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Funding Long-Term Care: Is There a Way to Ensure That Our Assets Will Last Longer Than We Will?

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Funding Long-Term Care: Is There a Way to Ensure That Our Assets Will Last Longer Than We Will?

Long-term care is a subject of great concern to most elders. Stripping away the emotional hype and confusing lingo surrounding this topic is essential to making sound decisions. This article pares away all the extraneous complications and lays out the options that are currently available to elders, paying particular attention to the methods available to fund long-term care if or when it is needed.

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Introduction

It is natural to want to fight against nature's most dirty trick, aging, and its ultimate result, death. Ironically, it is not death itself that many people fear most today. Rather, they fear that their long-term care costs will outstrip their assets, leaving them without sufficient funds to pay for these needs. Many aging people are asking themselves, "How will I survive and who will care for me when I cannot care for myself?" This concern has seniors scrambling for options, things that will help them hedge against this risk.

The number of people concerned with this issue is growing by leaps and bounds. The population is aging rapidly due to improvements in health care. By the year 2030, 18 percent of the population will be over 65 years old.[1] Regardless of how one feels about having the middle-class use Medicaid to cover long-term care needs, these statistics clarify the obvious: Medicaid cannot fund long-term care for the entire population. The system will simply go bankrupt if a large portion of the growing elderly population must rely on the wages of the rest of the population to fund their long-term care costs. The problem is that very few elders can afford to pay for their own care either, the costs for which are astronomical.

This article examines the options available to seniors for financing long-term care. It specifically explores the options for ensuring that one's personal funds are not outstripped by future long-term care

needs. No doubt, as baby-boomers age and prepare to move into the growing senior population themselves, many of them will put creative energy into solving this problem. We can only hope that this is true, given that the issue of how long-term care will be funded in the future is as difficult an issue as any other we have encountered as a society.

Medicare does not cover most home-health care or most nursing home stays, but most seniors do not know this.[2] Health care is covered by Medicare, as well as by a Medicare gap insurance policy that covers costs not picked up by Medicare (Medigap).[3] Health care is not the same as long-term care. Health care includes visiting doctors and hospitals, and seeking other medical care for specific ailments.[4] Long-term care, on the other hand, is defined as the need for assistance with two or more of the following tasks: eating, moving from the bed to a chair, using the restroom, bathing, or dressing. Long-term care includes a spectrum of means of providing assistance for these needs, from home-health care, to minimal health care provided with residential services, to full-blown nursing care services.[5] While health-care costs are covered by Medicare and Medigap policies, long-term care generally is not.[6]

These long-term care costs can be covered in three general ways:

1. They can be paid for with private funds;
2. They can be paid for from private funds as long as the funds last, and then paid for by Medicaid;[7] or
3. They can be paid through long-term care (LTC) insurance.

LTC policies are only valuable to the extent that seniors can afford to continue paying the premiums until they actually need the care. There is also fourth option for financing long-term care which is to contract with a continuing-care facility (CCF). Although this type of arrangement works off a different model, like LTC insurance, it attempts to contain long-term nursing care costs. This option allows a person to pay a substantial up-front fee, in exchange for guaranteed nursing-care for the rest of his or her life. Continuing-care facilities provide stepped-up care as the person ages. At first, the person lives in an independent apartment for which a monthly rent is paid. When additional care is needed, it is provided on site. There is no need to move out of the complex, thus eliminating reliance on family members and others and providing peace of mind about the future.

The Housing Options

We would all probably prefer to live in our own homes for our entire lives, if this were possible. As a next choice, most of us would probably prefer to live with children or other family members, once we can no longer care for ourselves. This option can make a person feel guilty about imposing on others and can also result in a loss of independence. As far as options go, being shipped off to a nursing home would be most people's very last choice. Today there are many excellent alternatives to traditional nursing homes.

Assisted-Living Facilities

One option is called assisted living. Residents pay rent for a typical apartment, and on-site services and facilities often include meals, social events, transportation, and general housekeeping.[8] Residents can also purchase home-care assistance for their daily needs. Residents pay for services on a monthly basis, and there is no up-front fee. Because residents pay for the services as they receive them, these arrangements do not help manage future long-term care costs in any way. Compared to traditional nursing homes that also do nothing to contain these costs however, assisted-living facilities are far more pleasant. Everyone who resides in such a facility can more or less take care of themselves, and residents live with companionship, freedom, and independence.[9]

There are between 20,000 and 30,000 assisted-living facilities in the United States, which house 25 percent of the 2.2 million seniors who live in senior housing.[10] Given that they are relatively new, these arrangements are incredibly popular.[11] They do have a significant downside, however. Once residents can no longer take care of themselves with relatively little assistance, they are required to leave the facility, typically for a traditional nursing home. Thus, while assisted living is a pleasant, though expensive, alternative for many seniors, using this option nearly always results in future relocation, something few seniors relish.

