2007

Tax and Economic Policy Responses to the Medicaid Long-Term Care Financing Crisis: A Behavioral Economics Approach

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TAX AND ECONOMIC POLICY RESPONSES TO THE MEDICAID LONG-TERM CARE FINANCING CRISIS: A BEHAVIORAL ECONOMICS APPROACH

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INTRODUCTION

The United States faces an unparalleled healthcare financing crisis.[1] In 2006, more than fifty-five million individuals in need of healthcare coverage turned to the federal and state governments for assistance through the Medicaid program.[2] Among those seeking coverage are low-income pregnant women and families with dependent children; the aged, blind, and disabled; the mentally ill; and acutely or chronically ill persons who lack private insurance coverage.[3]

Meeting the health insurance needs of these categorically[4] and medically[5] needy Americans through a public welfare program is no easy

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* J.D., 2005, University of Florida Levin College of Law; M.A. in Political Science, 1999, Florida International University. I owe a debt of gratitude to Patricia Dilley, Jeffrey Harrison, David Richardson and Danaya Wright for their attentive assistance and detailed comments on earlier drafts, and to Suzanne Hutton for mentoring me through complex legal questions in the area of assisted living. I am also grateful for the comments and guidance of Professor Barak Richman of Duke Law School. His recent article *Behavioral Economics and Health Policy: Understanding Medicaid's Failure*, 90 CORNELL L. REV. 705 (2005), served as both an inspiration and an example for my work. Perhaps more fundamentally, however, I thank the residents, families, and healthcare professionals I came to know when I worked in long-term care social services prior to law school. Their stories, insights, and thoughtful reflections motivated my research and enabled me to synthesize a wide range of interdisciplinary findings. I dedicate this Article to the memory of Mack Lomrance, whose dignity and grace continue to inspire me.

1 Even a cursory glance at recent newspaper headlines nationwide reveals the extent of the problem. *See, e.g.*, Robert Pear, *States are Facing Big Fiscal Crises, Governors Report*, N.Y. TIMES, Nov. 26, 2002, at A1; *Governors Fret Over Medicaid Meeting With Bush, They Fear States Will Go Broke if They Must Carry Costs*, PITTSBURGH POST-GAZETTE, Mar. 1, 2005, at A8.

2 Figures are for fiscal year 2006. U.S. DEP'T OF HEALTH & HUMAN SERVS., PRESIDENT'S FISCAL YEAR 2006 BUDGET IN BRIEF 3 (2004).

3 *See* sources cited *infra* notes 17-20.

4 *See* 42 U.S.C. §§ 1396a(a)(10)(C), 1396a(a)(13)(B), 1396d(a)(1)-(5) (2000). Medicaid was developed to provide healthcare coverage for the "categorically needy," or those that currently receive financial assistance from means-tested federal programs. *See also* 42 C.F.R. § 435.100-.135, .700-.735 (2004).

5 "Medically needy" individuals do not meet the income requirements for other public assistance programs, but have healthcare needs that cost far more than they are able to pay. 42

task. Healthcare costs steadily rise,[6] and income tax revenues have only recently begun to recover from the post-September 11 recession.[7] In 2003, the total federal and state outlay for Medicaid was $273 billion;[8] this figure is expected to have exceeded $300 billion in 2006.[9] On average, Medicaid expenditures already consume approximately 20 percent of state general funds,[10] while the federal share of costs will rise to approximately $199 billion in 2007.[11] Although these amounts may seem miniscule compared to other government expenditures, some analysts predict that the combined costs of Medicaid, Medicare, and Social Security could consume more than a quarter of the gross domestic product by the year 2050.[12]

Pressing against this broader budgetary quagmire, the nation's persistent reliance on Medicaid to finance long-term care for the elderly has become one of the most imperative dilemmas facing policy-makers today.[13] Medicaid was created in 1965 under Title XIX of the Social Se-

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C.F.R. § 435.300-.350, .800-.852 (2004); *see also* Mass. Ass'n of Older Americans v. Sharp, 700 F.2d 749, 750 (1st Cir. 1983) (describing the medically needy classification).

6 The mounting costs of healthcare are a significant burden on states, many of which are constitutionally bound to avoid budgetary deficits. *See, e.g., Editorial: Only Feds Can Cure What Ails Medicaid, Georgia's Efforts Can Alleviate Only The Symptoms, Not the Cause of Skyrocketing Healthcare*, ATLANTA J. & CONST., Feb. 27, 2005, at E6.

7 In fact, shortly after the tragic events of September 11, 2001, the National Association of State Budget Officers reported widespread state budgetary shortfalls for Medicaid payments, totaling approximately $15 billion. Press Release, Nat'l Governors Assoc., Governors Seek Increase in Federal Share for Medicaid (November 7, 2001), *available at* http://www.vor.net/nov-12-01.htm.

8 CTRS. FOR MEDICARE & MEDICAID SERVICES, U.S. DEP'T OF HEALTH & HUMAN SERVS., 2003 DATA COMPENDIUM 5 (2003) (providing benefit outlays by program).

