Marquette Elder's Advisor

Volume 2
Issue 4 *Spring*

Article 4

Spring August 2012

NAELA White Paper on Long-Term Care Reform

Follow this and additional works at: https://scholarship.law.marquette.edu/elders

Part of the Elder Law Commons

Repository Citation
(2012) "NAELA White Paper on Long-Term Care Reform," *Marquette Elder's Advisor*: Vol. 2: Iss. 4, Article 4.
Available at: https://scholarship.law.marquette.edu/elders/vol2/iss4/4

This Featured Article is brought to you for free and open access by the Journals at Marquette Law Scholarly Commons. It has been accepted for inclusion in Marquette Elder's Advisor by an authorized editor of Marquette Law Scholarly Commons. For more information, please contact elana.olson@marquette.edu.

NAELA White Paper on Long-Term Care Reform

The current system for addressing long-term care is a non-system. It is a hodgepodge of services that fails to meet its intended needs and is economically inefficient. This White Paper analyzes the problems and proposes recommendations to serve as policy solutions for citizens and government.

By the NAELA Long-Term Care Task Force

The *NAELA Long-Term Care Task Force*, includes Howard J. Atlas, CELA, Co-Chair; Thomas D. Begley, Jr., CELA, Co-Chair; Sean Bleck, Esq.; William J. Browning, CELA; Alfred J. Chiplin, Jr., Esq.; Don Chapin, Esq.; Ronald A. Fatoullah, CELA; A. Frank Johns, CELA, RG; Morris Klein, Esq.; Nora Kallen, Esq.; Susanna Lannik, Esq.; Brian W. Lindberg, NAELA Public Policy Consultant; Nancy Morith, Advisor; Raymond L. Parri, Esq., CELA; Charles Patrick Sabatino, Esq.; Richard L. Sayre, Esq., CELA; Emily S. Starr, Esq.; Judith A. Stein, Esq.; Harriette Steinberg, Esq.; Timothy C. Takacs, Esq. Special thanks to Professor Rebecca C. Morgan, Esq., for her ongoing contributions.

EXECUTIVE SUMMARY

1. Introduction

Although long-term care is a problem that affects all economic strata in the United States, financing long-term care is a uniquely middle-class problem. The time has come for the citizens and the government of the United States to address the issues of the delivery, accessibility, and financing of long-term care in our country.

Long-term care refers to a wide range of medical and personal services needed by individuals who have lost some capacity of caring for themselves due to functional limitations or chronic health conditions. These services include skilled nursing care, subacute care, respite care, rehabilitation, and assistance with activities of daily living, such as transferring, bathing, dressing, toileting, meal preparation, and housekeeping. These services can be provided in a variety of settings including nursing facilities, assisted-living facilities, adult day care facilities, congregate living facilities, continuing care retirement communities, or one's own home.

The current system of financing medical care favors acute care and disfavors chronic care and is thus disease discriminatory. Most Americans with chronic illnesses impoverish themselves paying for their care, at which point Medicaid pays for their care. For example, bypass surgery is covered by Medicare. However, Alzheimer's disease is not covered under Medicare, and an Alzheimer's victim must become destitute before receiving Medicaid coverage.

2. Purpose

The purpose of this White Paper is to identify the key components to the long-term care system, to analyze the problems that exist within its current

structure, and to present recommendations to serve as policy solutions for our citizens and government. To ensure access to quality and cost-efficient long-term health care for all Americans, now and in the future, the National Academy of Elder Law Attorneys[1] advocates for a comprehensive reform of the long-term health care system. This White Paper is divided into four sections:

- Development of a continuum of care
- Private financing of long-term care
- Public financing of long-term care
- Administration of the long-term care system

3. Elements of the Proposal

3.1. The Current System

The current system in our country for addressing long-term care is a non-system, a hodgepodge of services that fails to meet the needs of the elderly and disabled in the variety of long-term care settings. It is economically inefficient, and it fails to assure the quality of services that are provided.

The principal problem with the existing long-term care delivery system is that its major focus is on nursing home care, which is the most expensive level of care. Additionally, the system is fragmented among the elderly and those with mental retardation and developmental disabilities.

At a minimum, the necessary continuum of care should be a *fully* integrated system of medical and personal services provided to individuals who have lost some capacity for caring for themselves. Services should include:

- Skilled nursing care;
- Rehabilitative services;
- Respite care;
- Personal assistance with the activities of daily living (bathing, toileting, dressing, meal preparation, and housekeeping);
- Congregate living arrangements;
- Adult day care services;
- Assisted-living facilities;
- Home care;
- Nursing home custodial care;
- Hospice care.

Care should be coordinated by care managers trained to assess an individual's condition, to develop a written plan of care, to implement and coordinate a care plan, to monitor services, to make appropriate reassessments, and to discharge an individual when services are no longer required, similar to that done in the PACE programs.

3.2. Private Financing of Long-Term Care

Currently, the primary source of private financing of long-term care is the income and savings of the elderly and disabled and their families. Although long-term care insurance only pays for approximately three percent of the nation's nursing home costs, this type of insurance can play an important role in helping to provide protection against the cost of long-term care for the elderly and disabled since it would likely reduce government involvement and expense. However, before long-term care insurance can be considered a viable option in the financing of long-term care, there are intrinsic concerns about the product that must be addressed and improved or it will continue playing a limited role:

- Lack of public awareness;
- Cost of premiums;
- Confusion over policy options;
- Insurability.

3.3. Public Financing of Long-Term Care

NAELA proposes that long-term care be financed by a system of social insurance known as Medicare Part D. The Part D benefit would provide each beneficiary with a pool of money (i.e., $200,000 in the year 2000 and indexed for inflation) to be used as needed at any level on the continuum of care. There would be a $10,000 deductible, after which Medicare would pay eighty percent of the cost of care. After the pool of money is exhausted, the beneficiary would pay privately or through private insurance. The Medicaid program would pay for care for those unable to afford private payment or to purchase private insurance.

The Part D benefit would be financed by contributions from an increased payroll tax dedicated to the Medicare Part D trust fund and by dedicating receipts from the Federal Estate and Gift Tax to the trust fund. The benefit would be phased in over twenty years, with one-half of the benefit becoming available in ten years and the second half becoming available in twenty years.

To be eligible a beneficiary would have lost the ability to perform a minimum of two activities of

daily living (ADLs) as determined by a care manager. The person must be sixty-five years of age or disabled or be the spouse or child of a wage earner if the spouse or child is sixty-five years of age or disabled. The wage earner must have forty quarters of coverage (QC).

3.4. Medicaid Reform

NAELA proposes that the Medicare Part D program and the Medicaid program be administered in a manner similar to the current Medicare model. A strong audit system to insure compliance would be required, and a uniform federal standard of eligibility as under Medicare should be adopted. Reimbursement rates to providers must be fairly determined and administered, based on accurate cost information that reflects geographic considerations and severity of conditions. Additionally, due process requirements must always be observed.

