FEDERAL AND STATE INITIATIVES TO JUMP START THE MARKET FOR PRIVATE LONG-TERM CARE INSURANCE

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As the baby boom generation prepares for retirement in the upcoming decade, one issue that figures to be of special importance is the cost of long-term care, which has

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reached catastrophic levels. Neither Medicare nor private health insurance policies currently cover services such as nursing home care or home health care to any significant extent. Instead, most older Americans in need of long-term care must first exhaust personal financial resources and then turn to welfare in the form of Medicaid. As a result, long-term care expenditures not only drain an individual's retirement savings, but place a severe strain on the public fisc as well.

One possible solution to this crisis has been the advent of private long-term care insurance. Due primarily to their high cost, however, these policies have been slow to enter the market as a viable means of funding long-term care for the older population. In this article, the authors evaluate various strategies, at both the federal and state levels, designed to encourage the purchase of long-term care policies. One approach, used by the federal government and an increasing number of state legislatures, has been individual tax incentives in the form of tax deductions or credits to purchasers of private long-term care insurance. A similar tactic has been to provide tax incentives for employer contributions to long-term care insurance. At the same time, both state and federal governments have attempted to act as role models for private employers by offering long-term care insurance to their own employees. Finally, a limited number of states have formed so-called public-private partnerships for long-term care, which essentially relax the requirements of qualifying for long-term care coverage under Medicaid.

The authors conclude, though, that these initiatives have achieved only modest success in penetrating the market for long-term care insurance and their effect has been more symbolic than substantive. The failure of these proposals to increase the actual number of policies in force raises a host of fundamental policy issues, such as whether the government should encourage private long-term care insurance, which idealizes the American principle of self-reliance, or instead whether the government should fund long-term care insurance via direct spending in federal benefit programs. If the government decides to intervene in the private market, it is still unclear which particular strategy is the most effective and efficient. The authors stress that these underlying policy concerns must be addressed before any progress can be made on the issue of private long-term care insurance.

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I. Introduction

Long-term care in the United States is overwhelmingly financed through means-tested public programs and out-of-pocket payments.[1] People with disabilities and their families find, often to their astonishment, that nursing home and home care are not covered to any significant extent by either Medicare[2] or their private health insurance policies.[3] Instead, they must rely on their own resources or, when those have been exhausted, turn to welfare in the form of Medicaid.[4] With the cost of nursing home care exceeding $50,000 per year in 1997, it is not surprising that long-term care is a major source of catastrophic out-of-pocket costs for disabled elderly persons.[5] Due to the aging of the population and price increases greater than general inflation, Medicaid long-term care expenditures for the elderly are likely to roughly double between 2000 and 2020 in inflation-adjusted dollars, placing financial strain on individuals and their families, as well as both the federal and state governments.[6]

To address the problems of catastrophic out-of-pocket costs and rising public expenditures, many policymakers are assessing the potential of private long-term care insurance. Currently, private long-term care insurance plays only a small role in financing long-term care for the older population, accounting for only about 2.5% of national long-term care expenditures for the elderly population in 2000.[7] This low percentage reflects not only the small number of people with private long-term care insurance policies, but also the limitations contained in those policies. Only a small fraction of older Americans have private insurance to guard against the high costs of long-term care. With only about 3.2 to 3.8 million policies in force in 1997, pri-

1. *See* LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 131 (2d ed. 1999).
2. *See* 42 U.S.C. §§ 1395–1395ggg (1994).
3. *See* FROLIK & KAPLAN, *supra* note 1, at 131.
4. *See* 42 U.S.C. §§ 1396–1396v.
5. *See* Joshua M. Wiener et al., *Catastrophic Costs for Long-Term Care for Elderly Americans*, *in* PERSONS WITH DISABILITIES: ISSUES IN HEALTH CARE FINANCING AND SERVICE DELIVERY 182, 182–83 (Joshua M. Wiener et al. eds., 1995); Unpublished Data from the Office of National Health Statistics, Office of the Actuary, Health Care Financing Administration, Baltimore, Md. (1999).
6. *See* U.S. Congressional Budget Office, Projections of Expenditures for Long-Term Care Services for the Elderly, CBO Memorandum (1999).
7. *See id*.

vate insurance provided coverage to less than ten percent of the elderly population.[8]

While some reasons for the low market penetration of private long-term care insurance include misinformation about long-term care coverage under Medicare,[9] lack of knowledge about the spend-down requirements of Medicaid,[10] denial of the risks of long-term care,[11] and competition with other needs, the greatest impediment may be the high cost of good quality policies.[12] The average annual premium for high-quality, individual policies purchased at age sixty-five was $2305 in 1997,[13] rising to $7022 if purchased at age seventy-nine.[14] The policies are expensive for two reasons: first, eight out of ten policies are sold individually[15] and, consequently, carry high administrative and marketing costs;[16] second, most policies are bought by older people who have a greater risk of needing long-term care.[17] Despite the marked improvement in the financial position of the elderly over the past thirty years,[18] most studies estimate that only ten to twenty percent of the older population can afford good quality private long-term care insurance policies.[19] Other research has found the percentage of the elderly who can afford private insurance to be higher, but these studies have done so by assuming purchase of policies with more

8. A major difficulty with insurance industry statistics is that they only report the number of policies ever sold rather than the number of policies in force. *See* Interview with Marc Cohen, LifePlans, Inc., in Waltham, Mass. (Apr. 1999).

9. *See generally* FROLIK & KAPLAN, *supra* note 1, at 131–48.

10. *See id*.; *see also* 42 U.S.C. § 1396(p) (1994).

11. *See generally* FROLIK & KAPLAN, *supra* note 1, at 131–48.

12. *See* Jan Ellen Rein, *Misinformation and Self-Deception in Recent Long-Term Care Policy Trends*, 12 J. L. & POL. 195, 280–85 (1996).

13. *See* Susan Coronel, Health Insurance Assoc. of Am., Monograph, *Long-Term Care Insurance in 1997–98* (2000).

14. This was the average premium for policies providing $100 per day of nursing home care, $50 per day of home care, four years of coverage, a 20-day elimination period, five percent annual compound inflation adjustment, and a nonforfeiture benefit. *See id*.

15. *See* Rein, *supra* note 12, at 281.

16. *See id*.

17. *See id*.

18. *See* Committee on Ways & Means, U.S. House of Representatives, *The Green Book: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means,* 894 tbl.13-22 (1998) [hereinafter *1998 Green Book*].

19. *See* JOSHUA M. WIENER ET AL., SHARING THE BURDEN: STRATEGIES FOR PUBLIC AND PRIVATE LONG-TERM CARE INSURANCE (1994); William H. Crown et al., *Economic Rationality, the Affordability of Long-Term Care Insurance, and the Role of Public Policy*, 32 GERONTOLOGIST 478, 478–85 (1992); *see also* ALICE M. RIVLIN & JOSHUA M. WIENER, CARING FOR THE DISABLED ELDERLY: WHO WILL PAY? (1988).

limited coverage,[20] by assuming that the elderly would use a high percentage of their income and assets to pay premiums,[21] or by not requiring that purchasers have a minimum level of assets.[22] For example, by assuming that the older population is able to spend ten percent of its income on private long-term care insurance, Mulvey and Stucki estimate that thirty-one percent of people age sixty-five and older can afford a two- or five-year private long-term care insurance policy that covers two or five years of nursing home or home care coverage.[23]

Given the limitations of the current market for private long-term care insurance, policymakers have considered or enacted three strategies of governmental intervention that could increase the number of people with private long-term care insurance. One approach is to provide individuals with tax incentives that encourage purchase of long-term insurance policies by reducing the net price of such policies.[24] The second approach is to encourage employer-based private long-term care insurance through tax incentives and through the federal and state governments serving as role models for private employers by providing governmental employees, retirees, and their dependents the opportunity to purchase insurance.[25] The third approach is to waive some or all of the Medicaid asset depletion requirements for purchasers of qualified private long-term care insurance policies, allowing them to retain more of their assets and still qualify for Medicaid.[26] The intent of all three strategies is to induce more people to purchase long-term care policies by lowering premium costs: the first accomplishes this through tax breaks; the second operates under the principle that private long-term care insurance is far more affordable if purchased at a younger age;[27] and the third attempts to reduce the amount of insurance necessary to achieve lifetime asset protection.

20. *See* Marc A. Cohen et al., *Financing Long-Term Care: A Practical Mix of Public and Private*, 17 J. HEALTH POL. POL'Y & L. 403, 408–09 (1992) [hereinafter *Financing Long-Term Care*]; Marc A. Cohen et al., *The Financial Capacity of the Elderly to Insure for Long-Term Care*, 27 GERONTOLOGIST 494 (1987) [hereinafter *Financial Capacity*] .

21. *See* JANEMARIE MULVEY & BARBARA STUCKI, WHO WILL PAY FOR THE BABY BOOMERS' LONG-TERM CARE NEEDS? EXPANDING THE ROLE OF LONG-TERM CARE INSURANCE 9 (1998).

22. *See id*. at 10.

23. *See id*. at 14.

24. *See infra* notes 35–115 and accompanying text.

25. *See infra* notes 116–67 and accompanying text.

26. *See infra* notes 168–99 and accompanying text.