9 *Medicaid Spending Growth and Options for Controlling Costs: Hearing Before the S. Special Comm. on Aging*, 109th Cong. 1 (2006) (statement of Donald B. Marron, Acting Director, Congressional Budget Office), *available at* http://www.cbo.gov/ftpdocs/73xx/doc7387/07-13-Medicaid.pdf.

10 Susan M. Pettey, *State Budget Crises Endanger Medicaid Long-Term Care Services*, CARING FOR THE AGES, Jan. 2002, at 9, *reprinted at* http://www.amda.com/publications/caring/january2002/statebudget.cfm.

11 ROBIN RUDOWITZ & MOLLY O'MALLEY, THE KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUNDATION, THE PRESIDENT'S FY 2007 BUDGET PROPOSAL: OVERVIEW AND BRIEFING CHARTS 13 (2007), *available at* http://www.kff.org/uninsured/upload/7472.pdf.

12 Eric M. Patashnik, *Book Review*, 29 J. HEALTH POL. POL'Y & L. 1235, 1235 (2004) (reviewing STUART H. ALTMAN & DAVID I. SHACTMAN, POLICIES FOR AN AGING SOCIETY (2002)).

13 One author accurately described Medicaid as "America's de facto long-term care program." *See id.* Medicaid coverage for the elderly, and particularly for those in need of long-term care services, is the fastest growing segment of the total program costs. *See* THE KAISER

curity Act[14] as a federal and state partnership.[15] The program was originally designed to provide healthcare coverage for low-income families who meet eligibility requirements for the Aid to Families with Dependent Children program.[16] More recently, the Medicaid program has been expanded to include a wider range of families;[17] pregnant women;[18] the aged, blind, and disabled;[19] and acutely or chronically ill individuals who lack private healthcare insurance.[20] Medicaid has also become the nation's primary payer source for long-term care.[21] Since long-term care services are beyond the scope of Medi*care* and most private healthcare insurance programs,[22] Americans in need of long-term care come within the "medically needy" classification: they are entitled to receive Medi*caid* benefits if they cannot pay privately.

To be sure, most Americans are unable to finance long-term care without governmental assistance and must turn to Medicaid when the

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COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUNDATION, MEDICAID: FISCAL CHALLENGES TO COVERAGE 2 (2003), *available at* http://www.kff.org/medicaid/upload/Medicaid-Fiscal-Challenges-to-Coverage.pdf.

14 Pub. L. No. 89-97, 121-22, 79 Stat. 370 (codified as amended at 42 U.S.C. §§ 1396-1396s (2004) and 42 C.F.R. § 430-56 (2004)).

15 The federal and state governments fund Medicaid. The program is administered at the state level, though many aspects are authorized or mandated by federal law. *See* Shawn Patrick Regan, Note, *Medicaid Estate Planning: Congress' Ersatz Solution for Long-Term Health Care*, 44 CATH. U. L. REV. 1217, 1217-18 (1995).

16 *See* Catherine Hoffman, Diane Rowland, & Alicia L. Carbaugh, *Holes in the Health Insurance System: Who Lacks Coverage and Why*, 32 J.L. MED. & ETHICS 390, 392-93 (2004) (discussing Medicaid's origins in Depression-era welfare goals).

17 *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901(a), 111 Stat. 552 (1997) (codified at 42 U.S.C. § 1397 (2000)) (establishing the State Children's Health Insurance Program, which expanded Medicaid benefits for low-income families with children).

18 42 U.S.C.A. §§ 1396a(a)(10)(A)(i)(III), 1396d(n)(1) (2000) (providing Medicaid coverage for pregnant women who would be eligible to receive public assistance once the child is born); §§ 1396a(a)(10)(A)(i)(III) (providing Medicaid coverage for pregnant women with income below 133% of the federal poverty line).

19 42 U.S.C.A. §§ 1396a(a)(10)(A)(i)(II), (f); *see also* 42 C.F.R. §§ 435.120, 435.121 (2004).

20 For instance, according to one report: "Medicaid is the largest source of federal spending for HIV/AIDS care in the United States. The Centers for Medicare and Medicaid Services (CMS) estimates that FY 2006 federal Medicaid spending on HIV/AIDS will total $6.3 billion, or half of all federal spending on HIV/AIDS care. . . ." JENNIFER KATES, KAISER FAMILY FOUNDATION, HIV/AIDS POLICY FACT SHEET 1 (2006).

21 *See infra* note 32.

