PAYING FOR LONG-TERM CARE IN THE GEM STATE: A SURVEY OF THE FEDERAL AND STATE LAWS INFLUENCING HOW LONG-TERM CARE SERVICES FOR IDAHO'S GROWING AGED AND DISABLED POPULATIONS ARE-AND WILL BE-FUNDED

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I. INTRODUCTION

It is well recognized that as baby-boomers age and people live longer with chronic conditions, the need for long-term care ("LTC") services will increase nationwide. Given the costs involved in providing such LTC services, reforming policies related to LTC finance has been the topic of much public debate. Additionally, major efforts in recent years

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^{1.} See generally Joshua M. Wiener et al., Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance, 8 ELDER L. J. 57 (2000).

^{2.} See infra Part II.B.

have been dedicated to "rebalancing" America's LTC delivery system in favor of greater access to home and community-based care options.³

Meaningful discussion of how to address the looming LTC problem should be well informed by an understanding of the numerous state and federal laws affecting how LTC services are currently financed. In this Article, we seek to provide such a foundational overview of the current policy landscape affecting LTC funding in Idaho. Because many aspects of LTC finance are influenced by the laws and demographics of the particular state at issue, the specific policy landscape will vary from state to state. We also discuss potential alternatives to current policies and review major commentaries regarding LTC finance policy. While our focus is the policies affecting LTC in Idaho, our overview should be of utility in other states as well, particularly other states in the Mountain West region with population demographics similar to Idaho.

In Part II of this Article we provide a brief summary of what LTC entails, explain how the growing need for LTC services is projected to increasingly drain state budgets, and examine how LTC is generally paid for in Idaho. Next, in Part III, we provide a detailed summary of the complex array of provisions related to the major payer of LTC in Idaho and nationwide: Medicaid. This discussion provides an overview of eligibility criteria, "spend down" requirements, and estate recovery rules.

Part IV considers policies related to long-term care insurance ("LTCI"), an alternative financing source for LTC that has garnered significant attention in research and policy debates at both state and federal levels. Specifically, Part IV discusses Idaho state laws and model legislation regulating LTCI, state and federal laws enabling Medicaid Partnership Programs for LTCI in Idaho, state and federal tax incentives for purchasing LTCI, and laws affecting LTCI provided by public and private employers.

Part V examines laws and policies related to potential financing sources for LTC other than Medicaid or LTCI. In this section, we first

^{3.} See generally Debra Lipson et al., Mathematica Policy Research Inc., Money Follows the Person Demonstration Grants: Summary of State MFP Program Applications (2007), available at https://www1.cms.gov/CommunityServices/Downloads/StateMFPGrantSummaries-All.pdf.

^{4.} Accordingly, in large degree, this Article constitutes a policy "mapping study." As Professor Burris and colleagues explain, policy mapping studies "analyze the state of the law or the legal terrain and the application of laws surrounding a particular public health topic." Scott Burris et al., *Making the Case for Laws That Improve Health: A Framework for Public Health Law Research*, 88 MILBANK Q. 169 (No. 2), 180 (2010). These scholars further explain that while "[m]apping studies often contribute information that is useful in its own right," such studies "are typically an early phase of larger projects designed to evaluate the magnitude and nature of the effects of laws on health." *Id.* at 182. Indeed, the results reported in this Article are part of broader research efforts into LTC costs and financing options.

^{5.} See id. ("Mapping studies often contribute information that is useful in its own right—state and local policymakers are keen to know what other jurisdictions are doing and what they might consider borrowing or learning from policy experiments in other jurisdictions.").

consider laws and policies related to reverse mortgages, which use an individual's equity in his home to finance needed services. In addition, we will discuss laws related to LTC services that are informally provided by friends, neighbors, and family. Finally, we examine various programs intended to educate and encourage consumers to plan for LTC costs through private means.

II. LONG-TERM CARE: WHAT IT IS, WHY IT'S DRAINING STATE BUDGETS, AND HOW SERVICES ARE PROVIDED IN IDAHO

A. Overview of Long-Term Care

The phrase long-term care ("LTC") refers broadly to "a variety of individualized, well-coordinated services that [are designed to] promote the maximum possible independence for people with functional limitations, and are provided over an extended period of time" to meet the patients' physical, mental, social, and spiritual needs while maximizing their quality of life. Although the general public often associates LTC with the elderly, millions of younger Americans also require LTC services "due to a disability, disease or injury from a catastrophic event." Specifically, adults between 18 and 64 years of age constitute approximately 40% of individuals needing LTC services nationwide.

Depending on the context, however, definitions vary in terms of what constitutes LTC services. Important distinctions arise in relation to the care setting (e.g., nursing homes, assisted living facilities, or home and/or community-based service) or specific factors related to the patient. For example, Medicare (as opposed to Medicaid)⁹ will pay for LTC services provided in a skilled-nursing facility for a limited amount of time (under 100 days) when the patient is transferred directly to the LTC setting from an acute care hospital stay. ¹⁰ In contrast, Medicare will generally not pay for such LTC services in other situations. ¹¹ Similarly, LTC insurance policies will often place parameters on what types of services are covered under the policy. ¹² Lastly, state Medicaid regulations require an individual to document certain conditions in order to

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^{6.} Leiyu Shi & Douglas A. Singh, Delivering Health Care in America: A Systems Approach 381 (5th ed. 2012).

^{7.} Karen R. Palmersheim, Will the CLASS Act Solve Our Long-term Care Crisis? ABA HEALTH ESOURCE (June 2010), http://www.americanbar.org/newsletter/publications/aba_health_esource_home/CLASS.html; see also U.S. DEP'T OF HEALTH & HUMAN SERVS., Long-Term Care Homepage, NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION, http://www.longtermcare.gov [hereinafter National Clearinghouse].

^{8.} Palmersheim, supra note 7; see also National Clearinghouse, supra note 7.

^{9.} Unlike the Medicaid program, individuals can qualify for the Medicare program regardless of income statements. Applicants who are age 65 or older, meet the Social Security definition of fully disabled, or suffer from end-stage renal disease can qualify for Medicare. See Shi & Singh, supra note 6, at 211.

^{10.} Id. at 211-12.

^{11.} National Clearinghouse, supra note 7.

^{12.} See infra Part IV.A.2.b.

qualify for Medicaid LTC. Federal and state guidelines for LTC services are generally defined as skills needed by individuals to be able to perform "activities of daily living." These activities include skills such as bathing and dressing oneself, preparing meals and eating without assistance, and caring for one's home and finances. While the term "LTC" is often used to refer to care services that are provided on a regular basis over a long period of time, the term may also encompass services provided on an ad hoc basis.¹⁴

B. The Growing Need for LTC Services and Increasing Drain on the Idaho State Budget

It is estimated that 70% of individuals over the age of 65 will need LTC services at some point in their lives. ¹⁵ The number of elderly individuals needing LTC services is expected to rise as the population ages. ¹⁶ In the U.S., approximately 9 million individuals age 65 and over currently need LTC services. ¹⁷ Medicaid is commonly described as the "default" payer of formal LTC services, paying for approximately 45% of LTC expenses nationwide. ¹⁸ For these reasons, the proportion of state spending on Medicaid LTC is expected to continually increase over the coming years. ¹⁹ Specifically, overall long-term care expenditures are expected to, in real terms, triple in the coming decades. ²⁰ By 2030, institutional LTC services are expected to cost \$200,000 per year per person. ²¹

The Center for Medicare and Medicaid Services ("CMS") Office of the Actuary projects that LTC expenditures will grow by an annual average of 6.6% between 2011 and 2020 and notes that "[t]he aging of the population is one contributing factor to growth in expenditures for long-term care." The large proportion of state budgets currently being con-

^{13.} See Jeffery R. Brown & Amy Finkelstein, The Private Market for Long-Term Care Insurance in the United States: A Review of the Evidence, 76 J. RISK & INS. (NO.1) 5, 5 (2009); Palmersheim, supra note 7.

^{14.} See Holly Beard & Carissa Moffat Miller, Boise State Univ. Ctr. for the Study of Aging, Finding the Gaps: A State Inventory of Long-Term Care Services and Needs in Idaho 23 (2008), available at http://hs.boisestate.edu/csa/files/2011/06/finding thegapstateinventory2008.pdf (referring to services provided by the Idaho Commission on Aging, including "transportation, public information, ombudsman and adult protection" as long-term care services).

^{15.} Palmersheim, supra note 7.

^{16.} *Id*.

^{17.} Group Long-Term Care, Your Benefits Team, http://www.yourbenefitsteam.com/index.php?option=com_content&view=article&id=52&Itemid=52 (last visited Apr. 22, 2012).

^{18.} State Innovations to Encourage Personal Planning for Long-Term Care, NAT'L GOVERNORS ASS'N (June 18, 2004), http://www.subnet.nga.org/ci/2-financial.html [hereinafter NGA].

^{19.} Ic

^{20.} Brown & Finkelstein, supra note 13, at 6.

^{21.} NGA, supra note 18.

^{22.} CENTERS FOR MEDICARE & MEDICAID SERVICES, 2011 ACTUARIAL REPORT 22 (2012), available at https://www.cms.gov/ActuarialStudies/Downloads/MedicaidReport2011

sumed by Medicaid LTC, and the fact that this proportion is expected to increase, has raised concerns among lawmakers at both the federal and state levels. ²³ Moreover, economic research has demonstrated that even though Medicaid has, in many instances, become the default payer for LTC services, it "does not provide very good insurance" for individuals needing LTC because Medicaid "provides an inadequate consumption-smoothing mechanism for all but the poorest of individuals." ²⁴ From the perspective of both preserving state budgetary resources and assuring that the LTC needs of the aging citizenry are adequately met, encouraging the development of alternative funding sources for LTC has become a highly pertinent topic of policy debate.

As noted earlier, expenditures for LTC services are expected to increase substantially in coming decades as the population ages. ²⁵ A major challenge to this dilemma is for policymakers to find timely and affordable solutions for financing LTC services for the large number of aging middle-income individuals currently in the so-called "funding gap," defined as individuals who currently have inadequate insurance or resources for potentially needed LTC services. ²⁶ Given that LTC in the United States consists of a complex blend of services, payers, and providers, ²⁷ it is not surprising that we are in the midst of a complex and evolving policy and regulatory landscape. ²⁸

In recent years there have been a variety of policies implemented at both state and federal levels intended to facilitate funding for LTC through means other than state Medicaid programs. These policy changes cover a variety of ideas: policy initiatives to encourage the purchase of private long-term care insurance, ²⁹ individual tax incentives at both state and federal levels, ³⁰ increasing the ability of states to recoup Medicaid LTC expenditures from a deceased recipient's estate, ³¹ the cre-

.pdf [hereinafter ACTUARIAL REPORT].

- 23. NGA, supra note 18; Wiener et al., supra note 1, at 59.
- 24. Brown & Finkelstein, supra note 13, at 21; see also Jeffery R. Brown & Amy Finkelstein, The Interaction of Public and Private Insurance: Medicaid and Long-Term Care Insurance Market, 98 Am. Econ. Rev. 1083, 1083 (2008).
- 25. Leslie A. Curry et al., *Individual Decision Making in the Non-Purchase of Long-Term Care Insurance*, 49(4) THE GERONTOLOGIST 560, 560 (2009).
- 26. David G. Stevenson et al., *The Complementarity of Public and Private Long-Term Care Coverage*, 29(1) Health Aff. 96, 96 (2010); *see also* Carissa M. Miller et al., Idaho Commission on Aging Needs Assessment Survey Results (Boise State Univ. Ctr. for the Study of Aging, 2008); Anne Tumlinson et al., Kaiser Family Found., Closing the Long-Term Care Funding Gap: The Challenge of Private Long-Term Care Insurance i-iii (2009).
 - 27. BEARD & MILLER, supra note 14, at 3.
- 28. See generally Stevenson et al., supra note 26; see also TUMLINSON ET AL., supra note 26, at i.
 - 29. See generally TUMLINSON ET AL., supra note 26.
- $30. \;\;$ See NGA, supra note 18; Wiener et al, supra note 1, at 61: see also infra Part IV.C.
- 31. Marshall B. Kapp, *Medicaid Planning, Estate Recovery, and Alternatives for Long-Term Care Financing: Identifying the Ethical Issues*, 7 CARE MGMT. J. 73, 75–76 (2006).

ation of a voluntary, federally-run LTC insurance program,³² and the creation of educational programs to encourage individuals to plan for their LTC needs through private means.³³ In addition to these policy changes, numerous others have been proposed and could possibly be implemented in coming years.³⁴ Parts III, IV, and V of this Article provide further explanation of these various proposed reforms.