27. Policies purchased at age 40 cost about one-third of what they cost at age 65. *See* Coronel, *supra* note 13, at 28; *see also* MULVEY & STUCKI, *supra* note 21, at 14;

This paper explores these three strategies for increasing the size of the private insurance market and analyzes the strengths and weaknesses of each approach. In addition to a review of the literature, in-person and telephone interviews were conducted with over twenty long-term care insurance experts from the insurance industry, consumer advocacy groups, federal and state governments, and the research community.[28] Part II of this paper examines state and federal tax incentives that have been implemented to encourage the purchase of long-term care policies. Part III then reviews the effectiveness of private employers sponsoring long-term insurance for their employees. The government's role in fostering the employer-sponsored market for long-term care insurance is explored in Part IV, including the government acting as a role model by offering long-term care policies to public employees. Part V then looks at the efforts of public-private partnerships to provide long-term care insurance. Finally, Part VI concludes that these various strategies to increase the purchase of private long-term care insurance have not had a major effect on the number of policies in force and seem to be largely symbolic of policymakers' interests in promoting insurance.

II. Individual Tax Incentives for Purchase of Long-Term Care Insurance

Tax incentives to encourage the purchase of long-term care insurance have become law at the federal and state levels. Most directly, these tax subsidies reduce the net price of private long-term care insurance policies, although the amount of the decrease under existing tax incentives is modest at most. Beyond reducing the cost of policies, some insurance advocates argue that tax incentives have a "sentinel" effect, signaling potential purchasers that the government believes private long-term care insurance is a worthwhile product.

WIENER ET AL., *supra* note 19, at 62.

28. These interviews included government officials involved with providing long-term care insurance to government employees in five states and tax incentives for purchase of private long-term care insurance in 16 states. To encourage candor, respondents were assured that they would not be identified or quoted by name [hereinafter Personal Interview].

A. Federal Tax Incentives

The Health Insurance Portability and Accountability Act of 1996[29] (HIPAA) provides certain federal tax benefits for "qualified" private long-term care insurance premiums under certain circumstances.[30] Specifically, HIPAA:

1. Clarifies that out-of-pocket payments for qualified private long-term care insurance policies are medical expenses.[31] Medical expenses are deductible if they exceed 7.5% of the individual's adjusted gross income;[32]

2. Limits by age the amount of qualified long-term insurance premiums that can be counted toward a deduction, but increases the amount over time to account for inflation;[33]

3. Clarifies that qualified long-term care insurance benefits are not taxable as income up to certain limits, which are indexed annually for inflation.[34]

In contrast to federal tax policy as it relates to health insurance covering acute medical care, which places few restrictions on the medical services or persons covered,[35] HIPAA is relatively restrictive.[36] In particular, it uses the availability of the tax deduction as leverage to set minimum regulatory standards (albeit only for "qualified" policies).[37] It also restricts who may qualify for benefits by specifying the "benefit triggers" of "qualified" policies[38] and limits the size of the qualifying benefit[39] as a means for controlling revenue loss. However,

29. Pub. L. No. 104-191, § 301, 110 Stat. 1936, 2041–42 (1996) (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.).

30. *See* 26 U.S.C. § 213(a) (1994).

31. *See* 26 U.S.C. § 213(d) (Supp. III 1997).

32. *See* 26 U.S.C. § 213(a) (1994). To obtain this deduction, the taxpayer must itemize his or her tax return. *See id*.

33. *See* 26 U.S.C. § 213(d)(10) (Supp. III 1997). In 1999, up to $400 per year in qualified long-term care insurance premiums could be counted as a medical expense for persons aged 41–50 and up to $2660 for persons aged 71 and above. *See* INTERNAL REVENUE SERV., PUB. NO. 502, MEDICAL AND DENTAL EXPENSES 9 (1999).

34. *See* INTERNAL REVENUE SERV., *supra* note 33, at 9. In 1999, up to $190 per day ($69,350 per year) in qualified long-term care insurance benefits could be excluded from taxable income where payments were based on disability level or the full amount of long-term care costs incurred and reimbursed. *See id*.

35. *See* Nicole Tapay & Judith Feder, Federal Standards for Private Long-Term Care Insurance: Implementing Protections Through the Federal Tax Code (unpublished manuscript on file with author).

36. *See id.* at 3, 6.

37. *See* 26 U.S.C. § 213(d)(10).

38. *See* Tapay & Feder, *supra* note 35, at 5.

39. *See* 26 U.S.C. § 213(d)(10).

HIPAA differs from most insurance regulation in that it does not prohibit the sale of nonqualified long-term care insurance policies,[40] although the number of these policies seems to be declining.[41] In the end, the tax status of premiums and benefits of nonqualified long-term care insurance policies is unclear.[42]

To be qualified, long-term care insurance benefits are only "triggered" when a person needs substantial assistance in performing at least two of six activities of daily living and the assistance is expected to last at least ninety days,[43] or requires substantial supervision resulting from a severe cognitive impairment.[44] Qualified policies must also meet the 1993 National Association of Insurance Commissioner's (NAIC) model regulations.[45] Consequently, although HIPAA's benefit triggers are more restrictive than those that the NAIC recommends for long-term care insurance policies,[46] almost all insurers have modified their benefit eligibility requirements to reflect HIPAA's requirements.[47]

Although HIPAA provides some incentive for consumers to purchase long-term care insurance, most observers believe that the tax incentives are not large enough to lead to major increases in sales.[48] Several factors minimize the impact of HIPAA tax incentives. First, tax incentives are ineffective for people without tax liability, which is

40. *See* Tapay & Feder, *supra* note 35, at 16.
41. *See* Personal Interview, *supra* note 28.
42. *See* Tapay & Feder, *supra* note 35, at 31.
43. *See* 26 U.S.C. § 7702B (c)(2)(A)(i) (1996). HIPAA lists six activities of daily living and requires that at least five be used in the benefit trigger, but all six may be used. *See* Tapay & Feder, *supra* note 35, at 9. In fact, most qualified policies use all six activities in their benefit trigger. *See id*.
44. *See* 26 U.S.C. § 7702B (c)(2)(A)(iii). The law also authorizes a third trigger for a level of disability comparable to the inability to perform two of six activities of daily living. *See id.* § 7702B (c)(2)(A)(ii). However, this standard has been extremely difficult to develop and apply.
45. *See id.* § 7702B (g)(2)(B)(i). HIPAA incorporated the 1993 model because, unlike earlier versions, it does not include provisions related to mandatory nonforfeiture benefits and restrictions on premium increases that the insurance industry opposed. Many experts, including some from the insurance industry, advocated that HIPAA incorporate the Spring 1999 version of the NAIC regulations, which does not have the two provisions to which the insurers had objected. Industry experts cautioned against automatically incorporating any future changes to the NAIC models.
46. *See* Tapay & Feder, *supra* note 35, at 6. In part, this reflects a difference in purpose between HIPAA and the NAIC model: HIPAA's benefit triggers are maximums designed to limit tax loss while the NAIC's standards are designed as minimum standards to protect consumers.
47. *See* Personal Interview, *supra* note 28.
48. *See id*.

of special importance to older people who buy most private long-term care insurance policies.[49] Because most Social Security payments are excluded from federal income tax,[50] and states follow federal rules in this respect, only about half of older people pay any federal income tax at all.[51] Beyond that, relatively few taxpayers itemize their deductions. In 1997, only twenty-eight percent of all tax returns included itemized deductions, and only four percent claimed a deduction for medical expenses.[52] The 7.5% of income threshold for the deduction of medical expenses[53] also poses a formidable barrier to providing tax benefits. For example, a sixty-five-year-old single individual with $30,000 in adjusted gross income must have $2250 in out-of-pocket medical and long-term care expenses (i.e., 7.5% of $30,000) before deducting any medical expenses or long-term care insurance premiums. In addition, for the seventy percent of aged taxpayers in the fifteen percent tax bracket in 1998, this type of tax deduction reduces the cost of obtaining long-term care insurance only slightly, probably not enough to motivate very many additional people to purchase policies.[54]

Most advocates of long-term care insurance generally agree that changes to federal tax incentives are necessary to substantially increase sales. First, they argue that the entire premium should be tax deductible and not subject to the 7.5% adjusted gross income requirement.[55] Also, employers should be able to offer long-term care insurance in their cafeteria plans and flexible spending accounts.[56] In addition, some experts suggest that people ought to be able to draw funds from their retirement accounts to pay long-term care insurance premiums without having to pay tax on the withdrawal.[57]

Liberalizing tax incentives for long-term care insurance must be considered in the context of the tax revenue loss, the distributional ef-

49. In a 1994 survey of long-term care insurance purchasers, 81% were age 65 or older. *See* LIFEPLANS, INC., WHO BUYS LONG-TERM CARE INSURANCE: 1994–95 PROFILES AND INNOVATIONS IN A DYNAMIC MARKET 16 (1995).

50. *See* FROLIK & KAPLAN, *supra* note 1, at 306.

51. *See 1998 Green Book*, *supra* note 18.

52. *See* Scott M. Hollenbeck & Maureen Keenan Kahr, *Individual Income Tax Returns, 1997: Early Tax Estimates*, STATISTICS OF INCOME BULLETIN, Winter 1998–1999, at 126–50.

53. *See 1998 Green Book*, *supra* note 18.

54. *See id*.

55. *See* Taxpayer Refund and Relief Act of 1999, H.R. 2488, 106th Cong. § 222.

56. *See id*. §§ 222, 502.