22 *See* source cited *supra* note 9, at 6.

need arises.[23] A number of trends converge to create this heavy reliance on public assistance. Many seniors do not have private long-term care insurance[24] and most lack sufficient financial resources to pay the high cost of long-term care.[25] Meanwhile, many others simply ignore the need to plan for long-term care expenses, and enroll in Medicaid once the need arises.[26]

Since Medicaid is a means-tested program, beneficiaries must meet specific asset and income criteria.[27] Applicants with some savings will be required to "spend down" assets on long-term care services.[28] Medicaid will assume the cost of long-term care only after the applicant has exhausted most personal sources of funding.[29] Applicants are permitted to retain the principal residence and other exempted assets; however, these assets can be seized by the state upon the beneficiary's death, up to the value of benefits received.[30] To avoid the consequences of these provisions, many Americans engage in "voluntary impoverishment" by making inter vivos gifts of property to meet Medicaid's asset and income qualifications.[31]

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23 *See* Diane Lourdes Dick, *The Impact of Medicaid Estate Recovery on Nontraditional Families*, 153 U. FLA. J.L. & PUB. POL'Y 525, 531-34 (2004) (discussing the growing reliance on Medicaid to finance long-term care).

24 Jeffrey R. Brown & Amy Finkelstein, *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market* 1 (Nat'l Bureau of Econ. Research, Working Paper No. 10989, 2004), *available at* http://papers.nber.org/papers/w10989.pdf (noting that "[p]rivate insurance reimburses only 4 percent of long-term care expenditures.").

25 Personal or familial assets support only 38 percent of all nursing home residents. *See Retirement Survey Shows Vast Majority of Baby Boomers Have Misperceptions About Paying for Long-Term Care*, BUS. WIRE, June 1, 1999, at 2, *available at* LEXIS.

26 *See* source cited *infra* note 67.

27 *See* sources cited *infra* notes 28 and 29.

28 *See* 42 U.S.C. § 1396p (2000) (codifying Medicaid spend down provisions).

29 The principal residence is excluded from the applicant's assets upon initial application. *See id.* To reduce fraud, federal law directs state officials to determine whether assets have been transferred or divested by the applicant within a certain "lookback period" of either thirty-six or sixty months, depending on the nature of the transfer. *See* 42 U.S.C. § 1396p(c)(1)(A), (B). Any transfers of assets for less than fair market value within the lookback period will result in a penalty calculation. The applicant will be deemed ineligible for Medicaid benefits until he privately pays for long-term care services in an amount equal to the value of the assets transferred. *Id.*

30 *See infra*, Part II, discussing Medicaid estate recovery programs.

31 *See* John A. Miller, *Voluntary Impoverishment to Obtain Government Benefits*, 13 CORNELL J. L. & PUB. POL'Y 81, 81 (2003).

While statistics vary by state, almost two-thirds of all nursing home residents nationwide receive Medicaid benefits.[32] Elderly persons in need of long-term care services comprise a significant portion of Medicaid's total program beneficiaries. In 2004, approximately 35 percent of total Medicaid dollars were used to support long-term care for the elderly.[33] If the Medicaid program remains the primary payer source for long-term care, then the percentage of total Medicaid dollars spent on long-term care for the elderly will likely increase significantly over time. Not only are long-term care costs expected to rise,[34] but the number of elderly beneficiaries will likely increase as well—particularly as the baby boomers enter old age.[35]

In response to this fiscal predicament, policy-makers have identified a need to alleviate the burden of long-term care costs by encouraging those with sufficient financial resources to look beyond the Medicaid program for long-term care financing.[36] The federal and state governments have developed tax and economic policies to discourage reliance on Medicaid and encourage reliance on private resources. These incentives, which are discussed in detail in subsequent sections, include federal and state income tax deductions for the cost of long-term care insurance, Medicaid partnership programs to encourage the use of private insurance to pay for the minimum duration of care, and federal and state tax incentives for families that provide in-home care to loved ones.[37] These initiatives appear to be producing the desired short-term behavioral outcome: increasing numbers of Americans are purchas-

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32 *See, e.g.*, Jon M. Zieger, *The State Giveth and the State Taketh Away: In Pursuit of a Practical Approach to Medicaid Estate Recovery*, 5 ELDER L.J. 359 (1997) (explaining that Medicaid pays the costs of 60 percent of all nursing home bed days nationwide).

33 *See* THE KAISER COMMISSION ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUNDATION, THE MEDICAID PROGRAM AT A GLANCE 1 Fig.5 (2006), *available at* http://www.kff.org/medicaid/upload/7235.pdf.

34 The cost of long-term care rises by 8 percent each year. *See* Paul Palazzo, *Can You Afford To Grow Old? – Lack Of Planning For Long-Term Care Could Add Fiscal Ruin To Poor Health*, SEATTLE TIMES, Nov. 1, 1999, at D1.

35 *Long Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets: Hearing Before the S. Special Comm. on Aging*, 108th Cong. 1 (2002) [hereinafter *Hearing on Baby Boom Generation*] (statement of David Walker, Comptroller General of the United States), *available at* http://www.gao.gov/new.items/d02544t.pdf.

36 On the political debate surrounding the Medicaid and Medicare financing crises, see DAVID G. SMITH, ENTITLEMENT POLITICS: MEDICARE AND MEDICAID, 1995-2001 (2002).

