was handled by genuinely impartial parties, and the premiums were made fully tax-deductible, why should financing long-term care be a private responsibility? Why *should* Medicare cover hospital care but not long-term care? When a cancer patient needs treatment, we do not ask that person to forfeit a life's financial accumulation or reimburse the state after death for the care received while alive. The risk of hospital care is, in effect, socialized through the Medicare program, even for conditions that may have been caused, in part, by a patient's own lifestyle choices. How excruciatingly inhumane for that society to then demand impoverishment and post-mortem reimbursement when an older person needs long-term care for age-related debilitating conditions that he or she could not have prevented. More generally, why is the risk of acute care socialized while the risk of chronic care privatized?

When the Clinton Administration attempted to overhaul the U.S. health care system in 1993, it did not propose that Medicare be expanded to cover long-term care. Not only was the anticipated cost of providing such care huge (nearly \$100 billion per year), there was also a sense that this particular age cohort – namely, persons age 65 and over – was already receiving much government largesse, particularly with respect to health care. There simply were other groups, children especially, whose health care needs were more underserved. Accordingly, the Administration decided that private long-term care insurance would be the focus of its efforts. Those efforts consisted of several proposals: improve the product itself by standardizing its terms, strengthen the regulation of insurers and their practices, and encourage the purchase of this insurance via tax deductions.<sup>13</sup> As noted already, the desired tax treatment was eventually enacted, such as it is, but the regulatory improvements were never made.

The staggering cost of long-term care did not go away, of course. Instead of Medicare covering this expense, it was relegated to the existing convoluted and incoherent maze of Medicaid, private pay, and long-term care insurance. So, 35 years after Medicare was created, the question remains: should people be held responsible for the cost of their long-term care when they are essentially off the hook for the cost of their hospitalization and their doctors' bills?

Perhaps the answer is “yes,” because of the very different nature of acute and chronic care. That is, much of long-term care does not require highly trained personnel, special equipment, or dedicated facilities. Indeed, the bulk of long-term care in the United States is provided gratis, usually by family members – spouse, adult children, siblings – and friends (Kane, Kane, and Ladd 1998, 14-6; Emanuel et al. 1999). This care may be provided without charge, but it is not without cost. These so-called “informal caregivers” often decline overtime at work, refuse promotions that would require greater time commitments, or even give up compensated work altogether (*Kin Take Big Losses* 1999). The enormous emotional challenges of caregiving also affect their marriages and their social life, as well as their own health, both physical and mental. There certainly are compensations to providing needed care to loved ones, but there is also no doubt that caring for family members can be very stressful. Many situations are further burdened by a lifetime of

accumulated resentments and other hurts. In many ways, it may actually be easier to provide long-term care for strangers. Nevertheless, most long-term care is currently provided within extended families. If some government program would suddenly provide such care without direct charge and without requiring economic disruption, would families continue to provide long-term care on the same scale that they do presently? Some would, no doubt, but others might not.

Thus enters the so-called “woodwork effect.” That is, if a newly created government program covers long-term care services, would potential claimants come out of the woodwork? If so, the cost of such a program would escalate far beyond the expenditures for nursing homes and home health care that are currently paid by private parties. The number of covered patients might simply explode, busting every budget estimate in sight and making the program fiscally unsustainable.

While some commentators contend that Medicare has artificially stimulated the demand for medical services (Epstein 1997, 156-9), few would claim that its coverage of acute care substitutes compensated care for services that were formerly provided *gratis* by family members. After all, few families can perform chemotherapy in their own home, to say nothing of surgical procedures and other medical technology that hospitals typically provide. But with long-term care, newly provided coverage by Medicare might well substitute for family care. After all, why undertake the economic and emotional trauma of caring for loved ones for an extended period, if the government will pay for this care? Unless there is some way to limit this “outsourcing” of family caregiving, the prospect of extending Medicare’s coverage to include long-term care is remote. Indeed, in the current climate of skepticism about – and often hostility towards – governmental programs, such an extension is probably impossible from a political standpoint (Skocpol 1996, 173-88).