Continuing-Care Facilities

The other major alternative to a traditional nursing home is the continuing-care facility. These facilities

combine traditional nursing home care with independent living, and every imaginable level of care in between, all at one facility. The facilities themselves can be quite upscale. While many CCFs are affordable only by the upper-middle class, some facilities are within the reach of the middle class as well. The reason CCFs are expensive is because they require the payment of a very substantial up-front fee, in exchange for a guarantee of lifetime nursing care.[12] Residents also pay a monthly rental for their apartment, when they are living independently. Monthly fees are similar to those paid for assisted living, or perhaps a little less. Increases in monthly fees are often capped. Up-front fees vary greatly from state to state, but typically range from $80,000 to $200,000.

Every option has its downside, and the downside for CCFs is quite significant. Specifically, the large up-front entry fees that residents pay to live in these facilities are not protected from loss if a facility becomes insolvent. Thus, residents can lose large sums of money, even their life savings, when facilities fail financially.[13] This industry desperately needs legislation that will force the facilities to become stronger financially, and will protect resident fees in the event of insolvency.

Home-Health Care for the Elderly

A third and final alternative to traditional nursing home care is not really an alternative. This option, home-health care, essentially puts off moving to a nursing home but does not necessarily preclude it. Because most seniors prefer to stay in their homes for as long as possible, there is now an enormous market for in-home assistance to the elderly, for daily tasks of every kind. Adult day care, which provides structured activities and social interactions for seniors who often cannot stay home alone all day, is also becoming popular. These options are referred to loosely as "community-based care." Community-based care seeks to avoid shipping the elderly off to separate facilities, instead allowing people to age in place. There is a great deal of optimism about the future of these arrangements and even a movement afoot to permit more of these services to be paid for by Medicare or Medicaid. While this prospect seems unlikely given the current system, proponents claim that providing these community and home-based services could ultimately be cheaper for taxpayers than traditional nursing care. If this could be established, I have no doubt that people would soon have more access to these services through public funding. This would be a great improvement for all but the most medically needy elderly people. As it stands, however, few of these community-based services are covered by Medicare or Medicaid.[14] If seniors want to use them, they must pay for them from private funds or through an LTC insurance policy.

The Funding Options

The funding options for long-term care are not as plentiful as the housing options. They basically come in two flavors, private and public. Private funding of home-health care, nursing home care, and assisted living is a "pay as you go" proposition. You pay for the services you need for as long as you need them, and hope and pray that your life span does not exceed your savings. It is hard to know what to wish for in such a situation. While the extremely wealthy have nothing to fear, average middle-class Americans have to wish for either a miracle or a hasty demise, given that home-health care can run $20,000 to $40,000 or much more per year,[15] assisted living can cost $25,000 to $60,000 a year,[16] and a year in a nursing home now averages about $30,000 to $70,000 a year.[17]

There is always the option of divesting all assets voluntarily and becoming eligible for Medicaid. Most of us know someone who has done this, although I doubt that voluntary divestment abuse is as much of a problem as some people seem to think it is.[18] Given how quickly most people's assets are dissipated by paying for nursing care, it is not surprising that paying for it with private funds seems wasteful on some level. The private funds often cover a mere fraction of the costs anyway.

Yet very emotional debates are raging over whether middle-class people should be able to use Medicaid to cover their long-term care costs. People disagree about whether "Medicaid estate planning" constitutes wise financial planning or serious moral transgression. This debate has continued, despite the fact that in 1996, Congress took the unprecedented step of making it as federal crime to give away assets or set up trusts to qualify for Medicaid.[19] This provision, nicknamed by opponents as the "Granny Goes to Jail Law," was actually targeted at sanctioning lawyers who help people make such transfers.[20] Whether the law would actually be enforced against an elderly person remains to be seen.

Regardless of these criminal sanctions, transferring away all of one's assets has formidable downsides. First, I doubt that many elderly people actually want to transfer away all their assets. Doing so gives up complete control over where the person goes, what the person can buy for for personal use and for others, and how the person spends his or her days. It is a complete step away from independence, regardless of how much an elder trusts his or her children. It is often an irreversible step as well.

The biggest reason not to transfer away all of one's assets, however, is that the care received under Medicaid may be inferior to that purchased with private funds. The more desirable forms of care, assisted living and home-health care, for example, generally are not covered under Medicaid.[21] Moreover, even if traditional nursing care is to be used, a Medicaid recipient's choice of nursing care facilities may be severely limited. In some areas, the only Medicaid beds available are located in poorly funded places, in bad neighborhoods, clearly the stuff nightmares are made of.