37 *See infra* Part II.

ing long-term care insurance,[38] and in-home care remains a viable option within many families.[39]

However, although these indicators suggest that consumers are responding to tax and economic incentives, it is not necessarily clear that these responses will provide a durable or even adequate solution to the more imperative Medicaid financing crisis. In fact, the underlying expectations of policy-makers may be flawed. Policy-makers seem to expect that private long-term care insurance policies purchased today will ultimately assume the insured's lifelong risk of long-term care expenses, thereby removing the need to seek Medicaid benefits for such care.[40] This expectation requires that consumers purchase a policy, and then maintain that policy until long-term care needs arise. To achieve these ends without implementing a compulsory program, policy-makers must substantially modify consumer behavior—not simply in terms of their short-term immediate responses to financial planning incentives, but also in terms of their long-term, attitudinal reactions to the realities of aging and other more personal aspects of long-term care decision-making. The following sections reveal that the emergent behavioral economics model offers a more comprehensive model of aggregate consumer behavior,[41] and would enable policy-makers to develop a dy-

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38 *See* Robert Clofine & Gregory L. Kiersz, *Evaluating Long-Term Care Insurance Options*, 74 PA. BAR ASS'N Q. 147, 147 (2003) (citing THE HEALTH INS. ASSOC. OF AMERICA, LONG-TERM CARE INSURANCE IN 2000-2001, RESEARCH FINDINGS, (2003)) ("The total number of [insurance] policies sold has grown from 815,000 in 1987 to nearly 8.3 million in 2001.").

39 *See* BARBARA COLEMAN, AARP PUBLIC POLICY INSTITUTE, FACT SHEET: FAMILY CAREGIVING AND LONG-TERM CARE 1 (2002), *available at* http://assets.aarp.org/rgcenter/il/fs91_ltc.pdf (estimating that 80 percent of long-term care services are provided by family caregivers and that the value of this family caregiving has been estimated at $196 billion in 1997).

40 *See infra* Part III.

41 *See infra* Part I.B-C. Recently, legal scholars have used behavioral economics to scrutinize the broader healthcare financing quagmire. *See, e.g.*, Barak D. Richman, *Behavioral Economics and Health Policy: Understanding Medicaid's Failure*, 90 CORNELL L. REV. 705 (2005) (using a behavioral economics model to understand why Medicaid, as a public health insurance program, has failed to improve the overall health status of program beneficiaries). Richman explains that despite the growing use of this methodology, a dearth of literature remains. "[A]cademic efforts that use psychosocial data to inform, and perhaps radically alter, the rational actor model are virtually nonexistent." *Id.* at 723 n.63 (citing Richard G. Frank, *Behavioral Economics and Health Economics* (Nat'l Bureau of Econ. Research, Working Paper 10881, 2004), *available at* http://papers.nber.org/papers/w10881.pdf) ("[T]he application of behavioral economics to issues in health economics have been largely confined to understanding addictive behavior around cigarettes, drugs, and alcohol.").

namic picture of the short-term and long-term concerns that arise in this unique consumer market.

The behavioral economics model acknowledges certain unique preferences that motivate rational actors in the long-term care market. First, empirical evidence reveals that a deep discomfort at the thought of growing old causes many consumers to avoid the entire notion of long-term care planning.[42] Second, empirical observations suggest that most Americans prefer informal, in-home care over professional or institutional care; in fact, many believe that loved ones would decline to offer such care if a long-term care insurance policy was available to support institutional care.[43] Finally, studies reveal that a significant number of consumers grossly underestimate their own future need for long-term care.[44]

Beyond these preferences, empirical evidence also reveals that various motivations influence consumers differently depending on how close they are to old age. For instance, if long-term care planning primarily provides *future* utility maximization, then the likelihood of taking such steps will vary based upon how each consumer weighs the future benefits of long-term care.[45] Indeed, since the benefit of a sound long-term care financial plan would likely materialize when the consumer is elderly and perhaps incapacitated, planning will only provide utility maximization if the consumer accepts that this potentially incapacitated person is a future self, worthy of present-day sacrifices.[46] If, instead, the consumer chooses to deny the likelihood of becoming incapacitated, or if the consumer believes that the conscious "self" would cease to exist if and when the incapacitation occurs, then the benefits of planning would seem negligible.

These insights suggest that policy-makers should not unduly rely on today's statistics that show ever-increasing numbers of new long-term care insurance policies.[47] Even if governmental incentives successfully motivate large numbers of consumers to engage in present-day planning for future long-term care needs, the incentives may in fact only reach consumers who were already predisposed to plan. Furthermore, even these momentary steps toward planning could unravel as evolving emo-

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42 *See infra* notes 103-105.

43 *See infra* Part I.C.1.iii.

44 *See infra* Part I.C.1.ii.

