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Nathalie D. Martin

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# FUNDING LONG-TERM CARE: SOME RISK-SPREADERS CREATE MORE RISKS THAN THEY CURE

*Nathalie D. Martin\**

## INTRODUCTION

It is natural to want to fight against nature's most dirty trick, aging, and its ultimate result, death.<sup>1</sup> Ironically, it is not death itself that many people fear most today, but rather that their long-term care costs will outstrip their assets, leaving them without sufficient funds to pay for these health care needs.<sup>2</sup> Many aging people are asking themselves, "How will I survive and who will care for me when I cannot care for myself?" These concerns have seniors scrambling for options to hedge against this risk.

The number of people concerned with this issue is growing by leaps and bounds. The population is aging at a rapid rate, due to improvements in health care. According to one author, by the year 2030, eighteen percent of the population will be over age sixty-five.<sup>3</sup> These

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\* Assistant Professor of Law, University of New Mexico School of Law. The author is grateful for superb editorial assistance of Elizabeth Rourke, as well as the fine research assistance of Bryan Garcia and Marisol Cintron Garcia. The author thanks Robert Schwartz and Debbie Armstrong for their comments on an earlier draft of this Article. The author also thanks Reva Paley, without whom this Article would not exist.

1. See Veronica L. Jarnagin, Note, *A Call to Action for National Long-Term Care Reform: Indiana's Private-Public Cooperative as a Model*, 29 IND. L. REV. 405, 407 (1995) (noting that fear of death has been replaced with fear of living too long).

2. See *id.*

3. See Erick J. Bohlman, *Financing Strategies: Long-Term Care for the Elderly*, 2 ELDER L.J. 167, 168 n.4 (1994). According to Bohlman:

[I]n 1900, 4 percent of the population was age sixty-five or older. By 1977, 10.8 percent of the population was sixty-five or older. By 1980, that figure had increased to 11 percent. Projections are that by 2010, 12.7 percent of the population will be at least sixty-five, and that by 2030, 18.3 percent of the population will have reached that age. Within only fifty years, nearly one out of every five living Americans will be "elderly" by our current

statistics clarify the obvious: Medicaid cannot fund long-term care for the entire population. The system will simply go bankrupt if a large portion of the growing elderly population must rely on the wages of the working population to fund their long-term care costs. The problem is that few of the elderly can afford to pay for the astronomical costs of their own care.<sup>4</sup>

This Article examines the options available for seniors to finance long-term care. It specifically explores the options for ensuring that one's personal funds are not outstripped by future long-term care needs. No doubt, as baby-boomers age and prepare to move into the growing senior population, many of them will put their creative energies to work to come up with successful solutions. We can only hope that this is true, given that the issue of how long-term care will be funded in the future is as difficult an issue as any other encountered by our society.<sup>5</sup>

Medicare does not cover most home-health care or nursing home stays, and unfortunately, most seniors do not know this.<sup>6</sup> Health care is

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standards. Furthermore, the "elderly" as a group are getting older. The percentage of elderly individuals at least seventy-five years of age will rise from 37.7 percent of the total elderly population as of 1977 to 42.1 percent by 2030.

*Id.*

4. See *infra* notes 50-51 and accompanying text.

5. See, e.g., Robert L. Kane et al., *Variation in State Spending for Long-Term Care: Factors Associated with a More Balanced System*, 23 J. HEALTH POL. POL'Y & L. 363, 371 (1998). Concern is widespread about the costs of long-term care, particularly those paid for with public funds. The framers of Medicaid certainly never contemplated that it would be used so extensively to cover long-term care needs of the previously "middle class." See *id.* Medicaid was designed to serve the poor, particularly women and children, not frail "older persons who have become impoverished by health care costs uncovered by Medicaid." *Id.* at 368-69; see also Jeffery L. Solterman, *Medicaid and the Middle Class: Should the Government Pay for Everyone's Long-Term Health Care?*, 1 ELDER L.J. 251, 251-52 (1993). According to Mr. Solterman, the Medicaid system is facing serious financial collapse, created by rising health care costs and an exploding elderly population. See *id.*

6. See Lisa Schreiber Joire, Note, *After New York State Bar Association v. Reno: Ethical Problems in Limiting Medicaid Estate Planning*, 12 GEO. J. LEGAL ETHICS 789, 792 (1999) (noting that only about two percent of the elderly's long-term care needs are met through Medicare). Moreover, according to a survey conducted by the American Association of Retired Persons (AARP), an alarming seventy-nine percent of AARP members incorrectly be-

covered by Medicare and a Medicare gap insurance policy that covers costs not picked up by Medicare (Medigap).<sup>7</sup> Health care is not the same as long-term care. Health care includes doctor and hospital visits, and medical care for specific ailments.<sup>8</sup> Long-term care, on the other hand, is defined as the need for assistance with two or more of the following activities of daily living: eating, moving from the bed to a chair, using the rest room, bathing or dressing.<sup>9</sup> Long-term care includes providing assistance for these needs, from home-health care, to minimal health care provided with residential services, to twenty-four hour nursing care services.<sup>10</sup> While health care costs are covered by Medicare and Medigap policies, long-term care generally is not.<sup>11</sup>

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lieved that Medicare and Medicare supplemental policies would cover the cost of nursing care expenses. See Bruce A. Radke, Note, *Meeting the Needs of Elderly Consumers: Proposed Reforms for the National Association of Insurance Commissioners' Long-Term Care Insurance Mode Act*, 1 ELDER L.J. 227, 227 (1993). In reality, Medicare only covers a small portion of all nursing home stays in the United States, because Medicare and the gap policies that supplement it only cover short-term post-acute care for persons discharged from a hospital who need skilled nursing care. See *id.* at 228. Even then, Medicare will only cover 100 days of care, not the average 465-day stay in a nursing home. See *id.* Gap coverages add nothing in terms of new coverages. See *id.* at n.13.

7. See William G. Weissert et al., *Cost-Savings From Home and Community-Based Services: Arizona's Capitated Medical Long-Term Care Program*, 22 J. HEALTH POL. POL'Y & L. 1329, 1347 (1997); see also MARSHALL B. KAPP, *GERIATRICS AND THE LAW* 63-64 (1992). Medicare Part A, which funds hospital stays, is funded by payroll tax contributions, whereas Part B, which funds physician services and outpatient care, is funded by general federal revenue and beneficiary-paid premiums. Medigap insurance, to cover the costs and deductions not covered by Medicare, can be purchased as well, although the policies still do not cover long-term care. See Diane Belinkie, *Piecing Together Health Care Protection: Medicare v. Medicaid v. Medigap*, 16 FAM. ADVOC. 42, 45 (Summer 1993).

8. See Bohlman, *supra* note 3, at 170-71. Current annual nursing care fees range from an average of \$30,000 to \$70,000 a year. See *id.*

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

10. See *id.*

11. See *id.* at 533. Medicare does provide limited coverage in some circumstances. Medicare will cover some home health care programs, but will not pay for many services such as Meals on Wheels or adult day care. See Bohlman, *supra* note 3, at 171.. While Medicare provides minimal coverage

These long-term care costs can be covered in four general ways. They can be paid for with private funds;<sup>12</sup> paid from private funds as long as the funds last, and then paid for by Medicaid;<sup>13</sup> or they can be paid through long-term care (LTC) insurance, a relatively new insurance product now on the market.<sup>14</sup> These policies are only valuable to the extent that seniors can afford to continue paying the premiums until they actually need the care.<sup>15</sup> A fourth option for financing long-term care is to contract with a continuing-care facility (CCF).<sup>16</sup> Although this type of arrangement works off a different model, like LTC insurance, it attempts to contain long-term nursing care costs.<sup>17</sup> This option allows a person to pay a substantial fee up-front, in exchange for guaranteed nursing care for the rest of her life.<sup>18</sup> Continuing-care facilities

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for skilled nursing home care, in order to qualify for such coverage, the applicant must require skilled nursing or rehabilitative services on a daily basis. Skilled services are defined as those which "(1) are ordered by a physician; (2) require the skills of technical or professional personnel . . . and (3) are furnished directly by, or under the supervision of, such personnel." *Id.*

12. See Bohlman, *supra* note 3, at 169.

13. See *id.*; see also Jarnagin, *supra* note 1, at 407 (noting that few people actually choose to become paupers to qualify for Medicaid; far more become paupers as a result of paying for long-term care).

14. See *infra* notes 66-106 and accompanying text.

15. See *id.*

16. In 1987, there were between 600 to 700 CCFs serving 100,000 to 200,000 residents. See Eileen J. Tell et al., *New Directions in Life Care: An Industry in Transition*, 65 MILBANK Q. 551 (1987); see also Lisa Stearns et al., *Continuing Care Communities: Issues in State Regulation*, 8 ST. LOUIS U.PUB. L. REV. 245, 247 (1989). This proliferation of CCFs resulted in a similar proliferation of writing about CCFs. See Michael B. Floyd, *Should Government Regulate the Financial Management of Continuing Care Retirement Communities*, 30 ELDER L.J. 29, 29 n.1 (1993) (citing over 30 sources written about CCFs). Most scholars who have written about these facilities call them continuing care retirement communities or CCRCs. The author prefers CCFs because these are businesses, not merely "communities" of individuals. See John E. Fairbanks, *Lifetime Care Contracts: Are Senior Citizens Putting All Their Eggs in One Basket*, 4 PROB. & PROP. 4 (Mar./Apr. 1990); Stearns et al., *supra*, at 246; William B. Fisher, Note, *Continuing Care Retirement Communities: A Promise Falling Short*, 8 GEO. MASON L. REV. 47, 47 (1985).