NATIONAL ACADEMY OF ELDER LAW ATTORNEYS WHITE PAPER ON REFORMING THE DELIVERY, ACCESSIBILITY AND FINANCING OF LONG-TERM CARE IN THE UNITED STATES

1. Introduction

Although long-term care is a problem affecting all economic strata in the United States, financing long-term care is a uniquely middle-class problem. Acute care is financed by the existing Medicare system, but chronic care is expensive, and a significant portion of the elderly who require such care must often bankrupt themselves in order to qualify for Medicaid. The time has come for the citizens and the government of the United States to address the issues of the delivery, accessibility, and financing of long-term care in our country. Long-term care refers to a wide range of medical and personal services needed by individuals who have lost some capacity of caring for themselves due to functional limita- tions or chronic health conditions. These services include skilled nursing care, subacute care, rehabilitation, respite care, and personal assistance with activities of daily living, such as transferring, bathing, dressing, toileting, continence, meal preparation, and housekeeping. These services can be provided in a variety of settings including nursing facilities, assisted-living facilities, adult day care facilities, congregate living facilities, continuing care retirement communities, or one's own home.[2]

Science, technology, nutrition, and other factors have increased life expectancy and set our nation on a course for a major expansion of the midlife and older populations. One hundred years ago, at the beginning of the twentieth century, the average life expectancy in this country was less than fifty years. Now, at the beginning of this century, the average life expectancy is almost eighty.[3] The blessing of longer life means that diseases of aging that require long-term or custodial care, such as Alzheimer's disease, are more prevalent. The population of persons age sixty-five and over, and also of persons age eighty and over, is expected to almost double in the next quarter century.[4] This means that more people will require long-term care. Although long-term care is primarily a need of the aged, chronic diseases such as AIDS and accidents causing paralysis affect all ages, and forty percent of persons using long-term care services are between the ages of eighteen and sixty-five.[5]

Further complicating the picture is the changing of the nuclear family. At one time, the aging parent would move into the adult child's home for care, where one spouse worked and the other stayed home. Now, when an aging parent moves into an adult child's home for care, it is a two-earner household and less able to care for another family member.

Long-term care is expensive. According to the U.S. Census Bureau, the average cost of a stay in a nursing facility is $51,000 a year ($140/day), and the average length of stay is 2.3 years.[6] This cost can be $73,000 a year ($200/day) or more in large urban areas.[7] Neither private health insurance nor Medicare covers the costs of most long-term care services. According to the Health Care Financing Administration (HCFA), in 1996 only about eleven percent of nursing home revenues were derived from Medicare and Medicare supplemental insurance.[8] With recent changes in Medicare reimbursement methodologies, Medicare may pay even less.[9] As a consequence, persons requiring long-term care must pay for this care from their own savings until they are sufficiently impoverished to qualify for Medicaid. Thirty-seven percent of nursing home expenditures are paid for by residents' income and savings.[10] Persons requiring facility-based long-term care must spend down their assets to $2,000.[11] The high cost of nursing home care has resulted in more than fifty percent of those persons who enter a nursing home paying privately for services until their resources are exhausted; they then rely on the

federal-state Medicaid program for care.[12] In 1997 alone, Medicaid spent $56.1 billion on long-term care, including $32.5 billion for nursing home services and $10 billion for intermediate care facility expenses for the mentally retarded.[13] Medicaid thus has become the primary payer for long-term care in our country, causing a tremendous strain on federal and state budgets.

As stated previously, long-term care is not just a problem for the elderly. It is an intergenerational issue. According to American Association of Retired Persons (AARP), using a broad definition of functional disability, it is estimated that 11.5 million individuals of all ages have disabilities severe enough to require long-term care. Of those 11.5 million individuals, 5.7 million are children and persons 18 to 64 years old, and 5.8 million are persons 65 years old and older.[14] There are approximately 1.8 million nursing home beds in the United States with more than 1.5 million individuals residing in nursing homes.[15] About four percent of all persons sixty-five years of age or older live in nursing homes,[16] but fifteen percent of those over age eighty-five live in nursing homes.[17] With the aging of the baby boom generation and rapidly falling mortality rates for the elderly, these numbers will increase exponentially over the next thirty years. This will lead to significant public and private spending to meet this demand for nursing home care.

According to a researcher at the Health Insurance Association of America, it is difficult to know how many Americans currently have long-term care insurance, but it is estimated that as of the end of 1998, about six percent of Americans have purchased a policy at some time in the past.[18] Many experts believe that most Americans cannot afford long-term care insurance and that many of those who apply are uninsurable.[19] What is known is that private insurance currently pays for less than seven percent of long-term care services.[20]

Given the aforementioned description of some of the long-term care financing realities in the United States, one could certainly argue that the current system of financing medical care favors acute care and disfavors chronic care and is thus disease discriminatory. Most Americans with chronic illnesses impoverish themselves paying for their care, and then Medicaid pays for their care. For example, bypass surgery is paid for by Medicare. However, a person with Alzheimer's disease does not have long-term coverage for his or her care under Medicare and must become destitute before receiving Medicaid coverage.

The existing long-term care system lacks many, if not most, of the features that the system should have. Perhaps the greatest failing of the current system is the focus of available resources on care in the most acute and expensive setting, the nursing home. This focus has resulted in the wholly inadequate development and support of long-term care in other settings, including people's own homes and less restrictive residential settings such as assisted-living facilities and board-and-care homes. This focus minimizes personal independence and maximizes cost. The limited long-term care services that do exist outside of nursing homes are underfunded, riddled with gaps in essential services, and virtually bereft of quality assurance.

Compounding the problems created by the failure to focus on the full continuum of long-term care is the division of the delivery system based on type of disability. Parallel, but unequal, long-term care delivery mechanisms have been established to serve the developmentally disabled, the younger physically disabled, veterans, the elderly, those with mental health issues, and persons with AIDS, to name but a few. These divisions have pitted groups against each other to compete for dollars and have led to indefensible inequities and significant economic inefficiencies.

In theory, long-term care is something that should be insurable. According to the *Washington Post,* sixty percent of persons will require long-term care sometime in their lives.[21] According to the *New England Journal of Medicine,* twenty-six percent will stay three months or less, nineteen percent three months to one year, thirty-four percent one to five years, and twenty-one percent will stay five years or more.[22] Thus, while not everyone will require long-term care, those who do may have to spend significant resources. The spreading of risk through insurance may make sense. Persons who are fully covered under long-term care insurance would not need to spend their life savings, and the government would not have to provide benefits under Medicaid. Although long-term care insurance began to be offered to the public in the 1980s, according to HCFA, in 1995 only three percent of all nursing home costs were paid by long-term care insurance.[23] The American Council of Life Insurance estimates that, today, only six million Americans have purchased long-term care insurance.[24]

Medicaid is the largest public source of funding for long-term care in the United States. It accounted for more than thirty-eight percent of total long-term care expenditures in 1996. Medicaid spending for long-term care has more than doubled from 1987 to 1997, rising from $21.1 billion to $56.1 billion. In 1996, four percent of the Medicaid budget was spent on nursing home care and five percent was spent on home care.[25]

This White Paper identifies the key components to the long-term care system, analyzes the problems that exist within its current structure, and presents recommendations that serve as policy solutions for our citizens and government. To ensure access to quality and cost-efficient long-term health care for all Americans, now and in the future, the National Academy of Elder Law Attorneys advocates for a comprehensive reform of our long-term health care system. This White Paper is divided into four sections:

- Development of a continuum of care;
- Private financing of long-term care;
- Public financing of long-term care;
- Administration of the long-term care system.