C. Providing LTC in Idaho

Because the proportion of individuals age 65 and over in Idaho is expected to increase from 12% in 2010 to 15.5% in 2020, and to 18.3% in 2030, with the number of people who are 85 or older (the oldest-old) increasing by 147.4% between 2000 and 2030, LTC expenditures are expected to increase dramatically.³⁵ One study projects Idaho Medicaid LTC expenditures will more than double from approximately \$122 million per year in 2008 to \$304 million in 2027.³⁶ Moreover, given Idaho's rural demographics, providing adequate and timely LTC services will become increasingly problematic as the population ages.³⁷

As discussed earlier, Medicaid is often the primary payer for formal LTC services. In Idaho, many of these Medicaid LTC services are provided through Idaho's Aged and Disabled Waiver. The goal of Idaho's Aged and Disabled Waiver, which was introduced in 1999, is to "provide Idaho's elderly and physically disabled the ability to maintain their self-sufficiency, independence, and flexibility when designing and tailoring a care plan to meet their medical needs." Specifically, this Waiver allows Idaho's Medicaid program "to offer community services to individuals who would otherwise need to be institutionalized." Accordingly, a significant proportion of the Medicaid-financed LTC services provided in Idaho are for home and community-based services. In 2006, there were 7,768 individuals enrolled in Idaho Medicaid's Aged and Disabled Waiver program and 4,751 individuals in Medicaid-funded nursing home care. At 1

^{32.} Kaiser Family Found., Focus on Health Reform: Summary of New Health Reform Law 11 (2010), available at http://www.kff.org/healthreform/upload/8061.pdf.

NGA, supra note 18.

^{34.} Brown & Finkelstein, supra note 13, at 26–35.

^{35.} U.S. CENSUS BUREAU, POPULATION DIVISION, INTERIM STATE POPULATION PROJECTIONS: POPULATION PYRAMIDS OF IDAHO (2005), available at http://www.census.gov/population/www/projections/statepyramid.html.

^{36.} Daniel I. Shostak & Paul A. London, State Medicaid Expenditures for Long-Term Care 2008-2027 (2008).

^{37.} Beard & Miller, supra note 14, at 23.

^{38.} ICOA, LONG-TERM CARE SYMPOSIUM: UNDERSTANDING AND IMPROVING SYSTEMS OF CARE IN IDAHO 4 (2009), available at http://idahodocs.cdmhost.com/cdm/singleite m/collection/p15100coll7/id/236061/rec/1 [hereinafter LONG-TERM CARE SYMPOSIUM] (summary of comments by Melanie Belnap and Susie Cummins).

^{39.} Id.

^{40.} Id

^{41.} Beard & Miller, supra note 14, at 26, 31.

In a 2005 survey of Idahoans age 50 and over, fewer than 20% of respondents reported having any form of long-term care insurance. ⁴² Moreover, slightly more than half of the respondents reported that they plan to rely on Medicare for their LTC needs, even though Medicare does not cover LTC services under most circumstances. ⁴³ Given this lack of accurate information among respondents, it appears that in the absence of significant public education, a large proportion of Idahoans may end up relying on Medicaid to pay for their LTC needs in the coming decades.

III. THE "DEFAULT" PAYER FOR LTC: LAWS AND POLICIES RELATED TO FINANCIAL ELIGIBILITY FOR MEDICAID LTC IN IDAHO AND MEDICAID ESTATE RECOVERY

Considering that Medicaid is considered the "default" payer for LTC services in many instances,⁴⁴ we begin our overview with policies relating to Medicaid LTC. While Medicaid was arguably created as a "safety net" program with the sole purpose of providing health care for the poorest members of society, it is common for Medicaid to pay for LTC services for elderly individuals from a variety of economic backgrounds.⁴⁵ The CMS estimates that the cost of nursing home care can range "from \$5,000 to \$8,000 a month or more."⁴⁶ Accordingly, such high costs could, in only a few years, exhaust several hundred thousand dollars' worth of savings, LTC insurance benefits, and/or other assets. Because the need for high levels of LTC may extend for years or decades, even individuals with substantial initial savings could potentially come to rely on Medicaid to pay for services.

This situation raises a number of issues related to "spend down," defined as the process of expending one's assets to become eligible for Medicaid LTC. Another topic of public concern is "estate recovery," which is the process whereby Medicaid recovers an individual's assets after the individual's death to recoup the costs of Medicaid LTC services previously provided. We discuss the spend down and estate recovery processes in the sections that follow.

^{42.} MILLER ET AL., supra note 26, at 1.

^{43.} *Id.* at 422. Idaho is not alone in having a significant segment of the population apparently under the mistaken belief that Medicare will cover their future LTC needs. *See* Jacqueline Queener, Note, *Finding the Gold to Finance the "Golden Years": Options for Financing Long-Term Care in Arizona*, 45 ARIZ. L. REV. 857, 863 (2003) ("Many Americans mistakenly believe that Medicare or private health insurance will pay for nursing homes or other forms of LTC.").

^{44.} NGA, supra note 18, at 1.

^{45.} See Joseph S. Karp & Sara I. Gershbein, *Poor on Paper: An Overview of the Ethics and Morality of Medicaid Planning*, 79 Fla. B. J. 61, 61 (2005) ("There is debate, however, whether Medicaid is still intended to be exclusively a program for the poor.").

^{46.} Spousal Impoverishment: Eligibility, MEDICAID.GOV (last visited Mar. 28, 2012), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Eligibility/Spousal-Impoverishment-Page.html [hereinafter Spousal Impoverishment].

A. Idaho Medicaid Financial Eligibility—"Spend Down" and "Medicaid Planning"

Medicaid-funded LTC is a means-tested program for which an individual may qualify only if that person's assets and income fall under a designated level. Accordingly, before financially qualifying for Medicaid, a person in need of LTC funding must "spend down" his or her assets to a qualifying level. It is not uncommon for couples and individuals to engage in a practice often referred to as "Medicaid Planning," which one commentary defines as "the legal fiction of 'rearranging assets' to make someone poor on paper so that he or she may qualify for Medicaid." It is well established that such "Medicaid Planning" is legal and that it is professionally ethical, or acceptable, for attorneys and financial planners to assist clients in such planning. Nonetheless, the Medicaid planning and spend down processes are quite complex, potentially highly financially disruptive, and may lead to inequitable results. Moreover, although legal, Medicaid planning is often perceived as "gaming the system."

The potential confusion caused by the complexity of the "spend down" rules in Idaho is perhaps best highlighted by the case of *Stafford v. Idaho Department of Health & Welfare*. ⁵¹ This case considered whether a particular type of asset transformation transaction was a legitimate way to allow the Staffords to preserve assets and still qualify for Medicaid LTC. ⁵² The hearing officer who initially heard the case held that the transaction was legitimate. ⁵³ The Department of Health & Welfare ("H&W"), however, took a contrary view and reversed the hearing officer's decision. When the matter was taken to court, the district judge agreed with H&W's view. ⁵⁴ Finally, the Idaho Supreme Court, in a 3-2 split decision, also sided with H&W in determining that the transaction was not legitimate. ⁵⁵ All in all, a hearing officer and two Idaho Supreme Court justices viewed the transaction as legitimate, while officials at H&W, a district judge, and three Idaho Supreme Court justices viewed

^{47.} Karp & Gershbein, supra note 45, at 61.

^{48.} See id. at 62; see also Lisa S. Joire, Note, After New York State Bar Association v. Reno: Ethical Problems in Limiting Medicaid Estate Planning, 12 GEO. J. LEGAL ETHICS 789 (1999).

^{49.} Kapp, *supra* note 31, at 76; *see also* Karp & Gershbein, *supra* note 45, at 61 (providing an example comparing two retired school teachers and illustrating how the one who saved less over the course of her life is in a better position to receive Medicaid LTC); John A. Miller, *Voluntary Impoverishment to Obtain Government Benefits*, 13 CORNELL J.L. & PUB POL'Y 81 (2003).

^{50.} See Kapp, supra note 31, at 74.

^{51. 145} Idaho 530, 181 P.3d 456 (2008).

^{52.} See id. at 532, 181 P.3d at 458. Specifically, the Staffords deeded their home into a trust they owned, thus converting the home from an exempt to a non-exempt resource, in order to increase value of the resources of Mrs. Stafford (the community spouse).

^{53.} *Id*

^{54.} See id. at 532-33, 181 P.3d at 458-59.

^{55.} Id. at 533, 181 P.3d at 459.

the transaction as impermissible under the administrative rules in effect at the time. 56

While the case likely has little precedential value, given that the particular rule at issue has since been amended, the extent of disagreement over a particular regulatory provision is indicative of the confusion created by the complexity of the Medicaid spend-down regulations. The Court's majority opinion recognized this confusion by clarifying that the Court's conclusion "does not mean that the Staffords were somehow acting in an underhanded manner – they were just trying to use what appeared to be a loophole in the Medicaid law to preserve as much of their asset value as possible." ⁵⁷

The complexity surrounding Medicaid LTC requirements begs the question: is it good public policy to require a large proportion of middle-class, elderly individuals to navigate such a confusing myriad of administrative rules in order to obtain LTC services? Meaningful policy discussions regarding potential alternatives to current eligibility rules, however, must be facilitated by an understanding of the rules and the reasons they were created. The next section provides a survey of pertinent rules.

1. General Requirements Regarding Medicaid LTC Financial Eligibility in Idaho

Idaho's Medicaid "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)" set forth the criteria for Medicaid-funded LTC in Idaho.⁵⁸ A person who needs Medicaid LTC must establish financial need. In determining whether an applicant qualifies, Medicaid must consider both the value of the applicant's income (e.g., monthly pension plan payments) and "resources" (e.g., property or money in savings accounts).⁵⁹ The eligibility rules differ significantly depending on whether the applicant is single or married (and, if married, whether the applicant's spouse is also a Medicaid recipient).⁶⁰ We will first look at eligibility for single persons and then provide an overview of the more complex scenarios.

a. Idaho Medicaid LTC financial eligibility criteria – single applicant. The Medicaid Rules define "Resources" as "cash, personal property, real property, and notes receivable" which the Medicaid "participant, or spouse . . . ha[s] the right . . . to convert . . . []to cash." In order to qualify for Medicaid LTC, a single person may have no more than

^{56.} Id. at 532-33, 181 P.3d at 458-59.

^{57.} Id. at 538, 181 P.3d at 464.

^{58.} IDAHO ADMIN. CODE 16.03.05 (2011).

^{59.} Id.

^{60.} Id

^{61.} Idaho Admin. Code 16.03.05.200.

\$2,000 in non-exempt resources (or assets) at any given time. ⁶² The most significant exempt assets are a home (up to \$750,000 in equity), ⁶³ household goods and personal effects, ⁶⁴ one automobile, ⁶⁵ certain prepaid burial/funeral expenses, ⁶⁶ certain retirement accounts, ⁶⁷ and income-producing resources "essential for self-support." Unless a resource or asset falls within one of the exemptions, it will be considered in determining whether the applicant's resources exceed the \$2,000 eligibility threshold. ⁶⁹ Accordingly, these exemptions are one instance where individuals can "plan" for Medicaid by transforming resources from non-exempt to exempt resources (e.g., using savings to finance home renovations, purchase a burial plot, or purchase a new car).