45 *See id.*

46 *See id.*

47 *See supra* note 38.

tional motivations entice consumers to re-evaluate their initial planning decisions in unexpected ways. Specifically, as behavioral motivations become more pronounced, insured individuals may terminate the policy ("lapse") before long-term care needs arise.[48] Thus, even where initial policy purchases are based on financial considerations, the potential for lapses will increase over time as a particular age cohort begins to factor emotional and behavioral motivations. Each time a lapse occurs, the long-term benefits of a consumer's initial steps toward planning are erased: the federal and state governments may once again have to provide Medicaid benefits if long-term care needs arise and the individual lacks the ability to pay. Indeed, backpedaling of this sort appears to be taking place among insured persons. According to one report, consumers deliberately drop approximately 7 percent of in-force policies each year.[49]

Consequently, although current initiatives appear to have some limited applications, they are not likely to resolve the broader long-term care financing dilemma. Additional programs or incentives are necessary to resolve the Medicaid long-term care financing crisis, and such programs should be tailored to address behavioral tendencies. By developing a dynamic theoretical framework that captures the nuances of long-term care consumer behavior, policy-makers can make more informed decisions about whether and how to restructure our system of long-term care financing.[50]

This Article contributes to this dialogue by analyzing policy solutions to the Medicaid crisis against the backdrop of consumer choice theory. To this end, Part I introduces traditional rational choice theory and the emergent behavioral economics model, and identifies specific preferences and time functions that affect consumer behavior in the long-term care planning market. Part II describes federal and state tax and economic policy responses to the long-term care financing crisis,

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[48] *See infra* Parts III-IV. Although I've confined my analysis to the potential for insured-initiated lapses in long-term care insurance policies, the potential for insurer-initiated lapses or reductions in benefits should be explored further in subsequent works. A recent article provides some evidence that insurer-initiated lapses are likely. *See* Andrea Coombes, *Insurers Struggle With Long-Term Care*, WALL ST. J., June 15, 2005, at A1.

[49] *See* source cited *infra* note 179.

[50] Leading scholars in the field of aging and policy studies cite the need for additional research to assist policymakers in their efforts to refine public and private financing for long-term care. *See, e.g.*, FRANCIS CARO, ACADEMY HEALTH, LONG-TERM CARE: INFORMED BY RESEARCH (2003), www.academyhealth.org/publications/ltcresearch.pdf.

which are primarily designed to discourage individual reliance on public assistance for long-term care, while simultaneously encouraging the purchase of long-term care insurance. Part III describes the legislative intent behind these initiatives, and finds that the desired "pay out" of long-term care insurance is one that is highly susceptible to intervening events—namely, that the insured might allow the policy to lapse. To assess the potential for consumer-initiated lapses, Part IV uses the insights from behavioral economics to model aggregate consumer behavior. Concluding that current regulatory initiatives cannot guarantee continued reliance on private financing for long-term care, Part V recommends that that federal and state governments work together to develop a universal compulsory program, so that consumers are obligated to make a relatively small present-day sacrifice to provide benefits for the future incapacitated self. In the course of developing and conceptualizing a solution of this sort through a behavioral economics framework, this work contributes to the broader theoretical understanding of how and when economic policies—and particularly modifications to the income tax system—can be used to shape consumer behavior.

I. LONG-TERM CARE FINANCIAL PLANNING THROUGH A CONSUMER CHOICE LENS

By recognizing and understanding the particularly complex decisions consumers make in the area of long-term care planning, policymakers can more effectively achieve, *and sustain*, the desired decrease in public reliance on Medicaid. The following sections provide an overview of two social science models of consumer behavior: the traditional economics model of rational choice, and the emergent behavioral economics model.

A. *The Traditional Model of Rational Consumer Choice*

The traditional economics model of rational choice assumes, first and foremost, that individuals are self-interested and seek to maximize their expected utility when presented with an opportunity to make a choice.[51] Individuals increase overall utility when they advance finan-

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[51] *See* JAMES COLEMAN, THE MATHEMATICS OF COLLECTIVE ACTION (1973); ANTHONY HEATH, RATIONAL CHOICE AND SOCIAL EXCHANGE (1976); *see also* Russell B. Korobkin & Thomas S. Ulen, *Law and Behavioral Science: Removing the Rationality Assumption from Law and Economics*, 88 CALIF. L. REV. 1051 (2000).

cial, social, physical, emotional, or other interests.[52] The fundamental desire to maximize utility causes rational actors to identify specific "preferences" whenever they are confronted with a choice.[53] These preferences are then used to calculate costs and benefits of each alternative.[54]

To be considered a rational choice, the choice should be "complete," meaning that the individual was fully aware of the alternatives, and "transitive," meaning that the individual would consistently seek to advance the same preferences.[55] However, economists concede that sometimes consumers must make choices with incomplete information;[56] in these settings of uncertainty, the rational actor should calculate the probability of certain outcomes based on available information.[57]

At first glance, the tremendous cost of long-term care, combined with a regulatory scheme that encourages reliance on private funding sources, should lead the rational consumer with sufficient resources to develop and maintain an economically sound financial plan for long-term care.[58] Yet the fact remains that although the trend may be chang-

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52 The fundamental assumption of humans as self-interested is rooted in Hobbesian philosophy, and forms the backbone of rational choice theory. *See, e.g.*, CARL FRIEDRICH, MAN AND HIS GOVERNMENT 159 (1963) (describing the role of Hobbesian theory in developing a rational model of political actors).