17. See Floyd, *supra* note 16, at 38.

18. See Christine A. Semanson, *The Continuing Care Community: Will It Meet Your Client's Changing Needs?*, 1990 DET. C.L. REV. 771, 775 (1990). The author uses the female pronoun throughout this Article because most eld-

provide increased medical care for a person as she ages.<sup>19</sup> Initially, the person lives in an independent apartment for which she pays monthly rent.<sup>20</sup> When additional care is needed, it is provided on site. There is no need to move out of the complex, thus eliminating reliance on family members and others, and providing peace of mind in the future.<sup>21</sup>

The purpose of this Article is to explore two different aspects of the long-term care issue. First, what are the options for receiving long-term care, such as home-care, assisted living, CCFs or traditional nursing homes? Second, what are the methods of funding long-term care? This Article will consider the strengths and weaknesses of each option when considering how best to control the costs of long-term care. Because only two of the options, maintaining LTC insurance and entering into a contract with a CCF, attempt to control future long-term care costs through risk-spreading, the Article considers these two options in more detail than other options.

Part I discusses the alternatives to traditional nursing homes.<sup>22</sup> Given that over 1,600 of this country's traditional nursing homes have recently gone into bankruptcy, seniors will be more interested in options to traditional nursing homes than ever been before. Part II ex-

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erly people are women.

19. *See id.* The goal of the CCF community or "Life Care" community is to provide an environment in which elderly residents can maintain their highest level of independence for as long as possible, and also be sure progressive nursing care will be available for them when they need it. *See id.* The arrangements ensure elderly persons will have a place to live where they will be taken care of for the rest of their lives. *See Fisher, supra* note 16, at 47.

20. *See Semanson, supra* note 18, at 775.

21. In assisted-living facilities, by comparison, once seniors need certain levels of care, they typically are required to move out of an assisted-living facility. *See Stephanie Edelstein, Assisted Living: Recent Developments and Issues for Older Consumers*, 9 STAN. L. & POL'Y REV. 373, 375 (1998) (noting that one facility's advertisement touts "you'll never want to move again," without disclosing that when a resident's health needs reach a certain level, the resident is required, by either facility policy or state law, to move out of the assisted-living facility). Moving can be very taxing on an elderly person, which makes assisted-living a less attractive alternative, at least on one level. Even moving an elderly person from one room in a nursing home to another can be frightening and traumatic. *See Marilyn Denny, This is Who I Am, Don't Let Them Move Me*, 2 QUINNIPIAC HEALTH L.J. 203, 204 (1999).

22. *See infra* notes 26-49 and accompanying text.

amines the issue, in general terms, of funding long-term costs.<sup>23</sup> Part III analyzes long-term care insurance,<sup>24</sup> and Part IV looks at continuing-care contracts.<sup>25</sup> In the end, for people who want to avoid running out of money for long-term care before they die, long-term care insurance and CCF contracts appear to be the only options. At the moment, however, each provides far less protection against loss than one would hope.

### I. WHERE WILL I LIVE WHEN I'M OLD AND FRAIL?

Most people would probably prefer to live in their own homes their entire lives, if this were possible.<sup>26</sup> As a next choice, most would probably prefer to live with children or other family members, once they can no longer care for themselves. This option can make a person feel guilty about imposing on others, resulting in a loss of independence.<sup>27</sup> Moving to a nursing home would be most people's very last choice. However, today there exists many excellent alternatives to traditional nursing homes.

#### A. Assisted-Living Facilities

Assisted-living exists as an option to living in a nursing home. In assisted-living, residents pay rent for a typical apartment and on-site services that often include meals, social events, transportation, and

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23. See *infra* notes 50-65 and accompanying text.

24. See *infra* notes 66-106 and accompanying text.

25. See *infra* notes 107-38 and accompanying text.

26. See Radke, *supra* note 6, at 227; see also *The Best Home for Older Adults*, N.Y. TIMES, Aug. 17, 1991, at A20 (citing an AARP study reporting that eighty-six percent of the elderly prefer to live in their homes for the rest of their lives).

27. See Jan Ellen Rein, *Misinformation and Self-Deception in Recent Long-Term Care Policy Trends*, 12 J.L. & POL. 195, 209 (1996). In today's fast-paced, mobile society, this option is less available than it used to be. Today's modern family is extremely mobile, leaving many elderly people with no one geographically close upon whom to rely. See Semanson, *supra* note 18, at 772. Many people are declining to have children, leaving these people without children's support later in life. See Stearns et al., *supra* note 16, at 253 (noting that 34 percent of CCF residents in 1989 had no children, a percentage far higher than the number of persons having no children in the general population).

general housekeeping.<sup>28</sup> Residents can also purchase home-care assistance for their daily needs.<sup>29</sup> Residents pay for services on a monthly basis without an up-front fee.<sup>30</sup> Because residents pay for the services as they receive them, these arrangements do not help manage future long-term care costs in any way. Compared to traditional nursing homes that also do nothing to contain these costs, assisted-living facilities are far more pleasant. Those who reside in such a facility can more or less take care of themselves. Residents live with companionship, freedom and independence.<sup>31</sup>

There are between 20,000 and 30,000 assisted-living facilities in the United States, housing twenty-five percent of the 2.2 million seniors who live in senior housing.<sup>32</sup> Although these facilities are relatively new, they are incredibly popular.<sup>33</sup> There is a significant downside, however. Once a resident can no longer take care of herself with relatively little assistance, she is required to leave the facility, typically for a traditional nursing home.<sup>34</sup> Thus, while assisted-living is a pleasant, though expensive, alternative for many seniors, using this option nearly always results in future relocation, something few seniors relish.<sup>35</sup>

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28. See John Greenwald, *Elder Care: Making the Right Choice*, TIME, Aug. 30, 1999, at 54; Edelstein, *supra* note 21, at 376-77.

29. See Greenwald, *supra* note 28, at 54; see also Edelstein, *supra* note 21, at 373.

30. See Greenwald, *supra* note 28, at 55.

31. One problem with assisted-living is that there are few guidelines regarding which services must be offered to residents. See Edelstein, *supra* note 21, at 375-77. The important thing in considering this type of care is to ask plenty of questions and try to find out exactly what is offered, and at what price.

32. See Greenwald, *supra* note 28, at 52. This is by far the fastest growing segment of the senior housing market. See Timothy J. Boyce, *Financing Senior Living Facilities*, 10 PROB. & PROP. 23, 25 (1996).

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

34. See Edelstein, *supra* note 21, at 378-79.

35. A similar option, congregate living, allows very independent seniors to live in shared housing, with separate bedrooms, but with other people around



### B. Continuing-Care Facilities

The other major alternative to a traditional nursing home is the continuing-care facility. These facilities combine traditional nursing home care with independent living, including every imaginable level of care in between, all at one facility.<sup>36</sup> The facilities themselves can be quite upscale.<sup>37</sup> While many CCFs are affordable only by the upper-middle class, some facilities are within the reach of the middle class as well. The reason CCFs are expensive is they require the payment of a very substantial up-front fee in exchange for a guarantee of nursing care covering a person's entire life.<sup>38</sup> Residents also pay a monthly rental for their apartment while they are living independently. Monthly fees are similar to those paid for assisted-living, or perhaps a little less,<sup>39</sup> and increases in these monthly fees are often capped. Up-front fees vary greatly from state to state, but typically range from \$80,000 to \$200,000.<sup>40</sup>

Every option has its downside, and the downside for CCFs is quite

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with whom to share meals and socialize. Similar to other assisted-living arrangements, however, one can only stay in congregate living for as long as one can take care of herself. Once a senior needs a higher level of care, she typically must move into a traditional nursing home. Congregate living actually offers less "assistance" than assisted-living, so the need to move can occur more quickly than in an assisted-living facility. *See Wheeler, supra* note 33, at 110.

36. *See Boyce, supra* note 32, at 27-28.

37. The fees obviously vary from location to location. In 1980, the average fee was \$35,000 per year. *See* HENRY E. WINKLEVOSS & ALWYN V. POWELL, *CONTINUING CARE RETIREMENT COMMUNITIES: AN EMPIRICAL, FINANCIAL AND LEGAL ANALYSIS*, 34 (Richard D. Irwin ed., 1984). Like most of life's expenses, these entry fees continue to increase. The current average up-front fee for entrance into a California CCF is over \$800,000. Telephone interview by Brian Colon, Research Assistant, with Bill Woodward, Chairperson of the California State Government Counsel on Insurance, California Insurance Commission (July 23, 1999). In Connecticut, fees range from \$39,818 to \$455,900. *See* CONNECTICUT DEP'T OF SOCIAL SERVICES, *CONTINUING CARE RETIREMENT COMMUNITIES V* (1997).

38. *See Stearns et al., supra* note 16, at 246. The CCF contract acts as a hedge against impoverishment by limiting the costs of long-term care. *See id.*

39. *See id.* (noting that monthly fees ranged from \$250 to \$1,300 in 1989).

40. *See id.* (reporting that up-front fees ranged in 1989 from \$15,000 to \$200,000). Today fees are far higher. *See supra* note 37 and accompanying text.

significant. Specifically, the large up-front entry fees that residents pay to live in these facilities are not protected from loss if a facility becomes insolvent.<sup>41</sup> Thus, residents can lose large sums of money, even their life savings, when facilities fail financially.<sup>42</sup> Because of this risk, the CCF industry desperately needs legislation that will force the facilities to become stronger financially and will better protect resident fees in the event of insolvency.

### *C. Home-Health Care for the Elderly*

A third alternative to traditional nursing-home care is not really an alternative. This option, home-health care, essentially postpones the move to a nursing home, but does not necessarily preclude it. Because most seniors prefer to stay in their homes for as long as possible, there is now an enormous market for in-home assistance to the elderly covering daily tasks of every kind.<sup>43</sup> Adult day-care, which provides

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41. See *infra* notes 107-38 and accompanying text.