1.1. Concepts Central to the Long-Term Care Discussion

Over the years there have been many of proposals to fix the long-term care financing and delivery systems. Some of the primary concepts included the following:

- Social insurance in the form of a comprehensive Social Security-like approach, where all contribute though the workplace and comprehensive long-term care benefits are not means-tested.
- Limited social insurance in the form of variations on the above theme, including some means-testing for benefits, a capped entitlement, participation for workers only, cost sharing of premiums, etc.
- Voluntary public long-term care insurance or a public disability insurance program, possibly limited to certain age groups or offered as a one-time decision at retirement or another age.
- Social services programs, either means tested (SSI-type) or not (Older Americans Act-type).
- Medicaid expansion to cover a larger percentage of those who cannot afford private long-term care insurance, or to cover all long-term care services (e.g., respite care, adult day care).
- Merging of Medicare acute care coverage with Medicaid to cover the range of long-term care needs.
- Tax credits and deductions for long-term care costs and/or long-term care insurance.
- Modifications in Social Security, including credits for caregiver years.
- Tax incentives for employers to provide elder care programs.
- Individual or personal retirement accounts, where employers and employees create long-term care savings or annuities and are given tax incentives to do so.

1.2. Suggested Principles to Guide Recommendations

NAELA provides a set of principles to guide our recommendations for the public sector role in long-term care.

- Long-term care services should be available to all Americans who need them, even if they cannot afford such services. Criteria for eligibility should be related to the individual's physical, mental, or cognitive functioning.
- Services should be comprehensive—both community-based and institutional. They should be provided in the least restrictive setting possible. Services should be supportive of caregivers and offer respite care.
- Risk should be shared as in the social insurance model, at least for those that cannot afford private alternatives.
- Financing should include specific designated taxes and premiums that are reserved in a trust fund for long-term care coverage.
- The private sector should be allowed to build on this public sector foundation with its own products that would be regulated by the public sector.
- The federal government in partnership with states and the private sector should take responsibility for quality assurance systems for both institutional-based and community-based long-term care.

2. Toward a Continuum of Long-Term Care

2.1. Assessment

Universal assessment tools must be developed and adopted to identify the nature and scope of needs regardless of disability. This will contribute to a level playing field among the various types of disabilities

and will allow the focus of resources based on need rather than history or politics.

2.2. Development of Alternatives to Institutionalization

Delivery mechanisms must be established to deliver long-term care at all care levels—from one's own home, to minimally intrusive residential settings, to settings other than nursing homes for persons needing substantial assistance that can be more effectively provided outside of a nursing home (e.g., family homes serving physically healthy persons with advanced dementia). Standards of care need to be developed for these levels, including staffing, training, and facility standards. Resources need to follow the assessed needs of individuals so that appropriate revenue streams are available for these alternative settings.

2.3. Quality Assurance

Effective and appropriate quality assurance mechanisms for care in settings other than nursing homes must be developed. Certainly additional licensing and certification requirements are needed, but more flexible quality assurance vehicles such as ombudsmen might address this need. For example, regulation of assisted-living facilities is lax and a regulatory framework similar to the Nursing Home Reform Act needs to be considered.

2.4. Care Coordination

Mechanisms must be established to coordinate the provision of all long-term care services so that the right package of services is made available based on need. The pivotal role of the care manager must be recognized, empowered, and financed. This will involve tying together the functions of assessing need, authorizing services, and allocating the resources necessary to carry out the plan.

2.5. Support of Informal Provision of Long-Term Care

Family and other informal providers of long-term care need to be supported. This involves at least the provision of training, ongoing counseling and support, and the provision of respite care for breaks and vacations, etc.

2.6. Quality of Care: A Public Role

The federal and state governments also play major roles in the quality of long-term care. Under the Nursing Home Reform Law,[26] the federal government has set national quality standards for nursing homes and is responsible for enforcing those standards, although enforcement is uneven. State governments license nursing homes, board-and-care facilities, and assisted-living facilities and variations thereon (e.g., domiciliary care facilities, residential care facilities, life care facilities, continuing care retirement communities, and other adult foster care facilities). Some of the licensing is effective in keeping standards high. The remainder is not, leaving millions of elderly and disabled individuals vulnerable to the squalor of the facilities in which they must live; and in some cases, their very lives are at risk.

3. Private Financing of Long-Term Care

3.1. Private Insurance as a Long-Term Care Financing Strategy

3.1.1. The Role of Personal Savings

Saving to purchase long-term care services is not the same as using an insurance vehicle that pays for the care when it is needed. Not everyone will need the services and the cost will vary depending on the condition. It would be a coincidence if one saved for long-term care services and accurately saved the amount that was needed. A very small percentage of persons age seventy-four to eighty-four have saved enough to cover two years of nursing home care. For most people, it is likely that the cost of their care would be greater than the amount that they could save, and saving involves forgoing other possibilities for one's family. People are expected to insure (either themselves or through a public program) against the cost of care for a heart attack and not to give up their homes or all their savings, but the same is not expected in the area of long-term care. One might say that Medicaid is the ultimate high deductible insurance policy for long-term care.

3.1.2. Insurance

Long-term care is certainly an insurable event. Only a small percentage of elderly people will spend any significant time in a nursing home.[27] Therefore, the risk is relatively low for nursing home needs. The high and rising costs of long-term care are usually far beyond the amount one has saved for retirement.

3.1.3. Affordability

By most estimates, only ten to twenty percent of the elderly can afford private long-term care

insurance.[28] In fact, coverage is most affordable for those who would never spend down to Medicaid and therefore will not have a great impact on Medicaid expenditures over time. A public insurance program could be paid through taxes, either on income or on wages and salaries.

3.2. Long-Term Care Insurance Plans

Today, long-term care insurance policies offer consumers flexibility and comprehensive coverage in *all* current settings and provide for *future* developments in long-term care through their "alternate plan of care" provisions.

Most policies are now fashioned after a "pool of dollars" concept and pay for care in any combination of settings, in any order of need, with no requirement for prior hospitalization. They cover, up to certain limits chosen by the insured, costs of long-term care incurred in either the community setting (home health care and adult day care) or in facilities (assisted-living facilities and nursing homes). The insured can choose, at the time of application, the cap on the daily amount that will be covered (daily benefit amount), the benefit period, elimination period, and type of inflation protection. The daily benefit cap and benefit length together determine the amount of dollars in the spending account for long-term care (e.g., a 3-year policy at $100 per day equals 3 x 365 x $100 = $109,500 in the spending account). The elimination period is the number of days the insured will pay for care out-of-pocket before the policy begins to pay (same as a deductible), and the inflation rider protects the daily dollar maximums. The policies can thus be customized for the insured, taking into account age, health, assets, income, risk tolerance, etc.[29]

Coverage varies and may include payment of the costs of the insured's assisted-living or nursing care facility while home for a visit or in hospital; training for family members who want to provide some or all of the care; survivorship benefits for the remaining spouse; accelerated payment options for those who wish a fixed term to their premium payments (a good option for those still working); payments to change the home environment to make it safer for the insured to remain there as long as possible; greater flexibility in who can be paid to provide the care at home, extending in some cases even to family members or neighbors; and care management to help line up the care and/or equipment needed at home. Some policies provide spousal discounts to committed partners, recognizing that today's households come in many different sizes and shapes.

3.3. Reasons Long-Term Care Insurance Is Beneficial

For the person requiring long-term care and his or her family, a properly selected long-term care insurance policy will allow a policyholder to protect his or her life savings from depletion if long-term care is provided. Because insurance pays the cost of care, it may be more likely that a person will utilize at-home care, rather than choose nursing home care.

For government policy makers, a mechanism for persons to self-pay and spread the risk rather than rely on public benefits, would relieve a strain on taxpayer dollars. However, it is uncertain whether government expenditures associated with encouraging more persons to purchase long-term care insurance will be cost effective or otherwise in the public interest.

3.4. Problems with Current Long-Term Care Insurance Plans

3.4.1. Lack of Public Awareness

The public is unaware of the need to plan for long-term care. For example, seventy-three percent of Americans incorrectly thought Medicare is the primary funding source for long-term care.[30] Perhaps as importantly, employers also appear to be unaware of the option of offering long-term care insurance as part of their employee benefits package.