53 Theorists differ in how they believe the rational actor weighs and ranks various alternatives to make a choice. *See, e.g.*, ANATOL RAPPORT, TWO-PERSON GAME THEORY: THE ESSENTIAL IDEAS (1966) (discussing the manner by which rational actors rank preferences and outcomes).

54 *See* Korobkin & Ulen, *supra* note 51, at 1060-64.

55 AMARTYA K. SEN, COLLECTIVE CHOICE AND SOCIAL WELFARE 16 (1970).

56 *See* Herbert A. Simon, *A Behavioral Model for Rational Choice*, 69 Q.J. ECON. 99 (1955); *see also* HERBERT SIMON, MODELS OF MAN (1957). An important subfield of rational choice theory considers how individuals make choices in the often hectic, modern world. *See, e.g.*, 3 HERBERT SIMON, MODELS OF BOUNDED RATIONALITY (1997). Herbert Simon developed a theory of "bounded rationality": he theorized that although humans strive to make utility-advancing choices, they are fundamentally limited in their ability and willingness to collect and weigh all relevant information. *Id.* Accordingly, individuals will often fall significantly short of perfectly efficient processing, and instead perform whatever degree of processing that they believe to be "good enough." *See also* Oliver E. Williamson, *The Economics of Organization: The Transaction Cost Approach*, 87 AM. J. SOC. 548 (1981) (summarizing bounded rationality as an important development in the field of economics).

57 *See* ROBERT COOTER & THOMAS ULEN, LAW AND ECONOMICS 46-48 (4th ed. 2000). The consumer's ultimate choice would also depend on his individual preference for risk. *Id.* A consumer can be risk-averse, risk-neutral, or risk-preferring. *Id.*

58 *See infra* Part II.

ing,[59] most consumers do not have a financial plan in place.[60] Consumers who decline to develop an affirmative plan may be left with no other choice but to spend down assets, enroll in Medicaid, and relinquish the right to devise the principal residence upon death.[61]

Although these outcomes clearly frustrate policy-makers, the choices that lead to them are not necessarily irrational. Below the surface, these typical long-term care consumer choices may in fact satisfy the traditional economics model's basic assumption of utility maximization.[62] For instance, these choices might be explained by more accurately defining the nature of the decision faced by consumers, by evaluating the amount and quality of information available, or by studying the possible utility derived by advancing emotional and behavioral motivations. The emergent behavioral economics model expands the scope of traditional rational choice theory by identifying the multifaceted decision-making processes of psychologically complex, emotionally-motivated beings. As the following sections reveal, the behavioral model may be better suited to explain consumer decision-making in the long-term care financial planning arena.

B. *The Behavioral Economics Model of Consumer Choice*

The behavioral economics model of consumer choice provides more depth to the traditional model's recognition that rational actors seek to advance overall utility.[63] This theoretical framework identifies less obvious forms of utility, which are derived from emotional, psychological, social, and intellectual factors.[64]

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59 A 2002 report noted that "[b]etween 1995 and 2002, the number of long-term care insurance policies grew by at least 10 percent or 500,000 new policies each year." SUSAN CORONEL, AMERICA'S HEALTH INS. PLANS (AHIP), RESEARCH FINDINGS, LONG-TERM CARE INSURANCE IN 2002, at 13 (2004), *available at* http://www.ahipresearch.org/pdfs/18_LTC2002.pdf.

60 *See* sources cited *supra* notes 23-26 and accompanying text.

61 *See infra* Part II.A (discussing Medicaid estate recovery laws).

62 Economists argue that these choices are rational because they reflect the consumer's decision to rely on free Medicaid benefits rather than pay for private insurance. *See, e.g.*, Brown & Finkelstein, *supra* note 24, at 1.

63 For an overview of the behavioral economics model, see BEHAVIORAL LAW AND ECONOMICS (Cass R. Sunstein ed., 2000); see also Russell Korobkin, *A "Traditional" and "Behavioral" Law-and-Economics Analysis of* Williams v. Walter-Thomas Furniture Company (UCLA Sch. of L., L. & Econ. Research Paper Series, Research Paper No. 03-24) (analyzing a legal quagmire from the perspectives of traditional rational choice theory and behavioral economics legal theory), *available at* http://ssrn.com/abstract=471961.

64 *See generally* BEHAVIORAL LAW AND ECONOMICS, *supra* note 63.

The behavioral economics model is essentially a reflection of the insights gained from early works of B.F. Skinner, in which he posited that humans are often driven by positive or negative reinforcements, and can be profoundly motivated by emotional needs.[65] When behavioral psychologists build on this foundation to explain more subtle nuances of human decision-making, they supplement and bolster the traditional economics model's ability to explain and predict even the most complex choices. Thus, the behavioral economics model supplements the rational choice paradigm with additional insights from fields such as heuristics,[66] sociology, and psychology, so that theorists can better understand *why* rational actors can systematically arrive at seemingly irrational decisions.