42. This already has happened to some CCF residents. In Idaho, after one facility failed, some residents lost their life savings. See Idaho Home Health and Welfare Committee Minutes, Feb. 22, 1988 (testimony of Lorraine Gunderson). According to testimony given to the Idaho legislature, "two [of the] women who had used life savings for [the new living arrangement] learned that . . . they were, in a word, paupers. These were people who had worked and saved during their younger years in order to be independent." *Id.* In addition to the loss of life savings, "the loss in self-esteem to the residents and dread of the future cannot be calculated in dollars." *Id.* Recent changes in Medicare reimbursement policies will almost certainly result in more CCF insolvencies than ever before. Until recently, Medicare paid unlimited rehabilitation and therapy for senior citizens in nursing homes and CCFs, but the federal government is now severely limiting those reimbursements. As a result, huge numbers of nursing homes are now failing financially, and CCFs can be expected to follow suit. See e.g., Bruce Jaspen, *Integrated Health in Chapter 11, Nursing Home Chain Blames Reductions in Medicare Spending Growth*, CHI. TRIB., Feb. 4, 2000, at A1; Gayle Geis O'David, *Creditors, Sun Craft Debt Deal*, ALBUQUERQUE J., Oct. 27, 1999, at A1; Thomas J. Cole, *Troubled Times for Nursing Homes: Pressing for Cash*, ALBUQUERQUE J., Aug. 4, 1999, at A1; Thomas J. Cole, *Troubled Times for Nursing Homes: Awash in Red Ink*, ALBUQUERQUE J., Aug. 3, 1999, at A1; Thomas J. Cole, *Troubled Times for Nursing Homes: An Ailing Industry*, ALBUQUERQUE J., Aug. 2, 1999; Diane Scarponi, *Some Nursing Homes in State Are Headed for Trouble*, HARTFORD COURANT, July 20, 1999, at B1.

43. See Beatrice S. Braun, M.D., *Long-Term Care and the Challenge of an Aging America: An Overview*, 1 QUINNIPIAC HEALTH L. J. 113, 115-16 (1997).

structured activities and social interactions for seniors who often cannot stay home alone all day, is also becoming popular.<sup>44</sup> This option is

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As this author notes, seventy-eight percent of the population that needs assistance with daily living actually does live in the community, rather than in an institution. *See id.* This reflects Americans' preference for remaining in their homes and aging in place, as well as the immediate need to reform the law regarding use of public funds. Currently, public funds can be used only in institutions. *See id.*; *see also* Betsy Abramson, *Public & Private Financing*, 64 WIS. L. REV. 20, 20 (discussing the need to expand the options for receiving community-based care).

44. *See* Craig S. Meuser, *Why Government and Business Should Take A Closer Look at Adult Day Care*, 1 QUINNIPIAC HEALTH L. J. 219, 222 (1997) (describing adult day care as one of the fastest growing trends in health care, and citing other authors making the same claim). Currently, most people do not qualify to receive home care through Medicare or Medicaid. Medicare provides medically necessary intermittent skilled nursing and therapy services under the Medicare Part A Home Health benefit. *See* 42 U.S.C. § 426 (1994). This is short-term care, however, and is based on acute need. If skilled care is needed, then non-skilled care, such as help with bathing and other normal daily tasks can also be obtained through Medicare. Medicaid also provides some home-health care benefits for people who qualify for Medicaid but who are not covered by Medicare. *See* 42 U.S.C. § 1395 (1994). Because states have some flexibility in designing their Medicaid benefit plans, some states have less restrictive Medicaid home-health care benefits than others. Most of these home-health services are provided through Medicaid waiver programs, which allow states to "waive" certain Medicaid requirements to offer alternative benefits. *See* 42 U.S.C. § 1315 (1994); *see also* Marshall B. Kapp, *Health Care in the Marketplace: Implications for Decisionally Impaired Consumers and their Surrogates and Advocates*, 24 S. ILL. U. L.J. 1, 18 (1999) (discussing waivers for home health care). For example, New Mexico offers a Disabled and Elderly waiver program under which a person who qualifies for nursing home care can receive home and community-based care instead. One of the federal requirements of such a waiver program is that the home care services provided cost less than nursing home care. In New Mexico, the services that can be provided under a waiver include nursing, therapies, homemaker, personal care, and respite care, all provided in the home, or adult day care and assisted living. *See* STATE OF N.M. MED. ASSISTANCE PROGRAM MANUAL SUPPLEMENT, dated June 30, 1998 (copy on file with the author). After the Balanced Budget Act of 1997, however, the home-health care industry is in shambles and can provide relatively few services to anyone. *See* Diane Block, *Home Health Firm Hit Skids*, PITTSBURGH POST-GAZETTE, Feb. 7, 2000, at A1; Chris Meehan, *Abraham Aims to Halt Medicaid Bleeding*, GRAND RAPIDS PRESS, Sept. 21, 1999, at B1.

loosely referred to as "community-based care."<sup>45</sup> Community-based care seeks to avoid sending the elderly to separate facilities. Instead, it attempts to allow people to age at home. A great deal of optimism exists about the future of these arrangements and it has sparked a movement to permit more of these services to be paid for by Medicare or Medicaid.<sup>46</sup> While this prospect seems unlikely given the current system, proponents claim that providing community and home-based services ultimately could be cheaper for taxpayers than traditional nursing care.<sup>47</sup> If this system could be established, people would have more access to these services through public funding.<sup>48</sup> This would be a great improvement for all but the most medically needy elderly people. As it stands now, however, these community-based services are not covered by Medicare or Medicaid.<sup>49</sup> If a senior wishes to use them, she must pay for the services from private funds or through an LTC insurance policy.

## II. HOW WILL I FUND MY LONG-TERM CARE?

The funding options for long-term care are not as plentiful as the housing options. The options basically come in two forms, private and public. Private funding of home-health care, nursing home care, and assisted-living is a "pay as you go" proposition. Seniors pay for the services they need for as long as they need them, and then hope that

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45. See Abramson, *supra* note 43, at 20.

46. See Meuser, *supra* note 44, at 245-47; see generally Weissert et al., *supra* note 7, at 1329 (suggesting that home-health care might be cheaper than nursing home care, based on a recent study completed in Arizona); see also *supra* note 44 (explaining that most people are not sick or poor enough to receive home-health care services through Medicare or Medicaid).

47. See Meuser, *supra* note 44, at 239-41 (suggesting that community-based care might be cheaper than institutional care, and that as a result, allowing more community-based care to be paid for by Medicare and Medicaid could stave off financial disaster for Americans as a whole); see also Weissert et al., *supra* note 7, at 1342-44 (also suggesting that home health care might be more cost-effective than nursing home care).

48. See Weissert et al., *supra* note 7, at 1349. Despite indications that community-based care could be cheaper than nursing home care, many people believe that making these home-based services available will not save money, because the demand for the services will increase and drown out the unit cost savings. See Kane et al., *supra* note 5, at 363-64.

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

their life span does not exceed their savings. While the extremely wealthy have nothing to fear, average middle-class Americans are resigned to wish for either a miracle or a hasty demise. Home-health care can cost from \$20,000 to \$40,000 or more per year,<sup>50</sup> assisted living can cost \$25,000 to \$60,000 a year,<sup>51</sup> and nursing home costs average \$30,000 to \$70,000 a year.<sup>52</sup>

There also exists the option of divesting one's self of all assets voluntarily<sup>53</sup> to become eligible for Medicaid. It does not appear that voluntary divestment abuse is a significant problem.<sup>54</sup> Given how quickly

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50. See Greenwald, *supra* note 28, at 54 (stating that home care visits can run \$80 per visit); Robert D. Hayes et al., *What Attorneys Should Know About Long-Term Care Insurance*, 7 ELDER L.J. 1, 9 (1999) (stating that an all-day visit for home-health care runs \$110 per day).

51. See Greenwald, *supra* note 28, at 55. (stating that one assisted-living facility currently costs between \$2,850 to \$4,800 per month); Dana Shilling, *Securities Funding of Long-Term Care, A Step Toward a Private Sector Solution*, 19 FORDHAM URB. L.J. 1, 2 (1991) (stating that home health care costs can exceed nursing home costs, depending on the level of care needed).

52. See Bohlman, *supra* note 3, at 169; see also Shilling, *supra* note 51, at 2 (noting that in some areas on the coasts, nursing home care exceeded \$100,000 per individual per year, even in 1991); Rein, *supra* note 27, at 210 (nursing home costs ran between \$18,000 to \$60,000 per year in 1996). At this rate, paying \$100,000 or even \$200,000 for a continuing-care contract does not appear that expensive after all.

53. A common way is through \$10,000 bequests to family members, which are not taxable to the recipient. Aside from permitted gifts, Medicaid will scrutinize all transfers made within 36 months of eligibility for Medicaid. If a transfer is made at below market value, Medicaid has the right to take the value of the asset (less any amount received for the asset) and divide that amount by the average cost per month of nursing home care. The person will be ineligible for Medicaid until that amount of time has passed. See Pub. L. No. 103-66, § 13611(a) (amending 42 U.S.C. § 1396p(c)(1)).

54. See Radke, *supra* note 6, at 228. Two-thirds of all nursing home patients who begin paying for their own nursing home care are impoverished under the Medicaid guidelines within one year. See *id.* While many people complain that elderly people often voluntarily divest themselves of their assets in order to qualify for Medicaid, many more people legitimately run out of funds, despite a desire to pay for long-term care. See Jarnagin, *supra* note 1, at 412. For most elderly, asset depletion is no game. It is a frightful reality that can be as debilitating and frightening as any physical illness. See *id.* Financial impoverishment, and its inherent restrictions on lifestyle and independence, is the most feared result of the aging process. See *id.*; see also Rein, *supra* note 27, at 251-52, 255 (noting that most nursing home residents have few or no assets to

most people's assets are dissipated by paying for nursing care, it is not surprising that paying for it with private funds seems wasteful on some level. The private funds often cover a mere fraction of the costs.<sup>55</sup> Yet, emotional debates rage over whether middle-class people should use Medicaid to cover their long-term care costs.<sup>56</sup> People disagree about whether "Medicaid estate planning" constitutes wise financial planning or serious moral transgression.<sup>57</sup> This debate continues, despite the fact that in 1996, Congress took the unprecedented step of making it a federal crime to give away assets or to set up trusts to qualify for Medicaid.<sup>58</sup> This provision, nicknamed by opponents as the "Granny Goes to Jail Law," was actually targeted at sanctioning lawyers who help people make such transfers.<sup>59</sup> Whether the law will

shield, and that most fit the profile of the old, disabled, widowed and impoverished member society).

