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REALITY CHECK: THE DRA'S IMPACT ON SENIORS WITH DISABILITIES AND THEIR CAREGIVERS

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In February 2006, President Bush signed the Deficit Reduction Act of 2005 (DRA),[1] a sweeping federal spending bill that did little to address budget deficits and nothing to reduce the nation's debt. Among other things, the DRA made many significant changes in federal law pertaining to the Medicaid eligibility of persons sixty-five and older for Medicaid long-term care benefits.[2] The overriding goal of these amendments was to make it even more difficult for seniors with disabilities to receive public assistance in the event that they need long-term care. In the coming decades, proponents of the legislation claimed, the demands of these Americans with disabilities will place enormous stress on federal and state budgets; restricting

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1. Pub. L. No. 109-171, 120 Stat. 4 (codified as amended in scattered sections of 42 U.S.C.A.) (Westlaw current through Sept. 26, 2007).

2. For general overviews of the DRA's Medicaid related provisions, see CTR. FOR MEDICARE AND MEDICAID SERVS., DEFICIT REDUCTION ACT, OVERVIEW, *available at* http://www.cms.hhs.gov/DeficitReductionAct/01_Overview.asp#TopOfPage; Cong. Research Serv., CRS summary: S. 1932 [109th]: Deficit Reduction Act of 2005, *available at* http://www.govtrack.us/congress/bill.xpd?bill=s109-1932&tab=summary; JEFFREY S. CROWLEY, HENRY J. KAISER FAMILY FOUND., MEDICAID LONG-TERM SERVICE REFORMS IN THE DEFICIT REDUCTION ACT (2006) [hereinafter KAISER MEDICAID LONG-TERM REFORMS], *available at* http://www.kff.org/medicaid/upload/7486.pdf; NAT'L. CONF. OF STATE LEGISLATORS, DEFICIT REDUCTION ACT OF 2005, SUMMARY OF MEDICAID/MEDICARE/HEALTH PROVISIONS, http://www.ncsl.org/statefed/health/ReconDocs0206.htm (last visited Sept. 30, 2007).

eligibility for Medicaid is the only way to prevent a fiscal crisis and ensure that resources are available to the "truly needy."[3] According to the Congressional Budget Office, the Medicaid-related provisions of the DRA can be expected to reduce direct federal spending on Medicaid benefits for seniors by some $6.3 billion over the ten-year period from 2006-2015.[4]

In the grand scheme of the federal budget for health care, $6.3 billion saved is but a pittance. The Medicare prescription drug benefit *alone* will cost taxpayers more than $675 billion during the ten-year period over which these "savings" will be spread.[5] Moreover, as Ellen O'Brien demonstrates in her article, included in this symposium issue, there is considerable doubt as to whether the DRA will generate the cost savings that its advocates have claimed.[6]

Even if federal expenditures for long-term care will be reduced because of Title VI, however, the DRA transfers virtually all of these "savings" directly to our nation's most vulnerable and politically powerless seniors: those with serious disabilities, and their families.[7] They also exacerbate Medicaid's existing tendency to impose the great bulk of the economic, social, and emotional burdens associated with late life, long-

3. "As Medicaid costs grow, there is a growing interest by many policy makers, including some members of Congress, in restricting Medicaid eligibility to the 'truly needy'. Tightening the eligibility standards for persons who transfer assets is a key issue for many because they believe that existing standards permit upper income individuals who have the resources to pay for their own long-term services to qualify for Medicaid. Some contend that individuals may not plan properly for their future needs because they know that Medicaid is available as a safety net." KAISER MEDICAID LONG-TERM REFORMS, *supra* note 2, at 5. *See* GRACE-MARIE TURNER, THE FUTURE OF LONG-TERM CARE AND MEDICAID 6 (July 10, 2006), *available at* http://bartlett.house.gov/uploadedfiles/Turner%20SBA%20Testimony.pdf.

4. CONG. BUDGET OFFICE COST ESTIMATE, S. 1932, DEFICIT REDUCTION ACT OF 2005 37 (Jan. 27, 2006) [hereinafter CBO, 1932, DEFICIT REDUCTION ACT OF 2005].

5. HENRY J. KAISER FAMILY FOUND., CBO LOWERS 10-YEAR COST ESTIMATE OF MEDICARE PRESCRIPTION DRUG BENEFIT (2007), *available at* http://kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=42519.

6. *See generally* Ellen O'Brien, *What is Wrong with the Long-Term Care Reforms in the Deficit Reduction Act of 2005?*, 9 ELDER'S ADVISOR 103 (2007).

7. *See* DEFICIT REDUCTION ACT OF 2005, Pub. L. No. 109-171, 120 Stat. 4 (codified as amended in scattered sections of 42 U.S.C.A.) (Westlaw current through Sept. 26, 2007).

term disability on women. Implicitly, the DRA legitimizes and perpetuates the view that disabled Americans (particularly, but not exclusively, the elderly) and their families are not entitled to rights and privileges afforded so-called "able-bodied" persons. As such, the DRA is not a rational, neutral method of preserving scarce public resources to ensure the welfare of all, but is instead unjust and a reflection of society's general willingness to devalue and marginalize particular disempowered groups.

There is no immediate Medicaid "crisis" stemming from long-term care expenditures on the elderly; as such, the DRA should be repealed while policymakers and politicians work towards a long-term care financing scheme that fairly distributes the costs of providing long-term care across the broader population.

THE DRA IN CONTEXT

This section describes the phenomenon of the aging U.S. population and the current means of financing health care for the nation's older citizens.

APOCALYPTIC DEMOGRAPHY AND THE CHALLENGES OF AN AGING SOCIETY

> Global aging, like a massive iceberg, looms ahead in the future of the largest and most affluent economies of the world. Visible above the waterline are the unprecedented growth in the number of elderly and the unprecedented decline in the number of youth over the next several decades. Lurking beneath the waves, and not yet widely understood, are the wrenching economic and social costs that will accompany this demographic transformation-costs that threaten to bankrupt even the greatest of powers, the United States included, unless they take action in time.[8]

8. PETER G. PETERSON, GRAY DAWN: HOW THE COMING AGE WAVE WILL TRANSFORM AMERICAN – AND THE WORLD 3-4 (1999).

> [A] real tidal wave is approaching. Everyone has heard of it, so I suppose many think, since it is old news, it must have been addressed. It is the tidal wave of an aging population. It turns out that a tidal wave, or tsunami, may be an apt analogy. How did the recent tsunami manifest? Not in a single dramatic wave, but rather a relentless series of surges that overwhelmed what lay in their path.[9]

> The cost of health care and retirement benefits of an aging population threatens to bankrupt the nation unless dramatic changes are made. The average American retires five years earlier than in 1950 and lives twelve years longer. This phenomenon — work less, collect more — has ripped a hole in the senior citizen safety net. The longer we live, the bigger the hole.[10]

One can hardly turn on the television or open a newspaper without being confronted with grim warnings about the impact of the aging of the boomer generation on the national economy. Over the past two decades, as discussions of global population aging initiated by the United Nations, government agencies, and academics[11] have filtered down into the popular press, the rapidly increasing aging population in the United States is almost inevitably characterized in the media and by politicians as a social disaster that threatens to bankrupt the nation and create an intergenerational civil war. This "apocalyptic demography" has created a cult of fear of the inevitable and

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9. Posting of Glen Hiemstra to Futuristblog (Jan. 14, 2005), http://futuristblog.blogspot.com/2005/01/healthcare-and-elderly.html (last visited Sept. 30, 2007).

10. Dennis Cauchon, *Who Will Take Care of an Older Population?*, USA TODAY, Oct. 25, 2007, at B1.

11. *See, e.g.*, U. N. DEP'T. OF ECON. AND SOC. AFFAIRS, POPULATION DIV., POPULATION CHALLENGES AND DEVELOPMENT GOALS (2005), *available at* http://www.un.org/esa/population/publications/pop_challenges/Population_Challenges.pdf; U. N. DEP'T. OF ECON. AND SOC. AFFAIRS, POPULATION DIVISION, WORLD POPULATION AGING: 1950-2050 (2002), *available at* http://www.un.org/esa/population/publications/worldageing19502050/; U.S. DEP'T. OF STATE AND U.S. DEPT. OF HEALTH AND HUMAN SERVS., NAT'L. INST. ON AGING, NAT'L. INST. OF HEALTH, WHY POPULATION AGING MATTERS: A GLOBAL PERSPECTIVE (Mar. 13, 2007), http://www.state.gov/g/oes/rls/or/81537.htm (last visited Sept. 30, 2007).

very predictable graying of society that is the result of the unprecedented and unrepeated increase in birthrates, both in the United States and abroad, that followed World War II.

The argument that the nation's aging population presents an economic threat that calls for cutting public benefits (primarily Medicaid) is premised on the idea that as citizens age, the number of individuals with disabilities and disease will create a greater demand for health care, particularly long-term care, than taxpayers can support. DRA's proponents contend that by restricting access to government welfare programs now, the nation can stave off this fiscal disaster and preserve benefits for those who "really need them." The argument progresses something like this:

- The number and percentage of elderly is increasing rapidly. Between 2000 and 2050, the percentage of Americans who are sixty-five-plus will increase from 12.4% in 2005 to almost 20.7% in 2050.[12] The number of individuals eighty-five and older will more than triple; these "oldest old" Americans will comprise some 5% of the population by 2050, up from 1.5% in 2000.[13]
- Elderly dependency ratios[14] will increase dramatically from today's 18/100 to 31/100 in less than twenty-five years. This means that fewer "working persons" will be supporting each elderly person than ever before.[15]

12. U.S. CENSUS BUREAU, UNITED STATES INTERIM PROJECTIONS BY AGE, SEX, RACE, AND HISPANIC ORIGIN, TABLE 2A, (2004) *available at* http://www.census.gov/ipc/www/usinterimproj/natprojtab02a.pdf.

13. *Id.*

14. "Age-dependency ratios are a measure of the age structure of the population. They relate the number of individuals that are likely to be 'dependent' on the support of others for their daily living – youths and the elderly – to the number of those individuals who are capable of providing such support." ORG. FOR ECON. COOPERATION AND DEV., SOCIETY AT A GLANCE: OECD SOCIAL INDICATORS, 42 (2006), *available at* http://www.oecd.org/dataoecd/4/24/38148786.pdf.

15. These dependency ratios were generated from the U. N. DEP'T. OF ECON. AND SOC. AFFAIRS, POPULATION DIV., UNITED NATIONS WORLD POPULATION DATABASE, http://esa.un.org/unpp/index.asp?panel=7 (last visited Nov. 27, 2007)

- Age equals disability. The elderly experience higher levels of disability than younger populations; thus, a disproportionate share of the disabled population is elderly.[16]
- In future decades, national health care expenditures will comprise an increasing share of the gross domestic product.[17]
- Long-term care expenditures will comprise an increasing share of total health care expenditures and of the federal Medicaid budget.[18]
- The elderly demand disproportionately more health care, including long-term care, than other age groups.[19]
- Disabled persons demand more health care, including long-term care, than non-disabled persons.

Therefore, some contend, the nation cannot afford the cost of long-term care for the elderly and disabled, and their

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[hereinafter UNITED NATIONS WORLD POPULATION DATABASE]. The United Nations defines the old-age dependency ratio as "the number of working age persons (age 15 - 64 years) per older person (65 years or older)" for purposes of calculating and projecting dependency ratios in member nations.

16. Estimating levels of disability in any population is difficult because definitions of disability differ from person to person and from survey to survey. Nevertheless, it is virtually a truism that older persons are more likely than younger ones to have physical and cognitive impairments that affect their ability to perform various activities of daily living or to experience their environments. For example, the risk of developing Alzheimer's disease increases from 10% at age 65 to as high as 50% at age 85. ALZHEIMER'S ASS'N, ALZHEIMER'S DISEASE, CAUSES & RISK FACTORS, http://www.alz.org/alzheimers_disease_causes_risk_factors.asp (last visited Nov. 27, 2007).

17. *See* HENRY J. KAISER FAMILY FOUND., SNAPSHOTS: COMPARING PROJECTED GROWTH IN HEALTH CARE EXPENDITURES AND THE ECONOMY (2006), *available at* http://www.kff.org/insurance/snapshot/chcm050206oth2.cfm.

18. The Congressional Budget Office estimated in 1999 that inflation-adjusted expenditures for long-term care for the elderly would grow annually by 2.6 percent between 2000 and 2040. CONG. BUDGET OFFICE, PROJECTIONS OF EXPENDITURES FOR LONG-TERM CARE SERVICE FOR THE ELDERLY, 1-2 (1999), *available at* http://www.cbo.gov/ftpdoc.cfm?index=1123&type=0&sequence=0.

19. HENRY J. KAISER FAMILY FOUND., COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID AND LONG-TERM CARE SERVICE, 1 (2006), *available at* http://www.kff.org/medicaid/upload/Medicaid-and-Long-Term-Care-ServicesPDF.pdf.

entitlement to such care at public expense should be minimized. Instead, the elderly and disabled have a "personal responsibility" for any long-term care needs they may have in the future and should plan accordingly.