In addition to these resource ownership restrictions, in order to qualify for Medicaid, a single person's monthly income may not exceed three times the Federal Social Security Insurance benefit for a single person. This amount adjusts annually; however, in both 2009 and 2010, this amount was set at \$2,022 per month. If the applicant's income exceeds the \$2,022 eligibility threshold but the individual is still unable to cover the costs of LTC services without Medicaid, the person can qualify for Medicaid by creating a so-called "Miller Trust." A Miller Trust is an irrevocable trust into which an individual pays all of his/her income. The trust then pays the individual a monthly income below the permissible amount (\$2,022 in 2010), and the balance of the trust is transferred to Medicaid to help cover the costs of caring for the person.

b. Idaho Medicaid LTC financial eligibility criteria—married applicant. As noted above, the rules regarding Medicaid eligibility are significantly more complex for married couples. A married applicant's eligibility for Medicaid is determined by using one of three methods: the SSI method, the Community Property ("CP") method, or the Federal Spousal

^{62.} IDAHO ADMIN. CODE 16.03.05.720.01; see also Peter C. Sisson & Rosalie C. Sisson, The Consumer's Guide to Medicaid Planning 5 (2009), available at http://www.id ahoelderlaw.com/files/Consumer_Guide_to_Medicaid_Planning_08.pdf.

^{63.} Idaho Admin. Code 16.03.05.238.

^{64.} IDAHO ADMIN. CODE 16.03.05.234.

^{65.} Idaho Admin. Code 16.03.05.222.

^{66.} Idaho Admin. Code 16.03.05.223-.224.

^{67.} IDAHO ADMIN. CODE 16.03.05.279.

^{68.~} IDAHO ADMIN. CODE 16.03.05.244. There are also numerous other less commonly held types of exempt resources, such as Agent Orange Settlement payments, Austrian Social Insurance payments, Walker v. Bayer settlement payments, Indian Property, etc. See IDAHO ADMIN. CODE 16.03.05.222—281.

^{69.} Id

^{70.} IDAHO ADMIN. CODE 16.03.05.720.02.

 $^{71. \}quad See~CMS, 2010~SSI~AND~SPOUSAL~IMPOVERISHMENT~STANDARDS~(2010),~available~at~https://www.cms.gov/MedicaidEligibility/downloads/1998-2010SSIFBR122909.pdf~[hereinafter~2010~SSI~AND~SPOUSAL~IMPOVERISHMENT~STANDARDS].$

^{72.} See Idaho Admin. Code 16.03.05.723.03; see also Michael Wytychak III, Payment of Nursing Home Bills Through the Medicaid Program, 36 Idaho L. Rev. 243, 247 (2000).

^{73.} Wytychack, supra note 72, at 247.

Impoverishment ("FSI") method.⁷⁴ The applicable regulations indicate when each of these methods should be used.⁷⁵ In the fairly common scenario where one spouse needs Medicaid-funded nursing care, while the other spouse is able to remain in the community, the FSI method is generally the most advantageous to the applicant.⁷⁶ The FSI method is also the most complex.

The complex FSI rules were created by Congress in 1988 in reaction to concerns over "spousal impoverishment"—the situation where Medicaid covers LTC for one spouse, while the other spouse still living at home is left "with little or no income or resources." Under the federal spousal impoverishment provisions, the spouse remaining in the community is permitted to retain a greater portion of assets and income, while still permitting the spouse who needs Medicaid funded LTC to qualify for Medicaid.⁷⁸

Under the FSI rules, when a couple applies for Medicaid because one spouse enters a nursing home with the expectation that he or she will remain there for at least 30 days, Medicaid performs an assessment of the couple's resources. Excluding the exempt assets discussed above (home, automobile, and/or burial funds), the couple's resources are combined, and regardless of which spouse nominally owns which assets, one half of this total is assigned to each spouse as the "Spousal Share." ⁷⁹

Under the FSI method, Medicaid will then permit the community spouse to retain non-exempt assets worth \$109,560⁸⁰ while still permitting the other spouse to qualify for Medicaid.⁸¹ Moreover, if the community spouse's Spousal Share (one-half of the couple's total non-exempt resources) is less than \$21,912,⁸² Medicaid will assign a greater proportion of the couple's total resources to the community spouse's Spousal Share of the non-exempt assets so that the community spouse can have

^{74.} IDAHO ADMIN. CODE 16.03.05.731. For an explanation of the federal regulations affecting spouses of Medicaid LTC recipients, see generally Assistant Sec'y for Policy & Evaluation, U.S. Dep't of Health & Human Servs., Medicaid Eligibility for Long-Term Care Benefits Policy Brief No. 3: Spouses of Medicaid Long-Term Care Recipients (2005), available at http://aspe.hhs.gov/daltcp/reports/spouses.pdf [hereinafter ASPE Spouses of Medicaid Brief No. 3].

^{75.} IDAHO ADMIN. CODE 16.03.05.731.

^{76.} For a helpful explanation of how the SSI, CP and FSI methods of eligibility determination reach different outcomes, see Wytychak, *supra* note 72, at 248–50.

^{77.} Spousal Impoverishment, supra note 46, at 1.

^{78. 42} U.S.C. § 1396r-6 (2006).

^{79.} See Spousal Impoverishment, supra note 46, at 1.

⁸⁰. The applicable amount is calculated by multiplying \$60,000 by the total annual increase in the consumer price index ("CPI") since the FSI provisions were enacted in 1988. For 2009, and 2010, the applicable amount was \$109,560. IDAHO ADMIN. CODE 16.03.05.743; see also 2010 SSI AND SPOUSAL IMPOVERISHMENT STANDARDS, supra note 71.

^{81. 2010} SSI AND SPOUSAL IMPOVERISHMENT STANDARDS, supra note 71.

^{82.} The applicable amount is calculated by multiplying \$12,000 by the total increase in the CPI since 1988. For 2009 and 2010, the applicable amount was \$21,912. IDAHO ADMIN. CODE 16.03.05.743; 2010 SSI AND SPOUSAL IMPOVERISHMENT STANDARDS, supra note 71

access to \$21,912 worth of the resources.⁸³ In addition, while home equity in excess of \$750,000 is a non-exempt asset for a single person, the entire value of a married couple's primary residence is exempt regardless of value.⁸⁴

Regarding income, under the FSI provisions, the community spouse's income is not considered available to the institutionalized spouse. Accordingly, the two individuals are not considered a couple for income eligibility purposes, and the community spouse's income in excess of the eligibility threshold will not disqualify the institutionalized spouse from Medicaid. Additionally, prior to determining how much of an institutionalized spouse's monthly income must go to Medicaid to help cover the cost of care, a community spouse's monthly income allowance (between \$1,750 and \$2,750 in 2009 and 2010) can be deducted and given to the community spouse. In short, the FSI provisions provide a way for one spouse to receive Medicaid-funded nursing home care, while allowing the spouse remaining in the community to maintain an adequate standard of living.

2. Current Idaho Restrictions on Transfers of Assets

Out of concern that people were qualifying for Medicaid after willfully giving their assets away to family members and/or attempting to hide assets, Congress approved potentially onerous penalties for individuals or couples who transfer significant assets for less than fair market value in the five years prior to applying for Medicaid. ⁸⁷ When a person applies for Medicaid, the person must disclose all asset transfers conducted below fair market value for the prior 60 months. Below fair market value transfers occurring within this timeframe will result in a period of ineligibility for Medicaid. ⁸⁸ CMS provides the following illustration of how the ineligibility period is calculated:

The length of the penalty period is determined by dividing the value of the transferred asset by the average monthly private-pay rate for nursing facility care in the State. Example: A transferred asset worth \$90,000, divided by a \$3,000 average monthly private-pay rate, results in a 30-month penalty period. There is no limit to the length of the penalty period. 89

^{83.} Spousal Impoverishment, supra note 46, at 1.

^{84.} SISSON & SISSON, supra note 62, at 4.

^{80.} See 2010 SSI and Spousal Impoverishment Standards, supra note 72.

^{86.} Id.

^{87.} Important Facts for State Policymakers Deficit Reduction Act, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 8, 2008), http://www.cms.gov/DeficitReductionAct/Down loads/TOAbackgrounder.pdf.

^{88.} *Id.*

^{89.} Id.

In Idaho, the average monthly private-pay rate for nursing home care is closer to \$6,000,90 such that a \$90,000 below market value transaction would result in approximately a 15-month period of ineligibility.

For assets transferred on or after February 8, 2006, changes enacted by Congress made the gift penalty even more onerous. Prior to February 2006, the penalty period began running when the gift was made and the look-back period was only 36 months (except for transfers to trusts where the look-back period was 60 months). For gifts made on or after February 8, 2006, however, the look-back period was increased to 60 months, and the penalty period does not begin until the person applies for Medicaid. There are certain exceptions, however, to this gift asset transfer penalty. Most significantly, there is an exception where the applicant can prove "the assets were transferred exclusively for a purpose other than to qualify for Medicaid or to avoid recovery. (e.g., birthday gifts) or where imposing the penalty would create an "undue hardship" for the applicant.

In short, the Medicaid LTC eligibility rules are quite complex and entail potentially negative consequences, including ineligibility, for Medicaid LTC applicants who fail to plan and document appropriately. Moreover, these rules create situations where "individuals contemplating a future Medicaid application may be motivated to make themselves 'poor on paper'" through intricate Medicaid planning. ⁹⁶ Despite proposals to further limit certain "Medicaid planning" activities and to make the requirements for Medicaid LTC eligibility more stringent, some research suggests that such policy efforts will have only a minimal effect on reducing reliance on Medicaid for LTC financing. ⁹⁷

B. Estate Recovery

Under federal law, each state Medicaid program is required to attempt to recover the expenses of Medicaid LTC from the estates of deceased Medicaid recipients. Each state, however, has flexibility in how it defines "estate" and in exactly how it goes about the recovery process.

^{90.} SISSON & SISSON, supra note 62, at 5.

^{91.} Idaho Admin. Code 16.03.05.833.01 (2011).

^{92.} Idaho Admin. Code 16.03.05.833.02.

^{93.} See generally Idaho Admin. Code 16.03.05.841.

^{94.} IDAHO ADMIN. CODE 16.03.05.841.10.

^{95.} IDAHO ADMIN. CODE 16.03.05.841.11.

^{96.} Kapp, supra note 31, at 74 (citing Joseph S. Karp & Sara I. Gershbein, Poor on Paper: An Overview of the Ethics and Morality of Medicaid Planning, FLA. B. J., Oct. 2005, at 61).

^{97.} Specifically, one study concluded that even "if every state in the country moved from their current Medicaid asset eligibility requirements to the most restrictive Medicaid asset eligibility requirements allowed by federal law . . . demand for private long-term care insurance would rise by only 2.7 percentage points." Brown & Finkelstein, *supra* note 13, at 23 (discussing Jeffrey R. Brown et al., *Medicaid Crowd-Out of Private Long-Term Care Insurance Demand: Evidence from the Health and Retirement Survey*, 21 TAX POL'Y & ECON. 1 (2007)).

This section provides a brief overview of estate recovery, highlights the areas where states have flexibility, and discusses estate recovery in Idaho, specifically. We then briefly highlight commentary regarding the effectiveness of estate recovery and suggested improvements to the process.

1. Estate Recovery Requirements After the Omnibus Budget Reconciliation Act of 1993

When Medicaid was created in 1965, it permitted states to recover the costs of Medicaid services provided to persons over the age of 65 from the estate of the person after the person had died. 98 By 1990, however, only twelve states had estate recovery programs. 99 During the late 1980s, research conducted by the U.S. General Accounting Office highlighted that estate recovery programs could help offset the costs of providing LTC. 100 As a result of this research and concerns regarding the rising costs of Medicaid services to the elderly, as part of the Omnibus Budget Reconciliation Act of 1993, Congress required that states implement a Medicaid estate recovery program. 101 Reportedly, Medicaid-funded LTC is the only governmental health or social welfare program with mandated estate recovery procedures, making Medicaid LTC "benefits unique in this regard." 102

After 1993, states were required to seek fund recovery from the estates of deceased Medicaid recipients. These costs primarily included the major types of LTC services provided to the affected individual. Additionally, states are permitted, but not required, to pursue estate recovery for any other items covered by the Medicaid State Plan. As explained below, however, federal law gives states some flexibility as to the scope of such mandatory estate recovery.