Assuming neither of the financial risks discussed in this section are acceptable, namely the risk of running out of private funds for long-term care or the risk of simply living with the care provided by Medicaid, many seniors (and seniors-to-be) are desperately seeking ways to spread the risk of loss for long-term care. The only options currently available to address the financial risk of aging beyond one's savings are (1) purchasing and maintaining LTC insurance, and (2) entering into a continuing-care contract. Each of these risk-spreading options has significant weaknesses.

Long-Term Care Insurance

The same law that threatened to send Granny to jail, the Health Insurance Portability and Accountability Act (HIPAA),[22] gave purchasers of some long-term care insurance policies certain tax benefits, in order to induce people to buy the insurance policies.[23] These benefits became effective as of January 1997. The payments made for the policies are excluded from taxation, as are many of the benefits paid under the policies.[24] This law was passed to induce people to find affordable alternatives to funding long-term care.[25] The rationale was that if more people were to take out LTC policies, fewer would need to resort to Medicaid for long-term care. Thus, Medicaid funds could be reserved for the truly needy.

The idea of purchasing insurance to cover the costs of long-term care is excellent in theory, but has been somewhat problematic in practice. The first problem, which has no obvious cure, is that few people can afford to purchase and maintain LTC insurance premiums.[26] A typical policy, that contains meaningful but basic coverage and benefits, can cost a 65-year-old between $2,600 and $7,000 a year.[27] According to one study, only 25 percent of consumers in any state could afford the cost of basic, long-term care insurance.[28] Even those policies that are affordable today may not be affordable tomorrow, because rates can and do continue to rise as a person ages.[29] This is true *even if* the policies purport to have a *flat* premium rate. [30]

Policies also vary so significantly that many consumers have no idea what they are buying. Unlike Medicare and Medigap insurance, LTC policies can cover many different levels of long-term care, over a variety of periods of time.[31] The policies sometimes cover home-health care services as well, but often, one can only use a portion of the policy's dollar value for home-health care.[32] Most policies are indemnity policies that reimburse a set dollar amount of benefits for each day of care.[33] There also is typically a waiting period, up to 100 days, during which the consumer must pay for his or her own nursing care, before the policy can be used. These waiting periods are similar to deductibles on other insurance policies.

While some of the policies provide that these different levels of care can be received in a variety of home and institutional settings, consumers need to read the policies extremely carefully. Not all policies are this flexible. The best policies on the market offer the consumer the greatest number of ways to use the policy when the time comes. Most of the products on the market, however, do not offer all of these options. Some policies cover rehabilitative care for temporary medical conditions, custodial care for long-term nursing care needs, and residential in-home care. One big benefit is that they can be used to fund care in settings other than traditional nursing homes. Consumers are particularly drawn by the possibility of insuring for future home-health care costs. Not every policy actually covers home-health care, however, and most policies that do cover this type of care place severe restrictions on the use of the policy in this way. Naturally, the policies that offer the greatest number of care options are also

the most expensive, because it is far more expensive for insurers to pay benefits for these more desirable options.

While there is no question that exorbitant rates keep people from buying LTC policies, insurers that offer the policies claim that the high rates are unavoidable. Two risks, adverse selection and induced demand, are the reasons insurers cite for the high rates. Adverse selection occurs when policies are purchased primarily by people who expect to need nursing care, not by the general population. This fills the pool with high-risk individuals, which pushes up the costs of premiums. The other risk, induced demand, results in what some call the "woodwork effect." People who would not normally use the offered services come "out of the woodwork" and use the services, merely because they are available. LTC policies are medically underwritten, and insurers have found ways to contain costs. These cost-containment methods include increasing waiting periods, excluding many preexisting conditions from coverage, requiring prior hospitalization before benefits can be received under a policy, setting upper age limits for policy holders, and providing fewer benefits for noninstitutional care.

Needless to say, these cost-containment measures take away a great deal of the benefits provided by these policies. One way that Medicare contains costs for long-term care is by requiring that a person be hospitalized just prior to receiving long-term care.[34] Because over two-thirds of the people who enter a nursing home are not coming from a hospital,[35] their expenses are not covered by Medicare, and would similarly not be covered by many LTC insurance policies. Increasing waiting periods means that seniors *still* have to spend their nest egg on long-term care, despite having purchased LTC policies. Excluding services for preexisting conditions (and let's face it, by the time we all reach age 65, who will not have at least one?) will further limit the number of services covered by the policy and reduce the policy's value. Finally, some policies that are sold cannot be renewed past a certain age.[36]

The two most important things that seniors can do to improve their chances of buying a useful policy are to purchase inflation protection and to make sure their policy is renewable. While most states now forbid the sale of any LTC policy that is nonrenewable, this is not required in all states. Thus, it is important to be sure that any policy purchased is indeed renewable. When guaranteed renewability is not required, this feature as well as inflation protection, is available through policy riders. These riders cap the amount that the premiums can increase and also guarantee that the policy holder will always be able to renew the policy.[37]

An astronomically large percentage of LTC policies lapse before they are used, perhaps in part because consumers are not purchasing these riders. Yet insurance salespeople do not push inflation protection. Some agents cross off the provisions and others simply do a poor job explaining them. Salespeople discourage consumers from purchasing this protection in order to "keep the costs down." Without inflation protection and guaranteed renewability, however, most policies are not worth much to the consumer.