Apocalyptic demography, coupled with a fear of and disdain for elders with disabilities, lie at the heart of the "reforms" in the Medicaid eligibility rules reflected in the DRA. The notion that the United States population is aging is true. The DRA's proponents claim has painted a picture of a future United States that is devastated by the demands of its disabled elderly population. The disabled elderly must be held accountable to pay for their own health care needs now to ensure that benefits are available for others later. But the line of reasoning set out above as a justification for the mean-spirited assault on elders with disabilities implicit in the DRA does not withstand close scrutiny.

PUTTING THE MEDICAID "CRISIS" IN PERSPECTIVE

Because the doomsday scenario depicted by apocalyptic demography is grounded in readily documented facts, policymakers and others who would limit access to Medicaid by the nation's most vulnerable elders, those with severe disabilities, have eagerly exploited it. The big picture of global and national aging, though it requires our leaders' attention, is considerably less grim. On one hand, it is certainly true that the aging population will increase rather dramatically over the next fifty years as a percentage of the whole.[20] On the other, a rapid rise in the number and percent of elderly is not without precedent in this country. In fact, the total number of persons age sixty-five and older almost quadrupled in the United States between 1900 and 1950.[21] This demographic shift had eventual

20. *Id.*

21. ADMIN. ON AGING, OLDER POPULATION BY AGE: 1900-2050 (2005), *available at* http://www.aoa.gov/prof/Statistics/online_stat_data/AgePop2050.asp (showing elderly population increased from 3.08 million persons in 1900 to 12.27 million in 1950).

consequences—one of them was the Medicare program—but this demographic shift did not bankrupt the nation.

The growth of the sixty-five and older population that will occur over the next forty-odd years is not akin to an unpredictable natural disaster, nor is it a bizarre fluke. It is simply "the rat in the python," a bulge in the population pyramid representing the boomer generation as it moves from middle into old age. Just as a historically disproportional allocation of resources toward education was required in the 1950's and 1960's,[22] a larger allocation of resources towards health and long-term care will be required as our nation grows old. This phenomenon will demand a rethinking of fiscal priorities and a restructuring of the funding mechanisms that support the kinds of services most needed by the elderly, but it does not imply fiscal disaster. As will be discussed below, the DRA does not involve restructuring anything; rather, it ignores the realities of aging and disability in our society and tinkers with a fundamentally flawed health and long-term care financing mechanisms to achieve short-term, insignificant savings. The proper question is not, "how can we limit access to Medicaid-financed long-term care?". Instead, the question should be, "what is the most fiscally and morally responsible way to pay for the future long-term care needs of the baby boomer generation?".

Although the elderly dependency ratio is increasing, this ratio overstates the burden on public resources created by an elderly population. Among other things, the elderly dependency ratio assumes that persons sixty-five and older do not contribute to national economies.[23] In recent years, however, workers sixty-five and older have been participating in the paid workforce in increasing numbers.[24] The old-age dependency

22. *See* U.S. DEPT. OF EDUC., NAT'L. CTR. FOR EDUC. STATISTICS, THE CONDITION OF EDUCATION 2002, 111, *available at* http://nces.ed.gov/pubs2002/2002025.pdf (showing change in national public and personal expenditures for education, 1950-1999).

23. *See* UNITED NATIONS WORLD POPULATION DATABASE, *supra* note 15.

24. Abraham Mosisa & Steven Hipple, *Trends in Labor Force Participation in the*

ratio does not account for the value of unpaid services provided by older persons, such as informal care giving and volunteerism, which add hundreds of billions of dollars to the national economy.[25] More importantly, apocalyptic demography tends to ignore the fact that the nation's *total* dependency ratio, which considers the number of "working age" persons who are supporting children and the elderly combined, will never be as high as it was in 1960, when baby boom births were winding down. The total dependency ratio will not begin rising above its current level of 49/100 until 2010.[26] This ratio will be 62/100 in 2050, when the nation's elderly population peaks at about eighty-four million, which is well short of the 1960 peak of 67/100.[27]

	Elderly dependency ratio	Total dependency ratio
1950	13/100	54/100
1960	15/100	67/100
2005	18/100	49/100
2030	31/100	60/100
2050	34/100	62/100[28]

Even assuming that the elderly consume more tax-supported resources per capita than children, the rising old-age

United States, MONTHLY LABOR REVIEW 53 (Oct. 2006), *available at* http://www.bls.gov/opub/mlr/2006/10/art3full.pdf.

25. *See, e.g.*, Richard W. Johnson & Simone G. Schaner, *Value of Caregiving, Volunteering by Seniors Valued at $162 Billion Per Year*, *in* THE RETIREMENT PROJECT: PERSPECTIVES ON PRODUCTIVE AGING, NO. 4, 1 (Sept. 2005), *available at* http://www.urban.org/UploadedPDF/311227_older_americans.pdf.

26. U.N. DEP'T. OF ECON. AND SOC. AFFAIRS, POPULATION DIV., WORLD POPULATION PROSPECTS: THE 2006 REVISION AND WORLD URBANIZATION PROSPECTS, *available at* http://esa.un.org/unpp.

27. *Id.*

28. *Id.*

dependency ratio cannot be discussed in isolation from its broader context.

Moreover, although a correlation between age and disability exists, this correlation does not inevitably imply that our aging society will demand proportionately more resources for health and long-term care due to age-related disabilities. In recent years, conflicting data have emerged with respect to whether disability rates among the aged are in decline. Overall, disability rates by age have decreased over the last two decades.[29] While some researchers predict that they will soon stabilize or even begin increasing due to high obesity and diabetes rates among the boomer population, the jury is out on this issue.

Even as the number of elderly entering nursing homes declines, the total number of elderly individuals with limitations affecting their ability to perform important daily activities is increasing, primarily because of longer life spans. Assistive technology and community-based alternatives to institutional care contributed to declining per capita cost of addressing the long-term care requirements of elderly persons with disabilities. Although it is likely that the total number of elderly persons with significant disability will increase as the population ages and life expectancy increases, it is not clear which particular elderly individuals will need long-term care, what sort of assistance they will need, or how much that assistance will cost. Irrespective of how the statistics sort themselves out, it is more equitable to spread the future costs of age-related disability across the entire population rather than forcing particular individuals who experience disability due to disease or acute illness, to pay them in their entirety.

LONG-TERM CARE FINANCING FOR THE DISABLED ELDERLY IN THE UNITED STATES

The DRA was the product of an end-of-days

29. *Id.*

characterization of population aging combined with assertions that the tax base cannot sustain the current long-term care financing scheme unless undeserving seniors who benefit from the Medicaid program are rooted out immediately. To appreciate the defective picture the DRA's most vocal advocates paint, one must have some understanding of how long-term care for elders with disabilities has historically been financed and whether the DRA sought to alter that financing structure.

The components of health care generally include preventive care, acute care, and long-term care, although some may use different terminology to describe these components. Preventive care is "the systemic and systematically delivered population-directed services in areas such as vaccination, screening, and prenatal care."[30] Acute (or curative) care is that which addresses a specific, existing illness or injury. Acute care is provided in hospitals, emergency rooms, and physicians' offices. Long-term care, although not as easily definable as preventive and acute care, is a mix of medical, social, and personal services required because of a debilitating illness or disability that interferes with a person's ability to perform certain daily activities. Chronic care and custodial care are alternative terms for these components. When long-term care is provided in an institutional setting, it also includes a room and board component. It is not always easy to distinguish among these components when attempting to categorize a particular service provided to an individual receiving long-term care.

In most of the industrialized world, access to health care is treated as a right, not a privilege. The United States is alone among the world's major industrialized nations, as represented by the Organization for Economic Cooperation and Development[31] (OECD), in failing to guarantee access to primary

30. Martin Marshall et al., *OECD Health Care Quality Indicator Project. The Expert Panel on Primary Care Prevention and Health Promotion*, INT'L J. FOR QUALITY IN HEALTH CARE 21, 22 (Sept. 2006), *available at* http://intqhc.oxfordjournals.org/cgi/content/full/18/suppl_1/21?ijkey=BT8Q5QCoHyR1w&keytype=ref&siteid=intqhc.

31. OECD nations include Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Hungary,

and acute health care for all its citizens.[32] Although the particulars of national health insurance programs differ with respect to financing, administration, and range of services, all assure a basic level of preventive and acute care to everyone. Among the thirty nations composing the OECD, the United States contributes the smallest percentage of public funding towards total health care expenditures: less than forty-five percent compared with an OECD average of seventy-two and a half percent.[33] Although the United States spends far more on health care, both per capita and as a percentage of gross domestic product than any other nation,[34] health-related outcomes in our nation, as measured by life expectancy, infant mortality, and other factors, fall well short of those of its peers.[35]

MEDICARE: NATIONAL HEALTH INSURANCE FOR THE ELDERLY

Although the United States does not have national health insurance or anything comparable for the general population,[36]

Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Spain, Sweden, Switzerland, Turkey, the United Kingdom, and the United States. ORG. FOR ECON. COOPERATION AND DEV., OECD HEALTH DATA 2007, COUNTRY DIAGRAMS: CHARTS ON HEALTH CARE SYSTEMS (July 2007), http://www.ecosante.org/OCDEENG/12.html (last visited Nov. 27, 2007).

32. For general information about health care delivery and financing in the world's major developed nations, see ORG. FOR ECON. COOPERATION AND DEV., *supra* note 31.

33. ORG. FOR ECON. COOPERATION AND DEV., OECD IN FIGURES 2006-2007, DEMOGRAPHY AND HEALTH, HEALTH SPENDING AND RESOURCES (2007), http://dx.doi.org/10.1787/427077022807 (last visited Sept. 30, 2007).

34. *Id.*; ORG. FOR ECON. COOPERATION AND DEV., OECD HEALTH DATA 2007: HOW DOES THE UNITED STATES COMPARE? (2007), http://www.oecd.org/dataoecd/46/2/38980580.pdf (last visited Sept. 30, 2007).

35. *See generally* Karen Davis et al., *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, THE COMMONWEALTH FUND (May 15, 2007), *available at* http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=482678#areaCitation ("Compared with five other nations—Australia, Canada, Germany, New Zealand, the United Kingdom—the U.S. health care system ranks last or next-to-last on five dimensions of a high performance health system: quality, access, efficiency, equity, and healthy lives.")

36. Fewer than 60% of Americans who have health insurance obtain it through their own or their spouse's employer, or as the dependent of an insured. U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE HIGHLIGHTS 2006, *available at* http://www.census.gov/hhes/www/hlthins/hlthin06/fig07.pdf. The number of

the vast majority of the nation's elderly citizens have guaranteed access to acute and catastrophic health care through the federal Medicare program.[37] The idea of a publicly financed health insurance program limited to seniors was proposed as early as 1937,[38] and serious efforts began during the Truman administration[39] to provide a federal health care benefit to Social Security recipients.[40] As the cost of hospital care increased at exponential rates, the need for some form of universal health insurance for this population was apparent: only one in four

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uninsured Americans of all ages increased from 44.8 million in 2005 to 47.0 million in 2006, *see* U.S. CENSUS BUREAU, CURRENT POPULATION SURVEY, 2006 AND 2007 ANNUAL SOCIAL AND ECONOMIC SUPPLEMENTS: COVERAGE BY TYPE OF HEALTH INSURANCE: 2005 AND 2006, *available at* http://www.census.gov/hhes/www/hlthins/hlthin06/fig06.pdf. Eighteen percent of working-age women and twenty-two percent of working-age men lack any kind of health insurance. *See* HENRY J. KAISER FAMILY FOUND., STATE HEALTH FACTS, HEALTH INSURANCE COVERAGE OF WOMEN 19-64, STATES (2004-2005), UNITED STATES (2005), http://www.statehealthfacts.org/comparebar.jsp?ind=132&cat=3; HENRY J. KAISER FAMILY FOUND., HEALTH INSURANCE COVERAGE OF MEN 19-64, STATES (2004-2005), UNITED STATES (2005), http://www.statehealthfacts.org/comparebar.jsp?ind=133&cat=3.

37. *See generally* CTR. FOR MEDICARE AND MEDICAID SERVS., MEDICARE OVERVIEW, http://www.cms.hhs.gov/MedicareGenInfo/ (last visited Oct. 14, 2007) (describing the coverage of Medicare).

38. "The first person to suggest that Government health insurance be limited (at least at first) to Social Security beneficiaries was Dr. Thomas Parran of the Public Health Service, in 1937." PETER A. CORNING, THE EVOLUTION OF MEDICARE . . . FROM IDEA TO LAW CH. 4 THE FOURTH ROUND-1957 TO 1965 (1969), *available at* http://www.ssa.gov/history/corningchap4.html.

39. Throughout his presidency, President Truman pushed for national health insurance not just for the elderly, but for all Americans. In his memoirs, he wrote, "I have had some bitter disappointments as President, but the one that has troubled me most, in a personal way, has been the failure to defeat the organized opposition to a National compulsory health insurance program. But this opposition has only delayed and cannot stop the adoption of an indispensable Federal health insurance plan." HARRY S. TRUMAN, MEMOIRS BY HARRY S. TRUMAN, VOL. 2: YEARS OF TRIAL AND HOPE 23 (Doubleday & Co. 1956). Nine years after penning those words, Truman became the very first American to enroll in the Medicare program. HENRY J. KAISER FAMILY FOUND., MEDICARE: A TIMELINE OF KEY DEVELOPMENTS, *available at* http://www.kff.org/medicare/timeline/pf_entire.htm [hereinafter MEDICARE: A TIMELINE OF KEY DEVELOPMENTS].