3.4.2. Cost of Premiums

Those consumers who want to purchase long-term care insurance are confronted with additional problems. One is cost. The industry suggests a minimum annual income of $35,000 and assets of at least $100,000—2 percent of annual income—devoted to purchase long-term care insurance. Individuals above the $5 million asset range may be able to self-insure.

Long-term care insurance premiums are calculated based on the age of the person at the time the premium is first purchased. Although premiums are generally level, that is, they do not automatically increase as a policyholder gets older, the older the applicant, the higher the premium. The average annual cost of a policy that provides a $100 per day nursing home benefit, 50 percent for home health care, 4-year benefit period, and 20-day elimination period ranges from $247 to $805 for a 40-year-old,

$364 to $1,200 for a 50-year-old, $980 to $2,432 for a 65-year-old, and $3,967 to $7,740 for a 79-year-old. The higher-cost policies typically include a five percent compounded inflation adjustment to protect the policyholder from increases in the cost of covered long-term care services. Also available for higher premiums are nonforfeiture benefits, which return some portion of the value of premiums invested to the policyholder if the policy is ever dropped.

Although premiums are most affordable for persons in their forties and fifties, these individuals may have other priorities, such as home mortgages and the care and education of their children. A survey of baby boomers sponsored by the American Health Care Association revealed that fifty-six percent of respondents did not know that Medicare does not cover long-term care expenses, and sixty-eight percent admitted that they were not financially prepared for long-term care needs.[31] The realization that premiums may be paid for thirty or more years before benefits are realized may also discourage interest.

Premiums are calculated to be level so that a premium is set based on the policyholder's age at the time of purchase of the policy, with persons purchasing at a younger age paying less than persons who purchase at an older age. However, some long-term insurers have raised premiums for the entire class of policyholders, effectively defeating the level aspect of the price, and potentially discouraging younger persons from purchasing policies.[32]

By the time individuals realize that long-term care may be needed, premiums may be unaffordable. By the insurance industry's own estimates, less than one-third of Americans over age sixty-five can afford a policy.[33] Moreover, less than half of persons age thirty-five to forty-four can afford a policy with five years of coverage.[34] The Employee Benefit Research Institute also notes that some experts believe that long-term care insurance growth may be limited because only a small portion of those most likely to need long-term care insurance—the elderly—can afford it.[35]

Applicants must go through an underwriting process. It is estimated that one in four persons who apply for long-term care insurance cannot qualify due to preexisting health conditions.[36]

While modest federal income tax deductions are available, as well as tax credits in some states, it is unclear whether sufficient incentives are available to encourage the purchase of long-term care insurance. The Health Insurance Portability and Affordability Act of 1996[37] includes incentives to purchase long-term care insurance.[38] Premiums for long-term care insurance are treated as a medical expense. The deduction is limited to $210 for persons 40 years of age or under to $2,660 for persons 70 years of age or over. However, medical expenses are deductible only to the extent that they exceed 7.5 percent of adjusted gross income. As a result, most people who are healthy enough to obtain the insurance do not have sufficient medical expenses to realize the deduction. Those who have sufficient medical expenses to realize the deduction are not healthy enough to obtain the insurance. In 1999 *The Wall Street Journal* reported that fewer than four percent of taxpayers are able to meet this threshold.[39]

3.4.3. Consumer Confusion over Policy Options

A myriad of plan options makes it difficult for a consumer to select a policy. In addition, there are a number of variations, including benefits, payments, terms, and the fiscal soundness of the company to consider.

3.4.3.1. Variation on Amount of Benefits

Policies vary on the amount of benefits offered. Benefits are typically paid on a per-diem basis. A beneficiary can select, for example, a $100 a day benefit or, for a higher premium, a $150 a day benefit. The optimal benefit is one that will cover all of one's out-of-pocket costs for all types of care provided while coordinating with other payment sources that may be available, such as Social Security or pension benefits.

3.4.3.2. The Insurer

As with all insurance products, the soundness of the insurer may vary. Since long-term care insurance could be purchased many years before a claim is made, the fiscal quality of the company is an important variable.

3.4.3.3. Payment Benefit

Payments may be by actual reimbursement or a fixed daily rate. There may be daily or monthly maximums.[40]

3.4.3.4. Inflation Protection

Benefits may or may not factor in the cost of inflation. Inflation protection riders can be purchased that increase the daily maximum automatically by five

percent of the original daily maximum (simple inflator) or five percent of the prior year's amount (compound inflator). Also available are cost-of-living inflators, which allow insureds to purchase additional coverage under certain circumstances.

3.4.3.5. Variation in Elimination Periods Before Policy Goes into Effect

Plans offer a wide variety of options regarding when the payments begin. The longer the waiting period, the lower the premium. Plans qualified for tax deductions must be coordinated with Medicare payments and will not begin to pay benefits until Medicare is unavailable, so a day one qualified policy really means day one after Medicare payments cease.

3.4.3.6. Lack of Understanding of the Difference Between Qualified and Nonqualified Plans

The word *qualified* in this instance refers to plans that qualify for the 1996 federal HIPAA tax benefits. The industry itself is unsure as to which plan is better. Nonqualified policies often contain benefit triggers that make it easier for insureds to qualify for benefits. While qualified plans clearly provide that benefits paid under the policies are nontaxable, it is less clear whether benefits paid under nonqualified plans are taxable.

3.4.3.7. Variation in Length of Benefits

Policies can be customized to provide for different payout periods. The length that benefits are paid will depend on the cost of care provided and the policy length chosen (e.g., three years or four years or unlimited). For example, most persons may not stay in a nursing home more than four years, so a nursing home-only policy may not need a longer benefit period. However, a comprehensive policy that includes home care or assisted living may need to cover a longer period of time because the latter types of care may be needed prior to nursing home entry.

3.4.3.8. Types of Services Covered

Long-term care is more than just nursing home care. Most policies offer options that include at-home care and assisted living. However, services evolve over time so it may be difficult to know what will be needed in thirty years. Some plans may offer alternate plans of care to meet new, unforeseen care needs.

3.4.3.9. Protection Against Lapse in Case the Purchaser Forgets to Pay the Premium

In order for long-term care insurance policies to be approved for sale, many states require some protection against lapse if the purchaser forgets to pay the premium.

3.4.3.10. Medical Eligibility

Policies require medical underwriting. Each insurer has its own criteria as to who qualifies for the best rates, who is accepted but at higher premiums, and who is rejected.

3.5. The Partnership for Long-Term Care: The Model Revisited

In the late 1980s, the Robert Wood Johnson Foundation initiated a national program called the Partnership for Long-Term Care. The program sought to combine the efforts of the public and private sectors and to promote long-term care planning options for individuals, as well as comprehensive case management and data analysis. The partnership involves an alliance between state governments and private insurers to offer private insurance policies that are affordable to a broad range of individuals.

Under the direction of a national program office at the University of Maryland Center on Aging, Partnership programs have been implemented in four states: California, Connecticut, Indiana, and New York. Implementation was phased in over twenty-eight months, although each state began selling policies at different times: Connecticut in April 1992, New York in April 1993, Indiana in May 1993, and California in August 1994.[41] Partnership policies blend private and public insurance in a unique way. All four states use private long-term care insurance to cover the initial costs of long-term care. Consumers who purchase policies that meet state certification standards can become eligible for Medicaid long-term care services after their private insurance is exhausted, without spending down all their assets as is typically required to meet Medicaid eligibility criteria.