Other important things consumers definitely need to consider when choosing an LTC policy include the types of care covered, the length of the waiting periods, the duration of time during which one can receive benefits of various kinds, any requirements regarding prior hospitalization, excluded preexisting conditions, the total dollar value of the policy, the daily benefits compared to the costs of various care in one's community today, whether some kinds of care require consumers to pay a deductible, and whether the whole dollar value of the policy can be used for one form of care, or whether instead policy use is limited in some way.[38]

Whether the current weaknesses in LTC insurance products can be overcome depends primarily on whether insurance carriers can find a way to make the policies affordable, while at the same time improving the products enough to make more people want to buy them. If the policies no longer required hospital stays, failed to exclude so many medical conditions, and were subject to strict caps regarding rate increases, perhaps more consumers would buy them. The question remains, however, whether insurance companies can actually sell a useful long-term care product at a rate that people can afford.

The Risks of Continuing-Care Contracts

The continuing-care contract, which has already been described in some length above, is a product that I would love to see improved. These arrangements have many benefits, and with a few improvements, could accomplish so many things for so many people. A continuing-care contract allows an aging person to prepay for nursing care, in a lump-sum fee, and

also to live in a pleasant, independent environment prior to needing nursing care. Continuing-care contracts are designed to achieve three goals:

1. To allow older people to live independently for as long as possible;
2. To avoid making them move to a different facility as their medical needs increase; and
3. To allow them to ensure against the risk that their nursing care needs will outstrip their available funds.

People choosing this option could someday be assured of stepped-up care as they age, a place to live for the rest of their lives, and complete assurance that they will be taken care of, regardless of their future financial condition.[39]

The benefits to such an arrangement are obvious and the "insurance" component is one of the most desirable attributes.[40] In a typical contract, most residents are guaranteed some future level of nursing care, ranging from contracts that provide for full nursing care into the future with little or no increase in the monthly payments, to guaranteed nursing care up to a certain dollar cap, to virtually no nursing care except that paid for in cash at the time services are rendered.[41] Moreover, all levels of care are provided at one facility, eliminating the need to relocate later.

Before you sign up for such an arrangement yourself, or suggest that a client do so, you must first come to terms with the financial reality of these arrangements. Prepaying for any service is risky, but here the stakes are often life savings. Thus, one must pick a facility carefully, based on its current and future financial health. To do this, you must know what to look for.

One must first understand the way CCFs are financed and the various ways they spend residents' up-front entry fees. Unfortunately, financial vulnerability is a very real concern in the CCF field, which has been notorious for financial failure.[42] These failures are easily explained by the structure of the financial relationship between the CCF and its residents. Residents are charged up-front fees based on physical exams and amortization schedules. These fees are used for a number of things, including building the facility for new CCFs and improving the existing facility for established CCFs.[43] How these entrance funds are managed will in large part determine the financial health of the facility. Another factor in financial health is the balance between the up-front fees and the monthly fees. Unless investments are extremely successful, large up-front fees cause the facility to rely on resident turnover to stay afloat.

The CCFs' financial goal should be to set money aside from entrance fees to meet the future needs of these residents. In the past, however, many facilities have used the proceeds of new contracts to meet current obligations to existing residents.[44] To remain viable, a facility must set aside a portion of the funds received to care for residents in later years, when resident health care costs are far higher. The facility cannot view surplus cash as profits, given these costs, which are essentially defined financial obligations.[45]

If a CCF fails financially, residents lose their investments in lifetime nursing care. As daunting as this sounds, this option is still worth considering. Continuing-care contracts may still provide valuable benefits to some elderly people. The most important thing residents can do to protect themselves is visit desirable facilities and talk to other residents. Then, talk to management. Ask informed questions about the facility's use of residents' fees, as well as its financial condition. While you can never know exactly what the future holds, a long and successful track record is obviously a good sign.

It is also important to realize that future nursing care could be very costly for the facility. Consequently, it is probably best to avoid facilities with unbelievably low rates. While none of these precautions can ensure that a person will be protected if the chosen facility becomes insolvent, few things in life are certain anyway. Entering into such a contract may well be worth the risk. Better yet, if you can wait a few years, regulation in this area is likely to improve greatly.

Conclusion

The United States is aging rapidly and, as a result, the options for senior housing have expanded far beyond the traditional nursing home. Many of the new options allow seniors to live active, independent lives far more easily than in the past. As the human life span expands, however, many of us have lingering concerns about financing this future care. Unfortunately, the options for financing future nursing care have been less plentiful than the living arrangements. The simple reality is that long-term care is incredibly expensive, whether it is paid for

privately or publicly. Both of the currently available options for spreading the risk of these costs, long-term care insurance and continuing-care contracts, create their own financial risks. It is time to take steps to improve these options, and as well as to create additional ways to spread the risk of long-term care.