40. *See* CORNING, *supra* note 38. "The 1950 census showed that the aged population had grown from 3 million in 1900 to 12 million in 1950, or from 4 to 8 percent of the total population. Two-thirds of these people had incomes of less than $1,000 annually, and only 1 in 8 had health insurance. Old people were long considered "bad risks" by commercial insurers, and unions had not made much headway in obtaining coverage for retired workers through employer-sponsored plans." *Id.*

seniors had "adequate" catastrophic health care insurance.[41] Although the American Medical Association and private-sector insurance conglomerates spared no expense in opposing "socialist medicine" for seniors,[42] hospitals, which were bearing most of the costs of paying for health care for uninsured seniors, supported the legislation and were instrumental in securing final passage of the federal Medicare bill.[43]

Medicare, thus, is the nation's "universal" health care program for the elderly.[44] Financed primarily by payroll deductions, general federal revenues, and insurance premiums paid by beneficiaries,[45] Medicare assures universal coverage for some kinds of health care for virtually all the nation's seniors. Individuals who have accumulated enough Social Security work credits to qualify for Social Security benefits at age sixty-two are automatically entitled to Medicare Part A hospital benefits at age sixty-five and can receive Part B medical and Part D prescription drug benefits upon enrollment and payment of appropriate

41. *Id.* at 17. "By 1964 the proportion of the aged who were privately insured for hospital care seemed to be leveling off at about 50 percent. A Senate study that year estimated that only one-half of the policies issued to retirees provided comprehensive coverage (75 percent or more of the average hospital bill). In other words, only about 1 in 4 of the aged had adequate hospital insurance protection." *Id.*

42. *See id.*

43. *See id.*

44. Medicare also covers some non-elderly individuals who have permanent disabilities or certain terminal diseases. 42 U.S.C. 1395c. "The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act (or would be eligible for such benefits if certain government employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act (or would have been so entitled to such benefits if certain government employment were covered employment under such title) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease." *Id.*

45. HENRY J. KAISER FAMILY FOUND., MEDICARE FACT SHEET: MEDICARE SPENDING AND FINANCING 2 (June 2007), *available at* http://www.kff.org/medicare/upload/7305-02.pdf.

premiums.[46] Persons sixty-five years of age and older who do not qualify for the program based on their work history may buy into Medicare upon payment of a relatively modest premium. Individuals cannot be excluded due to health conditions, as they would be under the pre-existing private insurance model.[47] Medicare also covers limited preventive care such as some cancer, cardiovascular and diabetes screening tests, and a one-time "Welcome to Medicare" physical examination.[48] Beneficiaries can purchase a standardized supplemental "Medigap" policy that covers preventive care.[49] In some circumstances, Medicare provides coverage of a relatively short (up to 100 days) stay in skilled nursing or rehabilitation facilities, provided the stay is preceded by a hospitalization of at least three days for an acute illness or injury.[50] The Part D prescription drug benefit was implemented pursuant to the provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003 to remedy Medicare's long-time failure to cover prescription drugs.[51] In 2005, Medicare covered some 35.6 million elderly beneficiaries, totaling 97% of the nation's sixty-five and older population.[52]

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46. For detailed information on Medicare's eligibility requirements and scope of coverage, *see* CTR. FOR MEDICARE AND MEDICAID SERVS., MEDICARE AND YOU 8, 10, 28 (2007), *available at* http://www.medicare.gov/publications/pubs/pdf/10050.pdf [hereinafter MEDICARE AND YOU].

47. Vicki Gottlich, *Medical Necessity Determinations in the Medicare Program: Are the Interests of Beneficiaries with Chronic Conditions Being Met?*, PARTNERSHIP FOR SOLUTIONS, Jan. 2003, at 3 [hereinafter *Medical Necessity Determinations in Medicare*].

48. *See generally* MEDICARE AND YOU, *supra* note 46 (discussing scope of Medicare coverage with respect to preventive care services).

49. CTR. FOR MEDICARE AND MEDICAID SERVS. , CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INS. FOR PEOPLE WITH MEDICARE 3 (Mar. 2007), *available at* http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf [hereinafter CHOOSING A MEDIGAP POLICY].

50. CTR. FOR MEDICARE AND MEDICAID SERVS., MEDICARE COVERAGE OF SKILLED NURSING FACILITY CARE 8 (April 2002), *available at* http://www.medicare.gov/publications/pubs/pdf/snf.pdf

51. *See* DEFICIT REDUCTION ACT OF 2005, Pub. L. No. 109-171, 120 Stat. 4 (codified as amended in scattered sections of 42 U.S.C.A.) (Westlaw current through Sept. 26, 2007).

52. NAT'L. COMM'N. TO PRESERVE SOCIAL SECURITY AND MEDICARE, FAST FACTS ABOUT MEDICARE, http://www.ncpssm.org/medicare/fastfactm/ (last visited Sept. 30, 2007).

One of Medicare's most notable features is that it pays for virtually all hospital and acute care services that are determined, by a qualified medical professional, to be "medically necessary" to the beneficiary.[53] Medical necessity standards used to determine coverage come from the Medicare statute as interpreted by CMS and its delegates in national and local coverage determinations and other policy documents.[54]

Medical necessity is a notoriously complex concept that differs in its application depending on the nature of the services to be provided. CMS has defined it to mean "services or supplies that are needed for the diagnosis or treatment of [a] medical condition and meet accepted standards of medical practice."[55] Coverage determinations are "big picture" decisions based on whether a particular therapy or treatment is a generally reasonable response to specific clinical conditions. Beneficiaries who manifest these clinical symptoms are entitled to, and often receive, all approved treatments without regard to cost-benefit analysis in their particular situations.[56] This approach has resulted in greatly increased Medicare outlays for expensive medical technology and now poses as great a threat to Medicare's long-term solvency as does the nation's aging population.[57] Medicare beneficiaries receive their benefits free of any obligation to repay the government the amount it spends on their care, even if their lifestyle or health status is such that

53. The medical necessity standard is based on the statutory prohibition of payment for services that are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a mal-formed body member." DEFICIT REDUCTION ACT OF 2005, Pub. L. No. 109-171, 120 Stat. 4 (codified as amended at 42 U.S.C.A. § 1395(y)(a)(1)(A)) (Westlaw current through Sept. 26, 2007).

54. *See Medical Necessity Determinations in Medicare, supra* note 47, at 3.

55. MEDICARE AND YOU, *supra* note 46, at 98.

56. *See Medical Necessity Determinations in Medicare, supra* note 47, at 4.

57. *See* HENRY J. KAISER FAMILY FOUND., HOW CHANGES IN MEDICAL TECHNOLOGY AFFECT HEALTH CARE COSTS (Mar. 2007), *available at* http://www.kff.org/insurance/snapshot/chcm030807oth.cfm; Karen Davis et al., *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?*, THE COMMONWEALTH FUND, Jan. 2007, at 1, *available at* http://www.commonwealthfund.org/usr_doc/Davis_slowinggrowthUShltcareexpenditureswhatareoptions_989.pdf?section=4039.

they will use more Medicare resources than the "average" Medicare recipient is expected to consume.[58]

LONG-TERM CARE – THE ORPHAN OF NATIONAL HEALTH INSURANCE PROGRAMS

Notwithstanding their general commitment to providing universal health care access, the United States' peer nations have *not* historically included long-term care in the range of their provided services. The reasons for this omission include the amorphous nature of long-term care, which encompasses components that are not strictly "medical," as well as the fact that the vast majority of long-term care in these nations (as in the United States) has always been provided to the elderly in their homes, by unpaid family caregivers. It is only in recent years, as the number of and life expectancies of elderly persons have increased while family sizes have shrunk and more women are working outside the home, that the need to re-examine the means of caring for the frail elderly, and paying for this care, has become apparent globally. Interestingly, the world's "oldest" major industrialized nations, including Japan and Germany, have both recently implemented nationally-financed social insurance programs that provide a wide variety of long-term care services to elderly individuals with self-care limitations due to physical or cognitive impairments.[59] Other nations that have had a strong commitment to social welfare and health care access are likely to follow these examples in the relatively near future.[60]

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58. *See* CONG. BUDGET OFFICE, HIGH-COST MEDICARE BENEFICIARIES 10 (May 2005), *available at* http://www.cbo.gov/ftpdoc.cfm?index=6332&type=0.

59. *See* MARTIN KARLSSON ET AL., AN INT'L COMPARISON OF LONG-TERM CARE ARRANGEMENTS 27 (Apr. 26, 2004), *available at* http://www.cass.city.ac.uk/media/stories/resources/Full_report_-_LTC.pdf.

60. For example, the Canadian Medical Association recently called for inclusion of long-term care benefits in that nation's national health insurance program. Andre Picard, *Doctors' Orders: Expand Medical Coverage to Long-Term Care*, TORONTO GLOBE AND MAIL, Aug. 21, 2007, at A5.

FINANCING LONG-TERM CARE FOR ELDERLY AMERICANS WITH DISABILITIES

The United States' Medicare program does not offer a genuine "long-term care benefit" for the disabled elderly who will need chronic or custodial care for lengthy periods.[61] This is true even though their need for such care is almost inevitably the result of identifiable medical conditions such as diabetes, stroke, or Alzheimer's disease related dementia.[62] A considerable proportion of Medicare beneficiaries will need what might be called "short term long-term care" in a skilled nursing facility or rehabilitation center, but such stays rarely last more than twenty days. Of the nation's total outlay for long-term care in 2004, Medicare accounted for only sixteen percent of total long-term care expenditures.[63] The major gap in Medicare's coverage of the health care needs of seniors remains its lack of a long-term care benefit.[64] Medicare covers very expensive treatments for acute health conditions experienced by non-disabled persons, while failing to address the health care needs of a person with long-term disabilities such as those resulting from Alzheimer's disease or post-polio syndrome, an anomoly that Professor Kaplan notes reeks of "the stench of arbitrariness."[65]

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61. Medicare has a limited home health benefit that provides payment for some types of care given to persons who return to their homes after a hospital stay of three days or more, but this benefit is not the kind of "long-term care" at issue in the long-term care financing debate.

62. In 2004, 24.7 % of elderly nursing home permanent residents had dementia, 23.7% had diabetes, 36.6% had heart disease, and 24.8% had had at least one stroke. Most such residents had multiple diagnoses. *See* JUDITH KASPER & MOLLY O'MALLEY, HENRY J. KAISER FAMILY FOUND., CHANGES IN CHARACTERISTICS, NEEDS, AND PAYMENT FOR CARE OF ELDERLY NURSING HOME RESIDENTS: 1999 TO 2004 10 (June 2007), *available at* http://www.kff.org/medicaid/upload/7663.pdf [hereinafter CHANGES IN CHARACTERISTICS].

63. CONG. BUDGET OFFICE, FINANCING LONG-TERM CARE FOR THE ELDERLY 3 (Apr. 2004), *available at* http://www.cbo.gov/ftpdocs/54xx/doc5400/04-26-LongTerm Care.pdf [hereinafter FINANCING LONG-TERM CARE FOR THE ELDERLY].

64. Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-term Care*, 11 LEWIS & CLARK L. REV. 407, 409 (2007) [hereinafter *Retirement Planning's Greatest Gap*].

65. Richard L. Kaplan, *Cracking the Conundrum: Toward a Rational Financing of*

One might ask why a health care program designed specifically for the elderly would not cover such a critical component of health care as long-term care. There are a number of reasons that Medicare lacks a long-term care benefit, most notably because its original parameters were defined by reference to the coverage offered by the typical private health insurance plan then available,[66] which did not (and still do not) include long-term care benefits. Additionally, in 1965, most skilled nursing care of the sort now offered in nursing homes, and even in assisted living facilities, was provided in long-term care wards in hospitals so that the care was actually included within the Part A benefit.[67] In 1988, a bipartisan study group known as the Pepper Commission was established to consider whether a long-term care benefit should be included in Medicare.[68] The Pepper Commission recommended adding long-term and home-health care benefits to Medicare, but the recommendation was ignored.[69] Furthermore, Medicare beneficiaries whose disabilities are severe enough that they need long-term care must find other payment sources to finance such care. At present, some access long-term care through state medical assistance programs implemented under the federal Medicaid laws and regulations.

The federal-state Medicaid program, which has been characterized as an "afterthought" to Medicare,[70] dates back to 1965. Medicaid is a social welfare program financed from

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Long-term Care, 47 U. ILL. L. REV. 1, 84 (2004).

66. Thomas A. Scully, Adm'r of Ctrs. for Medicare and Medicaid Servs., Strengthening and Improving the Medicare Program, Hearing Before the Senate Finance Committee, 108th Cong. (2003), *available at* http://www.hhs.gov/asl/testify/t030606.html.

67. Kaplan, *supra* note 65, at 83.

68. MEDICARE: A TIMELINE OF KEY DEVELOPMENTS, *supra* note 38; *See* THE PEPPER COMM., A CALL FOR ACTION: FINAL REPORT 1990 (Sept. 1990).