57. *See* Personal Interview, *supra* note 28.

fect of the tax incentive, and the efficiency of the subsidy in encouraging additional purchases. When HIPAA was enacted, the Congressional Joint Committee on Taxation estimated the tax loss resulting from the long-term care provisions to be $645 million in 1999 and anticipated increasing annual losses reaching over one billion dollars by 2005.[58] Similarly, lost revenue from the full deductibility of long-term care insurance premiums is estimated to be an additional $1.3 billion by the year 2007.[59]

A simulation of an earlier income-related tax credit proposal to encourage the purchase of long-term care insurance found that the credit was likely to make private long-term care insurance affordable to only another eight percent of the older population in 2018, increasing the percentage of those who might be able to buy policies from twenty to twenty-eight percent.[60] Moreover, because most persons who would have benefited from the simulated tax incentives would have purchased insurance in the absence of the tax incentive, the study calculated the cost per additional policy induced by the tax benefit at between $1700 and $1900 per year.[61] An additional problem is that long-term care insurance incentives are likely to provide most tax benefits to relatively well-to-do taxpayers.[62] In fact, it has been estimated that in 2018, sixty-four percent of private insurance expenditures for long-term care would be spent on older people with annual incomes above $40,000 per year compared to seven percent of expenditures for Medicaid.[63]

58. *See* STAFF OF JOINT COMM. ON TAXATION, GENERAL EXPLANATION OF TAX LEGISLATION ENACTED IN THE 104TH CONGRESS 345 (Joint Comm. Print 1996). Some observers believe that this estimate is far too high because most policyholders were already counting private long-term care insurance as a medical expense.

59. *See* Joint Comm. on Taxation, *Estimated Budget Effects of the Conference Agreement for H.R. 2488: Fiscal Years 2000–2009,* JCX-61-99 R (visited Mar. 7, 2000) <http://www.house.gov/jct/x-61-99r.pdf>.

60. *See* WIENER ET AL., *supra* note 19, at 59–61. The simulated tax incentive would have provided a nonrefundable tax credit to single elderly persons with income of $40,000 or less and married persons with income of $60,000 or less. The tax credit would have decreased one percentage point for each $1000 increase in income for a cap of $60,000 for individuals and $80,000 for married couples. The income limits would have increased annually with inflation. *See id*. at 58–60.

61. *See id*.

62. *See id*. at 58.

63. Not surprisingly, the study found that the tax loss through 2018 far exceeded any Medicaid nursing home savings. *See id.*

B. State Tax Incentives for the Purchase of Long-Term Care Insurance

Over the last few years, a number of states have enacted tax incentives to encourage the purchase of long-term care insurance. As of 1999, eighteen states provided tax deductions or credits to purchasers of private long-term care insurance.[64] In another eighteen states, tax incentive legislation was introduced during the 1999 legislative session.[65] These tax incentives include both deductions and credits for taxpayers. Table 1 summarizes the provisions in eighteen states that have individual tax incentives, and the Appendix provides a detailed description of each state's tax incentive for individuals and employers as well as the appropriate statutory citation for each.
[insert Table I here]

64. *See infra* Appendix.
65. *See* Elana Mintz, *Long-Term Care Insurance Issue Brief* (last modified Oct. 1, 1999) <http://www.hpts.org>.

In general, these tax incentives are likely to have only a minimal impact on long-term care insurance premiums because of the relatively low state tax rates, which make a deduction or credit less attractive. Moreover, in some cases, a taxpayer can take either the federal or state incentive, but not both.[66] Although available to a broader population than the federal tax incentives under HIPAA,[67] state tax incentives are quite modest in reducing the cost of insurance, arguably providing more of a "sentinel" effect than an economic one.

Six states—Alabama, Iowa, Kentucky, Maine, Montana, and Wisconsin—allow taxpayers to deduct the total cost of long-term care insurance premiums, without limit, when calculating state taxable income.[68] And four states—Colorado, Minnesota, North Carolina, and North Dakota—offer individual taxpayers a small credit against their state tax liability if the taxpayers purchase insurance.[69]

New York allows only a partial deduction of long-term care insurance premiums and models its state tax incentives on HIPAA.[70] New York does not require taxpayers to meet the 7.5% medical and

66. *See* Personal Interview, *supra* note 28.
67. *See infra* Appendix.
68. *See id.* Indiana will also allow a similar deduction beginning January 1, 2000. *See* IND. CODE § 6-3-1-3.5 (1999).
69. *See infra* Appendix.
70. *See id*.

long-term care expense threshold to qualify for the tax deduction.[71] The amount of this deduction is limited, varies by the age of the purchaser, and is indexed annually for inflation.[72] For example, in 1998, New York allowed individuals under the age of forty to deduct up to $210, while allowing individuals over the age of seventy to deduct up to $2660.[73]

State tax credits for individuals are capped at relatively low levels. For example, Minnesota and North Dakota provide an individual tax credit equal to the lesser of $100 or twenty-five percent of premiums paid.[74] In North Carolina, the individual tax credit cannot exceed $350 for each qualified long-term care insurance contract for which a credit is claimed.[75]

In ten states, taxpayers have a choice of either taking the state tax incentive or the federal deduction for long-term care insurance premiums, but cannot take both.[76] Because state income tax liability is based on the federal adjusted gross income after federal itemized deductions are claimed,[77] filers are prevented from receiving a double benefit for the same expenses. For example, in Wisconsin, a filer who claims long-term care insurance expenses as a federal medical itemized deduction cannot use those expenses to also reduce their state taxable income.[78] Maine, North Dakota, and New York are the only three states that allow individual filers to take both the state tax deduction or credit and the federal tax deduction for long-term care insurance premiums.[79]

Tax incentives in ten of the states studied took effect between 1997 and 1999.[80] Given the recent implementation of these tax incentives and their small size, states have collected little information on the number of people who take advantage of these incentives and the expected tax revenue loss from these provisions. Only two states reported the number of taxpayers who elect to use a tax credit or de-

71. *See id*.
72. *See id*.
73. *See id*.
74. *See id*.
75. *See id*.
76. *See id*.
77. *See id*.
78. *See id*.
79. *See id*.
80. In Maryland, Minnesota, and North Carolina, the tax credit took effect for the 1999 tax year. Tax deductions in Kentucky and Wisconsin went into effect during the 1998 tax year. *See infra* Appendix.

duction for long-term care insurance. In 1997, Montana reported that some 4572 people took advantage of the state's tax deduction,[81] and North Dakota identified 943 people who took advantage of that state's tax credit.[82]

Several states noted that tax credits and deductions for long-term care insurance are not a "big ticket item" and have very little fiscal impact on states.[83] For states that had implemented tax incentives by 1999, estimated revenue losses ranged from a low of $120,000 in North Dakota to a high of $8 million in North Carolina.[84] In addition, four states estimated the impact of the tax incentive on an individual's tax liability.[85] On average, a taxpayer could expect to reduce his or her taxes by a low of $70 in Wisconsin to a high of $127 in North Dakota.[86] In part, this reflects the relatively low state tax rates. In twenty-nine of the forty-two states with an income tax in 1999 (including the District of Columbia), the maximum tax rate was seven percent or less.[87] Thus, the maximum tax reduction on a $2500 policy for the highest income group would only be $175 (i.e., seven percent of $2500) in those states.

Eight states allow individuals to claim a "front page" or "above the line" deduction for long-term care insurance premiums in addition to a standard deduction.[88] In another four states—Alabama, Montana, North Dakota, and Wisconsin—individuals must itemize their tax returns to take advantage of the long-term care insurance premium tax deduction or credit.[89] North Dakota, for example, offers two forms for filing taxes—a short form and a long form.[90] Ninety-five percent of all state filers submit the short form, which utilizes a lower tax rate schedule than the long form. In exchange for receiving lower tax rates on the short form, individuals may not take any credits or adjustments—including those for long-term care—on their tax returns.[91]

81. *See* Personal Interview, *supra* note 28.
82. *See id*.
83. *See id*.
84. *See infra* Appendix.
85. *See id*.
86. *See id*.
87. *See* Federation of Tax Adm'rs, *State Individual Income Tax Rates*, (visited June 14, 1999) <http://www.taxadmin.org/fta/rate/ind_inc.html>.
88. *See infra* Appendix.
89. *See infra* Appendix.
90. *See* N.D. CENT. CODE § 57-38-30.3(1) (1998).
91. *See* Personal Interview, *supra* note 28.

III. Employer-Sponsored Long-Term Care Insurance in the Private Sector

Employer-sponsored plans for younger people offer several advantages over policies that older people must purchase individually. First, premiums for young policyholders are less expensive than those for older people because earnings have time to build before the policies pay out benefits.[92] For example, in 1997 the average annual premium for a high-quality policy purchased at age forty was $770, compared to $7022 purchased at age seventy-nine.[93] Affordability problems would be greatly diminished if the younger population were to buy insurance.[94] Second, group policies can take advantage of economies of scale in marketing and administrative expenses, including agent commissions, and are also able to negotiate lower prices, all of which further reduce premiums when compared with policies sold to individuals. Because of low take-up rates, however, price differentials for individual and group private long-term care insurance are not as high as for acute care insurance. Third, the quality of employer-sponsored long-term care insurance plans could improve because benefit managers for such employer-sponsored groups have a stronger negotiating position with insurers than do individuals.