Endnotes

1. Erick J. Bohlman, *Financing Strategies: Long-Term Care for the Elderly*, 2 ELDER L. J. 167, 167, n.4 (1994).

2. Lisa Schreiber Joire, Note, *After New York State Bar Association v. Reno: Ethical Problems in Limiting Medicaid Estate Planning,* 12 GEO. J. LEGAL ETHICS 789, 792 (1999) (noting that only about 2 percent of the elderly's long-term care needs are met through Medicare).

3. William G. Weissert et al., *Cost-Savings from Home and Community-Based Services: Arizona's Capitated Medical Long-Term Care Program,* 22 J. HEALTH POL. POL'Y & L. 1329, 1347 (1997); *see also* MARSHALL B. KAPP, GERIATRICS AND THE LAW 63–64 (1992).

4. Bohlman, *supra* note 1, at 170–71. Current annual nursing care fees range from an average of $30,000 to $70,000 a year.

5. Janice Cooper Pasaba & Alison Barnes, *Elder Law Symposium: Public-Private Partnership and Long-Term Care: A Time for Re-Examination,* 26 STETSON L. REV. 529, 537 (1996).

6. *Id* at 533. Medicare does provide limited coverage in some circumstances. Medicare will cover some home health-care programs but will not pay for many services, such as Meals on Wheels or adult day care. Bohlman, *supra* note 1, at 171. While Medicare provides minimal coverage for skilled nursing home care, in order to qualify for such coverage, the applicant must require skilled nursing or rehabilitative services on a daily basis. Skilled services are defined as those which "(1) are ordered by a physician; (2) require the skills of technical or professional personnel . . . and (3) are furnished directly by, or under the supervision of, such personnel." *Id.*

7. *Id; see also* Veronica L. Jarnagin, Note, *A Call to Action for National Long-Term Care Reform: Indiana's Private-Public Cooperative As A Model,* 29 IND. L. REV. 405, 407 (1995) (noting that few people actually choose to become paupers to qualify for Medicaid; far more become paupers as a result of paying for long-term care).

8. John Greenwald, *Elder Care: Making the Right Choice*, TIME, Aug. 30, 1999, at 54; *see also* Stephanie Edelstein, *Assisted Living: Recent Developments for Older Consumers,* 9 STAN. L. & POL'Y REV. 373, 376–77 (1998).

9. One problem with assisted living is that there are few guidelines regarding which services must be offered to residents. Edelstein, *supra* note 8, at 375–77. The important thing is to ask plenty of questions and try to find out exactly what is offered, and at what price.

10. *See* Greenwald, *supra* note 8, at 52. This is by far the fastest growing segment of the senior housing market. *See* Timothy J. Boyce, *Financing Senior Living Facilities*, 10 PROB. & PROP. 23, 25 (1996).

11. Revenues generated by assisted-living facilities are expected to increase from $12.5 billion in 1990 to $30 billion in 2000, providing many opportunities for investors to make money. *Id.* The Marriott Hotel chain recently announced plans to open 300 assisted-living facilities by the year 2002, up from 92 facilities in April of 1998. Lisha Wheeler, *Assisted Living Facilities—The Elder Housing Boom,* 8 J. AFFORDABLE HOUSING & COMMUNITY DEV. 110, 110 (1999).

12. Lisa Stearns et al., *Continuing Care Communities: Issues in State Regulation,* 8 ST. LOUIS PUB. L. REV. 245, 247 (1989). Thus, the CCF contract acts as a hedge against impoverishment by limiting the costs of long-term care. *Id.*

13. This already has happened to some CCF residents. In Idaho, after one facility failed, some residents lost their life savings. Testimony of Lorraine Gunderson, *Idaho Home Health and Welfare Committee Minutes* (Feb. 22, 1988). According to testimony given to the Idaho legislature, "two [of the] women who had used life savings [for the new living arrangement] learned that . . . they were, in a word, paupers. These were people who had worked and saved during their younger years in order to be independent." In addition to the loss of life savings, "the loss in self-esteem to the residents and dread of the future cannot be calculated in dollars." *Id.* Recent changes in Medicare