Two program models have been developed, the *dollar-for-dollar* model, adopted in California and Connecticut, and the *total assets* model adopted in New York. Under the dollar-for-dollar model, consumers purchase an amount of private insurance coverage equal to the amount of assets they wish to protect. The model permits a variety of product de-

signs ranging from one year of coverage on up. Under the New York total assets model, consumers must purchase a policy that covers three years of nursing home care, six years of home care, or some combination (with two days of home care equaling one day of nursing home care), after which the beneficiary becomes eligible for Medicaid coverage without the need to dispose of any remaining assets.[42]

Indiana, originally a dollar-for-dollar state, began offering a hybrid model in March 1998. Under the hybrid model, consumers who purchase policies meeting a state-set dollar amount of coverage receive total asset protection, while those who purchase less coverage receive dollar-for-dollar protection.[43]

While each state differs in the specifics of their model, all must achieve similar goals:

1. Increase the percentage of middle class individuals with insurance that protects against impoverishment from long-term care expenses;
2. Constrain the growth of public expenditures for long-term care;
3. Improve the quality and availability of private long-term care insurance products;
4. Improve the quality and availability of consumer information on long-term care costs and options; and
5. Establish a public-use database on long-term care service utilization based on the use of private insurance.[44]

Instead of emphasizing estate recoveries, Congress should repeal the estate recovery legislation adopted in 1993[45] and encourage the states to adopt public-private partnership models to facilitate the sale of long-term care insurance. Any monies collected under the estate recovery program will be significantly outweighed by cost savings achieved from increased sales of long-term care insurance.

3.6. Limited Role of Long-Term Care Insurance

Long-term care insurance is an important way for persons to finance their need for long-term care. Certain segments of the population will never be able to afford long-term care insurance, and other funding sources such as Medicaid need to remain in place. As the cost of premiums increase with age, older persons are more likely to fall into this category. Insurers will not be willing to offer insurance to another group of individuals who may be able to afford long-term care insurance but are considered unacceptable risks—again, older persons are more likely to fall into this category. For these individuals, Medicaid must remain in place as the imperfect but dependable safety net.

Strong educational programs are needed to encourage people in their forties and fifties to purchase long-term care insurance. Long-term care insurance should be restructured as Medigap-type policies, standardized with clearly defined benefits and options.

The long-term care insurance industry needs to offer simplified and more understandable policy options. The industry should consider allowing all persons up to a certain age to qualify for long-term care insurance without medical underwriting.

The federal government has offered very modest tax incentives to encourage the purchase of long-term care insurance, but it is unclear how successful these incentives have been. It is uncertain whether additional tax incentives will actually save Medicaid expenditures. It is possible that such deductions will encourage people to purchase long-term care insurance who would not have applied for Medicaid in any event.

4. The Public Role in Financing Long-Term Care

4.1. General Public Program Recommendations

NAELA recommends that the Medicare program be expanded to become the primary provider of long-term care based on level of disability (physical, mental, cognitive). It should be financed through the current system with increases in the payroll tax and premiums and through dedication of receipts from the Federal Estate and Gift Tax.

4.1.1. Elements

- The program should be progressively financed, with protections for low-income persons, by use of cost sharing with a sliding fee scale.
- The expansion should not favor institutional care.
- The current aging network (Older Americans Act) and other service providers (Social Services Block Grant) should be used to expand availability of community-based long-term care services, including respite care and adult day care.
- The provision of community-based services under Medicaid for low-income individuals should be mandated.

- Financial assistance to caregivers should be provided through tax credits and deductions.
- HCFA enforcement of nursing home regulations should be improved and quality assurance programs expanded to cover assisted-living and other facilities providing long-term care.
- The ombudsman program should be expanded to cover these facilities and be provided with the necessary funding.
- The program should ensure that states address the quality concerns that come with capitated long-term care programs.
- The program should mandate and reimburse for appropriate care management, including a comprehensive assessment of beneficiaries' needs and discharge planning.
- Medicaid reimbursement should be increased to ensure that it is sufficient to cover appropriate labor costs in long-term care facilities.

4.2. Medicare and Medicaid Program Specific Discussion

4.2.1. Medicare as Part of the Services Picture—Not a Comprehensive Benefit, But Definitely a Place to Start

4.2.1.1. Home Health Care

Home health care, from its inception, has been part of a constellation of Medicare services, including hospital and post-hospital care, that comprise a defined set of acute care services.[46] Moreover, home health care, which started out as an open-ended benefit,[47] is now limited to one hundred visits under Part A for persons who have both Medicare Parts A and B, with additional necessary services available under Part B.[48] This new arrangement functions primarily as a financing scheme to save costs to the Part A Medicare Trust Fund.[49]

For persons with Part A only, or for persons with Part B only, there is no specific visit limit on access to home health care,[50] although other payment and coverage rules and home health agency practices significantly restrict access to this important benefit.[51] Similarly, there is no specific home health visit limit under Part B for persons eligible for Parts A and B who have exhausted the one hundred-visit limit under Part A.[52]

4.2.1.2. Home Health and Hospice

With respect to hospice services, there is no longer a limit on the number of times that an individual can be recertified for this benefit, including two periods of ninety days and an unlimited number of subsequent periods of sixty days,[53] extending the hospice benefit considerably. Of late, however, there has been a greater utilization of in-home hospice services as a vehicle for extending home health services, often provided by the same home health agency, particularly where agencies seek to stay within cost-caps under the Medicare home health care benefit. This utilization pattern is likely to be scrutinized for fraud, abuse, and overutilization.[54]

4.2.1.3. Other Part B Services

Access to other services under Part B,[55] including physician services, x-ray and other diagnostic services, and durable medical equipment, are more open-ended; although access and utilization is limited by strict coverage and payment rules.[56] In addition, therapeutic services such as physical and occupational services are limited by annual payment caps.[57]

4.2.1.4. Medicare+Choice (New Medicare Part C)

With respect to Medicare covered services provided through the Medicare+Choice program, new Medicare Part C,[58] there is great reliance on managed care organizations (MCOs) for the provision of Medicare covered services.[59] While MCOs must provide Medicare beneficiaries the services available under Medicare Parts A and B,[60] these organizations, working under a capitated payment system, strictly control utilization and access to services, often raising concerns about the quality of care received.[61] Of late, many MCOs have dropped their Medicare products, leaving many beneficiaries without a Medicare managed care option.

4.2.1.5. Chronic Care Currently Available

Although routinely denied, coverage for chronic conditions is available under the Medicare program.[62] Generally, a chronic condition is one for which there is little likelihood of medical improvement and for which medical services, including physical or other therapeutic services are necessary to maintain functioning or to prevent or slow deterioration.[63]

Current cost-containment efforts, particularly those directed toward the Medicare home health care program, have made it financially unattractive to treat long-term chronically ill patients. Many fiscal intermediaries, insurance companies, and other

entities under contract with the Medicare program to administer the payment of claims, discourage chronic care claims submissions. The Medicare program has often sent mixed signals about chronic care, discouraging it on the one hand, while recognizing its legitimacy in regulations and administrative manuals as descried above.

4.2.1.6. The Homebound Dilemma: Finding a Way to Define the Service and the Population to Be Served

The Medicare program is restrictive in its eligibility and access criteria to home health benefits under Medicare. Current concerns about program growth and the need to control costs are causing even greater scrutiny of the benefit and access to it, including ever more restrictive definitions of the concept of homebound, being applied by service providers on a day-to-day basis.