69. Numerous bills providing for public financing of long-term care have been introduced, and languished, since the Pepper Commission's report was published. *See, e.g.*, H.R. 1691, 103rd Cong. (1st Sess. 1993); H.R. 1200, 103rd Cong., (1st. Sess. 1993).

70. *E.g.*, Nancy De Lew, *Overview: 40th anniversary of Medicare and Medicaid*, HEALTH CARE FINANCING REV. 5, 7 (Winter 2005).

general state and federal revenues that affords access to health care for the nation's poorest citizens.[71] Only individuals at or very near the poverty level are income-eligible for Medicaid, and an applicant/recipient generally may retain only $2000 to $3000 in non-exempt assets.[72] Beneficiaries must liquidate excess assets and use them to pay for care before Medicaid assistance is available.[73] States are required to follow some federal standards in establishing Medicaid programs, but they have considerable leeway to create their own eligibility requirements and to interpret the language of Medicaid's implementing regulations in creating medical assistance programs financed in part through federal Medicaid appropriations.[74]

In every state, the range of services available to those eligible for Medicaid includes long-term care. Usually, this means chronic and custodial care offered in a skilled nursing facility or similar institution. For most of Medicaid's history, the program has had a distinct institutional bias and has not offered recipients the option of receiving long-term care in their own homes. This bias has begun to shift as a response to the Supreme Court's decision in *Olmstead v. Zimring*,[75] in which the Supreme Court affirmed the right of individuals with disabilities

71. *See* JEFFERY S. CROWLEY & RISA ELIAS, HENRY J. KAISER FAMILY FOUND., KAISER COMM. ON MEDICAID AND THE UNINSURED, Medicaid's Role for People with Disabilities 2 (Aug. 2003) (comprehensive overview of Medicaid benefits), *available at* http://www.kff.org/medicaid/upload/Medicaid-s-Role-for-People-with-Disabilities.pdf.

72. *See, e.g.*, CTR. FOR MEDICARE AND MEDICAID SERVS., MEDICAID ELIGIBILITY: OVERVIEW, *available at* http://www.cms.hhs.gov/MedicaidEligibility/; A. KIMBERLEY DAYTON, ET AL., ADVISING THE ELDERLY CLIENT, Chs. 29-30 (2006).

73. TIMOTHY WAIDMANN & KORBIN LIU, HENRY J. KAISER FAMILY FOUND., KAISER COMM. ON MEDICAID AND THE UNINSURED, ASSET TRANSFER AND NURSING HOME USE: EMPIRICAL EVIDENCE AND POLICY SIGNIFICANCE 1 (2006), *available at* http://www.kff.org/medicaid/upload/7487.pdf [hereinafter ASSET TRANSFER AND NURSING HOME USE].

74. This leeway derives both from the nature of the program itself, which contemplates state-by-state variations in the services available under the Medicaid moniker, and because there is very little accountability on the part of state administrative agencies that promulgate state rules and regulations and enforce them against a population that usually lacks the resources to challenge even clear violations of federal law. *See* Julia Belian, *State Implementation of the Optional Provisions of the Deficit Reduction Act of 2005*, 9 ELDER'S ADVISOR 63, 68-71 (2007).

75. Olmstead v. Zimring, 527 U.S. 581, 607 (1999).

to receive public benefits and services in the community if feasible. Forty-eight states and the District of Columbia have obtained a "home and community based service" waiver (sometimes called a section 1915 waiver) from federal authorities.[76] Home and community based services now account for about 37% of Medicaid's total long-term care expenditures, which is up from fourteen percent in 1991.[77] The DRA contains provisions that make it easier for states to implement systems for delivering all forms of long-term care (including custodial care) in non-institutional settings,[78] but in most states, Medicaid-financed long-term care for seniors with disabilities is still provided primarily in skilled nursing or similar facilities.

ASSET TRANSFER PENALTIES

As discussed earlier, Medicaid eligibility is based on both income and assets. Individuals seeking public benefits to pay for long-term care must apply for such benefits with the state agency responsible for administering the Medicaid program. Applicants for state medical assistance may retain no more than

76. General information on the home and community based services waiver is available *at* CTR. FOR MEDICARE AND MEDICAID SERVS., MEDICAID STATE WAIVER PROGRAM, GEN. INFO., HCBS WAIVERS - SECTION 1915(C), *available at* http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp; *See also, e.g.*, HENRY J. KAISER FAMILY FOUND., KAISER COMM. ON MEDICAID AND THE UNINSURED, MEDICAID 1915(C) HOME AND COMMUNITY-BASED SERVICE PROGRAMS: DATA UPDATE 2 (2006), *available at* http://kff.org/medicaid/upload/7575.pdf.

77. HENRY J. KAISER FAMILY FOUND., MEDICAID AND LONG-TERM CARE SERVICE 2 (2006), *available at* http://kff.org/medicaid/upload/Medicaid-and-Long-Term-Care-Services-PDF.pdf.

78. "Section 6086 [of the DRA] contains the provisions from Title II of S. 1602, the Improving Long-Term Care Choices Act, introduced by Senators Charles Grassley (R-IA), Evan Bayh (D-IN), and Hillary Clinton (D-NY) with the support of the disability community. These provisions of Section 6086 will: establish a new option for states to provide home- and community-based services (HCBS) without states needing to use a waiver process; allow states to provide any of the services now covered under HCBS waivers; and require states to establish stricter eligibility (level of care) criteria for institutional services than for community-based services. In addition, states may continue to provide services through their existing waiver programs." DISABILITY POLICY COLLABORATION, THE DEFICIT REDUCTION ACT OF 2005 P.L. 109-171 2, *available at* http://www.ucp.org/uploads/Deficit_Reduction_Act_of_2005_March_06.doc.

$2000 to $3000 in non-exempt, available assets.[79] The vast majority of elderly Medicaid applicants—historically, widows with disabilities who need long-term care in an institutional setting—are low or moderate-income individuals whose only significant asset is the equity in their homes.[80] One recent study indicated that the median net worth of Medicaid applicants, excluding home equity, is less than $24,000.[81]

The federal tax laws allow and perhaps encourage the nation's wealthiest taxpayers to make inter-generational transfers prior to death in order to reduce estate tax liability.[82] Similarly, federal Medicaid law has always permitted persons with disabilities who might face a need for long-term care to make gifts, transfer ownership of real property, and otherwise reduce the value of their non-exempt assets to meet Medicaid's asset restrictions.[83] Nevertheless, such transfers have consequences. Before 1993, transfers made within thirty months of the date of an application for state medical assistance could result in denial of benefits for a maximum of thirty months.[84] With the enactment of Omnibus Budget Reconciliation Act of

79. Assests vary somewhat by state. The laws and regulations determining what resources and assets are considered available and classifying particular kinds of assets are of dizzying complexity; a discussion of these concepts is well beyond the scope of this article. For a general overview of Medicaid's asset limits and transfer rules, see A. KIMBERLEY DAYTON, ET AL., *supra* note 71, at §§ 29:84 to 29:112.

80. *See* CHANGES IN CHARACTERISTICS, *supra* note 61, at 2.

81. U.S. GEN. ACCOUNTING OFFICE, MEDICAID LONG-TERM CARE: FEW TRANSFERRED ASSETS BEFORE APPLYING FOR NURSING HOME COVERAGE; IMPACT OF DEFICIT REDUCTION ACT ON ELIGIBILITY IS UNCERTAIN GAO-07-280 26 (Mar. 2007), *available at* http://www.gao.gov/new.items/d07280.pdf [hereinafter GAO LONG-TERM CARE].

82. *See generally, e.g.*, Melissa Street, *A Holistic Approach to Estate Planning: Paramount in Protecting Your Family, Your Wealth, and Your Legacy*, 7 PEPP. DISP. RESOL. L.J. 141 (2007) ("Estate planning encompasses a broad area of laws, from wills and trusts, to property and tax, to insurance and employee benefits. Over the years, it has become "a highly complex and specialized field in which tax and financial experts fine-tune plans to minimize taxes and maximize economic gain." Thus, what begins as the charitable intent of testators to pass gifts on to their loved ones, becomes tax-centered."(footnotes omitted)).

83. *See* A. KIMBERLEY DAYTON, ET AL., *supra* note 72, at § 29:85.

84. DEFICIT REDUCTION ACT OF 2005, Pub. L. No. 109-171, 120 Stat. 4 (codified as amended at 42 U.S.C.A. § 1396a(K)) (Westlaw current through Sept. 26, 2007).

1993 (OBRA '93),[85] such transfers, if made for less than fair market value, had the potential to subject an applicant to a period during which the applicant would be ineligible for public benefits for a much longer period.[86] Reduced to its essence, the asset transfer provisions of OBRA '93 required states to deny Medicaid benefits to otherwise eligible Medicaid applicants for a period of months equal to the ratio of the value of a transferred asset divided by a dollar amount determined by the state to reflect the average cost of nursing home care in the state.[87] The "start date" for calculating this penalty period began, under pre-DRA law, on the first day of the month following the date of the transfer.[88]

To discourage individuals with disabilities from making asset transfers, including those routinely made as part of a comprehensive estate plan (such as gifting to family members), OBRA '93 established a thirty-six month "look-back period." This obliged states to examine all transfers of assets by Medicaid applicants that occurred in the thirty-six months prior to the application date and calculate an appropriate penalty period for

85. OMNIBUS BUDGET RECONCILIATION ACT OF 1993, P.L. 103-66, 107 Stat. 312 (codified as amended in scattered sections of 7 U.S.C.A.) (Westlaw current through Sept. 26, 2007).

86. *See* A. KIMBERLEY DAYTON ET AL., *supra* note 72, at §§ 29:84 to 29:86.

87. DEFICIT REDUCTION ACT OF 2005, Pub. L. No. 109-171, 120 Stat. 4 (codified as amended at 42 U.S.C.A. § 1396p(C)(1)(b)(i)) (Westlaw current through Sept. 26, 2007). The value of this divisor varies widely among the states, but generally significantly understates the actual cost of institutional level care. In Minnesota, for example, the asset transfer penalty divisor was $4438 /month from July 2006 to July 2007. *See* Statewide Average Payment for Skilled Nursing Facility Care, http://hcopub.dhs.state.mn.us/hcpmstd/22_35.htm (last visited Sept. 30, 2007). In contrast, an independent survey of the cost of nursing home care the metropolitan Twin Cities area found the average cost of a semiprivate room in 2006 to be $191/day or $5730/ month. METLIFE MATURE MARKET INSTITUTE, LIFEPLANS, INC., METLIFE MARKET SURVEY OF NURSING HOME & HOME CARE COSTS (Sept. 2006), *available at* http://www.metlife.com/WPSAssets/18756958281159455975V1F2006NHHCMarketSurvey.pdf. Because the penalty divisor amount understates the actual cost of care even for the "average" beneficiary, the penalty period goes beyond providing a sort of restitution to the state, but actually operates to punish the disabled elder who transferred assets within the five year look-back period. As will be discussed later in this article, the punitive aspects of the asset transfer penalty are greatly magnified by the DRA.

88. 42 U.S.C.A. § 1396p(c)(1)(D)(ii) (Westlaw current through Sept. 26, 2007).

each such transfer.[89] Transfers were not cumulative; each individual transfer resulted in its own penalty consequences that began in the month after the transfer occurred.[90]

"PICKING THE BONES OF THE DISABLED ELDERLY"[91]: ESTATE RECOVERY UNDER MEDICAID[92]

One of OBRA '93's most draconian provisions was section 13612,[93] which required individual states to file so-called "estate recovery" claims against the estate of any person who received Medicaid benefits from the state prior to death.[94] For example, if a Medicaid recipient has equity in a home, the state can place a lien or assert a "notice of potential claim" against the property and enforce the lien during probate.[95] Implementation of OBRA '93's statutory mandate of estate recovery has been uneven,[96] but the value of payments recovered varies greatly among the

89. § 1396p(c)(1)(B)(i).

90. § 1396p(c)(1)(D).

91. ROGER SCHWARTZ & CHARLES SABATINO, COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, MEDICAID ESTATE RECOVERY UNDER OBRA'93, PICKING THE BONES OF THE POOR? (The American Bar Ass'n, Nov. 1994).

92. Although the Medicaid statute has always permitted states to utilize estate recovery tactics and place liens on real property owned by a beneficiary at the time of her death, prior to 1990 only twelve states had any kind of estate recovery program, and these were rarely enforced. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., MEDICAID ESTATE RECOVERY 2 (Thomson/MEDSTAT, Apr. 2005), *available at* http://aspe.hhs.gov/daltcp/reports/estaterec.pdf [hereinafter MEDICAID ESTATE RECOVERY].

93. *Id.*; 42 U.S.C.A. § 1396p.

94. "OBRA '93 requires states to recover, at a minimum, all property and assets that pass from a deceased person to his or her heirs under state probate law, which governs both property conveyed by will and property of persons who die intestate. A state's ability to recover from probate estates depends in some measure on Medicaid's standing vis-à-vis other claimants. The order of payment of debt is established under state law. Mortgages, unpaid tax or public utility bills, child support arrears, burial costs, or other debts may be paid before the Medicaid lien and reduce the amount that is actually recovered. The State's standing is also influenced by locally determined state priorities. For example, some state laws protect the family home in an estate from some or all claims against it, including Medicaid claims." *See* MEDICAID ESTATE RECOVERY, *supra* note 92.