Despite these advantages, the employer-sponsored market remains very small. By mid-1998, a cumulative total of 800,000 policies had been sold in the employer-sponsored market, with fewer policies in force.[95] A total of 2185 employers offered long-term care insurance to their employees and usually their retirees in 1998.[96] According to a survey of sixty-six companies offering private long-term care insurance, the two most important factors influencing employers' decisions to offer long-term care insurance were the desire to offer "leading edge benefits" and the fact that policies could be offered to employees without employers having to help pay the premiums.[97] In sharp contrast to acute care insurance where large employer contributions are the norm, more than two-thirds of the companies offering long-term

92. *See* WIENER ET AL., *supra* note 19, at 62.
93. *See id*.
94. *See* MULVEY & STUCKI, *supra* note 21, at 18; WIENER ET AL., *supra* note 19, at 61–73.
95. *See* Coronel, *supra* note 13, at 7.
96. *See id*. at 20.
97. *See* WILLIAM M. MERCER, INC., STATE OF THE ART IN LONG-TERM CARE INSURANCE: RESULTS OF A MERCER SURVEY OF EMPLOYERS (1997).

care insurance policies required employees to pay the entire premium.[98] Most companies that do help pay for long-term care insurance are relatively small, with fewer than one hundred employees.[99] On average, within companies offering policies, only about six percent of active employees were enrolled in the employer-sponsored plans in 1996.[100] Employer-sponsored policies reach a relatively young population, with the average age of purchasers being forty-five years old in 1997.[101]

IV. Government Intervention in the Employer-Sponsored Market

A. Tax Incentives

Both the federal government and some state governments provide tax incentives for employer contributions to long-term care insurance. At the federal level, HIPAA changed federal tax law to clarify that employer contributions to the cost of qualified private long-term care insurance are tax deductible as a business expense in the same way that employer contributions to health insurance are deductible.

At the state level, some states, such as Maine, Oregon, and Maryland, also provide small tax incentives to encourage employer contributions to the cost of private long-term care insurance for their employees.[102] Maine's employer tax credit is capped at the lowest of the following: (1) $5000 per firm; (2) twenty percent of the costs incurred by the employer in providing long-term care policy coverage as part of the benefit package; or (3) $100 for each employee covered by the policy.[103] Similarly, in Maryland, the amount of the employer tax credit may equal five percent of the costs incurred by the employer for providing the policy, but may not exceed $5000 per firm or $100 for each employee covered.[104] In Oregon, the employer tax credit is

98. *See* Coronel, *supra* note 13, at 21.
99. *See id*. at 20.
100. *See id*. at 12.
101. *See id*.
102. *See infra* Appendix.
103. *See* ME. REV. STAT. ANN. tit. 36, § 2525(1)(A)–(C) (West 1990).
104. *See* MD. CODE ANN., INS. § 6-117 (Supp. 1999); *see also* MD. CODE ANN., TAX-GEN. § 10-710 (Supp. 1999).

limited to the lesser of fifteen percent of the employer contribution or $500 per employee.[105]

While clarifying the tax deductibility of employer contributions is probably necessary to encourage employer contributions, it may not induce many employers to contribute to the cost of private long-term care insurance for their employees. Possible contributions are overwhelmed by the financial problems facing employer-sponsored acute health insurance benefits for retired employees. Prodded by changes to the accounting rules in the late 1980s, many companies concluded that they had very large unfunded liabilities for retiree health benefits.

As a result, a large number of employers, concerned about health care costs for both their active employees and retirees, have cut back on retiree acute care benefits and made retirees pay a larger part of the cost or have dropped the coverage altogether. A recent survey of large employers with five hundred or more employees found that thirty-one percent offered retiree health benefits to retirees aged sixty-five and over in 1997, compared with forty percent in 1993.[106] Employee demand for long-term care insurance has also been relatively low.[107] In this environment, it seems unlikely that many employers will want to contribute to a new, potentially expensive insurance plan that will primarily benefit retirees long after they have left the company. However, it is conceivable that employers may be more willing to offer private long-term care insurance on an employee pay-all basis to help compensate for decreases in acute care coverage.

B. Government as a Role Model

In addition to tax incentives, the other strategy to encourage long-term care insurance purchases has been for the federal and state governments to offer the insurance to their own employees, albeit on an employee pay-all basis. Governments hope that they will set a "good example" for other employers and bring visibility to the issue.

105. *See* OR. REV. STAT. §§ 316.680(2)(a), (b) (1999); *see also infra* Appendix.

106. *See* WILLIAM M. MERCER, INC., MERCER/HIGGINS SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS 1997 (1998), *cited in Hearing on Health Insurance and Older Workers Before the Comm. on Labor & Human Resources*, 105th Cong. 5 (June 25, 1998) (statement of Paul Fronstin, Senior Research Associate and Director, Health Security and Quality Research Program, Employee Benefit Research Institute). The same survey found that 38% of employers offered retiree health benefits to retirees under age 65 in 1997, compared with 46% in 1996. *See id*.

107. *See* Personal Interview, *supra* note 28.

As one official stated, state governments want to "lead the charge" for private long-term care insurance. State governments are also interested in offering long-term care insurance to their employees to give them a way to protect their retirement income and assets.[108] In at least one state, the hope is also that Medicaid expenditures will be reduced.[109] However, based on the experience in the private sector, several experts noted that offering insurance opportunities to federal and state employees could be counterproductive for the insurance industry if the high-profile government offerings suffer from low enrollment.[110]

1. LONG-TERM CARE INSURANCE FOR FEDERAL EMPLOYEES

As part of his 1999 long-term care initiative, President Clinton proposed to offer group private long-term care as a benefit to all federal employees.[111] The President's proposal would cost approximately $15 million over five years for administration of the insurance plans with an estimated 300,000 participants. Enrollees would pay the full cost of premiums, but such premiums would likely be lower than similar individual policies. Persons eligible to enroll would include federal employees, retirees, their spouses, former spouses entitled to annuities under a federal retirement system, and parents and parents-in-law.[112] Although Congress actively debated the President's proposal in 1999, it ultimately did not enact the proposal.

One of the key issues during the congressional debates on the proposal was the role of the Office of Personnel Management (OPM) in designing products and negotiating prices. Under the President's proposal, OPM would play an active role on both issues. During the first year, OPM would educate eligible persons about long-term care

108. *See id*.
109. *See id*.
110. *See id*.
111. *See President Clinton and Vice President Gore Unveil Historic Long-Term Care Initiative* (last modified Jan. 4, 1999) <http://www.pub.whitehouse.gov/uri-res/I2R?urn:pdi://oma.eop.gov.us/1999/1/4/3.text.1>. In the mid-1980s, similar legislation was introduced but never enacted. *See, e.g.*, *Federal Employees Long-Term Care Insurance Act of 1989, S.38: Hearing on Long-Term Care Before Subcomm. on Fed. Serv., Post Office & Civil Serv. of the Comm. on Governmental Affairs*, 91st Cong. (Nov. 2, 1998) (statements of Joshua M. Wiener & Raymond J. Hanley).
112. *See House Panel Examines Best Way to Offer Optional Coverage to Federal Workers*, 7 BNA HEALTH CARE POL'Y REP., Mar. 22, 1999, 505, at 505–06 [hereinafter *House Panel*]. Representative Constance Morella (R-MD) would extend the opportunity to purchase long-term care insurance to military personnel. *See id*.

insurance and solicit bids from insurers. It would also require insurers to comply with federal tax qualification rules and the newest standards set forth by the NAIC, which include standards restricting premium increases and the requirement to offer benefits to individuals whose coverage lapses because of certain premium increases (a "contingent nonforfeiture" benefit). Participating companies would need to be licensed in all states to sell group policies. OPM would establish a minimum benefit package based on NAIC standards, although more generous packages could be purchased. OPM would then select a small number of insurance carriers based on their products' quality, service, and price. Open enrollment for the plans would occur during the second year. Applicants would be subject to minimal medical underwriting during the open enrollment period.

The rationale for this activist approach on the part of OPM is largely based on two premises. First, the employer—here, the federal government—has the best interests of the employees at heart. Thus, active participation in the product design and pricing process by a knowledgeable OPM would result in better and lower cost products. Second, long-term care insurance is an extremely complicated product that few people understand, requiring individuals to project their financial status when they are very old (e.g., age eighty-five and older) and to guess what will be important to them decades into the future. Some experts argue that "too much choice leads to nonchoice" for consumers and note that nearly all employers offering private long-term care insurance use a single insurer.[113]

In contrast, some members of Congress, especially Republicans, envision a less prominent role for the federal government and would have it act mostly as a market facilitator or broker. For example, Representative Joseph Scarborough (R-FL) proposed a system where OPM would organize the federal employee market, collect premiums, and distribute information about available policies, but would not mandate minimum benefits, limit the number of insurers, or negotiate prices.[114] The rationale for this strategy is that maximizing consumer choice will lead to greater competition and lower prices, without administrative intervention. Under the President's plan, the fear is that

113. *See* Steven Lutzky et al., *Preliminary Date from a Survey of Employers Offering Group Long-Term Care Insurance to Their Employees: Interim Report* (last modified June 23, 1999) <http://aspe.hhs.gov/daltcp/reports/ltcinsir.htm>.

114. *See House Panel*, *supra* note 112.

OPM will be overly prescriptive in deciding what benefits must be covered, depriving consumers of the products they want. In addition, too many benefits may be required, driving prices up and making policies unnecessarily expensive and, therefore, unaffordable.

2. LONG-TERM CARE INSURANCE FOR STATE EMPLOYEES

At least nineteen states—Alabama, Alaska, California, Colorado, Connecticut, Florida, Georgia, Kansas, Montana, Nebraska, Nevada, New York, North Carolina, North Dakota, Ohio, Oregon, South Carolina, Washington, and Wisconsin—have laws making private long-term care insurance benefits an option for state employees and retirees. Although many of these states are just in the nascent stages of offering long-term care insurance to their employees, five states—California, Colorado, Connecticut, Washington, and Wisconsin—have approximately two years of experience in offering long-term care insurance to their public employees.[115] Information on these states is summarized in Table 2.