 $100.\$ $\emph{Id.};$ see also U.S. Gen. Accounting Office, GAO/HRD-89-56, Medicaid Recoveries from Nursing Home Residents' Estates Could Offset Program Costs (1989).

^{98.} OFFICE OF THE ASSISTANT SEC'Y FOR POLICY & EVAL., U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAID ELIGIBILITY FOR LONG-TERM CARE BENEFITS POLICY BRIEF No. 1: MEDICAID ESTATE RECOVERY 2 (2005), available at http://aspe.hhs.gov/daltcp/reports/estater ec.pdf [hereinafter ASPE MEDICAID ESTATE RECOVERY POLICY BRIEF].

^{99.} See id.

^{101.} See Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, \$ 13612, 107 Stat. 307, 627–29 (codified as amended in 42 U.S.C. \$ 1396p(b) (2006)); see also ASPE MEDICAID ESTATE RECOVERY POLICY BRIEF, supra note 98, at 2; Kapp, supra note 31, at 76.

^{102.} Kapp, supra note 31, at 76.

^{103.} See ASPE MEDICAID ESTATE RECOVERY POLICY BRIEF, supra note 98, at 3. Specifically, states are required to engage in estate recovery to recoup the costs of nursing home and other institutional LTC, home and community-based LTC services, and hospital and prescription drug services provided while the recipient was receiving institutional or home/community-based LTC. Id.

^{104.} *Id*.

2. Flexibility Allowed to States in the Definition of "Estate" and Legal Priority of Medicaid's Claim of Debt

While Medicaid LTC estate recovery is mandatory under federal law, states have flexibility as to how they define the term "estate." At a minimum, states are required to recover the deceased's assets that pass through probate according to that state's law. ¹⁰⁵ States are free, however, to have estate recovery programs that also recover other assets that do not pass through probate (i.e., life insurance payouts, annuity remainder payments, living trusts, joint tenancy interests, rights of survivorship, life estates, or other assets that pass directly to the surviving spouse outside of probate). ¹⁰⁶ One study found that 30 of 48 reporting states used the minimum definition of "estate" (meaning only the probate estate according to state law). ¹⁰⁷

Additionally, state law establishes the priority of Medicaid "debt" owed by the deceased recipient's estate, relative to the estate's other debts. ¹⁰⁸ For example, states have created laws that prioritize debts related to public utility bills, unpaid taxes, or child support payments in arrears over Medicaid estate recovery claims. Under such laws, Medicaid can only pursue estate recovery after any debts with priority over Medicaid's claim have been satisfied. Additionally, some states, including Florida and Texas, have laws that protect a family home from Medicaid estate recovery claims, as well as a variety of other claims. ¹⁰⁹

3. Consumer Procedural Protections, Idaho's Undue Hardship Exception, and Circumstances Where Federal Law Prohibits Estate Recovery

Although state policies vary widely as to what extent a deceased Medicaid recipient's assets may be recovered and how aggressively the state will seek recovery, federal law does provide some basic procedural requirements that must be followed. Specifically, a state's estate recovery program must include the following notice and procedural protections for Medicaid recipients and their families:

 Notice requirements for Medicaid LTC recipients: At the time of initially applying for Medicaid funded LTC, each individual must receive notice of potential recovery from the individual's estate.¹¹⁰ Additionally, each state Medicaid pro-

^{105.} Id. at 4.

^{106.} Id. at 4; Kapp, supra note 31.

^{107.} ASPE MEDICAID ESTATE RECOVERY POLICY BRIEF, *supra* note 98, at 5 (citing MEDICAID ESTATE RECOVERY WORK GROUP, REPORT TO THE PENNSYLVANIA INTRA-GOVERNMENTAL COUNCIL ON LONG-TERM CARE (2002)).

^{108.} Id

^{109.} Id. at 4 n.15.

^{110.} Id. at 7.

gram is required annually to re-notify a Medicaid recipient of potential estate recovery. 111

Procedural protections for surviving heirs: Upon beginning
the estate recovery process, surviving family members potentially impacted by estate recovery must be given notice
and the opportunity to seek an exemption from estate recovery based on hardship.¹¹²

Although federal law requires states to establish an "undue hardship" exemption to estate recovery policies, states have flexibility as to the specifics of what constitutes an undue hardship. ¹¹³ Federal guidelines suggest that states establish hardship waivers for two types of scenarios: (1) waiving recovery of a home of modest value where family members are living in it and would be deprived of a place to live if Medicaid recovered it, and (2) waiving recovery of income-producing property (i.e. farms) that surviving family members rely on as a source of income. ¹¹⁴ While commentaries suggest that obtaining a hardship waiver in many states may often involve subjective negotiations and partial recovery, ¹¹⁵ there is apparently no published research surveying how states administer hardship waivers. ¹¹⁶

In addition to requiring states to establish more discretionary hardship waiver criteria and procedures, federal law also prohibits estate recovery in certain situations and/or in relation to certain assets. Specifically, states cannot pursue estate recovery while a surviving spouse is still living or where the assets would otherwise go to a surviving child who is under 21, blind, or permanently disabled. 117 Additionally, federal law prohibits recovering a Medicaid recipient's former home where one or more of the recipient's siblings also has an ownership interest in the home and that sibling continuously resided in the recipient's home for at least one year prior to when the Medicaid recipient was admitted to an institution. 118 Additionally, if an adult child lived with the recipient in the home for two years prior to when the recipient entered institutional care and provided care that helped delay the time

112. Id. at 8; see also Kapp, supra note 31, at 76.

^{111.} Id.

^{113.} See HEALTH CARE FIN. ADMIN., STATE MEDICAID MANUAL: PART 3 – ELIGIBILITY § 3810(C) (2001), available at http://www.cms.gov/transmittals/downloads/R75SM3.pdf.

^{114.} ASPE MEDICAID ESTATE RECOVERY POLICY BRIEF, supra note 98, at 8.

^{115.} See id. at 8; see also Kapp, supra note 31, at 76 ("Under OBRA '93, states may waive estate recovery on a case-by-case basis when an attempt to recover would not be cost-effective. States also maintain discretion to waive estate recovery efforts in particular situations where enforcement would work an undue hardship on survivors of the Medicaid beneficiary.").

^{116.} ASPE MEDICAID ESTATE RECOVERY POLICY BRIEF, supra note 98, at 8.

^{117.} Id. at 6.

^{118.} *Id.*

the recipient finally needed institutional care, the state is prohibited from recovering the home. 119

These federal limitations on Medicaid estate recovery and hardship exemptions essentially mirror the requirements for establishing a hardship to remove assets from consideration for the purposes of Medicaid eligibility, as discussed above.

After one of these conditions prohibiting immediate estate recovery has been removed (e.g., the surviving spouse dies), Medicaid apparently has the right to then pursue recovery. States vary significantly, however, as to what extent they pursue estate recovery at later times. As one summary explained, "a number of states waive their future right to recovery altogether, others defer it, and yet others use a mix of approaches based on the specifics of each case." Similarly, it is unclear to what extent different states pursue estate recovery after the circumstances creating an undue hardship have been removed.

4. Idaho's General Estate Recovery Rules and Practices

As referenced above, although the Omnibus Budget Reconciliation Act of 1993 required that states attempt some form of estate recovery to recoup the costs of Medicaid-funded LTC services, states have broad flexibility in exactly how they implement estate recovery programs. This section examines Idaho's administrative rules implementing its estate recovery program.

Idaho's Department of Health & Welfare ("H&W"), the state agency that administers Idaho's Medicaid program, has the responsibility for estate recovery. The procedures for estate recovery in Idaho are set forth in a section of H&W's "Rules Governing the Medical Assistance Program" entitled "Liens and Estate Recovery" ("Rule"). With respect to areas where federal law gives states latitude, Idaho generally leans toward more aggressive estate recovery.

Specifically, regarding what constitutes a recoverable estate, H&W's Rule defines this term as broadly as possible:

All real and personal property and other assets including those in which the participant had any legal or beneficial title or interest at the time of death, to the extent such interest, including

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^{119.} *Id.* For further explanation of state Medicaid practices related to recovery of a deceased LTC recipient's estate, *see generally* OFFICE OF ASSISTANT SEC'Y FOR POLICY & EVAL., U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAID ELIGIBILITY FOR LONG-TERM CARE BENEFITS POLICY BRIEF NO. 2, MEDICAID TREATMENT OF THE HOME: DETERMINING ELIGIBILITY AND REPAYMENT FOR LONG-TERM CARE (2005), *available at* http://aspe.hhs.gov/d altcp/reports/hometreat.pdf; *see also* OFFICE OF ASSISTANT SEC'Y FOR POLICY & EVAL., U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAID ELIGIBILITY FOR LONG-TERM CARE BENEFITS POLICY BRIEF NO. 4, MEDICAID LIENS (2005), *available at* http://aspe.hhs.gov/daltcp/reports/liens.pdf.

^{120.} See HEALTH CARE FINANCING ADMINISTRATION, supra note 113, at § 3810(A)(5).

^{121.} ASPE MEDICAID ESTATE RECOVERY POLICY BRIEF, supra note 98, at 6.

^{122.} Idaho Admin. Code 16.03.09.900 (2011).

such assets conveyed to a survivor, heir, or assignee of the deceased participant through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.¹²³

Additionally, in the section of the Rule entitled "Assets in Estate Subject to Claims," the Rule further specifies how virtually everything of value that the recipient has some right to or interest in is considered a recoverable asset, including items such as payments under an installment contract, beneficial interests in trusts, or life insurance payouts. ¹²⁴ Considering these provisions, it is apparent that Idaho seeks to recover as much of a Medicaid LTC recipient's assets as possible.

Furthermore, the Rule gives Medicaid's estate recovery claim priority over most other debts, as set forth in the Uniform Probate Code. Specifically, in Idaho, a Medicaid estate recovery claim is given preference over all claims except costs and expenses associated with estate administration, reasonable funeral expenses, debts and taxes given preference under federal law, and medical expenses related to the decedent's last illness. 125

Idaho's estate recovery Rule is also fairly expansive in relation to the circumstances under which H&W will pursue estate recovery and is authorized to release estate recovery claims. As required by federal laws discussed above, the Rule provides that estate "[r]ecovery will not be made until the deceased participant no longer is survived by a spouse, a child who is under age twenty-one (21), or a blind or disabled child"126 Worthy of note, this subsection does not completely waive claims where a recipient is survived by a spouse, a child under 21 years, and/or a blind or disabled child.127 Rather, the subsection only defers such claims until circumstances have changed (e.g., the surviving child reaches age 21 or the surviving spouse dies).128

Idaho's estate recovery Rule authorizes H&W to waive estate recovery in only a narrow set of circumstances. Specifically, the Rule provides the following guidance regarding releasing estate recovery claims:

[H&W] shall release a claim when [H&W]'s claim has been fully satisfied and may release its claim under the following conditions:

a. When an undue hardship as defined in Subsection 905.07 of these rules has been granted; or

^{123.} Idaho Admin. Code 16.03.09.901.04.

^{124.} Idaho Admin. Code 16.03.09.904.05.

^{125.} See Idaho Admin. Code 16.03.09.21.b; Idaho Code Ann. § 15-3-805 (2007).

^{126.} Idaho Admin. Code 16.03.09.905.01.

^{127.} See id.

^{128.} See id.

b. When a written agreement with the authorized representative to pay [H&W]'s claim in thirty-six (36) monthly payments or less has been achieved.¹²⁹

Accordingly, under this Rule it appears that H&W is permitted to release a Medicaid estate recovery claim in only three situations: (1) where the claim has been paid in full; (2) where a hardship waiver has been granted; or (3) where a payment plan that will pay off the claim in three years or less has been reached. The last option is somewhat unclear, with the Rule's usage of the term "claim" presumably implying the claim in full—as opposed to only partial repayment of the claim.