reimbursement policies will almost certainly result in more CCF insolvencies than ever before. Until recently, Medicare paid unlimited rehabilitation and therapy for senior citizens in nursing homes and CCFs, but the federal government is now severely limiting those reimbursements. As a result, huge numbers of nursing homes are now failing financially, and CCFs can be expected to follow suit. *See e.g.*, Thomas J. Cole, *Troubled Times for Nursing Homes: Pressing for Cash,* ALBUQUERQUE J., Aug. 4, 1999, at A1; Thomas J. Cole, *Troubled Times for Nursing Homes: Awash in Red Ink*, ALBUQUERQUE J., Aug. 3, 1999, at A1; Thomas J. Cole, *Troubled Times for Nursing Homes: An Ailing Industry*, ALBUQUERQUE J., Aug. 2, 1999, at ___; Bruce Jaspen, *Integrated Health in Chapter 11, Nursing Home Chain Blames Reductions in Medicare Spending Growth*, CHI. TRIB., Feb. 4, 2000, at A1; Gayle Geis O'David, *Creditors, Sun Craft Debt Deal*, ALBUQUERQUE J., Oct. 27, 1999, at A1; Diane Scarponi, *Some Nursing Homes in State Are Headed for Trouble*, HARTFORD COURANT, July 20, 1999, at B1.

14. Omar N. Ahmad, *Medicaid Eligibility Rules for the Elderly, Long-Term Care Approach,* 20 J. LEGAL MED. 251, 272–73 (1999).

15. Greenwald, *supra* note 8, at 54 (stating that home-care visits can run $80 per visit.); Robert D. Hayes et al., *What Attorneys Should Know About Long-Term Care Insurance,* 7 ELDER L. J. 1, 9 (1999) (stating that an all-day visit for home-health care runs $110 per day).

16. Greenwald, *supra* note 8, at 55 (stating that one assisted-living facility currently costs between $2,850 and $4,800 a month); Dana Shilling, *Securities Funding of Long-Term Care, A Step Toward a Private Sector Solution,* 19 FORDHAM URB. L. J. 1, 2 (1991) (stating that home health-care costs can exceed nursing home costs, depending on the level of care needed).

17. *See* Bohlman, *supra* note 1, at 169. *See also* Jan Ellen Rein, *Misinformation and Self-Deception on Recent Long-Term Care Policy Trends,* 132 J. L. & POL. 195, 210 (1996) (nursing home costs ran between $18,000 and $60,000 per year in 1996); Shilling, *supra* note 16, at 2 (noting that in some areas on the coasts, nursing home care exceeded $100,000 per individual per year, even in 1991). At this rate, paying $100,000 or even $200,000 for a continuing-care contract doesn't sound that expensive after all.

18. Bruce A. Radke, *Meeting the Needs of Elderly Consumers: Proposed Reforms for the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act,* 1 ELDER L. J. 227, 228 (1993). Two-thirds of all nursing home patients who begin paying for their own nursing home care are impoverished within the Medicaid guidelines within one year. While many people complain that elderly people often voluntarily divest themselves of their assets in order to qualify for Medicaid, many more people legitimately run out of funds, despite a desire to pay for long-term care. Jarnagin, *supra* note 7, at 412. For most elderly, asset depletion is no game. It's a frightful reality that can be as debilitating and frightening as any physical illness. *Id.* Financial impoverishment, and its inherent restrictions on lifestyle and independence, is the most feared result of the aging process. *Id. See also* Rein, *supra* note 17, at 251–52, 255 (noting that most nursing home residents have few or no assets to shield and that most fit the profile of the old, disabled, widowed, and impoverished member of society).

19. 42 U.S.C. §§ 132a, 1395; Ahmad, *supra* note 14, at 272–73. These transfers only constitute a crime if they result in a period of ineligibility for Medicaid. If not, no crime occurs. *Id.* n.148. As a result, if transfers are made but they still leave an elderly person with the ability to pay for some nursing care, then the prior transfers presumably will not be a crime.

20. Ahmad, *supra* note 14, at 273. Interestingly, no one knows who actually added this particular provision to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. §§ 132a, 1395. Even the bill's sponsors, Senator Edward Kennedy (D-Mass.) and Nancy Kassenbaum (R-Kan.), knew nothing about the particular provision before it was passed. Ahmad, *supra* note 14, at 273.

21. Craig S. Meuser, *Why Government and Business Should Take a Closer Look at Adult Day Care,* 1 QUINNIPIAC HEALTH L. J. 219, 222, 224 (1977) (noting that home care and adult day care are not covered by Medicare).

22. 42 U.S.C. §§ 132a, 1395. For an excellent article on long-term care insurance, see Hayes et al., *supra* note 15, at 11–27 (containing the most recent information about the options available for long-term care insurance, as well the Medicare and Medicaid payment schemes).

23. Nancy L. Johnson & Katherine Ryan Sullivan, *Long-Term Care Financing: Federal Policy Implications, Actions and Options*, 1 QUINNIPIAC HEALTH L. J. 139, 147 (1997) (outlining the various tax benefits contained in the act).

24. *Id.* at 147.

25. *Id;* Bohlman, *supra* note 1, at 171 (remarking that long-term care insurance can be an insurable event altering financial planning strategies.)