95. *Id.*

96. Michigan has recently adopted OBRA 93's mandate. *See* MICH. COMP. LAWS § 400.112g (2007).

states.[97] Some states, such as Minnesota, have been extremely aggressive in enforcing estate recovery, going as far as to redefine fundamental concepts of property law for the purposes of Medicaid estate recovery, by treating "assets" that historically have had no value at the owner's death (such as a life estate) as having marketable worth for the sole purpose of asserting an estate recovery claim against the phantom asset.[98] Estate recovery has nothing to do with Medicaid eligibility. The victims of estate recovery are the families and heirs of persons who were legally entitled to benefits because of severe disabilities and the limited income and assets. OBRA '93's estate recovery mandate reflects a political judgment that persons with disabilities should not enjoy the benefit of "broadly held cultural values on the sanctity of intergenerational legacies."[99]

Medicaid estate recovery, as contemplated by the language of section 13612 and now enforced in most states, has no counterpart among similar taxpayer-funded programs having a limited class of beneficiaries. Medicare enrollees, for example, do not become subject to estate recovery because they (or more specifically, those who provide them with health care) tap into the Health Insurance Trust Fund and general federal revenues due to acute illnesses or injury. The parents of public school children do not become liable to pay back to the state the value of the education those children received at taxpayers' expense. Homeowners are not subject to "mortgage deduction recovery liens" that require them to repay the government the value of the tax benefits derived from the federal tax code's mortgage interest deduction they receive if they sell property that is the source of those tax benefits. Only members of our society who are disabled, those who happen to develop a disabling condition or disease in their later years, are deemed so undeserving of

97. In 2004, about $361 million was collected through the states' estate recovery efforts. This represents less than .8% of total Medicaid spending on institutional-level care in that year. These millions were paid by the family members of disabled seniors who were denied all or a portion of their inheritance. *See id.*

98. MINN. STAT. § 256B.15 (2006).

99. MEDICAID ESTATE RECOVERY, *supra* note 92, at 8.

taxpayer support that it is considered reasonable to strip their estates of any value they might have *after they die.* One can imagine the uproar that would ensue if legislators sought to ensure Medicare's future solvency through a federal estate recovery scheme. Medicaid estate recovery is tolerated not because of its inherent reasonableness, but because it pertains only to seniors with disabilities, whom politicians and voters hold in so little regard that a policy of estate recovery can be portrayed as legitimate.

WATCHING SAUSAGE BEING MADE

In the decade following OBRA '93, special interest groups such as the long-term care industry and conservative "think tanks" bent on cutting entitlement programs across the board, convinced state and federal legislators that "Medicaid millionaires" around the country, with the help of their elder law attorneys, were unethically (though legally) shifting large amounts of assets to their heirs and others in order to qualify for the Medicaid program.[100] The available empirical evidence regarding pre-Medicaid application transfers of assets belies the myth of the Medicaid millionaire. The Government Accountability Office itself has concluded that asset transfers made for the purpose of qualifying for Medicaid have virtually no impact on Medicaid expenditures.[101] One study found that

100. *E.g.*, Editorial, *Medicaid for Millionaires*, WALL ST. J., Feb. 24, 2005, at A14; JAMES R. CANTWELL, UNITED STATES HOUSE COMMITTEE ON THE BUDGET, REFORMING MEDICAID NCPA POLICY REPORT NO. 197 (Nat'l Ctr. for Policy Analysis, 1995), *available at* http://ncpa.org/studies/s197/s197.html.

101. *See* GOVERNMENT ACCOUNTING OFFICE, MEDICAID LONG-TERM CARE: FEW TRANSFERRED ASSETS BEFORE APPLYING FOR NURSING HOME COVERAGE; IMPACT OF DEFICIT REDUCTION ACT ON ELIGIBILITY IS UNCERTAIN GAO-07-280 7 (Mar. 2007), *available at* http://www.gao.gov/new.items/d07280.pdf. Despite this finding, the Ctr. for Medicare and Medicaid Svc. continues to cultivate the fallacy of self-impoverishment, maintaining on its website, "Some individuals, with assistance from financial planners and attorneys, have developed methods of arranging assets in such a way that they are preserved for the individual and/or family members, but are not countable when Medicaid eligibility is determined. Various techniques are used to artificially impoverish Medicaid applicants, including gifting of assets to family members, investing assets in financial instruments that are inaccessible, and executing financial transactions for which fair market value is not actually

only about eighteen percent of Medicaid beneficiaries transferred *any* assets prior to their admission to a nursing home and estimated the median value of pre-application transfers to be $2800.[102] Nevertheless, Congress bought into the specter of the "Medicaid millionaire"; the DRA is one result of its gullibility.

The DRA made two significant changes in the asset-transfer-penalty structure implemented through OBRA '93 whose purposes are (1) to further discourage disabled elderly persons from gifting and making other transfers at less than fair market value; and (2) to punish those who do. First, section 6011 increased the look-back period during which asset transfers were treated as suspect from three to five years.[103] More important, this section mandates aggregation of asset transfers made within the five years preceding application for medical assistance[104] and calculation of a penalty period based on the total sum of those transfers. This penalty period begins to run, not from the date that each transfer was made (or even from the date on which the most recent transfer was made), but from the later of the date of the transfer or the date on which the disabled applicant would otherwise be eligible for benefits.[105] In most cases, this means that the penalty period does not start until the person applies for, and is determined to be, income and asset eligible for benefits, and *has a need for long-term care.*

WHO REALLY PAYS FOR THE LONG-TERM CARE OF ELDERS WITH DISABILITIES?

A commonly cultivated misperception is that Medicaid is

received." CTR. FOR MEDICARE AND MEDICAID SERVS., DEFICIT REDUCTION ACT, TRANSFER OF ASSETS, *available at* http://www.cms.hhs.gov/DeficitReductionAct/10_TOA.asp.

102. ASSET TRANSFER AND NURSING HOME USE, *supra* note 73, at 5.

103. 42 U.S.C.A. § 1396p (Westlaw current through Sept. 26, 2007).

104. *Id.*

105. *Id.*

the principal source of long-term care financing for the disabled elderly.[106] This is not the case. The Congressional Budget Office estimated in 2004 that only twenty-two percent of all long-term care provided to the elderly seniors is paid for through the Medicaid program.[107] In fact, Medicare and Medicaid *combined* account for only thirty-eight percent of the nation's total long-term care expenditures for services required by disabled elders.[108] Sixty percent of long-term care costs are paid from private sources, including out of pocket expenditures by those in need of care.[109] The largest single source of financing of long-term care for the nation's seniors is not Medicaid, Medicare, or even out-of-pocket payments by those receiving care and their families (averaging about $5000/year per senior), but rather the informal, unpaid care giving provided to the elderly by their immediate and extended family members or other unpaid caregivers.[110] Most of these informal caregivers are women. Caregivers sacrifice hundreds of billions of dollars each year in income and related employment benefits as the opportunity cost of providing unpaid care to relatives. The direct contribution of informal, unpaid care giving accounted for thirty-six percent of total long-term care expenditures for the elderly in 2004.[111] One

106. On the other hand, a significant majority of seniors believe that Medicare pays for nursing home care. *See, e.g.*, THE COSTS OF LONG-TERM CARE: PUBLIC PERCEPTION VERSUS REALITY IN 2006 30 (AARP 2006).

107. FINANCING LONG-TERM CARE FOR THE ELDERLY, *supra* note 62, at 3. Long-term care accounted for 35% of total Medicaid expenditures in federal FY 2004. HENRY J. KAISER FAMILY FOUND., 2004 STATE AND NATIONAL MEDICAID SPENDING DATA TABLES 2 AND 2A, *available at* http://kff.org/medicaid/kcmu032406oth.cfm.

108. FINANCING LONG-TERM CARE FOR THE ELDERLY, *supra* note 63, at 3.

109. *Id.*

110. *Id.*; *see also* Peter Arno et al., *The Economic Value of Informal Caregiving*, 18 HEALTH AFFAIRS 184 (1999), *available at* http://content.healthaffairs.org/cgi/reprint/18/2/182.pdf.

111. FINANCING LONG-TERM CARE FOR THE ELDERLY, *supra* note 62, at 3. This estimate of the value of unpaid, informal care is based on valuing the work of caregivers at about $10/hour, which is considerably less than the actual market value of in-home long-term care. "According to the most comprehensive survey of home health costs, the average hourly charge in 2006 for homemaker services was $17.09 and $25.32 for home health aides . . . 'certified' home care providers charge even more—an average of $36.22 per hour for home health aides." *Retirement Planning's Greatest Gap*, *supra* note 62, at 412. Nor does this figure include the opportunity cost of caregiving to caregiver, future losses of pension and social

study has estimated that the availability of family caregivers saves the federal government between $257 billion annually.[112] In addition, those who have access to unpaid care giving tend to delay entering a nursing home.

Medicaid's role in financing long-term care for elders with disabilities, while significant, falls far short of the role that these elders and their families already play. By the time the average senior with a disability applies for Medicaid, he or she and family have already spent hundreds of thousands of dollars on his or her care through the value of their labor, their out-of-pocket expenditures, and the indirect loss to the caregivers of wages and benefits such as pension contributions and future Social Security payments. The pre-DRA eligibility standards for Medicaid provided means to deter these seniors from "hiding assets"; estate recovery guarantees that the state will get anything left over after a beneficiary dies. Unsatisfied with the contribution that was already being made by seniors with disabilities and their families to the national expenditures on long-term care, supporters of the DRA decided to impose additional burdens on these taxpayers. The next section contends that such a strategy is unjust.

Most feminist legal scholars would maintain that a law or legal practice might be considered just only to the extent that it does not particularly disadvantage women (as compared to men) in its application and consequences. Similarly, disability rights theorists contend that laws and policies must be ability-neutral to be legitimate.[113] As has been discussed above, this

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security benefits by caregivers, or the costs of caregiving on the caregivers' mental and physical health. When these are considered, the actual contribution of unpaid caregivers to the national economy is estimated at to be more than the entire budget of Medicare. *See, e.g.*, FAMILY CAREGIVER ALLIANCE, SELECTED CAREGIVER STATISTICS, *available at* http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=439 [hereinafter FAMILY CAREGIVER ALLIANCE].

112. FAMILY CAREGIVER ALLIANCE, *supra* note 111.

113. There are differences among feminist and disability rights scholars in the particulars of their jurisprudential claims and the remedies they would make available to rectify pervasive gender and discrimination embedded in law and policy. In this article, my goal is primarily to expose the DRA's general discriminatory character rather than propose a particular remedies (other than

nation's current long-term care financing scheme already imposes its greatest burdens on women and persons with disabilities. The lack of a long-term care benefit in Medicare means family members (spouses first, then daughters) are very likely to present the first line of defense when an older person with a severe disability can not perform essential activities of daily living. The asset transfer penalty and estate recovery work together to shift the cost of taxpayer-financed care back onto seniors and their immediate families. To the extent that the DRA transfers even greater economic, social, and emotional costs (for all of these are implicit in the DRA's key "cost-saving" measures), primarily to women or elders with disabilities, or both, the statute cannot be considered an acceptable solution to the alleged crisis it is intended to address.

Two aspects of the DRA in particular are illustrative of why the DRA is unjust from both feminist and disability rights perspectives. The first is section 6011(b), which directs states to change the start date for calculating the asset transfer penalty provision from the date of the transfer to the date on which a Medicaid applicant has "applie[d] and is otherwise eligible for" medical assistance benefits.[114] The second is section 6021,[115] which permits states to establish so-called "Long-term Care

repeal) aimed at correcting its deficiencies. For discussions of the varieties of feminist jurisprudence, see PATRICIA SMITH, FEMINIST JURISPRUDENCE (Oxford 1992). For a good summary of the principal tenets of feminist jurisprudence, see Kellye Y. Testy, *Capitalism and Freedom - for Whom?: Feminist Legal Theory and Progressive Corporate Law*, 67 LAW & CONTEMP. PROBS. 87, 94-95 (2004). For discussions of disability theory in law, see, e.g., ANITA SILVERS ET AL., DISABILITY, DIFFERENCE, DISCRIMINATION, PERSPECTIVES ON JUSTICE IN BIOETHICS AND PUBLIC POLICY (Rowman and Littlefield Publishers 1998); Theodore P. Seto & Sande L. Buhai, *Tax and Disability: Ability to Pay and the Taxation of Difference*, 154 U. PA. L. REV. 1053 (2006).

114. "In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection." *See* 42 U.S.C.A. § 1396p(c)(1)(D)(ii) (Westlaw current through Sept. 26, 2007).

115. *See* § 1396p(b).

Insurance Partnerships" with private insurance companies and in so doing privilege certain Medicaid applicants against all others in determining eligibility for state and federal benefits. For somewhat different reasons, neither of these components of the DRA can survive a feminist or disability-rights critique.