55. See Radke, *supra* note 6, at 228.

56. See Solterman, *supra* note 5, at 289 (arguing that private interests need to step up to the plate and help fund long-term care, because Medicaid cannot support, and was never intended to support, the long-term care costs of the middle class); Rein, *supra* note 27, at 251-55 (arguing that the middle class is becoming destabilized as a result of many factors, including increasing long-term care and other medical costs, and that very few elderly persons actually divest assets in order to qualify for Medicaid; rather, most divest as a result of paying for long-term care); Pasaba & Barnes, *supra* note 9, at 543-44 (doubting that widespread divestment is a serious problem).

57. See Pasaba & Barnes, *supra* note 9, at 538.

58. See Pub. L. No. 104-191 § 322, 110 STAT. 1936, 2060-62 (1996) (codified in 42 U.S.C. § 132a and 42 U.S.C. § 1395); Amhad, *supra* note 49, at 272-73. These transfers only constitute a crime if they result in a period of ineligibility for Medicaid. If not, no crime occurs. See *id.* n.148. As a result, if transfers are made but they still leave an elderly person with the ability to pay for some nursing care, then the prior transfers presumably will not be crimes. This provision has been criticized by many as being unduly ambiguous. Substantial questions remain as to whether "waiting out" the disqualification period would prevent criminal sanctions from being imposed. Some argue that this provision was designed to encourage the long-term health care insurance industry and to deter attorneys and accountants from advising that an elderly person spend down their estate or engage in "Medicaid estate planning." See Pasaba & Barnes, *supra* note 9, at 539. The provision was amended by the Balanced Budget Act of 1997. See *id.*

59. See Amhad, *supra* note 49, at 273. Interestingly, no one knows who actually added this particular provision to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 STAT. 1936, 2060-62 (1996) (codified at 42 U.S.C. § 132a and 42 U.S.C. § 1395). Even the

actually be enforced against an elderly person remains to be seen.

Regardless of these criminal sanctions, transferring away all of one's assets has formidable downsides.<sup>60</sup> First, it is unlikely that many elderly people actually want to transfer away all their assets. Such a transfer gives up complete control over where to travel, what to buy, and how to spend each day. It is a complete step away from independence, regardless of how much seniors trust their children.<sup>61</sup> This transfer is often irreversible as well.<sup>62</sup> Second, and more importantly, care received under Medicaid may be inferior to that purchased with private funds.<sup>63</sup> The more desirable forms of care, assisted-living and home-health care for example, are not currently covered under Medicaid.<sup>64</sup> Moreover, even if traditional nursing care is used, a Medicaid recipient's choice of nursing care facilities may be severely limited. Often, the only Medicaid beds available are located in poorly funded facilities in bad neighborhoods.<sup>65</sup>

Assuming neither of these financial risks are acceptable, namely the risk of running out of private funds for long-term care or the risk of

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bill's sponsors, Senator Edward Kennedy (D-MA) and Nancy Kassenbaum (R-KS), knew nothing about the particular provision before it passed. *See* Amhad, *supra* note 49, at 273.

60. *See* Jarnagin, *supra* note 1, at 407.

61. *See id.*; *see also* Pasaba & Barnes, *supra* note 9, at 543.

62. Moreover, some people simply have no one to whom to transfer their assets, thus making this option unavailable. The combination of impossibly high costs of private, long-term care, and the requirement of divestment to receive public care, demoralizes the middle class. *See* Solterman, *supra* note 5, at 277-78. It discourages savings and creates hopelessness. *See id.*

63. *See* Pasaba & Barnes, *supra* note 9, at 543 (noting that the quality of Medicaid services is generally inferior to services available on the private, long-term care market, particularly when one's choice of a facility is dictated by the availability of a Medicaid-paid bed).

64. *See* Meuser, *supra* note 44, at 224 (noting that home care and adult day care are not covered by Medicare).

65. *See* Pasaba & Barnes, *supra* note 9, at 543. Since the enactment of the Balanced Budget Act of 1997, thousands of traditional nursing homes now fall into the category of "poorly funded." *See* Jaspen, *supra* note 42, at A1. This legislation drastically reduced the amounts received by nursing homes from Medicare for rehabilitation services to the elderly. Between September 1999 and February 2000, the four largest nursing home chains in this country filed for protection under Chapter 11 of the Bankruptcy Code. *See id.* Today, over 1,600 of America's nursing homes, serving over 175,000 residents are in bankruptcy. *See id.*

simply living with the care provided by Medicaid, many seniors (and seniors to-be) are desperately seeking ways to spread the risk of loss of long-term care. Purchasing and maintaining LTC insurance or entering into a continuing-care contract are the only options currently available to address the financial risk of aging beyond one's savings.

### III. THE WEAK LINKS IN LONG-TERM CARE INSURANCE

The same law that threatened to send Granny to jail, the Health Insurance Portability and Accountability Act (HIPAA),<sup>66</sup> gave purchasers of some long-term care insurance policies certain tax benefits for buying the policies.<sup>67</sup> The payments made for the policies are excluded from taxation, as are many of the benefits paid under the policies.<sup>68</sup> Initially, Congress passed this law to induce people to find affordable alternatives to funding long-term care.<sup>69</sup> The rationale being that if more people were to take out these policies, fewer would need to resort to Medicaid for long-term care. Medicaid funds then could be reserved for the truly needy.

The idea of purchasing insurance to cover the costs of long-term care is excellent in theory, but problematic in practice. One problem, with no obvious cure, is that very few people can actually afford to purchase and maintain LTC insurance premiums.<sup>70</sup> A typical policy

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66. See Pub. L. No. 104-191, 110 STAT. 1936, 2060-62 (1996) (codified in 42 U.S.C. § 132a and 42 U.S.C. § 1395). For an excellent article on long-term care insurance, see Robert D. Hayes et al., *What Attorneys Should Know About Long-term Care Insurance*, 7 ELDER L.J. 1, 11-27 (1999) (containing the most recent information about the options available for long-term care insurance, as well the Medicare and Medicaid payment schemes).

67. See Nancy L. Johnson et al., *Long-Term Care Financing: Federal Policy Implications, Actions and Options*, 1 QUINNIPIAC HEALTH L.J. 139, 147-49 (1997) (outlining the various tax benefits contained in the Act). These benefits became effective in January 1997. See *id.* at 148.

68. See *id.* at 147.

69. See *id.*; Bohlman, *supra* note 3, at 171 (remarking that long-term care insurance can be an insurable event altering financial planning strategies).

70. See Radke, *supra* note 6, at 230; Braun, *supra* note 43, at 117. Some scholars believe many more people can afford the policies than those that actually buy them. See Marc A. Cohen, Nancy Kumar, Thomas McGuire & Stanley S. Wallach, *Financing Long-Term Care: A Practical Mix of Public and Private*, 17 J. HEALTH POL. POL'Y & L. 403, 408-09 (1992). According to these authors, it is not the high cost, but the other undesirable attributes relating to these policies, such as the absence of guaranteed premium levels and misrepre-



that contains meaningful but basic coverage and benefits can cost a sixty-five year old between \$2,600 and \$7,000 a year.<sup>71</sup> According to one study, only twenty-five percent of consumers in any state could afford basic, long-term care insurance.<sup>72</sup> Even those policies that are affordable today may not be affordable in the future because rates can continue to rise as a person ages.<sup>73</sup> This is true *even if* the policies purport to have a *flat* premium rate.<sup>74</sup>

Policies also vary so significantly that many consumers have no idea what they are buying. Unlike Medicare and Medigap insurance, these policies can cover many different levels of long-term care over a variety of periods of time.<sup>75</sup> The policies sometimes cover home-

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sentation by salespersons about the policies, that account for their lack of popularity. *See id.* at 403, 412.

71. *See* Radke, *supra* note 6, at 230 (noting that premiums can run up to \$7,000 per year, though not indicating the age to which such a premium would apply); Braun, *supra* note 43, at 117 (quoting rate of \$2,600 for a 65 year-old person).

72. *See* Pasaba & Barnes, *supra* note 9, at 72 n.542. Moreover, as these authors note, 80 percent of the elderly cannot afford to pay premiums on these types of policies. Just about everyone who has studied the issue agrees that the policies are just not affordable.

73. While some commentators suggest that consumers buy the policies when they are younger, the age of a person does not seem to make a great deal of difference in time of purchase. By the time a person reaches a certain age, the policy premiums could become too high to afford, regardless of when the policy was purchased. *See* Rein, *supra* note 27, at 286. Unlike term insurance policies, the costs for which also continue to rise, LTC policies end up being a complete waste of money. *See id.* At least term life insures against unexpected death, which could actually happen to a person. By contrast, LTC policies frequently lapse before any benefits are paid and the very event against which one is insuring, old age, is the same event that causes the policies to lapse before they pay benefits. *See id.*

74. *See* Cohen, *supra* note 70, at 405; *see also* Solterman, *supra* note 5, at 283 (noting that insurers always reserve the right to increase premiums, but only on a class basis for all policyholders of a given state); Jane Bryant Quinn, *Is a Backlash Brewing in LTC*, NEWSWEEK, Aug. 30, 1999, at 39.