C. *Long-Term Care Planning under the Behavioral Economics Model*

Under the behavioral economics model of rational choice, even the most baffling trends can be understood as rational choices. The following subsections highlight some of the most common motivations that emerge when consumers consider long-term care needs.

1. *Unique Preferences in Long-Term Care Planning*

Since long-term care generally foreshadows, or at least implicates, the end of one's life, individuals must necessarily grapple with certain emotional and behavioral responses. For a large portion of consumers, emotional preferences that arise when the consumer thinks about long-term care are the primary forces behind planning decisions. These deeply rooted preferences are discussed in the following sections.

i. *Preference 1: Diminished Utility at the Mere Thought of Long-Term Care Needs*

Although infinitely frustrating to policy-makers, the choice to avoid consideration of long-term care planning may very well be a rational one. Aging is not a favored topic of discourse; planning is often

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65 *See generally* B.F. SKINNER, THE BEHAVIOUR OF ORGANISMS (1938); B.F. SKINNER, SCIENCE AND HUMAN BEHAVIOUR (1953).

66 Heuristics is the study of human decision-making. For a general description of this body of research as it is typically applied in the social sciences, see, e.g., Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, *in* JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES (Daniel Kahneman et al. eds., 1982).

begun only when medical needs foreshadow long-term care placement.[67] Because many individuals do not wish to think about the prospect of growing old, any reflection on the subject of aging will most likely reduce emotional well-being and diminish overall utility. As a result, the rational actor may choose to avoid initial deliberation, and then ignore all subsequent information.

This preference may appear to be irrational in that it leads consumers to patently reject even the most advantageous planning options. However, behavioralists observe that in addition to being "bounded" by fundamental limitations on the human mind's ability to gather and evaluate evidence,[68] rational actors sometimes choose to willingly limit information intake before making a decision. In this manner, rational actors engage in what Herbert Simon has termed "satisficing" and choose to make a decision that will be "good enough."[69] Where a consumer decides to "satisfice" in his initial choice—as with the option to engage or not engage in financial planning—he in essence decides to forego the option to *make* rational choices about specific planning options.

ii. *Preference 2: Maximized Utility by Underestimating One's Future Need for Long-term Care*

Even among consumers who choose to think about long-term care, related motivations may lead some people that consider it to decide that planning is unnecessary. Rational actors make decisions with a human mind, and they are susceptible to certain biological and psychological tendencies.[70] Humans make choices based upon systematic and pervasive biases, which in turn affect the way that they perceive alternatives.[71] For instance, some of the earliest behavioral works observe that decision-makers often exercise "overconfidence," whereby they underestimate the

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67 One author explains, "Too often it is only when a family member becomes disabled that they learn that these expenses will have to be paid for out-of-pocket . . . . [I]ndividuals whose long-term care needs arise as a result of a sudden onset of a stroke or other illness do not have adequate time to plan." Janel C. Frank, *How Far Is Too Far? Tracing Assets in Medicaid Estate Recovery*, 79 N.D. L. REV. 111, 116 n.47 (2003) (quoting S. Rep. No. 106-229(I), at 153 (2000)).

68 Bounded rationality is discussed *supra*, note 56.

69 For a discussion of "satisficing," particularly as it relates to organizational behavior, see SIMON, MODELS OF MAN, *supra* note 36, at 204. *See also* JAMES MARCH AND HERBERT SIMON, ORGANIZATIONS 190 (1958).

70 Simon, *A Behavioral Model of Rational Choice*, *supra* note 56, at 101.

71 *See, e.g.*, COLIN CAMERER, BEHAVIORAL GAME THEORY (2003).

likelihood that unfortunate things might occur in their own lives and use subjective rather than objective factors to weigh risk.[72] As a result of this highly personal, skewed evaluation, the rational actor may at times make choices that deviate substantially from the clearly logical choice.[73]

In the arena of long-term care decision-making, many individuals grossly underestimate their own potential need for long-term care, even in the face of overwhelming contrary statistics. For example, an insurance industry report found that among individuals age fifty-five and over, "less than one in three believe they have a greater than 50 percent chance of needing nursing home care . . . in the future, even though the lifetime risk of needing such care is 43 percent."[74] Overconfidence is perhaps more likely among younger age cohorts: a recent poll of Massachusetts residents found that 41 percent of persons under the age of twenty-five do not anticipate any need for long-term care services in their lifetimes.[75] However, even among older age cohorts, the overconfidence heuristic can still figure prominently. A study conducted among AARP members in the state of New York found that almost one-tenth of respondents over the age of fifty do not believe they will ever need long-term care.[76]

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72 *Korobkin & Ulen, supra* note 51, at 1086. In a highly influential work, psychologists Amos Tversky and Daniel Kahneman developed "prospect theory" to describe the manner by which rational actors assess risks and benefits in ways that may differ from the actual, objective truth. *See* Amos Tversky and Daniel Kahneman, *Advances in Prospect Theory: Cumulative Representation of Uncertainty*, 5 J. RISK & UNCERTAINTY 297 (1992).