4.2.1.7. Long-Term Care as a Category of Service Under Medicare: The Current Situation

Currently, the Medicare program does not include a specific category of services designated as long-term care services. Rather, long-term care services, are included in the scope of services provided to persons who need chronic care services within the context of the services available under the home health benefit[64] or under other Medicare provisions allowing for physical, occupational, and speech therapy services narrowly defined by the Medicare program.[65]

4.2.2. Medicaid

Medicaid is the largest public source of funding for long-term care in the United States. It accounted for more than thirty-eight percent of total long-term care expenditures in 1996. Medicaid spending for long-term care has more than doubled from 1987 to 1997, rising from $21.1 billion to $56.1 billion.[66] State Medicaid programs are required to pay for nursing home care and home health care for individuals who qualify under the federal and state criteria.[67] States also have the option of providing services to Medicaid beneficiaries under the Personal Care program and the Home and Community-Based Care Waiver program.[68] These programs provide Medicaid eligible individuals with services that help with activities of daily living.

The MEDSTAT Group, a private research organization conducting research under a contract with the Health Care Financing Administration, has found that states increasingly are moving toward provision of services in the community through the waiver programs. Medicaid spending for long-term care increased 9.3 percent from 1996 to 1997, the highest rate of growth since 1992. Medicaid spending on nursing home care and intermediate care facilities as a proportion of total Medicaid long-term care spending dropped from 90.2 percent in 1987 to 75.8 percent in 1997. At the same time, home care spending as a percentage of total Medicaid spending more than doubled from 10.8 percent to 24 percent.[69]

In the late 1980s and early 1990s expenditures for Medicaid home health services were increasing annually by twenty percent to twenty-eight percent, but that began to slow in 1993. According to the MEDSTAT Group, the lower rates of growth in recent years may reflect the use of strategies by some states to maximize the use of Medicare home health benefits for those who are dual eligible. But most recent data show that long-term care spending was driven by a large increase in Medicaid home and community-based care waiver services, which increased by 44.6 percent from 1996 to 1997 ($8.1 billion in 1997 from $451 million in 1987).[70]

4.2.3. The Proposed Benefit

The proposed benefit would be known as Medicare Part D.

4.2.3.1. The Benefit

Under Medicare Part D, each beneficiary would be entitled to a pool of money (i.e., $200,000 in the year 2000 and indexed to inflation) to be used as needed at any level along the continuum of care. There would be a $10,000 deductible, after which Medicare would pay eighty percent of the cost of care. After the pool of money is exhausted, the beneficiary would pay privately or through private insurance. The Medicaid program would pay for care for those unable to afford private payment or to purchase private insurance. Care managers would assess the beneficiary's condition, develop a written plan of care, implement and coordinate the care plan, monitor services, make appropriate reassessments, and discharge the beneficiary when services are no longer needed.

Any system of long-term care financing must ensure that provider payments are adequate to cover the actual cost of care and provide a reasonable profit to the provider. The NAELA proposed system would

spread the risk of care across the population as a whole, recognizing long-term care as a normal life risk.

4.2.3.2. Eligibility

Physical eligibility would be based on advanced age limitation of functions (physical and/or mental disability) resulting in the loss of at least two ADLs or an equivalent disability. The financial eligibility requirements for Medicare Part D would be very similar to the rules for Social Security Disability Income (SSD).[71] To be eligible for Medicare Part D, a recipient would be age sixty-five or disabled as defined in Social Security Act.[72] The wage earner must have obtained insured status by accumulating forty quarters of coverage.[73] The spouse or children of a disabled wage-earner would be eligible provided the spouse or children were sixty-five years of age or disabled.

4.2.3.3. Financing the Benefit

Medicare Part D would be financed in a manner consistent with the funding structure used to fund the current Part A Trust Fund (i.e., payroll taxes). Increases must be based on sound actuarial principles, in keeping with established notions of social insurance as currently defined in our Social Security system. Additionally, receipts from the Federal Estate and Gift Tax would be dedicated toward funding Medicare Part D.

Since it will take a certain period of time to accumulate sufficient money through additional payroll taxes to pay for the program, it should be phased in over a number of years, so that one-half of the program benefits becomes available in ten years and the second half becomes effective in twenty years. By providing this basic coverage under a modified social insurance model, the benefits provided by private long-term care insurance would be significantly reduced, thereby lowering premiums and making them more affordable to a larger segment of the population.

NAELA proposes that, with the establishment of Medicare Part D, the Part D program and the Medicaid program be administered in a manner similar to Medicare. A strong audit system to ensure compliance and a uniform federal standard of eligibility would be required. Provider reimbursement rates must be fairly administered and determined, based on accurate cost information reflecting geographic considerations and severity of conditions. Additionally, due process requirements must always be observed.

5. Medicaid Reform

5.1. Structural Components and Observations of the Current System

The Medicaid system lacks coordination between the county and state level, between the state agency and the state legislature, between the state and the federal administrative agencies, and between the federal administrative agency (HCFA) and Congress. The current system of Medicaid waivers creates an even greater lack of continuity. States have great flexibility in denying waiver requests and can limit services to various populations through the waiver process. These various breaks in the chain of authority create many discrepancies and ensure inefficiency and disparate treatment between and within states. States that are inclined to ignore the process or take shortcuts are unlikely to be penalized, as the federal agency is also undisciplined in maintaining the appropriate controls and audit procedures. In short, the system fails.

The management and structure of the Medicare program versus the Medicaid program creates an interesting comparison. While the Medicare program is strictly a federal program that is administered by the federal government and insurance companies, the Medicaid program is a joint federal-state program. While the Medicare eligibility rules are comparatively straightforward, the Medicaid eligibility rules are a morass and a mystery to all but a chosen few. This theme continues into the review and appeal processes where fair hearings are often neither fair nor appealing.

5.2. The Federal-State Partnership

This concept has created turf wars between the counties and state governments as well as between the states and the federal government. Having reviewed approximately twenty-two state administrative codes in this area, the problems or deficiencies include:

1. Contradictions within sections of the state Medicaid regulations;
2. Contradictions between the state regulations and federal statutes;
3. Failure by the HCFA to enforce against those who have failed to adhere to principles of the statutory law and to the principals of equal protection and due process;

4. Failure by state or federal agencies to audit the policies and procedures of the state agencies; and
5. Uneven application of the same Medicaid regulations within states.

5.3. Suggestions Concerning Structural Improvements

NAELA makes a number of recommendations pertaining to program administration. While these recommendations relate to the existing Medicaid program, the concepts also need to be included in the proposed Medicare Part D.

5.3.1. Single Source (Long Term)

Legislation previously has been introduced that would have separated the Medicaid program from the general welfare programs. The purpose of this approach was to eliminate many of the positions in state governments that are duplicative and to establish a single system. Under such a proposal, it would be possible to either continue using the county governmental structure or contract the administration to the insurance industry, which has provided an efficient and uniform Medicare administration. It would be possible to transfer some duties to the companies immediately. While some politicians at the state level would oppose such an approach, many middle-class and lower middle-class senior citizens would benefit. The administration could also be performed by a subagency of the HCFA.

5.3.2. Substantive Model Code (Short Term)

State Departments of Human Services, along with AARP and groups such as NAELA could work together to create a model code as well as model notices that could be utilized and would represent a considerable improvement over the program administration in many states. First, a uniform state Medicaid system must be adopted. During this transition period, states would be free to determine eligibility standards within model code sections. By using model code sections, less effort would be expended and litigation would be less likely. Additionally, in poorer states or more rural states, the quality of the eligibility determinations would be improved and more credence given to case law.