75. *See* Bohlman, *supra* note 3, at 186-88; Radke, *supra* note 6, at 228-30; Braun, *supra* note 43, at 117. Six months to six years is a typical coverage for nursing home care. *See* Radke, *supra* note 6, at 230. However, many policies severely limit the amount of coverage available for home-health care. Typically, consumers can only use a percentage of the policy for home-health care, such as fifty percent of the policy's total dollar value, and may also have to pay a twenty percent co-pay for home health care services. *See* Solterman, *supra*

health care services, but often plan holders can only use a portion of the policy's dollar value for home-health care.<sup>76</sup> Most policies are indemnity plans that reimburse a set dollar amount of benefits for each day of care.<sup>77</sup> There is typically a waiting period of up to 100 days, during which time consumers must pay for nursing care before the policy can be used.<sup>78</sup> These waiting periods are similar to deductibles on other insurance policies. While some of the policies provide that these different levels of care can be received in a variety of home and institutional settings, consumers need to read the policies extremely carefully. Not all policies are this flexible. The best policies on the market offer the consumer the greatest number of ways to use the policy when the time arrives. Most of the products on the market, however, do not offer all of these options.<sup>79</sup>

Some policies cover rehabilitative care for temporary medical conditions, custodial care for long-term nursing care needs, and residential in-home care.<sup>80</sup> One large benefit to these policies is coverage of treatment in settings other than traditional nursing homes. Consumers are particularly drawn to insuring future home-health care costs. However, not every policy actually covers home-health care, and most policies that do cover this type of care place severe restrictions on the use of the policy in this way.<sup>81</sup> Naturally, the policies that offer the greatest number of care options are also the most expensive, because it is far more expensive for insurers to pay benefits for these more desirable options.<sup>82</sup>

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note 5, at 283.

76. See Solterman, *supra* note 5, at 284.

77. See *id.* While Mr. Solterman claims in his Article that many newer policies have shorter waiting periods, this depends on whether the consumer has paid extra for this feature. See *id.* at 283.

78. See *id.*

79. See Radke, *supra* note 6, at 235 (noting that one woman's claims were denied because she did not receive care at the right "type" of facility); see also Bohlman, *supra* note 3, at 187 (noting that products vary so much that it is difficult to determine exactly what your policy covers).

80. See Radke, *supra* note 6, at 231.

81. See *id.* Consumers must be careful to ensure that their policies actually cover home care, if that is a feature they want. See Solterman, *supra* note 5, at 283.

82. See *infra* notes 84-101 and accompanying text. Other things that make the better policies more expensive include high daily pay-outs and shorter waiting periods. See Radke, *supra* note 6, at 232.

While there is no question that exorbitant rates keep people from buying LTC policies, insurers that carry the policies claim that the high rates are unavoidable. Two risks, adverse selection and induced demand, are the reasons insurers cite for the high rates.<sup>83</sup> Adverse selection occurs when policies are purchased primarily by people expecting to need nursing care, not by the general population. This fills the pool with high-risk individuals, increasing the costs of premiums.<sup>84</sup> The other risk, induced demand,<sup>85</sup> results in what some call the "woodwork effect."<sup>86</sup> Those who would not normally use the offered services essentially come "out of the woodwork" to use the services, merely because they are available.<sup>87</sup> Long-term care policies are medically underwritten and insurers have found ways to contain their costs for long-term care. These cost-containment methods include increasing waiting periods, excluding many pre-existing conditions from coverage, requiring prior hospitalization before benefits can be received under a policy, setting upper age-limits for policy holders, and providing fewer benefits for non-institutional care.<sup>88</sup>

Needless to say, these cost-containment measures take away many of the benefits provided by these policies. One way that Medicare contains costs for long-term care is by requiring that a person be hos-

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83. *See id.*; *see also* HARVEY S. ROSEN, PUBLIC FINANCE 219 (4th ed. 1995). Those at a higher risk of needing insurance are those most likely to purchase it. *See id.* This can defeat the purpose of allocating the risk by insuring across a larger pool of people. *See id.* Another creative alternative, referred to as Social Health Care Maintenance Organizations, proposes to expand HMO coverage to include long-term care. *See* Shilling, *supra* note 51, at 23. Unfortunately, adverse selection in choosing these policies is predicted to make this option too costly for many people as well. *See id.*

84. *See* Radke, *supra* note 6, at 232-33.

85. *See* ROSEN, *supra* note 83, at 219. People may be less willing to avoid risks and assume a less healthy lifestyle. This is sometimes called "moral hazard." *See id.* There is the possibility that consumers of LTC insurance will over-consume health care because the costs of care have been deferred, creating a drain on the industry. *See id.*

86. Kane et al., *supra* note 5, at 371.

87. *See id.* It is easy to see how a person might seek assistance with home or personal needs, whether they really need the help or not, if her long-term care policy reimburses for such services. Over-consuming long-term care, particularly home-health care, can be seen as a form of moral hazard. *See supra* note 85 and accompanying text.

88. *See* Radke, *supra* note 6, at 230.

pitalized just prior to receiving long-term care.<sup>89</sup> However, because over two-thirds of those who enter a nursing home are not coming from a hospital,<sup>90</sup> their expenses are not covered by Medicare, and would similarly not be covered by many LTC insurance policies. Increasing waiting periods means that seniors *still* have to spend their nest eggs on nursing-home care, despite purchasing the policies. Excluding services for preexisting conditions will further limit the number of services covered by the policy and reduce the policy's value. Finally, some policies that are sold cannot be renewed past a certain age.<sup>91</sup> While most states now forbid the sale of any LTC policy that is not non-renewable, this is not required in all states. Thus, it is important to be sure that any policy purchased is indeed renewable.

The combination of confusing and almost endless variables, along with the failure of salespersons to clearly explain LTC policies, leads

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89. See Bohlman, *supra* note 3, at 171.

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

91. As Mr. Solterman points out, consumers can sometimes pay extra for a feature called "guaranteed renewability." See Solterman, *supra* note 5, at 283. Fortunately, 36 states now require any LTC policy sold in their state to be renewable. See ALASKA STAT. § 21.53.020 (Michie 1998); ARIZ. REV. STAT. ANN. § 20-1691.02 (West 1990); ARK. CODE ANN. § 23-97-208 (Michie 1992); CAL. INS. CODE § 10233.2 (1993); COLO. REV. STAT. ANN. § 10-19-107 (West 1998); DEL. CODE ANN. tit. 18, § 7105 (1989); FLA. STAT. ANN. § 627.9407 (West 1996); GA. CODE ANN. § 33-42-6 (1996); HAW. REV. STAT. § 431:10H-107 (1996); IDAHO CODE § 41-4605 (1998); 215 ILL. ANN. STAT. 5/351A-4 (Smith-Hurd 1993); IND. CODE ANN. § 27-8-12-9 (West 1992); IOWA CODE ANN. § 514G.7 (West 1998); KAN. STAT. ANN. § 40-2228 (1993); KY. REV. STAT. ANN. § 304.14-615 (Banks-Baldwin 1995); LA. REV. STAT. ANN. § 22:1736 (West 1995); ME. REV. STAT. ANN. tit. 24-A, § 5075 (West 1999); MICH. COMP. LAWS ANN. § 500.3907 (West 1993); MINN. STAT. ANN. § 62S.04 (West 2000); MO. ANN. STAT. § 376.955 (West 1991); NEB. REV. STAT. § 44-4513 (1998); N.M. STAT. ANN. § 59A-23A-6 (Michie 1999); N.C. GEN. STAT. § 58-55-30 (1999); N.D. CENT. CODE § 26.1-45-05 (1995); OHIO REV. CODE ANN. § 3923.44 (West 1996); OKLA. STAT. ANN. tit. 36, § 4426 (West 1999); OR. REV. STAT. § 743.655 (1998); 40 PA. CONS. STAT. ANN. § 991.1105 (West 1999); R.I. GEN. LAWS § 27-34.2-6 (1998); S.D. CODIFIED LAWS ANN. § 58-17B-5 (Michie 1996); TENN. CODE ANN. § 56-42-105 (1994); UTAH CODE ANN. § 31A-22-1405 (1999); VA. CODE ANN. § 38.2-5203 (Michie 1994); W. VA. CODE § 33-15A-6 (1996); WYO. STAT. ANN. § 26-38-105 (1999).

to tragic abuses.<sup>92</sup> One elderly woman spent over \$50,000 on thirty-one long-term care policies, all of which lapsed over a three-year period.<sup>93</sup> A ninety-five year old took out a policy years ago for \$1,100 and paid on it diligently.<sup>94</sup> He was ultimately forced to drop the policy when the premium reached \$8,200 a year, and he could no longer afford it.<sup>95</sup> Another woman purchased a policy because she was promised that if she had to go to a nursing home, she would never be a burden to her children.<sup>96</sup> Although she paid more than \$5,000 in premiums, her carrier denied the first claim for reimbursement because the place she chose to live did not qualify as a "skilled-care" provider as required by the policy.<sup>97</sup> Apparently, the policy limitations were never actually explained to her.

Industry representatives certainly paint a rosier picture of these plans and insist that elderly people can afford the policies.<sup>98</sup> As one web page announces, "you will pay less in long-term care insurance premiums in your entire life than you would pay for one year of nursing-home care."<sup>99</sup> This is true when considering that most people cannot afford to pay either the average \$40,000 cost to stay in a nursing home for a year or the LTC insurance premiums. Most premium owners indeed pay much less than that for their LTC policies, however, many of the policies lapse before ever being used.<sup>100</sup>

Purchasing both inflation protection and the option of guaranteed renewability are the two most important things that a senior can do to improve the chances of buying a useful policy. While guaranteed re-

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92. As Bruce Radke outlines in his article on LTC risks, stories of abuse are rampant. See Radke, *supra* note 6, at 234-35.