PENALTY START DATE AT DATE OF APPLICATION

As discussed earlier, Medicaid eligibility is based on both income and assets. While asset transfer penalties have applied to Medicaid applicants for many years, the DRA transforms the Medicaid penalty provision from a deterrent to a harsh, mean-spirited punishment on one particular class of elders: those with severe disabilities. This point is illustrated by comparing how the pre- and post-DRA penalty provision would operate in a particular situation.

Recall that, under OBRA '93, the asset transfer penalty period is determined by reference to individual (not cumulative) transfers, and begins to run on the first day of the month after the transfer. Suppose that Mary (age seventy-two) regularly tithed ten percent of her monthly income of $1000,[116] and made a gift on May 15 of $5000 to her grandson Tommy upon his graduation from college (from money she had received when her sister recently died). If the transfer penalty divisor in her state of residence were $4000, Mary's gift to her grandson would result in a period of ineligibility for Medicaid of 1.25 months, beginning on June 1 (or until July 8). Each gift of $100 to her church would result in a penalty period of $100/$4000, or less than one day. If Mary was neither receiving nor anticipating a need for institutional level care or Medical assistance at the time she made the transfers, and does not need it before July 8, her ultimate eligibility for program benefits will not be impaired.

116. The average annual income of a sixty-plus single woman in the United States is about $13,000/year. JANET C. GORNICK ET AL., LUXEMBOURG INCOME STUDY, OLDER WOMEN'S INCOME AND WEALTH PACKAGES: THE FIVE-LEGGED STOOL IN CROSS-NATIONAL PERSPECTIVE (2006), *available at* http://www-cpr.maxwell.syr.edu/faculty/smeeding/pdf/Older_Womens_Income.pdf.

Even if Mary already has a disability that could potentially result in a future need for long-term care, she (and her family) could effectively plan for the possibility that she will need to apply for public benefits. Mary, though she has disabilities, is not deprived of the opportunity to contribute to her church and community or support and reward a cherished grandchild. She can plan for the possibility that she will need institutional-level care, while retaining prerogatives given those who do not face a potential need for long-term care to be generous and support institutions and causes in which they believe.

In contrast, under the DRA, Mary's decision to tithe and to make a gift to her grandson will have serious consequences should her condition deteriorate to the point that she needs long-term care within the next five years. Under the amended penalty provisions of the Medicaid statute, assume Mary gives $100 a month to her church for the sixty months preceding her application for Medicaid (a total of $6000), and $2000 to each of her four grandchildren at some point during those sixty months as well. If the penalty divisor is $4000, her "transfers" of $14,000 will result in a penalty period of 3.5 months, which will begin only after approval of Mary's application for long-term care benefits. Assuming that Mary has moved into the nursing home while her application for benefits is pending, issues will likely arise regarding who can/will pay for her care during the 3.5 months in which she is ineligible for state benefits. Since the cost of care is likely to be considerably greater than the $4000 divisor used to calculate the penalty period, Mary, or her family members, will need to find some source of payment, or, more likely, attempt to provide long-term care for Mary themselves during the period that she has become ineligible for benefits.

Thus, a family that has already borne the great bulk of Mary's long-term care costs, through their provision of unpaid care giving and their payment of her out-of-pocket costs each year for many years, will spend still more due to the penalty period. Although nursing homes stand to lose much from

enforcement of the penalty,[117] Mary and her family members will ultimately pay not only the financial costs of Mary's "unethical" conduct, but also the emotional and physical costs that are inevitable if Mary is evicted from the facility for non-payment. The penalty provision deprives Mary of her personal dignity and punishes her for "irresponsible" support of her church and grandchildren. Ultimately, it sends a powerful message to persons with disabilities about the value of their contributions to our society. The position of those supporting the DRA is essentially that "Mary should have planned for this" and should be disciplined for failing to do so. It is irrelevant to the DRA's supporters that Mary and her family have already paid the vast majority of the cost of her care and that the "savings" that will result from application of the penalty start date are borne entirely by Mary and other elders with disabilities like hers.

Proponents of the revised penalty period start date note that the DRA codified a CMS policy, generally referred to as Transmittal 64, which required states to waive the Medicaid asset transfer penalty if application of the penalty would work "undue hardship"[118] on an institutionalized beneficiary. The

114. The DRA has been called "The Nursing Home Bankruptcy Act of 2006" with good reason. *See* The Coulson Law Group, *Nursing Homes and the New Medicaid Eligibility Rules*, MEDICAID PLANNING TODAY, May 2006, at 1, *available at* http://www.qualifyformedicaid.com/Newsletter_Vol2Iss3.pdf. Some sixty percent of all long-term care facilities stand to lose federal Medicaid payments as a result of the longer look back period and the application date forward principle. However, other federal laws preclude institutions from discharging a resident until an adequate discharge plan is in place. Such a plan must include alternative living and/or long-term care arrangements. When a resident has few or no resources available to pay for care, the facility may find itself without a speedy means to discharge the resident; when discharge does occur, it tends to be to a hospital emergency room or other facility not equipped to provide long-term care.

118. In November 1994, the Health Care Financing Administration (CMS's nominal predecessor) issued a policy statement referred to as "Transmittal 64." Transmittal 64 was intended to amplify OBRA '93's directives pertaining to liens, transfers, and estate recovery. To that end, it directed states to develop, describe in their State Medicaid Plans, and implement hardship waiver procedures pertaining to asset transfers, as follows:

> Undue Hardship Defined.--Undue hardship exists when application of the transfer of assets provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue

hardship exemption, it is suggested, provides a safety net for persons such as Mary who may have made prohibited transfers not knowing of the long-term consequences of their actions. Unfortunately, it is unlikely that the DRA's hardship provision will offer significant relief to individuals who are similarly situated to Mary. The Medicaid statute contains a presumption that all asset transfers are presumed to have been made for the purpose of qualifying for Medicaid. The states have been zealous in their allegiance to that presumption, some going as far as to re-codify it in state law. It is virtually impossible to identify the standards that states are using to administer the hardship waiver provision; as noted, decisions concerning Medicaid eligibility are usually made at the county level by state employees who have very little accountability for their actions. It may be safe to speculate, however, that the states' position on transfers of any kind made by persons with disabilities is that the hardship waiver cannot apply to such transfers inasmuch an elderly person who has a manifest disability should expect to need long-term care and should be saving her assets, not giving them away. The only individuals who are likely to have any chance of benefiting from the hardship waiver are persons who have neither symptoms of a disabling disease, or known risk of developing a severe disability, such as a completely healthy person who experiences an acute condition such as a brain stem

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> hardship also exists when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life. Undue hardship does not exist when application of the transfer of assets provisions merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him/her at risk of serious deprivation.

Health Care Fin. Admin., Transmittal No. 64 (Nov. 1994), *available at* http://www.elderlawanswers.com/resources/documents/Transmittal64Sec3258.pdf.

The DRA codified this aspect of Transmittal 64, but does not articulate particular criteria to be used in evaluating "hardship." See id. Because the Medicaid statute contains a presumption that any uncompensated transfer made during the applicable look-back period was made for the purpose of obtaining Medicaid eligibility, hardship waivers were rarely granted under Transmittal 64, and there is no evidence suggesting that states are being more generous after enactment of the DRA.

stroke or a traumatic brain injury. For the most part, such a standard will exclude the vast majority of seniors from consideration for the hardship waiver.

In short, the new penalty provisions of the DRA create a punitive restriction on access to publicly financed long-term care that applies only to seniors with disabilities. This select group, which already bears most of the explicit and implicit costs of long-term care, is now accountable for another six billion dollars. At the same time, pharmaceutical companies are receiving billions in federal taxpayer subsidies in connection with the Medicare Part D benefit. Such an approach to long-term care financing "reform" is unacceptable.

LONG-TERM CARE PARTNERSHIPS UNDER THE DRA

> [L]ong-term care insurance is not like Medicare, which accepts all enrollees who meet its age and work experience requirements. Instead, long-term care insurance is a private market product and therefore subject to whatever medical underwriting criteria that a private insurer wishes to employ to limit its cost exposure.[119]

One highly touted provision of the DRA is its codification of the prerogative of states to allow asset sheltering by persons who purchase qualified long-term care insurance policies. Unlike other aspects of the DRA, the long-term care partnerships contemplated by the DRA will not save taxpayers anything for the near future. The Congressional Budget Office estimates that the long-term care partnership provision of the DRA will actually *cost* taxpayers eighty-six million dollars over the next ten years.[120] The DRA confers its asset-sheltering benefit only on persons who can and do buy long-term care insurance. Because this benefit is not available on a non-discriminatory basis, this aspect of the DRA must also be considered unjust.

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119. *Retirement Planning's Greatest Gap*, *supra* note 64, at 436.

120. S. 1932, DEFICIT REDUCTION ACT OF 2005, *supra* note 4, at 36.

A BRIEF OVERVIEW OF THE LONG-TERM CARE INSURANCE INDUSTRY[121]

Long-term care insurance (LTCI) is a relatively new insurance product. There are nearly 200 licensed companies in at least one state to sell policies, but the market is highly concentrated–six companies control more than seventy percent of the market based on premiums paid.[122] In the early days of its marketing LTCI was significantly under-priced and not sufficiently "exclusive."[123] Not surprisingly, rates have gone up precipitously in recent years, and insurers and underwriters vigorously pre-screen potential applicants. Recent reports in the popular press suggest that some companies are denying as many as one in four LTCI claims made against older policies, and in May of this year, the industry became the subject of a congressional investigation due to news stories in the popular press reporting that some insurers were routinely denying legitimate claims.[124]

LTCI policies can vary widely in terms of the benefits offered and other factors. Differences among policies include the aggregate amount of the benefit, whether it is paid daily, monthly, or as an accumulated benefit, what event(s) will trigger entitlement to the policy benefit, the elimination period,[125] whether home or assisted living care is covered by the policy,

121. *See, e.g., Retirement Planning's Greatest Gap, supra* note 64, at 430-47.

122. Alfred Clapp, Jr., *Long-term Care Insurance,* THE CPA JOURNAL (Sept. 2003), *available at* http://www.nysscpa.org/cpajournal/2003/0903/features/f094003.htm.

123. *See, e.g.,* Sara Hansford, *Obama, Clinton call for investigation into LTC abuses,* INVESTMENT NEWS, Apr. 16, 2007, *available at* http://www.investmentnews.com /apps/pbcs.dll/article?AID=/20070416/FREE/70412010/-1/INIssueAlert04.

124. Large employers shopping for group policies presumably have access to somewhat better information for purposes of comparing policy costs and benefits.

125. The elimination period is the number of days of long-term care that must be paid for from other sources before the policy begins to pay–typically, ninety days. Only 1.4% of persons aged sixty-five to seventy-four and 6% of persons aged seventy-five to eighty-four will stay in a facility more than ninety days. MONTANA DEP'T OF INS., LONG-TERM CARE INSURANCE GUIDE 2, *available at* http://sao.mt. gov/seniors/GuideLongTermCare.pdf.

and whether and how much inflation protection is offered.[126] Policies sold in the 1990s rarely covered care provided elsewhere than in a skilled nursing facility, but nowadays a broader array of benefits may be available–for a price. Premiums vary significantly among policies, and it can be difficult to be an informed consumer when considering what policy to buy.[127] Companies do not make rate information readily available in a form that facilitates comparison-shopping by potential individual applicants.[128]

Employer-sponsored group policies, which are an option for just six percent of American workers,[129] are less expensive than policies available to individuals. Thus, a healthy fifty-five year-old state employee who has access to group long-term care insurance plan might expect to pay about $2400 annually for a policy offering a $200/day, inflation-protected benefit for three years.[130] A similarly situated individual buying a policy might have a premium that is 50% to 100% more. Pricing estimates

126. For good discussions of the vagaries of a long-term care insurance policy that will affect the premium, see *Retirement Planning's Greatest Gap, supra* note 64; NAT'L ASS'N OF INS. COMM'RS, CONSUMER ALERT: LONG-TERM CARE INSURANCE.: WHAT YOU SHOULD KNOW, *available at* http://www.naic.org/documents/consumer_alert_ltc.htm.

127. *See, e.g.*, FED. CONSUMER INFO. CTR., GUIDE TO LONG-TERM CARE (LTC) INSURANCE 5, 7 (2004), *available at* http://www.pueblo.gsa.gov/cic_text/health/ltc/guide.htm: "In 2002, a policy offering a $150 per day long-term care benefit for four years, with a ninety-day deductible, cost a fifty year old a national average of $564 per year. For someone who was sixty-five years old, the national average cost was $1,337, and for a seventy-nine year old, the national average cost was $5,330. The same policy with an inflation protection feature cost, on average nationally, $1,134 at age fifty, $2,346 at age sixty-five, and $7,572 at age seventy-nine. Please note that these are only national averages. The cost of long-term care varies significantly by state. For the cost of care and coverage in your area, check with a representative of a long-term care insurer, an insurance agent, or financial adviser." *See also, Beware of Long-term Care Insurance Cost Comparisons,* PR NEWSWIRE/INSURANCE NEWS NET, Jun. 2007, http://www.send2press.com/newswire/2007-06-0613-003.shtml (last viewed Sept. 17, 2007).

128. *See Retirement Planning's Greatest Gap, supra* note 64, at 449-50.