Perhaps a more realistic approach would make clear to all that long-term care is fundamentally a private responsibility and that people should plan accordingly (Center for Long-Term Care Financing 1998). If someone wants to shift that risk to others, that person should consider long-term care insurance – assuming that such insurance has been improved as suggested previously in this article. If the older person cannot afford the cost of such insurance, perhaps that person’s adult children should pay the policy’s premium. After all, the long-term care insurance is effectively protecting *their* inheritances, so it makes sense that they should pay for the coverage that protects their economic interests. These putative heirs have already benefitted from Medicare’s current coverage, safeguarding their parents’ assets from economic devastation by hospital costs and related charges. If these heirs want to plug Medicare’s largest hole *i.e.*, namely, long-term care, they can either pay for long-term care insurance or plan to provide the care themselves when it is needed.

This approach does not devalue Medicaid’s role as the payer of last resort when a person’s assets have been exhausted. If an older person uses his or her resources to pay for medical care, it is still appropriate that Medicaid take over when those resources are gone. Although state filial responsibility laws make children

financially liable for expenses of their parents, these laws have been preempted by the Medicaid statute (Narayanan 1996, 372-86). Changing this preemption would represent a radical realignment of the financial responsibility for long-term care in the United States. To be sure, nothing would grab the attention of older people's adult children faster than being potentially liable for the cost of long-term care. The phones of long-term care insurance agents would literally ring "off the hook."

But such a system would probably be considered unjust. It is difficult enough for many people to accept the present dichotomy whereby Medicare pays for acute care with no concern for a patient's economic status, while Medicaid pays for long-term care only after a person becomes indigent. Adding filial responsibility to the long-term care cost equation could well aggravate the acute care/long-term care discrepancy beyond the breaking point. From the elders' perspective, this financial obligation on their children would compound their fears of being a "burden" on their families. After all, we are no longer talking about a foregone inheritance; now, the children are facing an open-ended liability on their *own* assets. Instances of elder abuse, and worse, would undoubtedly increase.

A better approach directs individual families to decide for themselves how they want to finance their elders' long-term care. If they are willing to use up the older person's assets and thereby eliminate any potential inheritance, that is their prerogative. If, on the other hand, the heirs want to protect their inheritances, they should either arrange to provide the care themselves or shift the risk to others via the mechanism of long-term care insurance. This approach acknowledges the historically central role of the family in providing long-term care and has the least potential for upsetting current informal support arrangements. This approach is appropriate, however, only if all of the parties involved in these decisions understand the choices being presented and the consequences of those choices. That is clearly *not* the case today. As a result, the financing of long-term care in the United States is a financial calamity that befalls the unprepared when they are least able to deal with it – when they are in a "crisis."

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#### NOTES

- 1 42 United States Code § 1395ww(b).
- 2 42 United States Code § 1395x(i).
- 3 42 Code of Federal Regulations § 409.33(a)-(c).
- 4 Available at: <http://www.medicare.gov/basics/amounts2001.asp> (visited March 29, 2001).
- 5 42 United States Code § 1396.
- 6 42 United States Code § 1396p(c)(1)(A); Frolik and Kaplan (1999, 121-2).

- <sup>7</sup> Internal Revenue Code §§ 213(a), (d)(10), 7702B(b), enacted as part of the Health Insurance Portability and Accountability Act of 1996, Public Law 104, 104th Cong., 2d Sess., U.S. Statutes at Large 110 (1996): 1936, 2008.
- <sup>8</sup> 42 United States Code § 1395ss(s)(2)(A).
- <sup>9</sup> Available at: [http://www.tiaa-cref.org/lc/lc\\_quote.html](http://www.tiaa-cref.org/lc/lc_quote.html) (visited April 24, 2000).
- <sup>10</sup> Internal Revenue Code § 213(d)(10)(A).
- <sup>11</sup> Internal Revenue Code § 213(a).
- <sup>12</sup> Revenue Procedure 2001-13, 2001-3 Internal Revenue Bulletin 337.
- <sup>13</sup> Health Security Act, 103rd Cong., 1st sess., H.R. 3600, S. 1757 (1993), §§ 2301, 2321-26, 2342-46, 2401, 7701-04.

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