5.3.2.1. Government Model

If a government agency such as HCFA is to manage such a program, it would be most efficient to transfer employees and office space to the federal government. An intense and ongoing education and evaluation system would be required. Although this approach is inconsistent with the Medicare Administrative model, it would still represent an improvement over the current system.

5.3.3. Model Procedures Act

The adoption of a model act would apply to eligibility determinations for the Medicaid program and welfare programs. Due process violations at the state level have been a persistent problem, but for friendly courts and the Eleventh Amendment could have caused severe financial distress to many states. By adopting and conforming to such a model act, the populace would be better served and state governments could avoid the federal court system. The model act would include an application process, a review process, and notice forms, as well as penalties for the failure to comply. The model rules should also contain strict criteria for assisting with applications and hearings. A model act would alleviate many of the due process concerns set forth below.

5.3.4. Auditing System

There must be a system in place to audit compliance by government agencies. There are two possible models: a government audit or a private attorney general model. Procedures must be in place to avoid easily subverting government auditors.

5.3.4.1. Government Audit

A truly independent auditing agency is recommended. Such an agency should be part of the Justice Department since it is most familiar with due process issues.

5.3.4.2. Private Attorney General

Under this approach, any party who discovered violations would be permitted to pursue a court action and would be entitled to attorney's fees or perhaps a percentage reward. Conceptually, this would be similar to a *qui tam* action.

5.4. Due Process

The national Medicaid system, as currently structured, denies many applicants the basic and fundamental right of due process.

5.4.1. Inconsistent Decisions (Intrastate Administration)
In its present form, the Medicaid system varies significantly across state and even county lines, yielding inconsistent decisions and unreliable coverage. For example, the local Medicaid district in New York City often interprets New York State OBRA '93 eligibility regulations differently than the local district in Nassau County (a contiguous county). A single, uniform federal standard of eligibility and administration must be created. These uniform laws and regulations would offer detailed regulations not only for approval of Medicaid applications, but also for the denial of coverage as well as the appeals process.

5.4.2. Reconsideration
After denial of an application, the applicant is entitled to have the application reconsidered by the worker who performed the initial review. This is inherently unjust, as the worker who rendered the decision is unlikely to change his or her position. The review should, instead, be conducted by an independent party, perhaps another worker in a separate department created solely for the reconsideration of Medicaid denials. This would ensure that the request for reconsideration is given the serious attention it deserves. Currently, the reconsideration process is a mere formality. Every applicant who feels that his or her decision is in error should be able to have the decision reviewed and reversed without the necessity of a formal *fair hearing* or costly litigation. This would save time and money for the applicant as well as the local entity that administers the program.

5.4.3. Fair Hearings
Fair hearings are also often unjust and unfair. Review of the application is customarily performed by the same agency or subagency that acts as the defendant in the matter. Fair hearings for Medicaid applicants should be conducted by an independent administrative law judge like those for Medicare and worker's compensation cases.

It is important to retain the informal face-to-face nature of the fair hearing proceeding, so that individuals who cannot afford attorneys could nevertheless adequately represent themselves. Therefore, complicated rules of evidence should not be required in a fair hearing setting. However, fair hearing appellants must be given the formal *protections* of a traditional proceeding, including the ability to conduct a wide array of discovery, such as the right to subpoena documents, experts, and witnesses. Complete and unencumbered discovery and disclosures are essential to ensure that substantial justice and basic due process principles have been met.

5.4.4. Notices
One of the essential elements of due process is the right to reasonable notice. However, the notice of denial proffered by Medicaid is usually difficult to understand, if not illegible, especially for the elderly.

Notice of denials must be legible (*at least* twelve-point type), state clearly the reasons for the denial, inform the enrollee of all appeal rights, explain hearing rights and procedures, and provide instructions on obtaining supporting evidence. These basic due process protections must be as easily understood by an eighty-year-old widow as her thirty-five-year-old daughter. In the event that the recipient of the notice is incapacitated or infirm, notice must be given to a guardian, family member, and/or to a personal advocate for the individual appointed by the local administering agency. All notices should be given in the primary language of the applicant.

5.4.5. Failure of Timely Response
Due process also invokes the concept of speedy and just application of the law. In recognition of this, Medicaid regulations often include reasonable time frames with which the agency must comply in order to ensure that justice is met. Unfortunately, these time frames are frequently not met. For example, in Nassau County, New York, an individual will often have to wait approximately four months just to get an initial interview with the Department of Social Services. Further, there typically are no penalties imposed on the agency administering the Medicaid program for failing to meet these time frames.

5.4.6. Burden of Proof
There must be a *presumption* that the applicant is eligible for assistance. The burden of proof must be on the administering agency to prove, with clear and convincing evidence, that the applicant is not eligible. This strict standard is appropriate as the denial of benefits literally has life or death consequences for many individuals.

6. Conclusion

The current system fails to meet the long-term care needs of our aging population. Medicaid and long-term care insurance will cover the needed care in some cases. Medicare Part D will be the solution to this problem.

Endnotes

1. The National Academy of Elder Law Attorneys, Inc. (NAELA) was founded in 1988 as a professional association of lawyers who are dedicated to improving the quality of legal services provided to the elderly. The academy seeks to provide support to other organizations serving the elderly and has become a recognized leader in examining and advocating on public policy issues facing the elderly.

2. Continuum of Care: Integrating Community & Social Services, *The Official 1995 White House Conference on Aging Background Materials* 2 (1995 White House Conference on Aging).

3. *National Vital Statistics Reports, Births and Deaths: Preliminary Data for 1997*, http:\www.cdc.gov\nchs (accessed Mar. 18, 2000).

4. NAT'L GOVERNOR'S ASS'N, THE FISCAL SURVEY OF STATES: DECEMBER 1998.

5. JOHN HANCOCK MUT. LIFE INS. CO., HAVE YOU THOUGHT ABOUT YOUR FAMILY'S LONG-TERM CARE NEEDS? (1998).

6. CITIZENS FOR LONG-TERM CARE , LONG-TERM CARE: MEDICAID (1999).

7. The base rates for two nursing homes in Washington, D.C. exceed $200 a day. *Guide to Retirement Living*, Metropolitan Washington Edition 125 (Summer/Fall 1999).

8. Statement of Paul Fronstein, Ph.D., Employee Benefit Research Institute, Long-Term Care Insurance, Hearing Before the Subcommittee on Civil Service of the House Committee on Government Reform and Oversight (1998).

9. David S. Hilzenrath, *Nursing Homes Shun Some Medicare Payments*, WASH. POST, June 7, 1999, at A1.

10. AARP, THE AARP 1998 PUBLIC POLICY AGENDA, Chapter on Long-Term Care 7-3 (1998).

11. 42 U.S.C. § 401 *et seq.*; 20 C.F.R. § 404.1 *et seq.*

12. CITIZENS FOR LONG-TERM CARE, *supra* note 6.

13. ENID KASSNER & ROBERT W. BECTEL, MIDLIFE AND OLDER AMERICANS WITH DISABILITIES: WHO GETS HELP?, A CHARTBOOK 57 (1998).

14. AARP, *supra* note 10, at 7-1.

15. GENEVIEVE W. STRAHAM, AN OVERVIEW OF NURSING HOMES AND THEIR CURRENT RESIDENTS, Data from the 1995 National Nursing Home Survey, Advanced Data Number 289, National Center for Health Statistics (1997).