26. Radke, *supra* note 18, at 230; Beatrice S. Braun, M.D., *Long-Term Care and the Challenge of Aging America: An Overview,* 1 QUINNIPIAC HEALTH L. J. 113, 117 (1997). Some scholars believe that the policies can be afforded by many more people than actually buy them. Marc A. Cohen et al., *Financing Long-Term Care: A Practical Mix of Public and Private,* 17 J. HEALTH POL. POL'Y & L. 403, 408–09 (1992). According to these authors, it is not the high cost but the other undesirable attributes relating to these policies, such as the absence of guaranteed premium levels and misrepresentation by salespersons about the policies, that account for their lack of popularity. *Id.* at 401, 411.

27. Radke, *supra* note 18, at 230 (noting that premiums can run up to $7,000 per year, though not indicating the age to which such a premium would apply); Braun, *supra* note 26, at 117 (quoting rate of $2,600 for a 65-year-old person).

28. Pasaba & Barnes, *supra* note 5, at 542. Moreover, as these authors note, 80 percent of the elderly cannot afford to pay premiums on these types of policies. Just about everyone who has studied the issue agrees that the policies are just not affordable.

29. While some commentators suggest that consumers buy the policies when they are younger, from everything I can glean, this does not seem to make a great deal of difference. By the time a person reaches a certain age, the policy premiums could become too high to afford, regardless of when the policy was purchased. Rein, *supra* note 17, at 286. Unlike term insurance policies, the costs for which also continue to rise, LTC policies end up being a complete waste of money. At least term life insures against dropping dead unexpectedly, which could actually happen to a person. By contrast, LTC policies frequently lapse before any benefits are paid and the very event against which one is insuring, old age, is the same event that causes the policies to lapse before they pay benefits. *Id.*

30. Cohen et. al., *supra* note 26, at 405; Jeffery L. Solterman, *Medicaid and the Middle Class: Should the Government Pay for Everyone's Long-Term Health Care?* 1 ELDER L. J. 251, 251–52, 283 (1993) (noting that insurers always reserve the right to increase premiums, but only on a class basis for all policy holders of a given state). *See also* Jane Bryant Quinn, *Is a Backlash Brewing in LTC*, NEWSWEEK, Aug. 30, 1999, at 39. I actually read through several policies myself, without noticing that the insurer reserved the right to increase rates even on "flat rate" policies. After reading this *Newsweek* article, I looked again. If a law professor failed to catch this loophole, imagine how many consumers really understand the meaning of "flat rate."

31. Bohlman, *supra* note 1, at 186–88; Radke, *supra* note 18, at 228–30; Braun, *supra* note 26, at 117. Six months to six years is a typical coverage for nursing home care. Radke, *supra* note 18, at 230. However, many policies severely limit the amount of coverage available for home-health care. Typically, consumers can only use a percentage of the policy for home-health care, such as 50 percent of the policy's total dollar value and may also have to pay a 20 percent co-pay for home health-care services. Solterman, *supra* note 30, at 283.

32. Solterman, *supra* note 30, at 283.

33. *Id.* While Mr. Solterman claims in his article that many newer policies have shorter waiting periods, this all depends on whether the consumer has paid extra for this feature. *Id.* at 282–83.

34. Bohlman, *supra* note 1, at 171.

35. Requiring a previous hospital stay is one way that Medicare keeps its costs down. Consequently, consumers need insurance for long-term care that is *not* preceded by a hospital stay.

36. As Mr. Solterman points out, consumers can sometimes pay extra for a feature called "guaranteed renewability." Solterman, *supra* note 30, at 283. Fortunately, 36 states now require any LTC policy sold in their state to be renewable. ALASKA STAT. § 21.53.020 (Michie 1998); ARIZ. REV. STAT. ANN. § 20-1691.02 (West 1990); ARK. CODE ANN. § 23-97-208 (Michie 1992); CAL. INS. CODE § 10233.2 (West 1993); COLO. REV. STAT. ANN. § 10-19-107 (West 1998); DEL. CODE ANN. tit. 18, § 7105 (1989); FLA. STAT. ANN. § 627.9407 (West 1996); GA. CODE ANN. § 33-42-6 (1996); HAW. REV. STAT. § 431:10H-107 (Supp. 1996); IDAHO CODE