129. INS. INFO. INST., FACTS AND STATISTICS: LONG-TERM CARE INSURANCE, http://www.iii.org/media/facts/statsbyissue/longtermcare/ (last visited Oct. 11, 2007).

130. This estimate is based on the on-line LTCI rate estimator made available to California state employees who are part of the California Public Employee Retirement System. *See* Long-Term Care Monthly Rates Calculator, http://www.calpers.ca.gov/jasper.mi/ltc-rates/ltccalculator.jsp.

from publicly available sources are generally based on industry data that are several years old. In short, it is nearly impossible to articulate an "average" monthly or cost for long-term care insurance.

Policies that contain inflation protection are almost twice as expensive as those without it. A carrier can usually increase rates on existing policies for all members of a "class" of insureds when such an increase is reasonable, as determined by the state regulatory agency.[131] Loss ratios (the percentage of total premiums collected that are paid out to policyholders who collect on their policies) appear to be substantially lower than in other sectors of the insurance market.[132] The need for the type of services typically insured by a long-term care policy does not generally arise until the policyholder moves well into old age and develops disabilities requiring a relatively intense level of chronic or custodial care.

HISTORY OF THE "PARTNERSHIP" CONCEPT

The DRA's long-term care insurance partnership provisions are modeled after a demonstration program originally funded by the Robert Wood Johnson Foundation and approved by the Health Care Financing Administration (CMS's predecessor).[133]

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131. *See* Mila Kofman & Lee Thompson, *Issue Brief: Consumer Protection and Long-term Care Insurance: Predictability of Premiums*, GEORGETOWN UNIVERSITY LONG-TERM CARE FINANCING PROJECT 3, 5 (March 2004), *available at* http://ltc.georgetown.edu/pdfs/consumer.pdf.

132. Industry-wide loss ratios for long-term care insurance are about 59%. *See* Judith Feder, Harriet L. Komisar, & Robert B. Friedland, *Long-Term Care Financing: Policy Options for The Future* (June 2007) http://ltc.georgetown.edu/forum/ltcfinalpaper061107.pdf. Loss ratios on traditional health insurance typically range as high at 89%. *See* Statement of N.Y. State Ins. Dept. before N.Y. State Senate Standing Comm't on Insurance, April 15, 2003, Testimony by Gregory V. Serio, Super. of Ins. N.Y. State Ins. Dept., http://www.ins.state.ny.us/speeches/pdf/ty030415.pdf.

133. ROBERT WOOD JOHNSON FOUND., PROGRAM TO PROMOTE LONG-TERM CARE INSURANCE FOR THE ELDERLY, GRANT RESULTS (updated July 2007), *available at* http://www.rwjf.org/reports/npreports/elderlye.htm [hereinafter PROGRAM TO PROMOTE LTCI]; ALLIANCE FOR HEALTH REFORM, LONG-TERM CARE PARTNERSHIPS: AN UPDATE (Mar. 2007), *available at* http://www.allhealth.org/publications/Long-term_care/Long_Term_Care_Partnerships_53.pdf [ALLIANCE FOR HEALTH REFORM].

In 1987, the Foundation awarded grants for long-term care partnership pilot projects in California, Connecticut, Indiana, and New York.[134] The purpose of the pilots was to determine if consumers would purchase long-term care insurance if assured that the purchase of such insurance would allow them to shelter assets from the reach of state medical assistance administrators. The first partnership policies were sold in 1992.[135] In 1993, HCFA placed a moratorium on other state partnership programs until the results of the pilot programs could be assessed.[136]

Between 1992 and 2006, almost 250,000 partnership policies were sold in the four pilot states.[137] Of these, about eighty percent were in force in mid-2006; the remainder had lapsed due to non-payment of premiums, death of the policyholder, or for other reasons.[138] Over that fourteen year period, fewer than two percent of these policyholders (3822) accessed their long-term care benefits.[139] Perhaps more important, only 175 policy holders (two percent of those who were able to use their policies to pay for long-term care) had *both* exhausted their long-term care insurance benefit *and* gone on to qualify for Medicaid.[140] That is, of all the long-term care insurance partnership policies sold in the pilot states, only .0008% reaped the purported

134. *See* U.S. GEN. ACTG. OFFICE, LONG-TERM CARE INSURANCE: PARTNERSHIP PROGRAMS INCLUDE BENEFITS THAT PROTECT POLICYHOLDERS AND ARE UNLIKELY TO RESULT IN MEDICAID SAVINGS GAO-07-231 1 (May 2007), *available at* http://www.gao.gov/new.items/d07231.pdf [hereinafter GAO PARTNERSHIP PROGRAMS].

135. ROBERT WOOD JOHNSON FOUND., LONG-TERM CARE INSURANCE: CONNECTICUT'S PUBLIC-PRIVATE PARTNERSHIP HAS STEADY GROWTH (Jan. 2007), *available at* http://www.rwjf.org/pr/product.jsp?id=18002&topicid=1094.

136. *See generally* HEALTH CARE FIN. ADMIN., MEDICARE HOME HEALTH MORATORIUM IS LIFTED: NEW RULES AND PROCEDURES ESTABLISHED TO STOP FRAUD AND ABUSE (Jan. 1998), *available at* http://www.hhs.gov/new/press/1998pres/980113a.html (explaining that moratorium's were going to be lifted).

137. GAO PARTNERSHIP PROGRAMS, *supra* note 134, at 18.

138. LTCI is a "lapse driven" type of insurance–that is, companies expect to reap a significant portion of their profit from premiums paid by persons who allow the policy to lapse before they ever collect a benefit. *See* John L. Timmerberg, *Improving the Profitability of In-Force, Long-Term-Care Insurance. Policies*, CONTINGENCIES, Sept.-Oct. 2005, http://www.contingencies.org/sepoct05/Tradecraft_0905.asp (last visited Sept. 15, 2007).

139. ALLIANCE FOR HEALTH REFORM, *supra* note 133.

140. *Id.*

"advantage" offered by partnership policies of sheltering assets from the reach of the Medicaid program. In other words, some ninety-eight percent of those who bought long-term care insurance policies under the auspices of a LTCP never needed their policies or have yet to access them, and 99.9992% of them either never applied for Medicaid or were otherwise ineligible for it despite their purchase of a policy that allowed them to exclude substantial amounts of assets. Long-term care insurers collected billions in premiums on these taxpayer-subsidized policies. A study sponsored by the Robert Wood Johnson Foundation concluded that seventy percent of those who purchased Partnership Policies would have done so even without the promise of asset protection.[141]

It is against this backdrop that a variety of special interest groups led by the long-term care industry[142] persuaded Congress to authorize all fifty states to implement partnerships through the DRA.[143] Section 6012 permits the states to allow persons who have bought "qualified" long-term care insurance policies, and thereafter exhaust their benefits paying for long-term care, to shelter assets of significant value and still become eligible for Medicaid.[144] Specifically, an individual who

141. PROGRAM TO PROMOTE LTCI, *supra* note 133, at 8.

142. The long-term care industry has characterized the Partnership provisions of the DRA as "a gift from Uncle Sam." Victorson Assocs., Inc., Finally...A Gift from Uncle Sam, http://www.victorson.com/ltc/Medicaid%20Planning%20is%20Dead.htm (last visited Oct. 13, 2007).

143. For general information on the DRA's LTCP provisions, see CTR. FOR MEDICARE AND MEDICAID SERVS., BACKGROUND ON LONG-TERM CARE PARTNERSHIPS, *available at* http://www.cms.hhs.gov/DeficitReductionAct/Downloads/BackgrounderPartnership.pdf; CTR. FOR MEDICARE AND MEDICAID SERVS., DEFICIT REDUCTION ACT, LONG TERM CARE PARTNERSHIPS, *available at* http://www.cms.hhs.gov/DeficitReductionAct/09_LTCPartnerships.asp#TopOfPage

144. While many provisions of the DRA impose mandatory obligations on the states, the Long-term Care Partnership provision is optional. To effect a state Partnership, the state must amend its state Medicaid eligibility requirements to incorporate Partnership asset exemptions and obtain CMS approval of the amended plan. Insurance is regulated primarily at the state level, and state insurance laws and regulations may also be in need of modification before policies can be sold under the auspices of the Partnership. For example, the state must develop internal regulatory standards that comply with certain minimum standards for LTCI partnership policies established in the DRA and its implementing regulations (which are extremely minimal), and with the state's own insurance laws and

purchases a qualifying long-term care insurance policy and then later applies for Medicaid may exempt assets up to the value of the long-term care benefit her policy encompasses in determining the total value of her countable assets for purposes of determining Medicaid eligibility. Thus, an individual who buys a qualified Partnership policy that assures a $200,000 long-term care benefit may exclude $200,000 in assets (rather than only $2000 in assets) in addition to those assets already treated as exempt or within allowable limits for purposes of calculating the applicant's total assets and spend-down when she applies for Medicaid at some remote future date. The value of these assets is also off-limits from estate recovery. In essence, states implementing this aspect of the DRA "reward" those who buy long-term care policies with special privileges with respect to retention of personal assets in the event they live long enough and are poor enough to need Medicaid at some point in the future.[145] This privilege supplements the tax benefits and other advantages that states and the federal government have already implemented to encourage purchase of such policies.[146] Advocates of the DRA's long-term partnership provisions claim that the program will save billions in Medicaid costs over the next ten years.[147]

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regulations *See, e.g.*, S.D. ADMIN. R. 20:06:21:02 (2002).

145. Many details of the Partnerships have yet to be worked out–among them, portability of policies (that is, whether a Partnership policy purchased in one state will entitle the beneficiary to the asset exemption in a different state) and what measure of inflation protection individual states will mandate. To some extent, these problems make it unlikely that LTCP policies will be available at all in many states.

146. For example, the proceeds of a long-term care insurance policy are not treated as income, and in most states, persons who buy long-term care insurance are entitled to tax benefits such as deductions or credits for a portion of the premium cost. *See* David Nixon, *State Programs to Encourage Long-term Care Insurance, Policy Paper #001*, UNIVERSITY OF HAWAII AT MANOA, COLLEGE OF SOCIAL SCIENCES PUBLIC POL'Y CTR. 1 (Nov. 2006), *available at* http://www.publicpolicy center.hawaii.edu/documents/paper001.pdf.

147. As of late May 2007, at least twenty states had LTCPs or had taken the first steps towards amending their state plans to allow for them. *See* Long Term Care Partnership, http://www.dehpg.net/LTCPartnership/map.aspx (last visited December 18, 2007). These include four states–California, Connecticut, Indiana, and New York–that were involved in a federally-authorized, privately funded pilot program that began in the early 1990s, and at least twenty others that have obtained

INEQUITIES OF THE LTCP PROGRAM

As noted, federal and state officials are working closely with industry representatives to promote the sale of Partnership Policies. Arguably misleading statistics[148] scare laypersons into thinking they need LTCI no matter what it costs. Tax revenues are being used to support advertising campaigns that inure directly–and almost exclusively–to the benefit of the insurance industry. In truth, long-term care insurance products are not available at all to the majority of older Americans for two principal reasons. First, increasingly strict underwriting standards make LTCI products *completely off-limits* to persons who have a disability or are statistically likely to become disabled. Employer sponsored group LTCI is a rarity, and is exempt from federal requirements prohibiting discrimination by health insurers based on pre-existing conditions.[149] Second, LTCI is expensive and therefore not within the means of most middle class Americans, many of whom cannot afford basic health care insurance, much less long-term care policies. Women in particular are unable to afford such policies, and are more likely to be disqualified from purchasing them because of their higher risks of developing conditions that are deemed uninsurable.

CMS approval of state plan amendments and intend to roll out their programs by the end of 2007. *Id.* "Fast track" states that anticipate entering into Long-term Care Partnerships before the end of 2007 include Arkansas, Colorado, Florida, Georgia, Idaho, Maryland, Michigan, Minnesota, Mississippi, Nebraska, Oklahoma, Pennsylvania, South Dakota, Texas, and Virginia. For background information on the pilot LTCPs, see, e.g., ALLIANCE FOR HEALTH REFORM, *supra* note 132; AARP PUBLIC POLICY INST., FACT SHEET: LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAMS (2006), *available at* http://assets.aarp.org/rgcenter/il/fs124_ltc_06.pdf.

148. *See, e.g.*, ASSOC. OF HEALTH INS. ADVISORS, CONSUMER INFORMATION: LONG-TERM CARE GUIDE (2006), *available at* http://www.ahia.net/consumer/guide_ltc.html#likely [hereinafter CONSUMER INFORMATION: LONG-TERM CARE GUIDE].

149. For general discussions of the federal laws and regulations governing the employer-sponsored group health insurance, see, e.g., U.S DEP'T OF LABOR, AN EMPLOYEE'S GUIDE TO HEALTH BENEFITS UNDER COBRA (reprinted Sept. 2006), *available at* http://www.dol.gov/ebsa/pdf/cobraemployee.pdf; U.S. DEP'T OF LABOR, FACT SHEET: THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (Dec. 2004), *available at* http://www.dol.gov/ebsa/newsroom/fshipaa.html.