16. *Id.*

17. KASSNER, *supra* note 13, at 32.

18. Telephone Interview with Susan Coronel, Health Insurance Association of America (Mar. 2000).

19. J.M. WIENER ET AL., SHARING THE BURDEN: STRATEGIES FOR PUBLIC AND PRIVATE LONG-TERM CARE INSURANCE 6 (1994).

20. KATHERINE R. LEVIT ET AL., *National Health Expenditures*, 19 HEALTH CARE FIN. REV., 160–200 (Fall 1997).

21. Hilzenrath, *supra* note 9.

22. Peter Kemper & Christopher M. Murtaugh, *Lifetime Use of Nursing Home Care*, 324 NEW ENG. J. MED. 9 (1991).

23. CITIZENS FOR LONG-TERM CARE, LONG-TERM CARE: OVERVIEW (1999).

24. Statement by David Martin, Chairman of the Long-Term Care Committee of the American Council of Life Insurance (WUST Radio 1120, Apr. 10, 1999).

25. Health Care Financing Administration, *Medicaid Recipients by Type of Service*, http://www/hcfa.gov/medicaid/2082-4.htm (accessed Mar. 18, 2000).

26. 42 U.S.C. § 1395i-3; 42 U.S.C. § 1396r.

27. Korbin Liu et al., *Predicting Nursing Home Admission and Length of Stay: A Duration Analysis*, 29 Med. Core 125 (1991).

28. WIENER, *supra* note 19.

29. HEALTH INS. ASS'N OF AM., LTC MARKET SURVEY (1997).

Average Annual Premiums for Leading Individual and Group Association Long-Term Care Sellers in 1996*

Age	Base	With 5% Compounded Inflation	With Nonfortfeiture Benefit (NFB)	With IP & NFB
40	$247	$589	$338	$805
50	$364	$802	$503	$1200
65	$980	$1829	$1321	$2432
79	$3907	$5592	$5129	$7440

*Premiums are generally for $100 per day nursing home, $50 per day home health care, 4-year benefit period, and 20-day elimination period.

30. GALLUP ORG., INC., PUBLIC ATTITUDES ON LONG-TERM CARE: THE EBRI POLL 15 (1993).

31. FABRIZIO MCLAUGHLIN & ASSOC., BABY BOOMER IQ TEST—NATIONAL SURVEY (1999).

32. Jane Bryant Quinn, *Is a Backlash Brewing in LTC?*, NEWSWEEK, Aug. 30, 1999, at 39.

33. JANEMARIE MUVEY & BARBARA STUCKI, WHO WILL PAY FOR THE BABY BOOMER'S LONG-TERM CARE NEEDS? 14 (1998).

34. *Id.*

35. Fronstein, *supra* note 8.

36. CHRISTOPHER MURTAUGH ET AL., MYTHS AND FACTS ABOUT LONG-TERM CARE INSURANCE: RISKY BUSINESS 277 (1995).

37. Pub. L. No. 104-191.

38. AARP, *supra* note 10.

39. Tom Herman, *A Special Summary and Forecast of Federal and State Tax Developments*, WALL ST. J., July 21, 1999, at A1.

40. SPECIAL COMM. ON AGING, DEVELOPMENTS IN AGING: 1997 AND 1998,VOL. 1 180, Report 106-229 (Feb. 7, 2000).

41. LAGUNA RESEARCH ASSOC., PARTNERSHIPS FOR LONG-TERM CARE, NATIONAL EVALUATION SUMMARY STATISTICS AS OF DECEMBER 31, 1997 (1999).

42. LAGUNA RESEARCH ASSOC., THE PARTNERSHIP FOR LONG-TERM CARE AND THE FUTURE POLICY DEBATE ON LONG-TERM CARE FINANCING 3 (1998).

43. *Id.*

44. Telephone Interview with Mark Meiners, Ph.D., Director, National Program Office, Partnerships for Long-Term Care, University of Maryland Center on Aging (July 29, 1999).

45. Pub. L. No. 103-66 (1993).

46. 42 U.S.C. § 1395c.

47. *See* 42 U.S.C. § 1395x(m), pre-Balanced Budget Act of 1997 (BBA-97), Duggan v. Bowen, 619 F. Supp. 1487 (D.D.C. 1988).

48. Pub. L. No. 105-33, § 4611, amending § 1811(a) of the Social Security Act, 42 U.S.C. § 1395d; *see also, id.*, § 4612, amending § 1812 of the Social Security Act, 42 U.S.C. § 1395x(m).

49. *See* Conf. Committee Report, accompanying Pub. L. No. 105-33, § 4611, (H. REP. 105-217).

50. Pub. L. No. 105-33, § 4611, amending § 1812(a) of the Social Security Act, 42 U.S.C. § 1395d.

51. *Id.*

52. *Id.*

53. 42 U.S.C. § 1395d.

54. The HCFA, which administers the Medicare program, has several initiatives involving fraud and abuse. Overutilization in all aspects of the Medicare program is a focus of much of this effort.

55. 42 U.S.C. § 1395k(a).

56. *See*, for example, Medicare reasonable charge limitations, 42 U.S.C. § 1351(a); 42 C.F.R. § 405.501; *see also* §§ 410.152 and 410.160; other examples include coverage for durable medical equipment (42 C.F.R. §§ 410.38, 410.152(d)) and physicians services (42 C.F.R. §§ 410.20(b), 410.22–410.25).

57. *See* Pub. L. No. 105-33, § 4541(a) *et seq.*, amending § 1833(a) of the Social Security Act, 42 U.S.C. § 1395I(a) *et seq.*

58. *See* Pub. L. No. 105-33, § 4001, creating new § 1851(a) of the Social Security Act.

59. The HCFA is developing extensive informational resources for beneficiaries in anticipation of

beneficiary movement toward the Medicare+Choice program. At this juncture, few Medicare+Choice options are available and beneficiaries are being encouraged by advocates and counselors to look carefully before joining MCOs. In some instances, managed care entities are dropping Medicare+Choice options and leaving certain geographic areas.

60. *See* Pub. L. No. 105-33, § 4001, creating new § 1852(a)(1), (2) of the Social Security Act.

61. MEDICARE PAYMENT ADVISORY COMM. (MEDPAC), REPORT TO CONGRESS 45 (the need for further study and reporting to Congress) (Mar. 2000).

62. 42 C.F.R. § 409.44(b)(3)(iii); MEDICARE HOME HEALTH MANUAL 11, § 205.1A4; Fox v. Bowen, 656 F. Supp. 1236 (D. Conn. 1986).

63. *See* Smith v. Shalala, 855 F. Supp. 658 (D. Vt. 1994); Bergeron v. Shalala, 855 F. Supp. 665 (D. Vt. 1994).

64. Generally, if a beneficiary can meet the Medicare home health criteria, including the need for skilled care services on a part-time or intermittent basis, is homebound, and obtains appropriate recertification of his or her care plan, ongoing services should be available. 42 U.S.C. § 1395x(m).

65. *See* 42 U.S.C. §§ 1395l, 1395m.

66. BRIAN BURWELL, MEDICAID LONG-TERM CARE EXPENDITURES IN 1997 (1998).

67. 42 C.F.R. § 440.230.

68. 42 U.S.C. § 1396a(a)(10)(A)(ii)(vi).

69. BURWELL, *supra* note 66.

70. *Id.*

71. 42 U.S.C. § 401 *et seq.*; 20 C.F.R. § 404.1 *et seq.*

72. 42 U.S.C. §§ 416(1)(1), 423(d)(1)(A); 20 C.F.R. § 404.1505(a).

73. 42 U.S.C. § 401 *et seq.*; 20 C.F.R. § 404.1 *et seq.*