§ 41-4605 (Michie 1998); 215 ILL. COMP. STAT. ANN. 5/351A-4 (West 1993); IND. CODE ANN. § 27-8-12-9 (West 1992); IOWA CODE ANN. § 514G.7 (West 1998); KAN. STAT. ANN. § 40-2228 (1993); KY. REV. STAT. ANN. § 304.14-615 (Banks-Baldwin 1995); LA. REV. STAT. ANN. § 22:1736 (West 1995); ME. REV. STAT. ANN. tit. 24-A, § 5075 (West 1999); MICH. COMP. LAWS ANN. § 500.3907 (West 1993); MINN. STAT. ANN. § 62S.04 (West Supp. 2000); MO. ANN. STAT. § 376.955 (West 1991); NEB. REV. STAT. § 44-4513 (1998); N.M. STAT. ANN. § 59A-23A-6 (Michie 1999); N.C. GEN. STAT. § 58-55-30 (1999); N.D. CENT. CODE § 26.1-45-05 (1995); OHIO REV. CODE ANN. § 3923.44 (West 1996); OKLA. STAT. ANN. tit. 36, § 4426 (West 1999); OR. REV. STAT. § 743.655 (1998); 40 PA. CONS. STAT. ANN. § 991.1105 (West 1999); R.I. GEN. LAWS § 27-34.2-6 (1998); S.D. CODIFIED LAWS § 58-17B-5 (Michie 1996); TENN. CODE ANN. § 56-42-105 (1994); UTAH CODE ANN. § 31A-22-1405 (1999); VA. CODE ANN. § 38.2-5203 (Michie 1994); W. VA. CODE § 33-15A-6 (1996); WYO. STAT. ANN. § 26-38-105 (Michie 1999).

37. Solterman, *supra* note 30, at 288. These are often two different riders, so be sure to ask exactly what any rider covers. Inflation protection is sometimes called "future purchase option." Hayes et. al., *supra* note 15, at 22.

38. Given the length of this list, it is not surprising that consumers are confused. After inflation protection and guaranteed renewability, the most desirable feature that a policy could have would be a *truly* flat fee. If this ever becomes available at an affordable rate, I suggest buying the policy immediately.

39. I say "someday" because these products currently present many risks to consumers. *See generally* Nathalie Martin, *The Insolvent Life Care Provider: Who Leads the Dance Between the Federal Bankruptcy Code Continuing-Care Statutes?*, 61 OHIO ST. L. J. 267 (2000) (discussing how the insolvency or bankruptcy of a continuing-care facility affects the rights of residents).

40. Marc A. Greene, *Life Care Centers: A New Concept in Insurance*, 48 J. RISK & INS. 403, 410 (1981).

41. Stearns et al., *supra* note 12, at 246–47 (noting that in 1987, about 67 percent of all CCFs charged an up-front fee and thereafter guaranteed certain long-term, continuing-care services at little or no extra cost).

42. According to one 1988 study, one-third of the facilities studied suffered from either negative net income or negative net worth. Hirsh S. Ruchlin, *Continuing Care Retirement Communities: An Analysis of Financial Viability and Health Care Coverage*, 28 GERONTOLOGIST 156 (1988). As one would expect, facilities that offered full nursing care, at essentially one up-front cost, were in the worst financial condition. *Id.*

43. Michael B. Floyd, *Should Government Regulate the Financial Management of Continuing Care Retirement Communities*, 30 ELDER L. J. 29, 37 (1993) (noting that entrance fees may provide capital to build a new facility or to upgrade an existing facility). I found it surprising to learn that CCFs could use up-front fees to finance new facilities, assuming these fees had to be invested for the future health care needs of residents. It seemed far more appropriate to finance new construction through the more typical means, such as conventional or tax-free bonds. Apparently, however, this industry is considered too risky to generate much interest in the lending or tax-free bond markets. STEVEN R. EASTAUGH, FINANCING HEALTH CARE 181 (1987). Moreover, as it turns out, most states require very little reserves from the up-front fees, and only 20 states require any reserves at all. Martin, *supra* note 39, at 301–06.

44. While several of such instances are noted in William B. Fisher, Note, *Continuing Care Retirement Communities: A Promise Falling Short*, 8 GEO. MASON L. REV. 47, 47 (1985), the most notorious case involving a failure to reserve is *In re Pacific Homes, Inc.*, [1 B.R. 574 (Bankr. C.D. Cal. 1979)]. Pacific Homes was a CCF originally formed to take care of retiring Methodist ministers. It eventually expanded its facilities to serve almost 1,900 people in seven facilities located in four states. Residents could pay for their services in one of three ways: total up-front cash fee, transfer of all assets, or up-front fee plus a monthly fee. Fisher, *supra* note 44, at 50. In the vast majority of the CCF contracts in place, residents paid no monthly fee, making the facilities dependent upon reserves and sound investments for continued viability. Thus, when Pacific Homes began directing its capital toward expansion, speculative investment, and financing its resulting operating losses, its financial condition crumbled. It began entering into new CCF contracts to finance not just operating expenses but also losses, creating a "ponzie scheme" that ultimately resulted in bankruptcy. *Id.* at 51.

45. Howard Winklevoss, *Continuing Care Retirement Communities: Issues in Financial Management and Actuarial Prediction, in* CONTINUING CARE RETIREMENT COMMUNITIES 57, 59–61 (1985).