Regarding an undue hardship waiver, the Rule provides four specific bases upon which such a waiver may be granted:

The estate subject to recovery is [the sole] income-producing property that provides the primary source of support for other family members; or

Payment of [H&W]'s claim would cause heirs of the deceased participant to be eligible for public assistance; or

[H&W]'s claim is less than five hundred dollars (\$500) or the total assets of the entire estate are less than five hundred dollars (\$500), excluding trust accounts and other bank accounts; or

The recipient received [Medicaid benefits] as the result of a crime committed against the participant. 130

Accordingly, it appears that H&W has broad authority to pursue Medicaid estate recovery compared to what is required by federal law. Such rules, coupled with aggressive enforcement, may account for the fact that Idaho ranks third in the nation in the percentage of Medicaid expenditures recovered through estate recovery. Given the ethical and practical issues raised by the estate recovery process, however, it is unclear whether greater estate recovery efforts will significantly off-

^{129.} IDAHO ADMIN. CODE 16.03.09.905.06.a-.b.

^{130.} IDAHO ADMIN. CODE 16.03.09.905.

^{131.} U.S. DEP'T OF HEALTH & HUMAN SERVS., ASSISTANT SEC'Y FOR POLICY & EVAL., MEDICAID ESTATE RECOVERY COLLECTIONS 3 (2005). Specifically, in 2004 Idaho reportedly recouped 4.5% of its Medicaid LTC expenditures through estate recovery, behind only Oregon at 5.8% and Arizona at 10.4%. *Id.*

^{132.} See Kapp, supra note 31, at 76 ("[T]he opponents of estate recovery as a component of the Medicaid program contend that estate recovery laws offend the ethical principles of beneficence (doing good for others) and nonmaleficence (preventing harm to others).").

^{133.} U.S. DEP'T OF HEALTH & HUMAN SERVS., ASSISTANT SEC'Y FOR POLICY & EVAL., MEDICAID ELIGIBILITY FOR LONG-TERM CARE BENEFITS POLICY BRIEF No. 6: MEDICAID ESTATE RECOVERY 5, available at http://aspe.hhs.gov/daltcp/reports/estreccol.pdf [hereinafter ASPE MEDICAID ESTATE RECOVERY COLLECTIONS POLICY BRIEF] ("Estate recovery engenders considerable political controversy and resistance in some regions of the country, which can compromise [collaborative attempts] between Medicaid estate recovery programs and state legislatures and executive officials to implement effective policies and procedures.").

set the increasing drain Medicaid LTC expenses are expected to impose on state budgets. 134

IV. LAWS RELATED TO LONG-TERM CARE INSURANCE IN IDAHO

While Medicaid remains the primary payer for LTC, in recent years much policy discussion has focused on ways to encourage individuals to purchase long-term care insurance ("LTCI"). Moreover, a substantial body of research addresses questions related to why more Americans do not purchase LTCI. ¹³⁵ Given this dialogue, an understanding of the various laws and regulations governing LTCI is important to the policy discussion of LTC funding options. In this Part, we will (1) discuss the laws generally relating to LTCI in Idaho, (2) look at the statutes and regulations creating Idaho's Medicaid Partnership Program for LTCI, (3) examine state and federal tax incentives to purchase LTCI, and (4) discuss laws affecting the availability of LTCI through governmental and private employers. In doing this, we will highlight major issues related to LTCI and various policy measures intended to address these concerns.

A. General Regulation of LTCI in Idaho

Idaho's "Long-Term Care Insurance Act," enacted in 1999, sets forth the general standards for long term care insurance policies in Idaho. With authority delegated to it under statute, the Idaho Department of Insurance (IDOI) regulates LTCI pursuant to administrative rule provisions contained in the "Long-Term Care Insurance Minimum Standards" ("LTCI Rule"). Both the statute and the LTCI Rule are based on the National Association of Insurance Commissioners ("NAIC") Long Term Care Model Act and Regulation. The LTCI Rule was initially created in 2000, with some minor amendments made in 2001. In 2007, the LTCI Rule was substantially revised to implement changes made to NAIC's Model Regulation. 139

^{134.} See id. at 7 ("Amounts collected from Medicaid recipients' estates are not insignificant in absolute terms. They do, however, pale next to total Medicaid spending for long-term care.").

^{135.} See generally Brown & Finkelstein, supra note 13 (reviewing literature); see also infra Part IV.B.2 (discussing difficulties insurance producers have in marketing some types of policies).

^{136.} IDAHO CODE ANN. §§ 41-4601 to -4611 (2007).

^{137.} Idaho Admin. Code 18.01.60 (2011).

^{138.} Compare Long Term Care Model Act (1998), with Idaho Code Ann. \$\$ 41-4601 to -4611; compare Long Term Care Model Regulation (1998), with Idaho Admin. Code 18.01.60.

^{139.} See generally Long Term Care Model Regulation (2000); see generally Idaho Admin. Code 18.01.60.

1. Idaho's "Long-Term Care Insurance Act"

Idaho's Long-Term Care Insurance Act sets forth the general framework for the regulation of long-term care insurance, provides definitions, describes how to address long-term care policies issued in other states, and, most importantly, delegates authority to the IDOI to create administrative rules regulating LTCI. ¹⁴⁰ Several provisions in the Act provide helpful background into some of the issues surrounding LTCI and what types of services such private LTCI policies generally cover. First, the Legislature explained that the purposes of the Act are,

to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage. ¹⁴¹

This statement of legislative purpose speaks to several general concerns commentators have discussed in relation to the private LTCI market. Specifically, it addresses concerns about availability and ensures that consumers understand what they are buying when purchasing private LTCI. The Act then establishes its scope by defining the term "[l]ong-term care insurance" as:

[A]ny insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one (1) or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital.¹⁴²

2. Idaho's Administrative Rules Governing Long-Term Care Insurance

The Idaho Department of Insurance's (IDOI) LTCI Rule provides detailed regulations regarding a number of issues including usage of certain defined terms in LTCI policies, certain minimum standards to which all LTCI policies must adhere, and certain minimum standards to which insurers issuing LTCI policies must adhere (i.e. risk of loss ratios). A survey of some of these provisions provides a helpful background into the nature of private LTCI.

^{140.} See IDAHO CODE ANN. § 41-4608.

^{141.} *Id.* § 41-4601.

^{142.} Id. § 41-4603(5).

a. Minimum requirements needed to trigger payment of benefits. Under this Rule, the trigger for payment of benefits under an LTCI policy may "not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment." Activities of daily living ("ADLs") are defined as including "[a]t least bathing, continence, dressing, eating, toileting, and transferring," and cognitive impairment is defined as "[a] deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness." Accordingly, under this Rule, an LTCI policy may not require more than the need for assistance with three ADLs or the presence of a cognitive impairment to trigger payment of benefits. It would be permissible, however, to have less restrictive terms regarding the trigger of benefits (e.g., requiring a deficiency of only two ADLs). 146

b. Currently no requirement that LTCI provide comprehensive LTC benefits. The Rule recognizes three general categories of policies: policies providing only institutional LTC benefits, policies providing only non-institutional LTC benefits, and policies providing comprehensive LTC benefits. 147 Currently there is no requirement that an LTCI policy pay for home or community-based LTC services. It is permissible for insurers to issue LTCI policies covering only institutional care—not homebound care. One nationwide study conducted in 2000 found that approximately one-fourth of private LTC policies provided coverage only for institutional care. 148 In other words, an individual who holds such a policy would not be able to make a claim until and unless he or she moved into a nursing home. With this type of a policy in place, the individual may actually have easier access to home-health services by spending down assets and applying for Medicaid. In light of this situation, policymakers should consider placing restrictions on such policies.

c. Coverage for home and community-based services. Although LTCI policies are not required to reimburse holders for home and community-based LTC services, if a policy does offer such a benefit, Rule 18.01.60.016 sets forth certain minimum standards for such benefits. Specifically, the Rule prohibits policies from requiring a claimant to demonstrate the need for skilled nursing care if "home health care" was not provided—with home health care defined as "[m]edical and non-medical services, provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with

 $^{143. \}quad \text{IDAHO ADMIN. CODE } 18.01.60.033.01 \text{ (emphasis added)}.$

^{144.} Idaho Admin. Code 18.01.60.010.01; 18.01.60.033.02.

^{145.} Idaho Admin. Code 18.01.60.010.05.

^{146.} This is the case with the voluntary, public LTCI under the newly created CLASS Act, discussed supra.

^{147.} $See\ Idaho\ Admin.\ Code\ 18.01.60.010.17.$

^{148.} See Brown & Finkelstein, supra note 13, at 9.

activities of daily living, and respite care services."¹⁴⁹ Accordingly, if a policy includes home and community-based services as a benefit, and the claimant otherwise meets the criteria to trigger benefits, an LTCI policy may not require that the claimant be a candidate for institutional skilled nursing care before the claimant is entitled to homemaker and other home health care services under the policy.¹⁵⁰

Other similar provisions in the Rule include the following prohibitions on limitations or exclusions: requiring the claimant to also receive certain nursing or therapeutic care for home health care to be covered, requiring registered nurses or licensed practical nurses to provide the services if a home health aide or similar provider would be qualified to provide such services, excluding adult day care services, or requiring the claimant to have acute conditions before home health care services are covered. Additionally, the Rule provides that for an LTCI policy providing home or community services, the policy "shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) year's coverage available for nursing home benefits under the policy"¹⁵²

As touched upon above, if an insured individual need not move to an institutional setting before he or she can make a claim on an LTCI policy, there exists the potential for an increased number of claims. Because of this risk, insurers may seek ways to cause undue hardships for those insured to make claims for home or community LTC services—even if such services are provided under the policy. These provisions in the Rule seek to prevent such conduct and assure that an LTCI policy purporting to provide home and community-based care actually provides the types of benefits that consumers would reasonably expect.

d. Inflation protection. Considering that all health care costs—including the costs of LTC services—are expected to continue to increase and LTCI policies are often purchased years in advance of when the insured is reasonably expected to make a claim, a key component to such policies is some provision "that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy." These so-called inflation protection provisions of LTCI policies may be important to protect consumers although inflation protection adds to the cost of policy premiums.

IDAPA 18.01.60.017 requires that insurers offer consumers the option to purchase inflation protection when they purchase LTCI. With the exception of Medicaid Partnership LTCI policies, however, there is no requirement that an LTCI policy actually include inflation protection

^{149.} IDAHO ADMIN. CODE 18.01.60.010.11.

^{150.} IDAHO ADMIN. CODE 18.01.60.016.01.a.

^{151.} IDAHO ADMIN. CODE 18.01.60.0160.01.b-.i.

^{152.} IDAHO ADMIN. CODE 18.01.60.016.02.

^{153.} Idaho Admin. Code 18.01.60.017.01.

provisions. As discussed in greater detail below, the Rule requires that Medicaid Partnership LTCI policies have specific inflation protection provisions—the requirements of which vary significantly depending on the age of the insured at the time the policy is purchased.¹⁵⁴

B. Availability of Medicaid "Partnership" Long-Term Care Insurance Policies in Idaho

Under state and federal laws enacted within the last five years, Idaho residents can now purchase so-called Qualified Medicaid Partnership LTCI policies. If an individual insured by such a Partnership policy eventually applies for means-tested Medicaid LTC, Medicaid will disregard the individual's assets in the amount equal to the value of the benefits provided under the policy. The Idaho Department of Insurance provides the following helpful explanation of how such a Partnership Program insurance policy works:

Under the Partnership Program, the state will disregard the policyholder's personal assets equal to amounts paid out under a qualifying insurance policy when it determines the person's eligibility for Medicaid assistance. For example, if a qualifying insurance policy pays out \$50,000 in benefits to cover a person's long term care needs, Medicaid would not count up to \$50,000 of the person's assets when it determines whether the person is eligible for Medicaid assistance with long term care costs. This means the person would be able to qualify for long term care assistance through Medicaid without first having to spend all their personal assets on care. ¹⁵⁵

The following sections provide an overview of the requirements of the laws and rules facilitating Partnership plans in Idaho and then summarize trends and commentary related to these Partnership plans.