93. See *id.* at 234.

94. See *id.*

95. See *id.* In 1996, the average income of people over age 65 was just \$16,684 per year. See Jill Uylaki, *Promises Made, Promises Broken: Should We Rethink Priority Status For the Pension Benefit Guaranty Corporation?*, 7 ELDER L.J. 1, 9 (1999).

96. See *id.*

97. See *id.*

98. See Mark E. Battista & Brigitte Emmons-Touchette, *Covering the Financial Risk of Long-Term Care: Responding to the Myths*, 1 QUINNIPIAC HEALTH L.J. 175, 175 (1997) (insisting that LTC insurance is for everyone, young and old).

99. Phyllis Shelton, *LTC Consultants* (visited Oct. 25, 1999) <<http://www.ltcshelton.com/csmrpgs/csmrfms/csartset.html>>.

100. See Rein, *supra* note 27, at 286-87.

newability is required in some states, where it is not required, this feature as well as inflation protection, is available through policy riders. These options are available through policy riders that cap the amount premiums can increase and also guarantees that the policyholder retains the right to renew the policy.<sup>101</sup> An astronomically large percentage of LTC policies lapse before they are used, perhaps in part because consumers are not purchasing these riders.<sup>102</sup> Yet, insurance salespeople do not push inflation protection. Some agents cross off the provisions while others simply do a poor job explaining them.<sup>103</sup> Salespeople may discourage consumers from purchasing this protection in order to "keep the costs down."<sup>104</sup> Without inflation protection and guaranteed renewability, however, most policies are not worth

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101. *See id.* at 288. These are often two different riders, so an individual must ask exactly what any rider covers. Other important things consumers need to consider when choosing an LTC policy include: the types of care covered, the length of the waiting periods, the duration of time during which one can receive benefits of various kinds, any requirements regarding prior hospitalization, excluded pre-existing conditions, the total dollar-value of the policy, the daily benefits compared to the costs of various care in one's community today, whether some kinds of care require consumers to pay a deductible, and whether the whole dollar value of the policy can be used for one form of care, or whether instead policy use is limited in some way. Inflation protection is sometimes called "future purchase option." *See* Hayes et al., *supra* note 50, at 22.

102. *See* Rein, *supra* note 27, at 286-87. In the area of home care, the misrepresentations are more widespread and harder to spot

A Florida agent pushing Medico's home-care policy tried to sell a \$100 daily benefit instead of a \$70 plan. 'If you go above \$70, you can get people to come in and clean,' he advised. 'I have a lot of clients who like someone to change their sheets and comb their hair. You're not going to get that for \$70 a day. A \$70 benefit buys only the medical things; \$100 allows the agency to give you some things for health and comfort.' Policyholders may not get their sheets changed, vacuuming done, or their hair combed, even for \$100. According to a sales brochure the agent left, the policy covers only nursing care service . . . medical and health related services . . . prescribed by a physician.

*Id.* at 290.

103. *See id.* at 298.

104. *See id.* The author suspects that some agents do not mention these options because they would make the policies too expensive. Salespeople also may not want to alert people to the fact that these policies might become non-renewable, or that inflation could diminish the value of the policy.

much to the consumer.

Whether the problems with LTC insurance can be cured depends primarily on whether insurance carriers can find a way to make the policies affordable, while at the same time improving the products enough to make more people want to buy them. Current policies are too expensive and provide little in the way of benefits in any event.<sup>105</sup> If the policies no longer require hospital stays, fail to exclude so many medical conditions, and are subject to strict caps on rate increases, perhaps more consumers would buy them. The question remains, however, whether insurance companies can actually sell a useful long-term care product at a rate that people can afford.<sup>106</sup>

Legislation regarding LTC insurance that will better balance the needs of seniors and carriers should be enacted. This could create a larger market for these products. These insurance products already have a bad reputation, and before becoming useful they need to be improved to meet consumer demands. It is unquestionably in everyone's interest to relieve the strain on Medicaid in any way possible.

#### IV. THE RISKS OF CONTINUING-CARE CONTRACTS

The continuing-care contract, which has already been described in some length above, is a product that needs to be improved. These arrangements have many benefits, and with a few improvements, could accomplish many things for many people. A continuing-care contract

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105. See Radke, *supra* note 6, at 247.

106. An optimistic movement is afoot in some states which would allow people to purchase long-term care products now. If they are unable to continue to carry them, the state will pay Medicaid benefits for them later. See David J. Guttchen, *The Connecticut Partnership for Long-Term Care: A Public/Private Partnership to Finance Long-Term Care*, 1 QUINNIPIAC HEALTH L.J. 155, 156 (1997). Under an initiative recently enacted in Connecticut, participants can qualify for Medicaid without completely divesting themselves of all assets, as long as they carry long-term care insurance for a certain period of time. See *id.* Residents are allowed to shield one dollar's worth of asset for every dollar spent on long-term care insurance, assuming they later need to go on Medicaid because the policy has lapsed. See *id.* The general goal of the program is to improve the quality of long-term care policies by insisting on certain benefits in the eligible policies, to improve public perception of these policies, and to reduce the state's burgeoning Medicaid costs. See *id.* at 158. It is too early to tell if public/private initiatives like this will improve these policies or improve the financial condition of Medicaid over the long-term, but at least people are thinking about solutions.

allows an aging person to pre-pay for nursing care, in a lump sum fee, and to live in a pleasant, independent environment prior to needing nursing care. Continuing-care contracts are designed to achieve three goals: (1) allow older people to live independently for as long as possible, (2) avoid making seniors move to a different facility as their medical needs increase, and (3) allow them to insure against the risk that their nursing care needs will outstrip their available funds. People choosing this option could someday be assured that they will receive increased medical care as they age, a place to live for the rest of their lives, and complete assurance that they will be taken care of, regardless of their future financial condition.<sup>107</sup>

The benefits of such an arrangement are obvious because the "insurance" component is one of the most desirable attributes.<sup>108</sup> Most continuing-care contract holders are guaranteed a future level of nursing care, ranging from full nursing care into the future with little or no increase in the monthly payments, to guaranteed nursing care up to a certain dollar cap, to virtually no nursing care except that paid for in cash at the time services are rendered.<sup>109</sup> Moreover, all levels of care are provided at one facility, eliminating the need to relocate later.

Before entering into such an arrangement, or suggesting that a client do so, seniors must first come to terms with the financial reality of these arrangements. Pre-payment for any service is risky, but here the stakes are often life savings. Elders must pick facilities carefully, based on their current and future financial health. To do this, they must know what to look for.

Seniors must be attuned to how CCFs are financed and the various ways they spend residents' up-front entry fees. Unfortunately, financial vulnerability is a very real concern in the CCF field, a field which has been notorious for financial failure.<sup>110</sup> These failures are easily ex-

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107. "Someday" is used because these products currently present many risks to consumers. See *infra* notes 109-138 and accompanying text.

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

109. See Stearns et al., *supra* note 16, at 246-47 (noting that in 1987, about sixty-four percent of all CCFs charged an up-front fee and thereafter guaranteed certain long-term, continuing-care services at little or no extra cost).

110. According to one 1988 study, one-third of the facilities studied suffered from either negative net income or negative net worth. See Hirsh S. Ruchlin, *Continuing Care Retirement Communities: An Analysis of Financial Viability and Health Care Coverage*, 28 GERONTOLOGIST 156 (1988). As one



plained by the structure of the financial relationship between the CCF and its residents. Residents are charged up-front fees based on physical exams and amortization schedules.<sup>111</sup> These fees are used for a number of things, including building facilities for new CCFs and improving existing facilities for established CCFs.<sup>112</sup> How these entrance funds are managed will in large part determine the financial health fa-

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would expect, facilities that offered full nursing care, at essentially one up-front cost, were in the worst financial condition. *See id.* In a well-known magazine article, one author noted that of the fifty CCFs that were financed with tax exempt bonds since 1980, ten percent defaulted on their debts, and fourteen percent failed to meet their occupancy rates. *See* Denise M. Topolnicki, *The Broken Promise of the Life Care Communities*, MONEY, April 1985, at 150.

111. There are numerous different financial models through which life care can be arranged or "purchased," though most arrangements do include an up-front fee. These fees ranged from \$15,000 to \$200,000 in 1990. *See* Fairbanks, *supra* note 16, at 6. While it is recognized that using actuarial information is critical to charging residents a sufficient up-front fee, few CCFs actually hire the professionals necessary to properly use such actuarial information. *See* Stearns et al., *supra* note 16, at 256; Howard Winklevoss, *Continuing Care Retirement Communities: Issues in Financial Management and Actuarial Prediction*, in CONTINUING CARE RETIREMENT COMMUNITIES 57, 61-62 (1985), few CCFs actually hire the professionals necessary to properly use such actuarial information. As Dr. Winklevoss noted, the burning question about the financial liability of CCFs is as follows:

Is it possible to have a life care community with only 300 residents and, based on predictions of their life expectancies, financial projections and fee setting structures, to make the system work? The industry has been claiming for many years that it does not have the data, the information or the methodology to answer this question. Well, those excuses are no longer valid because our book sets forth all the ABC's of the actuarial end of the [CCF] business.

*Id.* at 58.