None of these five states help pay the premiums for the long-term care policies.[116] Instead, they use their purchasing power to negotiate good quality products and somewhat better prices than could be achieved in the individual market for comparable products.[117] Despite the states' efforts, though, only a small percentage of public employees and retirees—less than seven percent—have actually purchased policies.[118]

States generally have taken a very expansive view of their target population. All of the five states mentioned above offer public employees, retirees, and their spouses the opportunity to purchase long-term care insurance. In addition, three of the five states examined extend this offer to parents and parents-in-law, and one state further extends the offer to grandparents and grandparents-in-law. However, dependents are generally not covered. Despite the efforts to offer policies to a broad set of potential purchasers, almost all enrollees are employees, retirees, and their spouses.

115. *See* Personal Interview, *supra* note 28.
116. *See id*.
117. *See id*.
118. *See* Lutzky et al., *supra* note 113. In a small, exploratory survey of 39 employers, the authors found that participation rates varied greatly. Although nearly 40% experienced participation rates below 2%, almost 30% had participation rates of 10% or higher. *See id*.

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In all five states, the responsible government agency took an active role in choosing the insurers that would offer policies. No state contracted with a large number of companies.[119] In three of the five states, a competitive bidding process resulted in the selection of just one insurer to handle the long-term care insurance offering.[120] Wisconsin allows three companies meeting the state's standards to offer long-term care insurance.[121] California's system, CalPERS, is the only self-funded program and was the result of a feasibility study which showed that contracting with a commercial insurer would add little value to the long-term care insurance offered and that premiums would be twenty to thirty percent lower if the program were self-funded.[122]

When offering long-term care insurance to their employees, all states use some form of medical underwriting for long-term care policies to prevent adverse selection and moderate premium costs, which is a departure from their acute care insurance practices.[123] State agencies generally feel they have little choice but to use underwriting because of the relatively low take-up rate which increases the possibility of adverse selection.[124] Active full-time employees generally have to answer several questions to determine whether they are at immediate risk of needing long-term care services, but this level of underwriting is generally less than would be required for individual policies.[125] Retirees are subject to full underwriting in all of the five states.[126] Three states reported that twelve to sixteen percent of applicants, mostly retirees, were rejected as a result of their medical conditions.[127] In California, a disability rights organization argued that underwriting discriminates against people with disabilities.[128]

Benefits vary greatly from state to state, but states generally have not imposed very strict standards. For example, in California, Colorado, Connecticut, and Washington, inflation protection must be of-

119. *See infra* Appendix; *see also* Personal Interview, *supra* note 28.
120. *See* Personal Interview, *supra* note 28.
121. *See id*.
122. *See id*.
123. *See id*.
124. *See id*.
125. *See id*. An exception is Connecticut, which guarantees issue to full-time employees (i.e., those working at least 30 hours per week). *See id*.
126. *See id*.
127. *See id*.
128. *See* Interview with Alison Aubrey, Disability Rights Advocates, Oakland, Cal. (Apr. 20, 1999).

fered, but is not required (except for those under age sixty-five in Connecticut). Wisconsin mandates inflation protection for all purchasers because inflation is likely to dramatically erode purchasing power. As another example, Colorado, Washington, and Connecticut require some form of mandatory nonforfeiture benefits for people who let their policies lapse; this same benefit is offered but not required in California, where few people have purchased this form of protection.

While state administrators believe that they obtain better premiums than individuals could obtain in the marketplace on their own, the somewhat higher minimum standards imposed in a group setting and the relative lack of underwriting may make premiums the same or higher than the cost of average policies purchased in a nongroup setting. In California and Wisconsin, state administrators contend that premiums for their policies are twenty to thirty percent lower than equivalent individual policies.[129] However, in Colorado and Connecticut, premiums for state-sponsored policies are equivalent to or greater than similar individual policies because of their less restrictive underwriting practices.

The number of policies sold in all five states has been extremely small. In Colorado, Connecticut, Washington, and Wisconsin, sales penetration rates in 1999 were around one percent of eligible purchasers. And in California, despite very aggressive marketing, CalPERS estimates that only three to four percent of active employees and five to seven percent of retirees have purchased policies.

Observers speculate that there are several factors that may limit employee demand. First, although premiums are comparatively low at young ages, prices may remain too high for potential purchasers. Second, middle-aged workers have competing expenses, such as child care, mortgages, and college educations for their children, which demand more attention. Third, it is difficult to design a product for a younger population who might not use the benefits until forty years into the future. Over such a long period of time, the long-term care system could change in major ways and old policies may not be able to adapt, leaving beneficiaries with coverage for an obsolete set of services.

129. *See* Personal Interview, *supra* note 28.

Little data is available about lapse rates and claims experience. However, CalPERS reports lapse rates of 2.5% per year, while Connecticut reports a cumulative lapse rate of four percent, not counting refusals to continue coverage during the thirty-day free look period.[130] Connecticut contends that payroll deductions may discourage lapse rates because people have to take affirmative action to stop deductions.[131] Because the products are new and the age of the purchasers is relatively young, claims experience is limited. Connecticut has had only one claim,[132] while California had five hundred claimants by February 1999.[133] So far, claims experience in California is forty percent less than actuaries had predicted.[134]

V. Public-Private Partnerships for Long-Term Care

A. Background

A few states—Connecticut, Indiana, California, and New York—are currently experimenting with a third approach for promoting private long-term care insurance, known as "partnerships for long-term care." Under these initiatives, states provide higher levels of protected assets under Medicaid to persons who purchase state-approved private long-term care insurance policies. Thus, partnership policyholders have easier access to Medicaid than do policyholders who purchase comparable nonpartnership policies because the partnership policyholders do not have to spend down as much of their assets to qualify for Medicaid. Whereas employer-paid plans and tax incentives seek to reduce the net cost of insurance, these public-private partnerships attempt to increase the amount of benefits provided per dollar spent by combining insurance with more liberal Medicaid financial eligibility standards.[135] Information about the partnerships for long-term care in these four states is summarized in Table 3.

130. *See id*.
131. *See id*.
132. *See id*.
133. *See id*.
134. *See id*.
135. *See* Nelda McCall et al., *Public/Private Partnerships: A New Approach to Long-Term Care*, HEALTH AFF., Spring 1991, at 164; Mark R. Meiners, *Paying for Long-Term Care Without Breaking the Bank*, 3 J. AM. HEALTH POL'Y 44 (1993); Mark R. Meiners & Stephen C. Goss, *Passing the 'Laugh Test' for Long-Term Care Insurance Partnerships*, HEALTH AFF., Winter 1994, at 225; Mark R. Meiners & Hunter L. McKay, *Beware the Comparison: Private vs. Social Insurance*, GENERATIONS, Spring 1990, at 34–36; Mark R. Meiners, *Public-Private Partnerships in Long-Term Care*, *in*

[table 3 here]

State policymakers have several goals in implementing these partnerships for long-term care. First, they seek to provide incentives for individuals to purchase long-term care insurance as a way of enhancing private responsibility. In particular, states hope to expand the market for private long-term care insurance beyond upper-income persons to include the middle class. Advocates of this strategy also hope that giving the middle class a more explicit stake in the Medicaid program will generate political support for program improvements. Second, they want to provide additional asset protection for older persons without increasing, and perhaps even decreasing, Medicaid expenditures. Third, because only "approved" policies are eligible for the enhanced asset protection, state regulators use this additional benefit as a carrot to induce insurance companies to upgrade the quality of their products.

The key observation supporting the public-private approaches is that long-term care insurance products that cover shorter periods of nursing home and home care are less expensive and more affordable than policies that cover longer periods of care.[136] Without the partnership, if an individual buys a policy that covers two years of nursing home care and stays in a nursing home for five years, then the insured still can lose all of his or her assets despite the purchase of insurance.

PUBLIC AND PRIVATE RESPONSIBILITIES IN LONG-TERM CARE: FINDING THE BALANCE 115 (Leslie C. Walker et al. eds., 1998).

136. In a sample of companies offering long-term care insurance in 1995, the average premium for a 68 year old for a policy that covered three years of nursing home and home care with inflation protection cost $2316 a year, while a similar policy with unlimited coverage cost $3628. *See* LEWIN-VHI & THE BROOKINGS INST., KEY ISSUES FOR LONG-TERM CARE INSURANCE: ENSURING QUALITY PRODUCTS, INCREASING ACCESS TO COVERAGE, AND ENABLING CONSUMER CHOICE (1996).

Thus, under these initiatives, it is possible to obtain lifetime asset protection without having to buy an insurance policy that pays lifetime benefits. Moreover, many people using nursing home care do not stay for long periods, which means that policies of relatively short coverage (i.e., one to two years) provide full coverage for about half of all users.[137]

In essence, these four states allow individuals with private long-term care insurance to become Medicaid eligible while holding substantially higher levels of financial assets than is normally permitted.[138] At present, Medicaid only allows unmarried nursing home residents to retain roughly $2000 in assets excluding the home, which is subject to estate recovery for the costs of Medicaid long-term care expenses after the death of the beneficiary.[139] While additional assets are protected, nursing home residents must still contribute all of their income toward the cost of care except for a small (usually $30 per month) personal needs allowance.[140]

There are two ways states link higher Medicaid asset protection levels and private insurance. In both cases, Medicaid acts as a kind of reinsurance for persons with limited private long-term care insurance coverage. In one model, used by Connecticut, California, and Indiana, the level of Medicaid-protected assets is tied to the amount that the private insurance policy pays out. For example, if a person buys a policy that pays $100,000 in long-term care benefits, then that individual can keep $100,000 in assets and still be eligible for Medicaid. As a result, consumers are able to purchase insurance equivalent to the amount of assets they wish to preserve, potentially reducing the amount of insurance individuals need to buy.