1. Laws and Rules Governing Medicaid Partnership LTCI

Prior to 1993, states were permitted to create programs that would allow Medicaid, in assessing an applicant's eligibility for Medicaid LTC, to disregard the value of assets equivalent to the value of benefits received under a previously exhausted qualifying LTCI policy. During this time period, only four states—Connecticut, Indiana, California, and New York—created such programs. In 1993, however, Congress

^{154.} See IDAHO ADMIN. CODE 18.01.60.017.01.d.

^{155.} Long-Term Care Insurance Partnership Program, IDAHO DEP'T OF INS., http://www.doi.idaho.gov/company/LTC partnership.aspx (last visited Mar. 21, 2012).

^{156.} CTR. FOR MEDICARE & MEDICAID SERVS. ("CMS"), QUALIFIED LONG-TERM CARE PARTNERSHIPS UNDER THE DEFICIT REDUCTION ACT OF 2005, at 2 (2006).

^{157.} Joshua M. Wiener et al., supra note 1, at 83.

amended the Social Security Act to disallow the new creation of such plans that had not been approved prior to May 14, 1993. 158

As part of the Deficit Reduction Act ("DRA") of 2005, however, Congress amended section 1917(b)(1)(C)(ii) to permit other states to create programs to exempt the value of benefits provided under qualifying exhausted LTCI policies from Medicaid estate recovery. As a result of these provisions, at least 30 states, including Idaho, have created such Partnership Programs. The NAIC has provided a helpful summary of the seven key requirements that must be met for state Partnership Programs to qualify under the DRA of 2005:

- 1. The insured was a resident of the state when coverage became effective;
- 2. The policy is tax-qualified;
- The policy meets certain specified consumer protection requirements of the NAIC Long Term Care Insurance Model Act and Regulation;
- 4. The policy contains specified inflation protection if sold to an individual under age 76;
- 5. The state Medicaid agency provides information and technical assistance to the state insurance department (DOI) on the DOI's role of assuring that producers of partnership policies are trained:
- 6. The issuer provides regular reports to the Secretary of the Department of Health and Human Services (HHS) (to be set by the Secretary in regulation); and
- 7. The state does not impose any requirements on a partnership policy that it does not impose on other LTC policies. 161

In 2007, the Idaho State Legislature enacted S.B. 1170 and made changes to IDAPA 18.01.60.017 and .027 to enable the creation of Idaho's Partnership Program. ¹⁶² Specifically, IDAPA 18.01.60.017.01.d sets forth the specific types of inflation protections, which reflect the requirements set forth in federal law that must be provided as part of a qualifying Partnership Plan LTCI policy:

d. With respect to inflation protection for a Partnership policy only: . . .

160. Tumlinson et al., supra note 26, at iii.

^{158.} CMS, *supra* note 156, at 2.

^{159.} Id.

^{161.} NAT'L ASS'N OF INS. COMM'RS. ("NAIC"), SUMMARY: LONG TERM CARE PARTNERSHIP PROVISIONS OF DEFICIT REDUCTION ACT OF 2005 1 (2006), available at http://www.naic.org/documents/committees_b_senior_issues_ltc_partnership_revisions_dra.pdf.

^{162.} S.B. 1170, 2007 Leg., 57th Sess. (Idaho 2007).

- i. If the policy is sold to an individual who has not attained age sixty-one (61) as of the date of the purchase, the policy must provide compound annual inflation protection; . . .
- ii. If the policy is sold to an individual who has attained age sixty-one (61) but has not attained age seventy-six (76) as of the date of purchase, the policy must provide some level of inflation protection; and . . .
- iii. If the policy is sold to an individual who has attained age seventy-six (76) as of the date of purchase, the policy may (but is not required to) provide some level of inflation protection. 163

Neither this rule nor federal law specifies the amount of "compound annual inflation protection" or "some level of inflation protection" that must be provided. Therefore, there has been some debate over what types of inflation protections must be provided, specifically "whether options that let long term care insurance policyholders buy more coverage are equivalent to policy provisions that automatically increase LTC coverage levels each year." ¹⁶⁴ The Idaho DOI interpreted the inflation requirements more strictly, and, citing "limited guidance regarding what was intended by Congress when it imposed the inflation protection requirement," determined that Idaho Partnership Program LTCI policies must contain the following levels of inflation protection:

If the policy is sold to a person under the age of 61, it must provide automatic compound annual inflation protection of at least 5%; if sold to a person aged 61 to 75, the policy must provide automatic annual inflation protection of at least 5%; and, if sold to a person aged 76 or older, there will be no level of inflation protection required.¹⁶⁵

Additionally, IDAPA 18.01.60.027 was significantly amended to add a variety of training requirements for producers (salespersons) of Partnership Program policies and requirements for the DOI to maintain records of such producer training. 166

 $^{163. \}quad \text{Idaho Admin. Code } 18.01.60.017.01.d\ (2011).$

 $^{164. \}quad \textit{Idaho LTC Partnership Sets Inflation Shield Standards}, \ NAT'L \ UNDERWRITER: \\ \text{LIFE \& HEALTH (Dec. 27, 2006), http://edit.lifeandhealthinsurancenews.com/ News/2006/12/Pages/Idaho-LTC-Partnership-Sets-Inflation-Shield-Standards.aspx.}$

^{165.} IDAHO DEP'T OF INS., BULLETIN NO. 06-7, NOTICE REGARDING INFLATION PROTECTION REQUIREMENTS FOR LONG-TERM CARE PARTNERSHIP POLICIES (2006), available at http://www.doi.idaho.gov/laws/06 7.pdf.

^{166.} See IDAHO ADMIN. CODE 18.01.60.027.04.d.

2. Trends and Commentary Regarding Medicaid Partnership LTCI

Considering the program has only been in place for a few years, it is likely premature to assess how successful Idaho's Partnership Program will be in incentivizing individuals to purchase private LTCI. Considering commentary and research from the several states with longstanding Partnership Programs, however, it is likely Partnership Program LTCI will not fully address LTC finance needs in a state with Idaho's demographics. In the four states operating Partnership Programs prior to the passage of the DRA of 2005, such Partnership LTCI policies failed to have "a major impact on the financing of long-term care. . . ."¹⁶⁷ Specifically, in 1999, even though there were over seven million older people living in the four states with Partnership Programs, only 52,560 such policies had been purchased, representing less than 0.1% of the potential market. ¹⁶⁸

Partnership Program LTCI policies are most attractive to individuals who are not so wealthy that they anticipate never relying on Medicaid LTC, but who still have a significant amount of non-exempt assets (e.g., other than their home) that they want to protect from Medicaid estate recovery. Accordingly, the demographic that may be most attracted to Partnership Program LTCI may be quite small, especially in Idaho.

Wiener and colleagues summarized the reasons why Partnership Program policies may not be desirable to many consumers as follows: "(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." ¹⁶⁹

Partnership Program policies generally have significantly higher premium prices due to the added costs of the mandatory inflation protection provisions. While there are sound policy reasons for mandating inflation protection to ensure that LTCI policies retain their value for consumers, an upshot of such a mandate is potentially making Partnership Programs unaffordable for certain consumers. Specifically, a report published by the Kaiser Family Foundation indicated that "inflation protection appears to be the feature [in LTCI policies] that varies the most with income level," with a lower proportion of lower-income individuals purchasing LTCI with inflation protection provisions. Additionally, of the group LTCI policies with inflation protections sold in 2006, 45.4% contained the future option to purchase inflation protection—which, by itself, would not qualify a policy for Partnership Program status. It is sum, the expense necessary to fulfill inflation protection requirements may make Partnership Program qualifying LTCI policies.

^{167.} Wiener et al., supra note 1, at 87.

^{168.} Id.

^{169.} Id. at 88

^{170.} See Tumlinson et al., supra note 26, at 5.

^{171.} Id

icies cost prohibitive for many of the middle-class individuals who are eventually at risk of needing Medicaid-financed LTC, and therefore would otherwise be most interested in Partnership Program policies.

Additionally, Wiener and colleagues suggested that producers might have difficulty and/or limited interest in marketing Partnership policies, explaining as follows:

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. 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 distribution. There is still plenty of the low-hanging fruit—relatively upper-income people—to whom they can market."172

Considering the availability of high quality home and community-based Medicaid-financed LTC services in Idaho, the perception of the poor quality of Medicaid LTC may not be as strong of a selling point for private LTCI in Idaho. The observations quoted above, however, highlight the potentially narrow market of individuals well served by Partnership policies: those who are both wealthy enough to afford potentially very expensive Partnership LTCI policies *and* concerned that they may eventually require Medicaid-financed LTC.

Given these factors, while the creation of Medicaid Partnership Program LTCI represents an innovative way to encourage individuals to appropriately plan to finance future LTC needs, it likely will not be a "silver bullet" in addressing Idaho's impending LTC finance crisis.

C. State- and Federal-Level Tax Incentives to Purchase LTCI

Similar to twenty-eight other states and the District of Columbia, ¹⁷³ Idaho offers state tax incentives to purchase LTCI. Specifically, Idaho

^{172.} Wiener et al., supra note 1, at 90-91.

^{173.} AM. COUNCIL OF LIFE INSURERS, STATE TAX INCENTIVES FOR LONG-TERM CARE INSURANCE, LTC CONSULTANTS, http://www.ltcconsultants.com/pdfdocs/taxincentivesbystate

offers a state income tax deduction for the cost of premiums for long-term care insurance.¹⁷⁴ Idaho Code Section 63-3022Q provides a full state income tax deduction for premiums paid for long-term care insurance "for the benefit of the taxpayer, a dependent of the taxpayer or an employee of the taxpayer."¹⁷⁵ Prior to 2004, Idaho law provided a tax deduction for only one-half of the premiums. In that year, however, with the passage of H.B. 567, the Idaho legislature increased the deduction to the full amount of LTCI premiums. ¹⁷⁶

Because this is a tax deduction rather than a tax exemption or credit, it benefits only individuals who have some state income tax liability that "is not otherwise deducted or accounted for by the taxpayer for Idaho income tax purposes." Certain other states offer tax credits rather than deductions—even if such credits are for less than 100% of the premium costs. The Colorado, for example, offers a credit of 25% of the premium cost or \$150 per year per policy.

At the federal level, as part of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, Congress enacted tax incentives related to the payment of LTCI premiums. Specifically, premiums for LTCI are considered medical expenses and therefore are tax deductible to the extent that they exceed 7.5% of the taxpayer's adjusted gross income. The federal deduction for LTCI premiums is capped, however, at certain rates set forth in § 213(d) of the Internal Revenue Code, which vary depending on the taxpayer's age. Since these federal tax incentives are in the form of an itemized deduction, they offer no benefit to taxpayers who do not earn enough to exceed the standard deduction.

D. LTCI Availability Through Employers in Idaho

As part of its initiative to encourage individuals to finance future LTC needs through private means, the National Governors Association ("NGA") has sought to encourage employers to offer LTCI to employees. Specifically, the NGA has advocated that as an employer, state governments should "serve as a model for other employers and help state employees plan for their own LTC financial needs" by "encouraging state employees and retirees to purchase LTC insurance." In this regard, the State of Idaho has offered voluntary LTCI programs to its employ-

^{020508.}pdf (last updated Feb. 5, 2008) [hereinafter STATE LTCI TAX INCENTIVES].

^{174.} See IDAHO CODE ANN. § 63-3022Q (2007).

^{175.} Id

^{176.} See H.B. 567, 57th Leg., 2d Reg. Sess. (Idaho 2004), available at http://legislature.idaho.gov/legislation/2004/H0567.html#sop.

^{177.} IDAHO CODE ANN. § 63-3022Q.

^{178.} See State LTCI Tax Incentives, supra note 173.

^{179.} Id.

^{180.} Long-Term Care Insurance Tax Deductibility Rules: Individual Purchase, AM. ASS'N OF LONG-TERM CARE INS., http://www.aaltci.org/long-term-care-insurance/learning-center/tax-for-business.php#individual (last visited Feb. 29, 2012).