112. *See* Floyd, *supra* note 16, at 37 (noting that entrance fees may provide capital to build a new facility or to upgrade an existing facility). CCFs can use up-front fees to finance new facilities, assuming these fees had to be invested for the future health care needs of residents. It seemed far more appropriate to finance new construction through the more typical means, such as conventional or tax-free bonds. This industry is considered too risky to generate much interest in the lending or tax-free bond markets. *See* Steven R. Eastaugh, FINANCING HEALTH CARE 181 (1987). Most states require very little reserves from the up-front fees, and only twenty states require any reserves at all. *See infra* notes 132-34 and accompanying text.

cilities.<sup>113</sup> Another factor in financial health is the balance between up-front fees and monthly fees.<sup>114</sup> Unless investments are extremely successful, large up-front fees cause facilities to rely on resident turnover to stay afloat.<sup>115</sup>

The financial goal of CCFs should be to set money aside from entrance fees to meet the future needs of residents.<sup>116</sup> In the past, however, many facilities have used the proceeds of new contracts to meet

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113. A portion of the up-front fees "may go to fund the residents' future nursing care needs." Floyd, *supra* note 16, at 37. Where most of the fees are paid up front, however, it is absolutely critical to a CCF's survival that it set aside a large percentage of the up-front fees for residents' future long-term care. *See id.*

114. While not all CCFs charge a monthly fee, in addition to the up-front fee, a failure to charge such a fee should raise a "red flag" for residents. *See Fairbanks, supra* note 16, at 7. Regardless of how accurate an actuarial analysis is, inflation and other unpredictable factors require a facility to be able to make adjustments to its cash flow based on future circumstances. *See id.* CCFs can make up for insufficient up-front charges by increasing their monthly charges, which ranged in 1989 from \$695 to \$1,000, depending on the size of the unit. *See id.* Of course, if monthly fees go up too much, residents will have lost one of the primary benefits of their CCF contracts, the ability to limit future expenses. *See Floyd, supra* note 16, at 38 (noting that high entrance fees could outstrip residents' ability to pay and thus remove much of the benefit of such a contract in the first place). Out of fairness to residents, some states regulate fee increases by restricting the frequency and the increments of such increases, similar to the way rent control statutes control costs in landlord-tenant situations. *See Fairbanks, supra* note 16, at 6.

115. *See Floyd, supra* note 16, at 38.

116. If CCFs are going to serve their populations, up-front fees must be reserved or set aside for the future needs of residents. *See Winklevoss, supra* note 111, at 59. Fifteen states require that a portion of the up-front fees be placed in reserve for future use, so they are not depleted by short-term construction and other needs. In many states, pre-occupancy payments must be escrowed and released according to a set schedule. *See id.* These statutes may not sufficiently protect residents, however, because the required reserves are far too small and, moreover, the CCFs need not maintain the reserves for very long. *See id.*

Very few state statutes actually require that reserves be set up to handle future obligations. *See infra* notes 132-34 and accompanying text. While the AAHA recommends that CCFs establish a reserve fund equal to the annual principle and interest payments on all debt service, plus enough to cover two to six months of operating costs, only fifteen state statutes require any reserves whatsoever. *See id.*

current obligations to existing residents.<sup>117</sup> Facilities cannot view surplus cash as profits, given these costs are essentially defined financial obligations.<sup>118</sup> As Dr. Winklevoss, an expert on CCFs, has aptly explained:

A major problem in the financial management of a life care community is the very deceptive nature of the income and cash flow of these communities over the first decade and a half of their existence. When you open up a community, you get a tremendous influx of funds in the form of entry fees, while the health care utilization of the residents admitted does not accelerate for about 10 or 15 years. What that means is that the overseers of that community have to have enough patience and fortitude to reserve the monies that they are receiving during the first 10 years until there is an inevitable increase in health care utilization. Lack of reserves has been a big problem. As was noted above, when communities start out they have quite a bit of money, health care utilization is low, and they run the finances of the community in such a way that the amount of money coming in equals the amount going out. Thus, a substantial hidden liability begins to build up. Then if they should have a minor adverse experience, such as a cash flow problem, they find out that there is a tremendous unfunded health care liability, which is very difficult to remedy financially.<sup>119</sup>

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117. While several of such instances are noted in Fisher, *supra* note 16, at 47, the most notorious case involving a failure to reserve is *In re Pacific Homes, Inc.*, 1 B.R. 574 (Bankr. C.D. Cal. 1979). Pacific Homes was a CCF originally formed to take care of retiring Methodist ministers. It eventually expanded its facilities to serve almost 1,900 people in seven facilities located in four states. Residents could pay for their services in one of three ways: total up-front cash fee, transfer of all assets, or up-front fee plus a monthly fee. See Fisher, *supra* note 16, at 50. In the vast majority of the CCF contracts in place, residents paid no monthly fee, making the facilities dependent upon reserves and sound investments for continued viability. Thus, when Pacific Homes began directing its capital toward expansion, speculative investment and financing its resulting operating losses, its financial condition crumbled. It began entering into new CCF contracts to finance not just operating expenses but also losses, creating a "Ponzie scheme" that ultimately resulted in bankruptcy. See *id.* at 51.

118. See Winklevoss, *supra* note 111, at 59-61.

119. *Id.* at 59-60.

Because of their pre-paid structures, CCFs are particularly susceptible to insolvency.<sup>120</sup> Once insolvency occurs, the prospects for residents can be grim. In Idaho, after one facility failed, some residents lost their life savings.<sup>121</sup> When a provider fails financially, it has a number of legal options, none of which are very helpful for residents. First, the facility can cease its operations and hope the state provides for the transfer of the residents.<sup>122</sup> Second, it may file for a state insolvency proceeding, which will normally require liquidation, but may also permit a home to stay in business and reorganize its debts in some way. Third, it could file a federal bankruptcy petition, which has one immediate advantage for the facilities over state proceedings, namely a regular method of reorganizing under the provisions of Chapter 11 of the Bankruptcy Code.<sup>123</sup> Under Chapter 11, the provider can continue to operate without the immediate appointment of a trustee and will receive the benefits of specialized bankruptcy provisions that aid rehabilitation.<sup>124</sup>

If reorganization under Chapter 11 of the Bankruptcy Code makes rehabilitation easier for a debtor facility, it obviously does so at the expense of other parties. One of the primary benefits a debtor obtains in bankruptcy is the ability to reject pre-petition contracts, including those executed by CCF residents, for which some residents may have paid their life savings.<sup>125</sup> Pre-payment for anything is risky, but the risks of pre-payment are particularly great for parties to continuing-care contracts. Residents whose contracts are rejected receive only bankruptcy claims for their losses, which are typically paid at extremely low rates, and for which replacement services cannot be ob-

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120. The financial health of a life-care provider will depend upon as many factors as any other business, as well as on the provider's accuracy in predicting the nursing care costs and life span of residents, investment success, and ability to jump through the necessary hoops to obtain various federal funds. See Floyd, *supra* note 16, at 40-44.

121. See Idaho House Health and Welfare Committee Minutes, Feb. 22, 1988 (testimony of Lorraine Gundersen).

122. Florida, for example, covers some of the costs of moving residents to another facility, from a general state fund. See FLA. STAT. ANN. § 651.119 (West 1996).

123. See 11 U.S.C. §§ 101-1330.

124. See *id.*

125. See 11 U.S.C. § 365.

tained.<sup>126</sup>

Increased risks for continuing-care residents have caught the attention of state legislatures, who have enacted a variety of state statutes to address them.<sup>127</sup> While the precise goal of enacting legislation is to protect residents from the loss of the savings, many statutes do not achieve this goal. It is therefore necessary to draft improved legislation that will protect the rights of CCF residents, even in the face of a Chapter 11 bankruptcy filed by their facility.<sup>128</sup>

While these problems are admittedly large, people around the country have begun to work hard to solve them. Thirty-six states have en-

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126. See 11 U.S.C. § 365(g). Section 365(g) treats the breach as a pre-petition breach by the debtor. See *id.* The nondebtor party then becomes a creditor, as defined in Section 101(10)(B). See 11 U.S.C. § 101(10)(B). Section 502(g) then classifies the nondebtor party's rejection damage claim as a general unsecured claim. See 11 U.S.C. § 502(g).

127. See ARIZ. REV. STAT. ANN. §§ 20-1801-1812 (West 1990); ARK. CODE ANN. §§ 23-93-101-114 (Michie 1992); CAL. HEALTH AND SAFETY CODE §§ 1770-1793.62 (West Supp. 1993); COLO. REV. STAT. ANN. §§ 12-13-101-12-13-119 (West 1991 & West Supp. 1992); CONN. GEN. STAT. ANN. §§ 17a-360-375 (West 1992); DEL. CODE ANN. tit. 18 §§ 4601-4605 (1998); FLA. STAT. ANN. §§ 651.011-651.125 (West 1996); GA. CODE ANN. §§ 33-45-1-33-45-12; IDAHO CODE §§ 67-2750-67-2764; ILL. ANN. STAT. ch. 111 ½, para. 4160-2-12 (West 1988 & Supp. 1992); IND. CODE ANN. §§ 23-2-4-1-4-24 (West 1989 & Supp. 1992); IOWA CODE ANN. §§ 523.D1-523.D14 (West Supp. 1993); KAN. STAT. ANN. §§ 40-2231-40-2238 (Supp. 1992); LA. REV. STAT. ANN. §§ 51:2171-51:2188 (West Supp. 1993); ME. REV. STAT. ANN. tit. 24-A, §§ 6201-6226 (West 1990); MD. CODE ANN., Art. 70B, §§ 7-15 (1989); MASS. GEN. LAWS ch. 93, § 76 (West 1993); MICH. COMP. LAWS §§ 554.810-554.844 (West 1988); MINN. STAT. ANN. §§ 80D.02-80D.20 (West 1986 & Supp. 1993); MO. REV. STAT. §§ 376.900-376.950 (1986 & Supp. 1992); N.H. REV. STAT. ANN. §§ 420-D:1-420-D:27; N.J. REV. STAT. ANN. §§ 52:27D-330-52:27D-360 (West Supp. 1993); N.M. STAT. ANN. §§ 24-17-1-24-17-18 (Michie 1991); N.Y. PUB. HEALTH LAW §§ 4600-4622 (McKinney Supp. 1993); N.C. GEN. STAT. §§ 58-64-1-58-64-85 (1996); OHIO REV. CODE ANN. § 173.13 (West 1992); OKLA. STAT. ANN. tit. 36, § 4423 (West 1990); OR. REV. STAT. ANN. §§ 101.010-101.160 (1991); PA. CONS. STAT. ANN. §§ 3201-3224 (West 1992); R.I. GEN. LAWS §§ 23-59-1-23-59-17 (1989); S.C. CODE ANN. §§ 37-11-10-37-11-140 (Law, Co-op Supp. 1992); TENN. CODE ANN. § 4-3-1305 (1991); TEX. HEALTH & SAFETY CODE ANN. §§ 246.001-246.117 (West 1992); VA. CODE ANN. §§ 38.2.4900-38.2.4917 (Michie 1990 & Supp. 1993); VT. STAT. ANN. tit. 8, §§ 8001-8018 (Supp. 1992); WIS. STAT. ANN. §§ (West 1993).