137. *See* Peter Kemper & Christopher M. Murtaugh, *Lifetime Use of Nursing Home Care*, 324 NEW ENG. J. MED. 598 (1991). Kemper and Murtaugh used data from the 1986 National Mortality Follow Back Survey and estimated that 45% of elderly nursing home users had stays lasting less than one year. *See id*.

138. Federal Medicaid law allows states great flexibility in determining countable income and assets of medically needy beneficiaries—patients with high medical bills in relation to their income. Technically, states using this strategy exclude insurance-related assets from their definition of resources that must be counted in determining Medicaid eligibility.

139. Community-based spouses of Medicaid nursing home residents are allowed to keep substantially more resources. Federal law allows a community-based spouse to retain between $16,392 and $81,960 in assets in 1999. *See* Interview with Roy Trudel, Health Care Financing Administration (July 15, 1999).

140. *See* 42 U.S.C. § 1396a(q) (1994).

The other model, used by New York and also by Indiana (which uses both approaches), provides protection of an unlimited amount of assets if an individual purchases a policy that meets state standards. In New York, policies must include coverage of at least three years of nursing home care, six years of home care, or a combination of the two (where two home care days equal one nursing home day) with a minimum payment of $134 per day for nursing home care and $67 per day for home care. In Indiana, policies purchased in 1999 must provide at least $140,000 in initial benefits, a figure that is indexed annually by five percent.[141] As a result, New York and Indiana are targeting a higher income population, with potentially more assets, than are the other states. The rationale for not requiring any asset test for Medicaid coverage is that nursing home costs are so high that few individuals can avoid Medicaid over an extended period of time.

In addition to the four states currently operating partnership programs, at least seven other states have expressed an interest in them, and a similar version has been proposed in the United Kingdom as well. However, replication of these initiatives in other states has been severely restricted by provisions in the Omnibus Budget Reconciliation Act of 1993[142] (OBRA 1993), which requires states to recover the cost of Medicaid-financed long-term care from the estates of Medicaid beneficiaries and to include insurance-related protected assets in their definition of an estate.[143] The initial four states now operating partnership programs, as well as possible future programs in Iowa and Massachusetts, were grandfathered in and exempted from these requirements. Thus, in all other states, additional assets may be protected while an individual is alive, but persons who become Medicaid beneficiaries by virtue of these initiatives may not be able to pass on these additional funds to their heirs, substantially lessening the appeal of this approach.

141. At full cost, this equals approximately 3.5 years in a nursing home. The average cost of nursing home care in Indiana in 1998 was approximately $111 per day or $40,515 per year. It is about 4.75 years at the $85 per day required minimum for partnership policies in Indiana. *See* IND. CODE ANN. § 12-15-39.6 to 39.10 (West 1999).

142. Pub. L. No. 103-66, 107 Stat. 312.

143. *See id.* § 13612(a), 107 Stat. at 627.

B. Market Experience

To date, the partnerships for long-term care have not had a major impact on the financing of long-term care in the states where programs have been implemented. As of September 30, 1999, only 52,560 policies were in force in the four states, compared to over seven million older people living there.[144] Connecticut, for example, which implemented its program in 1992 and is the home of much of the insurance industry, had 6551 policies in force in September 1998, even though 469,112 older people resided in the state in that year.[145] Partnership officials report a sharply increasing number of sales during 1998 and 1999.[146]

For those people who do purchase partnership policies, the initiative appears to have had some success in broadening the reach of private long-term care insurance. In a study of California insurance buyers, partnership purchasers appear to have lower levels of income and assets than do purchasers of nonpartnership policies.[147] And, although partnership purchasers have somewhat higher income and significantly more assets than a randomly chosen comparison group aged fifty-five to seventy-five, the differences are not as stark as some feared would be the case.[148] However, a high proportion of respondents failed to report their income and assets, making it difficult to draw accurate conclusions. Similarly, a 1997 study in Connecticut found that eighty-two percent of partnership purchasers had annual incomes over $30,000 and forty percent had incomes above $60,000—well above national income levels for most older people.[149] Almost

144. *See* Personal Interview, *supra* note 28; U.S. Bureau of the Census, *Population Estimates for the U.S. Regions and States by Selected Age Groups, Annual Time Series July 1, 1990 to July 1, 1998* (visited Apr. 8, 2000) <http://www.census.gov/population/estimates/state/st98elderly.txt>.

145. *See* LAGUNA RESEARCH ASSOCS., *supra* note 144; U.S. Bureau of the Census, *supra* note 144.

146. *See* Personal Interview, *supra* note 28.

147. *See* Nelda McCall, *How Partnership Purchasers Differ from Purchasers of Other Long-Term Care Insurance in California,* Health Policy Research Series Discussion Paper #97-5 (San Francisco, Cal.: Laguna Research Associates, 1997).

148. A major problem in the analysis is that the comparison group is much younger and has much higher labor force participation than do partnership purchasers. In addition, Medicaid eligibles and non–English speaking individuals are excluded. The net effect of these design choices is a sample that has much higher income and probably assets than a representative sample of the entire elderly population would have. *See* Nelda McCall et al., *The Partnership for Long-Term Care: Who Are the Partnership Purchasers*, 54 MED. CARE RES. & REV. 472 (1997).

149. *See Evaluation Studies: Executive Summary for the Annual Report for the Connecticut Partnership for Long-Term Care Evaluation Studies—January 1, 1997 to Decem-*

one-half of partnership purchasers reported assets over $350,000, while seventeen percent indicated that their assets were less than $100,000.[150] In New York, individuals need an income of at least $26,600 per year to cover the copayment for nursing home care left by the minimum partnership benefit for nursing home care, although that amount varies by geographic area.[151]

C. Consumers

From the perspective of consumers, three important reasons can be identified that help explain the low participation rate in partnership programs: (1) the policies are still expensive; (2) asset protection is not a driving force for the purchase of insurance; and (3) easier access to Medicaid is not perceived as desirable. First, although the premise of the partnership was to reduce costs by limiting the amount of insurance needed to protect assets, policies are still fairly expensive, in part because they contain certain consumer-protection requirements, such as mandatory inflation protection, that increase their prices. Among the four states, the annual average premium ranged from $1359 to $2129 in 1997.[152] Thus, buying a policy requires a substantial financial investment, especially by married couples if both spouses are to be covered.

Second, the asset protection feature that is the heart of the partnership plans may not be a major inducement to participate in the program. Indeed, in a survey of policyholders, while most partnership purchasers reported that it was important "to leave an inheritance" to their heirs, only seven percent of buyers indicated that it was the single most important reason for purchasing a long-term care insurance policy.[153] This is consistent with other studies that showed people buy long-term care insurance to preserve autonomy and to avoid being a burden on their relatives.[154] Somewhat in contrast, a

ber 31, 1997 (visited Mar. 7, 2000) <http://www.opm.state.ct.us/pdpd4/ltc/Researcher/evalrept> [hereinafter *Evaluation Studies*]. Nationally, only about 31% of the older people had incomes above $30,000 in 1995. *See 1998 Green Book*, *supra* note 18, at 1038 tbl.A-9.

150. *See Evaluation Studies*, *supra* note 149.

151. *See How Much Coverage Do I Need?* (visited June 1999) <http://www.nyspltc.org/consumer/#2>; *New York State Nursing Home Costs* (visited June 1999) <http://www.nyspltc.org/consumer/#3>.

152. *See* LAGUNA RESEARCH ASSOCS., *supra* note 144.

153. *See* McCall et al., *supra* note 148, at 472–89.

154. *See* LIFEPLANS, INC., *supra* note 49, at 28.

Connecticut survey of partnership purchasers found that eighty-four percent purchased a policy to protect their assets, but eighty-six percent also said that they bought a policy to pay for future services, and eighty-nine reported that they bought a policy to protect their spouse and family.[155] Pure asset protection, however, may have a narrow appeal because most older people have relatively modest levels of financial wealth, excluding the home.[156]

Proponents of this approach contend that the goal of the partnerships is not asset protection per se, but rather to preserve financial autonomy toward the end of life. According to one expert,

> [p]eople say that what they want is independence, choice, and to avoid being a burden on their children. All of those things come down to having some money. The protected assets afford people some flexibility in what services they get. By buying a policy, people maintain choices over their long-term care services and improve access to a good nursing home.[157]

Third, although partnership officials argue that most purchasers will not exhaust their insurance benefits, easier access to Medicaid for those who do may not be an incentive to purchase because of Medicaid's problems related to access and quality of care in nursing homes.[158] Indeed, one of the major reasons people buy long-term care insurance is to avoid having to apply for welfare. One survey of general long-term care insurance purchasers found that ninety-one percent of respondents reported that avoiding Medicaid was an "important" or "very important" reason for buying a policy.[159] According to one insurance company official: "The programs play differently among the states. In New York and, to some extent, Connecticut, Medicaid is not regarded as welfare, so New Yorkers are more receptive to the partnerships and its link to Medicaid than are people in Indiana and California."[160] Another insurance industry expert contends

155. *See Evaluation Studies*, *supra* note 149.

156. *See* JAMES P. SMITH, THE CHANGING ECONOMIC CIRCUMSTANCES OF THE ELDERLY 8 (1997). In 1992, median total wealth (including home equity) was about $85,000 for households headed by persons aged 70 and older; excluding home equity, median wealth for this age group was about $9000. *See id.*

157. Personal Interview, *supra* note 28.

158. *See* CHARLENE HARRINGTON ET AL., PREDICTING NURSE STAFFING IN NURSING FACILITIES IN THE U.S. 15 (1998); James D. Reschovsky, *Demand for and Access to Institutional Long-Term Care: The Role of Medicaid in Nursing Home Markets*, 33 INQUIRY 15, 16 (1996); Jacqueline S. Zinn, *Market Competition and the Quality of Nursing Home Care*, 19 J. HEALTH POL. POL'Y, & L. 555, 557 (1994).