^{181.} NGA, supra note 18, at 7.

ees, retirees and their family members. However, the success of the initiative appears to have been limited. As of December 2006, there were only 932 enrollees in LTCI offered through the state—only 2.8% of the 25,066 state employees at that time. 182

There are, however, approximately 50 companies licensed to sell LTCI policies in Idaho. Accordingly, while offering voluntary LTCI through employers may raise awareness regarding the availability of such insurance, it appears that such an offering has not had a significant impact on the actual purchase of such insurance.

As part of the large health care reform, Patient Protection and Affordable Care Act, signed into law in March 2010, were intended to create a publicly operated "national, voluntary, long-term care insurance program" that would have been operated through employers. ¹⁸⁴ Under this program—the Community Living Assistance Services and Supports Act ("CLASS Act") ¹⁸⁵—individuals would have to enroll in a government-run long-term care insurance program by voluntarily having certain amounts deducted from their paychecks and paid into the program. ¹⁸⁶ Additionally, although the CLASS Act would be government run, the legislation required the program to be fully self-supported by premium payments—not subsidized with tax-dollars. ¹⁸⁷

In October 2011, however, the Obama administration announced that it was abandoning its effort to implement the CLASS Act. ¹⁸⁸ In announcing this change, Kathleen Sebelius, Secretary of Health and Human Services, cited concerns that "not enough young, healthy people would sign up." ¹⁸⁹ Secretary Sebelius further explained that "[t]his could have led to a vicious cycle where premiums would have to be set higher and higher to cover the likely costs of benefits, leading fewer and fewer healthier people to sign up for the program." ¹⁹⁰

The program would have provided an enrollee who needed assistance with two or more activities of daily living ("ADLs") with a daily benefit of at least \$50 per day. ¹⁹¹ One novel feature of the CLASS Act, when compared to other types of LTCI, is the flexibility the beneficiary

184. Palmersheim, supra note 7.

^{182.} BEARD & MILLER, supra note 14, at 23.

^{183.} Id.

^{185.} Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. \S 8002 (2010) (adding sections 3201 through 3210 to title 42 of the United States Code).

^{186.} Palmersheim, supra note 7.

^{187.} Id.

^{188.} Kathleen Sebelius, *The CLASS Program*, HEALTHCARE BLOG (Oct. 14, 2011), http://www.healthcare.gov/blog/2011/10/class10142011.html.

^{189.} *Id.*

^{190.} *Id.* Prior to enactment, the Congressional Budget Office estimated that the premium would be around \$123 per month. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Honorable Tom Harkin, Chairman of the Comm. on Health, Educ., Labor, and Pensions, United States Senate (Nov. 25, 2009), *available at* http://www.cbo.gov/sites/def ault/files/cbofiles/ftpdocs/108xx/doc10843/class additional information miller letter.pdf.

^{191.} Palmersheim, *supra* note 7. The specific daily benefit amount was to be set by HHS and would have been higher for individuals with more significant needs. *Id.*

would have in how the money is spent. Specifically, the statute broadly provided that a beneficiary could use the funds "to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community "192 In addition to daily home health services, this would have included costs of home modifications and assistive technology. 193 Moreover, the program would allow the benefits to be used to compensate a family member for services provided. 194

Although some commentators suggest that "[p]ublic policy that supports a coordinated public-private financing approach holds the greatest promise for achieving efficient and equitable outcomes for taxpayers and consumers,"195 it currently does not appear that the CLASS Act will be implemented to achieve those ends. Accordingly, at present, it appears that employer-based programs to encourage voluntary purchase of LTCI do not have a significant impact on how LTC is funded in Idaho.

V. OTHER POTENTIAL OPTIONS FOR FUNDING AND PROVIDING LTC

A. Reverse Mortgages

In recent years, there has been a greater emphasis placed on allowing individuals who need certain LTC services to remain in their homes and in the community as long as possible. Reverse mortgages allow individuals to access the equity value of their homes to pay for LTC while permitting them to continue to own and reside in their homes. In this section we first briefly describe how reverse mortgages work and then discuss their potential application in Idaho.

1. Programs Facilitating Reverse Mortgages

The Robert Wood Johnson Foundation explains that "[r]everse mortgages are a special type of loan that allows people age 62 and older to tap into the equity (value) they have accumulated in their homes and convert it into cash, which they can use to pay for home and community-

^{192.} Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 8002 (2010) (to be codified at 42 U.S.C. § 3204(c)(1)(B)).

^{193.} Id.

Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 8002 (2010) (to be codified at § 3004(g)). CLASS Act LTCI also offers certain potential benefits related to qualifying for Medicaid. If an enrollee receives Medicaid benefits to pay for home and community-based care in addition to CLASS Act benefits, only 50% of the benefit must go to Medicaid, while the other half may be retained by the beneficiary. See Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 8002 (2010) (to be codified at § 3004(c)(1)(D)). Accordingly, CLASS Act benefits will not prevent a beneficiary from qualifying for Medicaid if the CLASS Act benefits alone are insufficient to meet all LTC needs.

^{195.} David G. Stevenson et al., The Complementarity of Public and Private Long-Term Care Coverage, 29 HEALTH AFF. 96, 100 (2010).

based long-term care services and insurance."¹⁹⁶ The most common type of reverse mortgage is the Home Equity Conversion Mortgage ("HECM"), which is a product offered through the Federal Housing Authority ("FHA"). In addition to the HECM, banks also offer a number of other proprietary reverse mortgage products.

In order to qualify for an HECM on a principal residence, the borrower must be at least 62 years old, own the property outright or owe only a small amount on the mortgage, not be delinquent on taxes or other federal debt, and participate in a consumer information session provided by an approved HECM counselor.¹⁹⁷ HECM counseling includes discussion of "program eligibility requirements, financial implications and alternatives to obtaining a HECM."

HECMs can be structured to pay out the borrowed amounts in a variety of methods, including: equal monthly payments for as long as one of the borrowers occupies the home, equal monthly payments for a fixed term, as a line of credit, or some combination of these. ¹⁹⁹ Accordingly, borrowers can use funds from an HECM to purchase LTC insurance, purchase an annuity, and/or pay for the costs of LTC services directly. ²⁰⁰

The difference between reverse mortgages like HECMs and traditional home equity loans is that the borrower is never required to repay the borrowed amount directly.²⁰¹ HUD's summary of HECMs explains this distinction as follows:

Unlike ordinary home equity loans, an FHA reverse mortgage HECM does not require repayment as long as the home is your principal residence. . . . Lenders recover their principal, plus interest, when the home is sold. The remaining value of the home goes to the borrower or his or her heirs.²⁰²

If the sales proceeds are insufficient to pay the amount owed, FHA will pay the lender the amount of the shortfall.²⁰³ FHA collects an insurance premium from all borrowers to provide this coverage.²⁰⁴

199. Id

^{196.} ROBERT WOOD JOHNSON FOUND., STUDY FINDS REVERSE MORTGAGES BENEFIT OLDER HOMEOWNERS – AND SAVES MEDICAID MONEY. TOO (2008).

^{197.} U.S. DEP'T OF HOUS. & URBAN DEV., FHA REVERSE MORTGAGES (HECMS) FOR SENIORS, available at http://www.hud.gov/offices/hsg/sfh/hecm/hecmabou.cfm (last visited Mar. 21, 2012) [hereinafter FHA REVERSE MORTGAGES].

^{198.} Id.

^{200.} ROBERT WOOD JOHNSON FOUNDATION, supra note 196.

^{201.} FHA REVERSE MORTGAGES, supra note 197.

^{202.} FED. HOUS. INSPECTORS GEN., COMPENDIUM OF FEDERAL SINGLE FAMILY MORTGAGE PROGRAMS AND RELATED ACTIVITIES, 31 (2011), *available at* http://www.hudoig.g ov/pdf/compendium11-3-11v3.pdf.

^{203.} FHA REVERSE MORTGAGES, supra note 197.

^{204.} Senior Bank Servs., http://www.seniorbankservices.com (last visited Feb. 29, 2012).

If the borrower's heirs want to keep the home, they must repay the loan. ²⁰⁵ Generally, the amount an individual can borrow is based on the value of the home, the age of the borrower, and the prevailing interest rate. ²⁰⁶ Accordingly, an older individual with a highly valuable home who obtains a reverse mortgage at a time when interest rates are low will generally be able to borrow more money with a reverse mortgage than with a home equity loan. One study found that nationally, individuals eligible for HECMs in 2004 received an average of \$72,128 with such a reverse mortgage. ²⁰⁷

Several studies have indicated that reverse mortgages can help alleviate the burden future Medicaid LTC expenditures will impose on state budgets. Specifically, one survey estimates that increasing the use of reverse mortgages among individuals who are eligible for, and interested in, such financing would decrease overall Medicaid expenditures by 6% to 9%. ²⁰⁸ Looking more broadly at all potential methods for accessing liquid home equity to finance future LTC needs, another study demonstrated that such home equity may be a viable option. ²⁰⁹ Unfortunately, both of these studies were conducted several years ago. And given the overall national decline in home values in recent years, ²¹⁰ there is likely not as much home equity available to finance LTC needs as these studies contemplated.

2. The Potential for Reverse Mortgages in Idaho

In Idaho, there is apparently little information regarding the availability and use of reverse mortgages, ²¹¹ and the potential financing mechanism has not received a significant amount of attention. As discussed above, in order to obtain a Home Equity Conversion Mortgage, an applicant must first receive reverse mortgage counseling from a HUD approved counselor. Currently there are only two Idaho organizations on HUD's HECM counselor roster—one in Lewiston and the other in Pocatello. ²¹² Nonetheless, over 91% of older Idahoans surveyed in

209. THOMAS DAVIDOFF, ILLIQUID HOUSING AS SELF-INSURANCE: THE CASE OF LONG-TERM CARE (2007); see also Brown & Finkelstein, supra note 13, at 22.

^{205.} FHA REVERSE MORTGAGES, supra note 197.

^{206.} U.S. Dep't of Hous. & Urban Dev, Frequently Asked Questions about HUD's Reverse Mortgages, HUD.GOV, http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/sfh/heem/rmtopten (last visited Apr. 22, 2012).

^{207.} ROBERT WOOD JOHNSON FOUNDATION, supra note 196.

^{208.} See id.

^{210.} See, e.g., Housing, N.Y. TIMES, Mar. 30, 2011, http://topics.nytimes.com/top/refe rence/timestopics/subjects/h/housing/index.html?scp=6&sq=decline%20in%20housing%20pri ces&st=cse; see also JOINT CTR. FOR HOUS. STUD. OF HARVARD UNIV., THE STATE OF THE NATION'S HOUSING 7 (2011), http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/son2011.pdf.

^{211.} BEARD & MILLER, supra note 14, at 24.

^{212.} See U.S. DEP'T OF HOUS. & URBAN DEV., HECM COUNSELING AGENCY LIST, IDAHO, https://entp.hud.gov/idapp/html/hecm_agency_search.cfm (select "Idaho" in "State:" dropdown box; then click "Send") (last visited May 22, 2012).

2005 reported owning their own homes.²¹³ Given this figure, Idaho policymakers should not rule out accessing home equity through reverse mortgages as a way to finance at least some future LTC needs. In light of the overall decline in the real estate market in recent years, however, reverse mortgages and other mechanisms to use home equity to fund LTC will likely present a viable alternative only in the long term.

B. Informally Provided LTC

There is an increasing recognition of the important role that family members, neighbors, friends, and other community members serve in providing long-term care services. In this section, we will discuss the role that informal caregivers play nationwide and in Idaho, and then specifically consider policies related to compensation of family members for informal long-term caregiving.