128. See *id.*

acted legislation regulating the industry.<sup>129</sup> Moreover, while this legislation is not as protective of residents as it should be, work on improving this legislation to better protect resident fees against insolvency has been occurring. The first step to improving these statutes is to enact legislation in all states requiring CCFs to reserve a portion – hopefully a large portion – of resident fees for future care. While reserving entrance fees for future nursing care costs is virtually the *only* way to preserve ongoing financial viability in this industry,<sup>130</sup> only fifteen states currently require facilities to do so, and most of these requirements are far from stringent.<sup>131</sup>

The most common reserve provisions require that the facility reserve, on a current basis, an amount equal to the principal and interest payments due during the next twelve months for any first mortgage or other long-term financing of the facility.<sup>132</sup> These statutes require reserves to sufficiently cover *long-term debt* for one year, but do not require reserves for *ongoing operating expenses* for any period.<sup>133</sup> Some states do require reserves for some minimal operating expenses. For example, Florida requires that a facility set aside operating reserves in an amount equal to thirty percent of the total operating expenses projected in the facility's feasibility study for the first twelve months of operation.<sup>134</sup> These operating expenses must only be reserved during the start-up phase and most financial failure occurs after this period. States that require reserves for ongoing operating expenses only mandate them for two or three months.<sup>135</sup>

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129. See *supra* note 127.

130. See Winklevoss, *supra* note 111, at 58-60.

131. See ARIZ. REV. STAT. ANN. § 20-1804; ARK. CODE ANN. § 23-93-111; CAL. HEALTH & SAFETY CODE § 1775; COLO. REV. STAT. ANN. § 12-13-107; FLA. STAT. ANN. § 651.035; ME. REV. STAT. ANN. tit. 24-A, § 6215; MD. CODE ANN., art. 70B, § 11; MINN. STAT. ANN. § 80D.06; MO. REV. STAT. § 376.945; N.H. REV. STAT. ANN. § 420-D:8; N.J. REV. STAT. § 52:27D-339; OR. REV. STAT. § 101.060; 40 PA. CONS. STAT. ANN. § 3201; TEX. HEALTH & SAFETY CODE ANN. § 246.077; VT. STAT. ANN. tit. 8, § 8009.

132. See, e.g., ARIZ. REV. STAT. ANN. § 20-1806; MINN. STAT. ANN. § 80D.06; TEX. HEALTH & SAFETY CODE ANN. § 246.077.

133. See *id.*

134. See FLA. STAT. ANN. § 651.035.

135. When calculating reserves, New Hampshire adds that portion of two months' operating expenses that relate to life care residents, and Oregon adds operating expenses for three months. See N.H. REV. STAT. ANN. § 420-D:8; OR. REV. STAT. § 101.060. Still, having secured status in the first place is

Some state statutes also require CCFs to take other steps to improve their financial condition or protect resident entry fees. For example, some states require CCFs to procure surety bonds to protect these fees.<sup>136</sup>

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better than nothing. Holding a statutory lien provides some negotiating power, unless, of course, the statutory lien is only effective upon bankruptcy or insolvency. Other states have developed alternative reserve methods. Pennsylvania requires each facility to hold the twelve months' worth of debt service payments in reserve, or ten percent of the projected annual operating expenses of the facility, whichever is greater. *See* 40 PA. CONST. STAT. ANN. § 3209 (1998). Vermont's and New Jersey's statutes are similar. Vermont requires the equivalent of a year's principal and interest payments or purchase inflation protection and to purchase the option of guaranteed renewability or fifteen percent of annual operating expenses, whichever is greater. *See* VT. STAT. ANN. tit. 8, § 8009. New Jersey requires the same yearly equivalent or fifteen percent of the projected annual operating expenses of the facility, exclusive of depreciation. *See* N.J. REV. STAT. ANN. § 52:27D-339. Colorado's statute requires that each facility maintain reserves equivalent to the next eighteen months' principal and interest on those debt obligations that are collateralized by the provider's facility. It also requires a balloon payment, *plus* an amount equal to the next twelve months' principal and interest for all other debt obligations that are collateralized by the provider's facility, *plus* an amount not less than twenty percent of the facility's operating expenses for the immediately preceding year. *See* COLO. REV. STAT. § 12-13-107. Other states base the reserve requirements on the actuarially determined annual refund amount, *see* ARK. CODE ANN. § 23-93-111, which is based on the amount residents have a right to receive, in cash, if they die or leave the facility. Again, this figure is not based on what is necessary for the long-term survival of the facility, and constitutes a far lower number than what would support the operations of the facility over the long term. The most effective statute by far, and the only one that requires reserves in amounts sufficient to support the facility over the long term, is Maine's statute. The law requires that each provider's reserves must equal the excess of the present value of the future benefits promised under the continuing care agreement over the present value of the future revenues and any other available resources, based on conservative actuarial assumptions. *See* ME. REV. STAT. ANN. tit. 24-A, § 6215.

136. *See* CAL. HEALTH & SAFETY CODE § 1774 (for employees and agents with access to substantial amounts of funds); GA. CODE ANN. § 33-45-4 (requiring a compliance bond of not less than \$10,000); IDAHO CODE § 67-2756 (requiring a surety bond, reserves, or a letter of credit or other financial arrangement in undesignated amount, to establish financial security); S.C. CODE ANN. §§ 37-11-40 (requiring a surety bond, reserves, or a letter of credit or other financial arrangement in undesignated amount, to establish financial security). Michigan's statute states that the state *may* require a bond if necessary

Other statutes require ongoing actuarial studies.<sup>137</sup> Like the reserve provisions, however, these provisions are underutilized in the state continuing-care statutes. If they were required more frequently and a facility liquidates, the surety bonds would help pay for residential care to be received elsewhere. The actuarial studies would keep the facility informed of deteriorating financial conditions so it could attempt to reverse them. The reserve requirements, more than any other requirement, would help avoid insolvency entirely by forcing facilities to prepare for a strong financial future. These goals are all extremely important and this subject matter is clearly worthy of more state legislation.

Enacting statutes that require reserves of entrance fees, procurement of surety bonds, and ongoing actuarial studies, would unquestionably improve the financial health of CCFs. In addition to taking these steps, states also should enact valid statutory liens in favor of residents that will protect them if insolvency occurs anyway. While additional legislation can be proposed to further protect CCF residents' up-front entrance fees, taking these two steps alone would greatly improve the financial viability of this industry.

Continuing-care contracts may still provide valuable benefits to some elderly people. The most important thing residents may do to protect themselves is visit desirable facilities, talk to other residents, and then talk to management about the facility's use of residents' fees, as well as its financial condition.

It is also important to realize that future nursing care could be very costly for the facility. Consequently, it is probably best to avoid fa-

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to protect residents. *See* MICH. COMP. LAWS § 544.816.

137. *See, e.g.*, ARIZ. REV. STAT. ANN. § 20-1807 (requiring an actuarial study at least every three years); CONN. GEN. STAT. ANN. §§ 17b-527, (annually); IDAHO CODE § 67-2754; (five years); ME. REV. STAT. ANN. tit. 24-A, § 6223 (annually); MD. CODE ANN., art. 70B, § 11 (three years); MINN. STAT. ANN. § 80D.025, (annually, to establish reserves); N.Y. PUB. HEALTH LAW § 4604 (annually); TEX. HEALTH & SAFETY CODE ANN. § 246.114 (five years). South Carolina requires a summary of an actuarial report to be updated every two years and New Mexico's statute provides that providers must produce an annual disclosure statement which must include, for those communities that charge an entrance fee that were not in operation on the effective date of the Continuing Care Act, an actuarial analysis of the community performed by an actuary experienced in analyzing continuing care communities. *See* S.C. CODE ANN. § 37-11-30; N.M. STAT. ANN. § 24-17-4.



cilities with unbelievably low rates. While none of these precautions can ensure that a person will be protected if her chosen facility becomes insolvent,<sup>138</sup> few things in life are certain anyway. Entering into such a contract may well be worth the risk. Better yet, if the senior can wait a few years, regulation in this area is likely to improve greatly.

## V. CONCLUSION

The United States population is aging rapidly, and as a result, the options for senior housing have expanded far beyond the traditional nursing home. Many of the new options allow seniors to live active, independent lives, far more easily than in the past. As the human life span expands, however, many people have lingering concerns about financing this future care. Unfortunately, the options for financing future nursing care are less plentiful than the living arrangements. The simple reality is that long-term care is incredibly expensive, whether it is paid for privately or publicly. Both of the currently available options for spreading the risk of these costs, long-term care insurance and continuing-care contracts, create their own financial risks. It is time to take steps to improve these options, as well as create additional ways to spread the risk of long-term care.

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138. Given that there is no way to guarantee that an entrance fee will be protected if a facility becomes insolvent, these arrangements are best for people who can afford to pay the entrance fee at a stable facility and have money remaining.