159. *See* LIFEPLANS INC., *supra* note 49, at 28.

160. Personal Interview, *supra* note 28.

that partnership policies "have limited appeal because of the Medicaid stigma."[161] As a result of the importance of Medicaid, partnership program officials generally support improvements (except for the financial requirements) in the program that would make Medicaid more attractive, but are strong advocates of prohibitions against transfer of assets.[162]

D. The Insurance Industry

Although the insurance industry initially advocated the partnership and continues to see it as a way of increasing the size of the private long-term care insurance market, it has subsequently offered only lukewarm support to the initiative. Participating insurers have been disappointed in the number of policies sold.[163] From the insurer's perspective, a long-term care partnership is unattractive because it requires reversing basic sales strategies and lacks the portability of Medicaid benefits.

A significant factor in the limited sales under a partnership is that relaxing eligibility requirements for obtaining Medicaid benefits is inconsistent with the primary message that insurance agents use to sell long-term care insurance. Long-term care insurance is sold primarily by stressing that Medicaid is a "terrible" program with inferior access to poorer quality facilities.[164] The sales pitch is essentially this: "Buy long-term care insurance and you will avoid depending on that 'horrible' Medicaid program." The partnerships, however, require agents to make exactly the opposite argument: "If you ever run out of your insurance, the partnership provides access to the Medicaid program, which is not such a bad program, without having to impoverish yourself." It seems that few agents are willing to make this fundamental switch in their "sales pitch." According to one observer, "[t]o the extent that the partnership creates a new market, it is a plus for agents. But agents tend to market to the top of the income distribu-

161. *Id*.

162. *See id.* They also support stricter insurance standards because inadequate benefits may result in people spending down assets to qualify for Medicaid even while they are insured. *See id*.

163. *See* JODI KORB ET AL., LAGUNA RESEARCH ASSOCS., INSURERS' VIEWS OF THE PARTNERSHIP FOR LONG-TERM CARE 22 (1998).

164. *See, e.g.,* CENTER FOR LONG-TERM CARE FIN., THE MYTH OF UNAFFORDABILITY: HOW MOST AMERICANS SHOULD, COULD, AND WOULD BUY PRIVATE LONG-TERM CARE INSURANCE (1999).

tion. There is still plenty of the low-hanging fruit—relatively upper-income people—to whom they can market."[165]

Another factor is that, because the Medicaid asset protection feature of the partnership only applies to the state in which the policy was purchased, the program lacks portability. This means that if individuals move to a different state, they lose the asset protection feature of the partnership, although they still retain the basic insurance protection. That limitation has an especially important impact on large employers. According to one expert,

> [e]mployers cannot offer partnership policies across the U[nited] S[tates]. The lack of portability makes it especially hard for insurers to offer group partnership policies because there is a strong likelihood that people will move away. Some of the partnership states are working on reciprocity agreements, but with only four states, that approach can go only so far.[166]

E. Budget Neutrality or Savings?

From a state policy perspective, a major selling point of the partnership strategy is the assertion that older people can have higher asset protection without any additional costs—and perhaps some savings—to the Medicaid program. This argument is probably stronger for the approach used by Connecticut, Indiana, and California, where there is a "dollar-for-dollar" correspondence between the amount the insurance pays and the level of Medicaid protected assets.[167] In New York and under the dual scheme in Indiana, the ability to protect potentially very large amounts of assets makes this argument weaker, although very wealthy individuals can pay for long-term care out of current income and do not have to worry about asset protection.[168] To the extent that these systems are budget-neutral, the partnerships will make some people better off without making any others worse off. In the case of long-term care partnerships, insurance dollars are simply substituted for private asset dollars.

Whether the public-private partnership will truly be budget-neutral is open to question, and a case can be made that expenditures will increase, at least marginally. After all, significant Medicaid benefits are being provided to people who would not otherwise be eligible,

165. Personal Interview, *supra* note 28.
166. *Id*.
167. *See supra* notes 140–45 and accompanying text.
168. *See supra* note 145 and accompanying text.

and insurance coverage is likely to induce some additional utilization that would not have occurred otherwise. But because most policies are sold to healthy older persons, who are at least ten to twenty years away from needing nursing home care, even fragmentary evidence as to the effect of the partnership on the public purse will not be available for some time. In total, only about two hundred people have actually used benefits through 1998.[169]

A critical element in assessing the effect of the partnerships on the Medicaid budget is establishing a comparison level of expenditures. In a world with no private long-term care insurance at all, the partnerships would have a better chance of being roughly budget-neutral. However, modest growth in the number of private long-term care insurance policies sold is likely to continue. Compared to this scenario, the partnership must entice substantial numbers of additional insurance purchasers in order to be budget neutral or produce savings. This is because under current Medicaid rules, purchasers who would have bought policies without the public-private partnership would have to spend down almost all of their assets after their insurance benefits have been exhausted before qualifying for Medicaid, something that they are not required to do under the partnership. Although purchasers appear to be overwhelmingly first-time buyers, nearly seventy percent of buyers reported in a purchaser survey that they "definitely" or "probably" would have purchased a long-term care insurance policy even if the partnership program did not exist.[170]

Partnership officials also contend that Medicaid savings are obtained through the reduction of legal and illegal transfers of assets for the purpose of obtaining Medicaid eligibility. Instead, they argue that older people have the alternative of protecting their assets by purchasing more affordable long-term care insurance policies. Current rules prohibit the transfer of assets at less than fair market value for thirty-six months prior to application for Medicaid eligibility.[171] As

169. In Indiana, Connecticut, California, and New York, only 26, 55, 88, and 46 people, respectively, claimed benefits in 1998. *See* LAGUNA RESEARCH ASSOCS., *supra* note 144, at 33. As of 1997, only 39 people in California, 37 people in Connecticut, and 18 people in Indiana had received benefits. *See id*. at 24. Information was not available for New York.

170. *See* McCall et al., *supra* note 148, at 472–89.

171. *See* Brian Burwell & William Crown, *Medicaid Eligibility Policy and Asset Transfers: Does Any of This Make Sense?*, 20 GENERATIONS 78 (1996), *available in* 1996 WL 10572170, at *15.

one observer noted, "[i]f we can get the middle class to stop divesting assets and buy partnership policies, then we can save money."[172] Some modest evidence supports this contention. In surveys in New York and Connecticut, twenty-five percent and thirty-two percent of purchasers of partnership policies, respectively, stated that they purchased a policy as an alternative to transferring their assets.[173] Although the subject of many anecdotes, systematic evidence of the prevalence of transfers of assets is lacking, but limited data suggests that it may be less common or less financially important than often assumed.[174]

From a cost savings perspective, one problem is that once the partnerships encourage older people to look to Medicaid as a way to protect their assets, some potential purchasers may deduce that they can transfer or shelter their assets and obtain Medicaid benefits without purchasing any long-term care insurance policy. Thus, the partnerships conceivably might actually increase rather than reduce the level of asset transfer. Although partnership officials unanimously and strongly rejected this hypothesis, several insurers have agreed with it.[175]

F. Improving Long-Term Care Insurance Products

Because only "approved" policies are eligible for enhanced asset protection, states seek to use the partnerships as a carrot to induce insurance companies to upgrade the quality of their policies. Although only a modest number of partnership policies have been sold, they are generally of a much higher quality than nonpartnership policies.[176] All four states have been adamant about requiring inflation protection at a minimum rate of five percent compounded annually.[177] For ex-

172. Personal Interview, *supra* note 28.

173. *See Evaluation Studies: Executive Summary for the Annual Report for the Connecticut Partnership for Long-Term Care Evaluation Studies, Jan. 1, 1997 to Dec. 21, 1997* (visited Mar. 6, 2000) <http://www.opm.state.ct.us/pdpd4/ltc/researcher/evalrept.htm>; Adrianna Takada & Gregory Belardi, *NY Partnership Profiles Buyers* (visited Mar. 6, 2000) <http://www.nyspltc.org/library/profile.html>.

174. *See* Joshua M. Wiener, *Public Policies on Medicaid Asset Transfer and Estate Recovery: How Much Money to Be Saved?*, 20 GENERATIONS 72 (1996), *available in* 1996 WL 10572174, at *3.

175. *See* Personal Interview, *supra* note 28.

176. *See* NELDA MCCALL & JODI KORB, CHARACTERISTICS OF THE PARTNERSHIP FOR LONG-TERM CARE INSURANCE POLICIES 34 (1997).

177. *See* WIENER ET AL., *supra* note 19, at 103. Because policies are generally purchased years before the purchaser expects to use the long-term care services,

ample, Connecticut policies must offer: automatic inflation protection at a minimum of five percent compounded annually; case management as part of a home care benefit (if purchased); a minimum daily rate for nursing facility, home, and community-based services; the option to switch coverage to a shorter benefit period than originally purchased, thereby reducing the premium. In addition, by state law, partnership policyholders in Connecticut are guaranteed at least a five percent discount of nursing facility rates.[178] Moreover, despite the fact that medical underwriting is the industry norm, Connecticut currently offers a guaranteed issue partnership policy to state employees who work at least thirty hours per week. In New York, insureds are entitled to a review of denied requests for benefit authorization on a case-by-case basis, and insurers cannot underwrite based on social factors, such as marital status, jobs, and lifestyle.