MYTHS ABOUT THE LONG-TERM CARE PARTNERSHIP PROGRAM

At first blush, the LTCP seems to be a reasonable tradeoff: states and the federal governments will achieve cost savings because large numbers of middle class taxpayers will purchase long-term care insurance that will cover their long-term care expenses, thus reducing their need to take Medicaid benefits away from the truly needy. Virtuous taxpayers–those who have both the foresight and the integrity to purchase their own long-term care insurance—will "own their futures"[150] and obtain privileges that are not available to less-responsible citizens. Joint promotional efforts by federal and state officials working closely with industry representatives have created the impression that everyone can and should buy long-term care insurance to avoid future impoverishment and ensure access to public benefits in the event that taxpayers need long-term care.

Unfortunately, the government's involvement in the marketing of LTCP insurance lends legitimacy to an industry that routinely misleads consumers and profits from legal discrimination against persons with disabilities and women. For example, insurance companies cite vague statistics[151] to scare

150. *See generally* CTR. FOR MEDICARE & MEDICAID SERVS., OWN YOUR FUTURE: PLANNING GUIDE FOR LONG-TERM CARE 3-7, 15-20, *available at* http://www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Campaign/Kit/index.aspx [hereinafter OWN YOUR FUTURE]. The overarching thrust of the "Own Your Future" campaign is that individuals should plan for their potential future need for long-term care by purchasing long-term care insurance policies in the private market.

151. *See, e.g.*, "More than half of the U.S. population will require some type of long-term care during their lives-nursing home care, home health care, assisted living facility care, or rehabilitation facility care. One out of five Americans over the age of fifty is at risk of needing [long-term care] in the next 12 months." CONSUMER INFORMATION: LONG-TERM CARE GUIDE, *supra* note 147. While it is true that "more than half" of all persons now living will require some type of care in a nursing home, the vast majority of these will need what I have dubbed "short-term long-term care" that is currently reimbursed through the Medicare program. Astonishingly, the federal government itself is involved in similar questionable marketing tactics. *See, e.g.*, U.S. DEPT. OF HEALTH AND HUMAN SERVS., NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION, *available at* http://www.longtermcare.gov/LTC/Main_Site/index.aspx [hereinafter NATIONAL CLEARINGHOUSE]: "[A]t least 60 percent of people over age 65 will require some long-term care services at some point in their lives. And, contrary to what many people believe, Medicare and private health insurance programs do not pay for the majority of

laypersons into thinking they need LTCI no matter what it costs. Whether these efforts will result in increased sales of the product is debatable, as the pilot programs suggest. But a far more important criticism of the partnerships is that long-term care insurance products are not available at all to those who are most likely to need them–persons with disabilities, and older women who lack both the resources and the "qualifications" that will enable them to purchase long-term care insurance. As discussed above, this is because increasingly strict underwriting standards make LTCI products off-limits to persons who have a disability or are statistically likely to become disabled, and because LTCI is expensive and therefore not within the means of most middle class Americans. Employer sponsored group LTCI, still expensive but somewhat less so than individual policies, is a rarity, and is exempt from federal requirements prohibiting discrimination based on pre-existing conditions.

THE DRA DOES NOT REQUIRE THAT LTCI BE AVAILABLE TO ALL

I contend that the Long-term Care Partnership as a Medicaid cost-saving device is just only to the extent that it creates a benefit available to all taxpayers irrespective of gender or disability. Neither the DRA nor the state mechanisms now being designed to implement and promote the partnerships impose any mandate on the industry to sell policies to particular persons. State laws regulating the sale of long-term care insurance, including Partnership policies, do not prohibit discrimination against persons with disabilities by LTCI sellers and underwriters. Federal laws that forbid discrimination against persons with pre-existing conditions in group health insurance do not apply to long-term care policies.[152] Almost

long-term care services that most people need - help with personal care such as dressing or using the bathroom independently." *Id.*

152. As one article on the tax benefits of LTCI for "business owners and key executives" put it, "HIPAA Legislation in 1996 created generous incentives for business owners to purchase LTCI for themselves, [their] spouses and/or their key executives . . . discrimination ('carve out') is allowed." Steve Cain, *Long-Term Care Planning: Tax Advantages for Business Owners and Key Executives*, TODAY'S ENGINEER

universally, underwriting standards preclude the sale of LTCI policies to persons with even the most minor of disabilities. This is not simply a matter of setting higher premiums for those who have an identifiable condition that could result in a need for long-term care at some future date. Rather, companies simply *will not insure* disabled persons. Indeed, Professor Kaplan noted recently that some twenty-five percent of all persons sixty-five and older (who have a disability) are not eligible for LTCI under current medical underwriting requirements.[153]

Most older individuals who require institutional-level long-term care have one of three conditions: Alzheimer's disease, diabetes, or disabilities resulting from a stroke.[154] Coincidentally, a person who has experienced any one of these is categorically ineligible to purchase LTCI:

> This list of *uninsurable conditions* has been created to assist you with prescreening prior to referring a proposed insured to a Long-term Care Insurance Specialist. Do not refer anyone who currently: (1) requires assistance with any one of the six activities of daily living (bathing, dressing, feeding, toileting, continence, transferring from bed to chair); (2) requires assistance with any basic activity of daily living (e.g. grocery shopping, use of transportation, use of telephone, banking); (3) uses care services (e.g. home health, nursing home or adult day care); [or] (4) uses a walker, multi-pronged cane, crutches, or wheelchair.[155]

Agents are also warned not to refer anyone who has or has

ONLINE, May 2006, *available at* http://www.todaysengineer.org/2006/May/LTC.asp.

153. *Retirement Planning's Greatest Gap, supra* note 64, at 436.

154. *See* CHANGES IN CHARACTERISTICS, *supra* note 62.

155. Sun Life Financial, Sun Long-Term Care Insurance - Underwriting overview for referring partners, http://tinyurl.com/23m3xk (last visited Oct. 21, 2007) [hereinafter Sun Life Financial]. "Your health does not have to be perfect to purchase long-term care insurance; however, there are certain health conditions and combinations of health conditions that can cause you to be uninsurable. Sample of Uninsurable Conditions: Alzheimer's Disease, Parkinson's, Multiple Sclerosis, Dementia, Stroke, Cirrhosis of the Liver, Congestive Heart Failure, Diabetes with complications, AIDS, current limitations with activities of daily living, use of walker, wheelchair or quad cane, Muscular Dystrophy, oxygen use, severe arthritis limiting activities." *See also, e.g.*, AM Warner Insurance, Do You Even Qualify for Long-term Care Insurance?, http://www.amwarnerinsurance.com/do_you_qualify.html (last visited Oct. 21, 2007).

ever had, AIDS or HIV infection, Alzheimer's disease, amyotrophic lateral sclerosis (ALS), cystic fibrosis, dementia, diabetes, hemophilia, hepatitis (C, non-A, non-B, or autoimmune), kidney failure, liver cirrhosis; memory loss, multiple sclerosis, muscular dystrophy, paralysis, Parkinson's disease, post polio syndrome, schizophrenia, sickle cell anemia, or lupus.[156] Individuals with a history of alcohol or drug abuse, or individuals who have had a recent heart attack or stroke, are also usually precluded from obtaining coverage.[157]

Not a single state in the country has a long-term care insurance high-risk pool that makes coverage available to those who are unable to obtain it in the private market. In short, persons with disabling conditions or even a family history of diseases will not be able to buy LTCI policies (even though they and their families are paying taxes to support the federal and state governments' promotion of the Partnerships). This market reality particularly affects women and minorities, who are more likely than white males to have or develop disqualifying conditions such as Alzheimer's, diabetes, and cardiovascular disease and are significantly more likely to need long-term care during their lifetimes.[158] Even assuming that the LTCI will cut Medicaid costs substantially over the long haul–a doubtful proposition at best–is such a policy one that taxpayers should be required to support financially? Is it one that our state officials should be permitted to promote as special agents for the private insurance industry? To the extent that long-term care insurance is a solution to an impending crisis in the long-term care arena, such insurance should be available without regard to existing disability, a la Medicare or group health insurance-given tax preferences under ERISA.

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156. Sun Life Financial, *supra* note 155.

157. *Id.*

158. *See* ALZHEIMER SOCIETY, ALZHEIMER'S DISEASE: CAUSES OF ALZHEIMER'S DISEASE 4, *available at* http://www.alzheimer.ca/english/disease/causes-riskfac.htm: "Twice as many women get Alzheimer's disease than men. This is partly due to their living longer than men on average, partly because women are more prone than men to get diabetes, but also in large part because in post-menopausal women there is a decline of the important hormone estrogen." *Id.*

LTCI IS TOO EXPENSIVE FOR MOST WOMEN

As noted, it is very difficult to estimate an otherwise qualified (that is, healthy, non-disabled) individual's expected cost of long-term care insurance in either the short or long runs. LTCI was originally under-priced and oversold; as a result, LTCI rates have been increasing at an extraordinary rate in the last few years. In California, state employees were shocked when notified of a thirty-four percent rate increase in the average CalPERS long-term care insurance policy premium.[159] The full impact of such rate increases on the cost of long-term care insurance policies is almost impossible to know, but it is clear that historical "averages," such as those set out the federal government's "Own Your Future" website (the goal of which is to encourage the purchase of private long-term care policies),[160] understate the current and future costs of these policies.

What we do know is that women are far less likely to have the means to buy LTCI. Data available from the original Partnership program indicate that most participants in the program were married couples having incomes substantially higher than the national average.[161] Women, particularly divorced women and widows, have virtually no "surplus" income. The median income of working women ages fifty-five to sixty-four (the age at which most financial advisors recommend purchase of long-term care insurance) is $20,810,

159. The CalPERS Board of Trustees said that these rate increases were the result of a number of factors, including that policyholders were "collecting benefits earlier and using them longer. Claims volume has doubled over the last three years. Program lapse rates have been less than anticipated. Significantly more members have chosen plans with built-in inflation protection." *See* CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM, MEMBER INFORMATION, LONG-TERM CARE, Q&A: CALPERS LONG-TERM CARE PROGRAM RATE INCREASE 1, *available at* http://www.calpers.ca.gov/eip-docs/member/ltc/ltc-rate%20increase-faqs%20pdf%20file.pdf.

160. *See* NATIONAL CLEARINGHOUSE, *supra* note 151.

161. "Partnership and traditional long-term care insurance policyholders tend to have higher incomes and more assets at the time they purchase their insurance, compared with those without insurance. In two of the four states, more than half of Partnership policyholders over 55 have a monthly income of at least $5,000 and more than half of all households have assets of at least $350,000 at the time they purchase a Partnership policy." GAO PARTNERSHIP PROGRAMS, *supra* note 134.

which is about half that of men of the same age.[162] The median annual income of Medicare eligible women is only $12,000, also about half that of elderly men.[163] The demographic make-up of existing long-term care policy holders does not appear to be available from either industry or government sources, but it is safe to assume that the vast majority of current owners are men. The notion that long-term care insurance is a viable solution to most women's greater lifetime risk of needing long-term care borders on the ridiculous.

In summary, the LTCP is a government-sponsored program that will make a significant public benefit available to only a particular group of Americans–upper middle class persons, mostly males, who are fortunate enough not to have experienced any physically or cognitively disabling health conditions. Viewed through this lens, the program cannot survive a feminist or disability-rights critique. Even if the Partnerships have the potential to save Medicaid significant sums twenty or thirty years from now, which does not appear likely, this aspect of the DRA must be rejected as a means of protecting public benefits for the "truly needy."

CONCLUSION: TOWARDS NON-DISCRIMINATORY FINANCING OF LONG-TERM CARE

There is no question that this nation needs to look closely at the means by which long-term care for elders with disabilities–indeed, all heath care, for everyone–is financed. Many options for restructuring the financing of long-term care for the elderly are available–including adding a long-term care benefit to Medicare or following the leads of Japan and Germany in creating a separate social insurance program to provide long-

162. U.S. DEP'T OF LABOR, WOMEN'S BUREAU, QUICK FACTS ON OLDER WORKERS, OLDER WOMEN WORKERS, AGES 55 AND OVER, *available at* http://www.dol.gov/wb/factsheets/Qf-olderworkers55.htm.

163. ELLEN O'BRIEN, GEORGETOWN UNIVERSITY LONG-TERM CARE FINANCING PROJECT, MEDICAID'S COVERAGE OF NURSING HOME COSTS: ASSET SHELTER FOR THE WEALTHY OR ESSENTIAL SAFETY NET? 4 (May 2005), *available at* http://www.canhr.org/reports/nursinghomecosts.pdf.

term care for older Americans. These will require additional taxes and may involve some general cost-shifting back to consumers who use government-financed health care services. But such cost-shifting should impact everyone, not just the elderly and disabled.

The DRA's solution to a crisis (that at the moment is largely manufactured) entailing the shifting of additional burdens onto groups that already bear most of the tremendous economic and emotional burdens that long-term disabilities implicate should not be considered acceptable. Nor should taxpayers be forced to support the long-term care partnerships, which amount to government sponsored discrimination benefiting a small group of wealthy, non-disabled Americans. The asset-transfer and LTCP provisions of the DRA should be repealed while Congress seeks gender- and ability-neutral solutions to the nation's future financing of long-term care for the millions of seniors who will need it in the coming decades.

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