1. Impact of Informal Caregiving

One commentary notes that such "informal" caregivers are the "bedrock" or "backbone of the long-term care system in the U.S. to-day." Specifically, the value of this unpaid informal long-term caregiving has been estimated to be as high as \$375 billion a year. 215 Despite the important role that informal caregivers fulfill, some commentators argue that such caregivers have been ignored in the policy arena. 216 Still, some policymakers have recognized the need to support informal caregivers based on "a fear that if family members burn out, their relatives will end up in nursing homes at public expense." 217

In Idaho, recent research into LTC needs indicates a particular need for flexible assistance at crucial "serviceable moment[s]" to prevent burnout of informal caregivers. 218 Below, we discuss various policies and policy proposals that affect informal long-term caregiving in Idaho. Moreover, given the limited access to formal home and community LTC services in some of Idaho's more remote rural and frontier re-

^{213.} MILLER ET AL., supra note 26, at 6.

^{214.} Carol Levine et al., Bridging Troubled Waters: Family Caregivers, Transitions, and Long-Term Care, 29 HEALTH AFF. 116, 116 (2010).

^{215.} Id.

^{216.} See id. at 118 (summarizing commentaries).

^{217.} Id.

^{218.} See BEARD & MILLER, supra note 14, at 40. Specifically, these researchers report the following in speaking with several focus group interviewees:

Several interviewees referred to a "serviceable moment," meaning providing the right type of service during a small window of opportunity. The "serviceable moment [is] when a person is right at the breaking point of where 'I can't do this anymore.' And if you can provide some relief at that time, they will carry on. If you catch them just past that serviceable moment, it doesn't matter that the service might be there; they're done." *Id.*

gions, ²¹⁹ informal caregivers may play a particularly important role in Idaho.

2. Policies Supporting Family Members in Providing LTC

Historically, most state Medicaid laws prohibited compensating individuals for home-health services provided to relatives. 220 In recent years, there have been various efforts to increase the availability of "participant-directed" LTC through which the LTC recipient has greater control over the providers and types of services received. 221 Through programs seeking to expand the availability of participant-directed LTC service models, 222 however, most state Medicaid programs now allow family members that are not legally responsible (i.e., other than a parent or spouse) to receive compensation, under certain circumstances, for care provided.²²³ As such, under certain circumstances under Idaho Medicaid's Aged and Disabled Waiver, certain family membersincluding adult children—or friends can be compensated for providing personal care services to relatives in the community.²²⁴ Furthermore, there appears to be substantial interest in allowing other family members to receive some compensation for services that allow an individual to remain in the community rather than going to a nursing home.²²⁵

In this regard, Arizona is apparently a pioneer in paying family members for services provided to community-based Medicaid LTC recipients. Specifically, Arizona's Medicaid program received a waiver from federal law permitting its Medicaid program to compensate family members for home-health services provided in certain situations. ²²⁶ This

224. Lynn Friss Feinberg et al., Family Caregiver Alliance, The State of the States in Family Caregiver Support: A 50-State Study 105–08 (2004), available at http://www.caregiver.org/caregiver/jsp/content/pdfs50_state_report_complete.pdf.

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^{219.} See BEARD & MILLER, supra note 14, at 3 ("Idaho is a rural state and the uniform delivery of long-term care services in each region is and will become more difficult as Idaho ages."); see also Hong Li, Rural Older Adults' Access Barriers to In-Home and Community-Based Services, 30(2) Soc. Work Research 109, 109–18 (2006) (reporting study findings that the unavailability of home- and community-based LTC services was the principal access barrier for older adults in rural areas).

^{220.} NAT'L RES. CTR. FOR PARTICIPANT-DIRECTED SERVS., DEVELOPING AND IMPLEMENTING SELF-DIRECTION PROGRAMS AND POLICIES: A HANDBOOK (2010), 1-9 to -10, available at http://www.bc.edu/content/dam/files/schools/gssw_sites/nrcpds/cc-full.pdf.

^{221.} See id. (defining participant- or self-direction as "a service model that empowers public program participants and their families by expanding their degree of choice and control over the long-term services and supports they need to live at home").

^{222.} The most significant of these programs are the Medicaid Independence Plus and Cash and Counseling programs. Id. at 1-4.

^{223.} *Id.* at 1-9 to -10.

^{225.} Long-Term Care Symposium, *supra* note 38, at 11. Specifically, during a panel discussion at a symposium on long-term care in Idaho hosted by the IOCA in June 2009, participants inquired regarding moving "toward paying family members to provide some home and community-based services." In response, Paul Leary, Deputy Administrator at Idaho Medicaid, responded that federal law prohibits Medicaid from paying legally responsible relatives (spouses or parents) for such services. *Id.* at 11.

 $^{226. \}quad \hbox{Queener, } supra \hbox{ note } 43, \hbox{ at } 873.$

waiver permits Arizona's Medicaid LTC program "to remunerate individuals who provide informal home care services" to Medicaid LTC recipients. Arizona's Medicaid program also provides informal caregivers with funding for short-term respite care given "by a professional caregiver to give an informal caregiver an interval of rest." Moreover, looking to LTC finance policy reform initiatives undertaken in other countries, Germany now has a governmental program that compensates family members for LTC services provided. 229

Although legally responsible family members cannot be compensated by Medicaid for LTC services, other policies recognize the monetary value of such informally provided services. For example, so long as there is a written contract in place, payment given to a family member in return for care-giving services is not considered an impermissible gift for the purposes of "spending down" assets to qualify for Medicaid LTC. Similarly, as discussed above, benefits paid pursuant to LTCI offered under the CLASS Act may be paid in return for services provided by a family member. LTCI policies may allow benefits to be paid out in return for LTC services provided by a family member.

C. Consumer Resources Regarding LTC Services in Idaho

In addition to LTC services provided under major governmental programs such as Medicaid, other publicly supported programs offer certain limited LTC-related services. In this Part we briefly discuss such programs, as well as recent efforts to better educate consumers about LTC planning options.

While Medicaid certainly finances more LTC services than any other government program, other government programs also pay for and/or directly provide a variety of LTC services. Specifically, the Idaho Commission on Aging ("ICOA") provides a variety of LTC services through the Area Agencies on Aging ("AAA") throughout the state. ²³² The ICOA provides support for LTC services including transportation, home hot meal delivery, ombudsman services, adult protection, and public information services. The ICOA reported that between July 2006 and June 2007, more than 25,000 people were served per month. ²³³

Research in Idaho indicates that "[p]roviding good information about available services" and options to LTC recipients and family

229. John Creighton Campbell et al., Lessons from Public Long-term Care Insurance in Germany and Japan, 29(1) HEALTH AFF. 87–90 (2010).

^{227.} Id. at 874.

^{228.} Id

 $^{230. \}quad \textit{See} \, \text{Idaho Admin.} \, \text{Code} \, \, 16.03.05.831.02 \, (2011).$

^{231.} See supra Part IV.E.

^{232.} See Beard & Miller, supra note 14, at 23; see Long-Term Care Symposium, supra note 38, at 5.

^{233.} Beard & Miller, supra note 14, at 23.

members is just as important as having those services available at crucial times.²³⁴ Accordingly, in recent years there have been a variety of educational efforts to help inform consumers about LTC planning options.

Worthy of note, in 2003, while Dirk Kempthorne was both Idaho's governor and the president of the National Governors Association, the NGA launched a variety of consumer- and policymaker-focused educational activities related to LTC.²³⁵ Additionally, the federal government maintains a web-based National Clearinghouse for Long-Term Care Information,²³⁶ which provides a variety of educational and planning resources related to LTC.²³⁷ In 2009, the Idaho Commission on Aging held a symposium on LTC needs in the state²³⁸ and state-supported Area Agencies on Aging²³⁹ throughout Idaho offer "options counseling" to assist individuals in making LTC-related decisions.²⁴⁰

VI. CONCLUSION

As illustrated in this Article, a variety of federal- and state-level policies influence and are related to how LTC services are paid for in Idaho. Additionally, the particulars of many policies also vary from state to state. Finding solutions to the looming budgetary crises caused by the projected growing need for Medicaid LTC in a state like Idaho may be

^{234.} Id. at 40.

^{235.} See Dirk Kempthorne, A Message from the Chairman, NATIONAL GOVERNORS ASSOCIATION, http://www.subnet.nga.org/ci/message.html (last visited Mar. 21, 2012). Moreover, while the "Own Your Future" educational campaign was initially created by the NGA under the Deficit Reduction Act of 2005, federal funding was made available to states to implement such educational programs. See U.S. Dep't of Health & Human Servs., Long-Term Care Consumer Awareness Campaign: Call for Proposals: Own Your Future, NAT'L CLEARING HOUSE FOR LONG-TERM CARE INFO. (May 11, 2006), http://www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Campaign/Reports/Documents/2006/Phase%20III%20Campaign%20Call%20for%20Proposals.pdf.

^{236.} See U.S. Dep't of Health & Human Servs., NAT'L CLEARINGHOUSE FOR LONG-TERM CARE INFO., http://www.longtermcare.gov/LTC/Main_Site/index.aspx (last visited Mar. 21, 2012).

^{237.} For example, the National Clearinghouse for Long-Term Care Information offers extensive free long-term planning resources. See U.S. Dep't of Health & Human Servs., Planning for LTC, NAT'L CLEARINGHOUSE FOR LONG-TERM CARE INFO., http://www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Campaign/Kit/index.aspx (last visited Mar. 21, 2012).

^{238.} See LONG-TERM CARE SYMPOSIUM, supra note 38, at 1.

^{239.} Specifically, there are six Area Agencies on Aging throughout the state, which, in partnership with the Idaho Commission on Aging, assist Idahoans through "a broad array of services and programs to individuals in Idaho over the age of 60, their families, and vulnerable adults aged 18 and older." See IDAHO COMMISSION ON AGING, http://www.idahoaging.com/about/index.html (last visited Mar. 12, 2012).

^{240.} See ICOA, 2011 STRATEGIC PLAN: ICOA GOALS, OBJECTIVES, STRATEGIES AND OUTCOME MEASURES 1 (2011) ("Options counseling supports informed long term care decision-making by assisting individuals and families in their own care by understanding their strengths, needs, preferences, and unique situations and translating this knowledge into possible support strategies, plans and tactics.").

complex for a variety of reasons. Moreover, in addressing specific questions of how LTC services are paid for, it is important to not lose sight of the fact that these issues are also affected by changes in policies and practices related to how LTC services are provided. For example, in recent decades there has been an increased emphasis on home and community-based services.²⁴¹ Furthermore, several provisions in recently enacted legislation create incentives for state Medicaid programs to increase offerings to such home and community based LTC services.²⁴² Similarly, providing Medicaid LTC through managed care models has been a topic of policy experimentation and discussion over the last several decades.²⁴³ While not directly related to how LTC services are paid for, policy changes affecting how LTC services are provided could have appreciable impacts on Medicaid LTC expenditures. Accordingly, discussions regarding state-level policy reforms on how LTC is financed should be informed by an understanding of the broad range of laws and regulations affecting LTC services in each state.

241. See, e.g., Kapp, supra note 31, at 74 ("Over the last several years, however, a strong combination of consumer preferences and legal edicts based on the integration mandate of the Americans with Disabilities Act (Olmstead v. L.C., 1999) has resulted in more Medicaid funding becoming available . . . to pay for formal care services delivered in [home and community-based] settings.").

^{242.} VERNON K. SMITH ET AL., KAISER FAMILY FOUND., HOPING FOR ECONOMIC RECOVERY, PREPARING FOR HEALTH REFORM: A LOOK AT MEDICAID SPENDING, COVERAGE AND POLICY TRENDS 50 (2010) (providing an overview of several federal-level initiatives contained in the Deficit Reduction Act of 2009 and PPACA of 2010 intended to increase the availability of Medicaid home and community-based LTC services).

^{243.} See, e.g., WENDY FOX-GRACE & PAUL SAUCIER, AARP PUBLIC POLICY INST., IN BRIEF: MEDICAID MANAGED LONG-TERM CARE, INB NO.108 (2005) (discussing various Medicaid-managed LTC proposals); see also Queener, supra note 43, at 864–66 (discussing Arizona's Medicaid-managed LTC program); William G. Weissert et al., Cost Savings from Homeand Community-Based Services: Arizona's Capitated Medicaid Long-Term Care Program, 22 J. HEALTH POL., POL'Y & L. 1329 (1997) (discussing the same topic).