No state requires all insurers to sell only policies that meet the partnership standards and most policies do not meet the partnership standards; nor have states actively considered reducing their standards to the level of the typical product sold today. Because requiring inflation protection roughly doubles the costs of policies, such a requirement would result in a dramatic increase in price and is viewed as the "third rail" of insurance regulation. As a result of allowing the sale of other policies, a substantial majority of policies sold in the four states do not meet partnership standards.[179] Because insurers are neither required to offer partnership policies nor actively market the ones they do offer, the initiatives must balance consumer protection with affordability and the willingness of insurers to offer products. On the one hand, according to one observer, "[i]n California, the value of the partnership consumer protections have been recognized and many provisions added to state statute."[180] On the other hand, although standards remain high, some state requirements were dropped in recent years to reduce the price differential between partnership and nonpartnership policies. For example, Indiana eliminated

nursing home inflation can have a devastating impact on the purchasing power of policies where the benefits are not indexed for inflation. *See id*. at 42–43.

178. *See Frequently Asked Questions* (visited June 1999) <http://www.opm.state.ct.us/pdpd4/ltc>; *Private Pay Long-Term Care Rates* (visited June 1999) <http://www.opm.state.ct.us/pdpd4/ltc/Consumer/nhrate>.

179. *See* Personal Interview, *supra* note 28.

180. *Id*.

its requirement for home care coverage,[181] and California ended its nonforfeiture benefit requirement.[182]

VI. Conclusion

Following the collapse of proposals for comprehensive health care reform in 1994 and for a Medicaid block grant in 1996, long-term care reform proposals have focused on private insurance. The unwillingness of Congress to spend the large sums of public money necessary to substantially address the many problems of long-term care reinforces the emphasis on private solutions.[183] The fundamental problem with this strategy is that despite more than a decade of double-digit sales growth, private long-term care insurance remains a small niche product. Affordability is arguably the principal barrier to purchase,[184] but lack of knowledge about the risks of needing long-term care, misinformation about Medicare coverage, and competing priorities also play a role.

This low market penetration has led to a range of proposals, some of which have been implemented, to provide public subsidies as a way to "jump start" the market for private long-term care insurance. These proposals reduce the net price of insurance through federal and state tax incentives, encourage people to buy policies when they are younger by offering insurance through employers, including federal and state governments, and lessen the amount of insurance that people need to buy by allowing people who purchase a state-approved private long-term care insurance policy to keep more of their assets than is normally allowed and still qualify for Medicaid long-term care benefits. Advocates of these proposals also argue that they provide a government "seal of approval" that legitimizes private long-term care insurance and thereby encourages sales independently of their price effects.

181. *See id.*
182. *See id.*
183. For example, President Clinton's 1993–94 proposal would have cost $38 billion a year in new federal spending when fully implemented in 2003, but would only have addressed home care for people with quite severe disabilities. *See* OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING & EVALUATION, COST ESTIMATES FOR THE LONG-TERM CARE PROVISIONS UNDER THE HEALTH SECURITY ACT (1994).
184. *See* WIENER ET AL., *supra* note 19, at 14.

In the last few years, versions of these initiatives have been implemented by the federal government and a number of states. HIPAA allows private long-term care insurance premiums to be counted toward the 7.5% of income threshold for income tax deduction of medical expenses and clarifies that employer contributions toward the cost of private long-term care insurance are tax deductible as a business expense. At least eighteen states allow tax deductions or credits for the purchase of private long-term care insurance. Moreover, nineteen states offer long-term care insurance to government employees. And four states are operating partnership programs that meld private insurance with Medicaid asset protection.

So far, the incentives that have been implemented are quite modest and are likely to have only minimal effect on the number of people with policies. The value of the HIPAA tax deduction is low because only about half of the elderly population pays any federal taxes, the marginal tax rates are low for the vast majority of people, and few people have enough out-of-pocket medical expenses to qualify for any deductions. In addition, state tax incentives are extremely small, averaging $100 or less, and virtually no official interviewed at the state level thought that the incentives were having a major impact on increasing the number of purchasers.[185] The employer market has remained small, with very few employers contributing toward the cost of premiums, in part reflecting the decline in employer-sponsored and paid retiree acute care insurance. Take-up rates for state employer-sponsored long-term care insurance for employees and retirees are low. Although sales of partnership policies continue to increase, the numbers remain small and represent a modest portion of the market for long-term care insurance, even in the states where they operate. Overall, these initiatives have not dramatically made policies less expensive and appear to be largely symbolic. They have not significantly changed market dynamics.

Because of the limited results, more aggressive tax incentives and other legislative changes have been proposed to promote private long-term care insurance. For example, the Tax Refund and Relief Act of 1999 passed by Congress but vetoed by President Clinton would have provided an "above the line" tax deduction for long-term care insurance premiums.[186] Other proposals would remove the obstacles

185. *See* Personal Interview, *supra* note 28.
186. An "above the line" tax deduction would allow an individual to deduct

to more state partnership programs established by OBRA and would permit tax-free withdrawals from individual retirement accounts for the purchase of private long-term care insurance. All of these proposals, except arguably the partnership policies, would involve significant revenue losses, which may never be offset by future Medicaid savings.

These proposals raise two difficult issues. First, how hard should policymakers try to make private long-term care insurance a major source of financing for long-term care? At some level, money spent or revenue lost in support of promoting private long-term care insurance is money not available for tax credits for informal caregivers or persons with severe disabilities (as proposed by President Clinton[187]) or for direct funding of services through Medicaid,[188] Medicare,[189] the Older Americans Act,[190] or the Social Services Block Grant.[191] Private long-term care insurance is appealing because it reflects the American tradition of individuals taking responsibility for their own lives and offers the possibility of prefunding the inevitable societal burden that will occur when the baby boom generation needs long-term care.

That attractiveness notwithstanding, the high cost of long-term care policies means that there is no country in the world where private long-term care insurance is a major source of financing long-term care.[192] In addition, private long-term care insurance policies have very high administrative, marketing, and profit expenses, reducing the amount of services that a dollar's worth of expenditures will buy. Moreover, because policies are contracts that are implemented at a particular point in time, they offer benefits that potentially cannot easily adjust to delivery system changes over time. Finally, because agents largely market private insurance as a way to avoid the Medi-

the cost of private long-term care insurance without having to meet the current 7.5% of adjusted gross income threshold for the deductibility of medical expenses.

187. See Robert Pear, *Clinton Seeks Aid for Care of those with Chronic Ills*, N.Y. TIMES, Jan. 1, 1999.

188. *See* 42 U.S.C. §§ 1396–1396v (1994).

189. *See id.* §§ 1395–1395ggg.

190. *See id.* §§ 3001–3002.

191. *See id.* § 303.

192. An arguable exception is Germany, where private insurance is available to upper-income persons who choose to opt out of the mandatory system of quasi-public, quasi-private "sickness funds." *See* Joshua M. Wiener & Alison Evans Cuellar, *Public and Private Responsibilities: Home and Community-Based Services in the United Kingdom and Germany*, 11 J. HEALTH & AGING 3 (1999).

caid program's negative aspects, promoting private long-term care insurance could significantly reduce political support for improving Medicaid's long-term care services.[193] As one proponent of long-term care insurance analogized, "[y]ou can't sell apples (i.e., long-term care insurance) on this side of the street if someone (i.e., Medicaid) is giving them away on the other side of the street."[194] In other words, generous public financing of long-term care impedes the development of a private market for private long-term care insurance.

Another factor to consider is that many proposals to promote private long-term care insurance depend on tax incentives, which raises the question of whether the federal tax code should be used to subsidize private long-term care insurance. Tax incentives inevitably raise vexing issues of equity and efficiency. From an equity perspective, society may wish to financially reward (or at least lessen the financial burden for) those who take individual responsibility by purchasing private long-term care insurance. But because insurance policies are costly and many of the incentives regressive, these subsidies are likely to disproportionately benefit upper and upper-middle income older people and further skew income and wealth distribution. Moreover, tax incentives are likely to be an inefficient way of promoting changes in behavior because benefits cannot be limited to people who would not have bought the policy without the incentive. As a practical matter, most of the tax loss will be spent on people who would have bought insurance without the tax incentive. Thus, a large amount of money must be spent to generate a relatively small amount of behavioral change.

Despite these policy concerns, there appears to be a willingness, which is shared by the Clinton administration, to use tax incentives to achieve certain social goals. However, Congress has resisted the urge to expand direct spending programs like Medicaid or Older Americans Act programs. Thus, although increases in direct spending programs are likely to be more efficient than tax subsidies, they are less likely to be enacted in the current environment. Moreover, the fact that these are tax proposals means that they compete against other tax

193. Exceptions to this generalization are the partnership program officials who believe that the negative view of Medicaid inhibits sales of their products. In general, these officials favor improvement in Medicaid quality and service delivery, but not in the financial eligibility standards. They strongly support enforcement of prohibitions against transfer of assets.

194. *See* Personal Interview, *supra* note 28.

proposals. For that reason, tax incentives for long-term care must be weighed against proposed cuts in the capital gains tax or increasing the estate tax exemption, as well as against proposals for increasing funding for Older Americans Act programs. Depending on whether policymakers view these proposals through the lens of tax or health policy, they may come to very different conclusions about whether incentives for private long-term care insurance are desirable.

In conclusion, demand for long-term care and the financial pressures related to its financing are sure to increase with the aging of the population. Americans may not be willing to spend the money necessary to improve the system, but they should be realistic about their expectations from private sector initiatives to ameliorate the situation. Private insurance can do more than it does now but, even with a variety of incentives, it is unlikely to finance more than a small proportion of long-term care expenses. The public policy question then becomes: What should society do about the large majority of disabled older persons who have no private long-term care insurance?

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