73 One theorist explains:

> Prospect theory also differs from expected utility theory in the way it handles the probabilities attached to particular outcomes. Classical utility theory assumes that decision makers value a 50 percent chance of winning as exactly that: a 50 percent chance of winning. In contrast, prospect theory treats preferences as a function of "decision weights," and it assumes that these weights do not always correspond to probabilities. Specifically, prospect theory postulates that decision weights tend to overweight small probabilities and underweight moderate and high probabilities.

SCOTT PLOUS, THE PSYCHOLOGY OF JUDGMENT AND DECISION MAKING 98 (1993).

74 LIFEPLANS, INC., HEALTH INS. ASS'N OF AMERICA, WHO BUYS LONG-TERM CARE INSURANCE IN 2000? A DECADE OF STUDY OF BUYERS AND NONBUYERS 21 (2000), *available at* http://www.ahipresearch.org/pdfs/17_WhoBuysLTCI2000.pdf.

75 Francis G. Caro, *Elders in Massachusetts Prefer Paid Caregivers* 1 (Gerontology Inst., Univ. of Mass. Boston, 2002), *available at* http://www.geront.umb.edu/inst/WorkingPapers/PaidLTCrev.pdf.

76 When asked why they do not own long-term care insurance, 9 percent of respondents said they "Don't think [I] will need long-term care." KATHERINE BRIDGES, AARP, LONG-TERM CARE: A SURVEY OF NEW YORK AARP MEMBERS 2 (2004), *available at* http://assets.aarp.org/rgcenter/health/ny_ltc.pdf.

iii. *Preference 3: Diminished Utility at the Thought of Institutional Care; Maximized Utility at the Thought of Informal Care from Loved Ones*

Rational actors are deeply biased by traditions and customs; these biases can affect the values assigned to each option, and the manner in which costs and benefits are weighed.[77] Empirical evidence reveals that a majority of Americans strongly prefer in-home care provided by loved ones; paid home-based or institutional care is generally considered to be a less attractive option.[78] For some, this desire may be rooted in a sense of nostalgia or a feeling of expectancy.[79] One possible explanation may be that today's older Americans grew up in a time when the majority of women remained in the home and tended to children, so that they were also available to provide assistance to aging relatives.[80] Caregivers appear to be driven by the same deeply-rooted preferences. In fact, a 1995 qualitative study found that family caregiving is often provided based on a "commitment to social standards of behavior and role fulfillment, 'natural' responses to crises, being the 'only one,' and a commitment to family precedent."[81]

The behavioral model takes these findings even further by demonstrating how certain preferences can become so entrenched that they can ultimately influence decision-making more profoundly than more ephemeral likes and dislikes.[82] For instance, where a preference rises to

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77 Korobkin & Ulen, *supra* note 51, at 1085. *See also, e.g.*, Jonathan Bendor, Daniel Diermeier & Michael Ting, *A Behavioral Model of Turnout*, 97 AM. POL. SCI. REV. 261 (2003) (noting that "citizens may have a sense of duty to vote that outweighs the cost of participation").

78 A recent study surveyed adults about their preferences for future long-term care, finding that the majority preferred in-home or community-based care, either by relatives or non-relatives; few participants were amenable to nursing home care. J. Kevin Eckert et al., *Preferences for Receipt of Care Among Community-Dwelling Adults*, 162 J. AGING & SOC. POL'Y 49 (2004). Similarly, a 2004 AARP telephone survey of 1,006 AARP members residing in the state of New York found that the majority (61 percent) of respondents preferred home-based care, with assistance from family members. BRIDGES, *supra* note 76, at 60-61.

79 Emotional motivations to expect informal, in-home care are explored more fully in WENDY LUSTBADER, COUNTING ON KINDNESS: THE DILEMMA OF DEPENDENCY (1994).

80 On the disproportionate burden women carry for providing long-term care to loved ones, see NANCY R. HOOYMAN & JUDITH GONYEA, FEMINIST PERSPECTIVES ON FAMILY CARE: POLICIES FOR GENDER JUSTICE (1995).

81 KATHRYN B. MCGREW, OHIO LONG-TERM CARE RESEARCH PROJECT, CAREGIVING PATHS, PATTERNS, AND PERSPECTIVES 4 (1995), *available at* http://casnov1.cas.muohio.edu/scripps/publications/Sum_CaregivingPaths.html.

82 For a discussion of the manner by which economic institutions contribute to the formation of deeply-rooted, all-consuming preferences that ultimately frame decision-making more profoundly than exogenous preferences, see Samuel Bowles, *Endogenous Preferences: The Cultural*

the level of a custom or tradition, the rational actor may be prone to overestimate the likelihood that informal, in-home care will be provided—even if the consumer should clearly recognize that family members may not be able to provide such care.[83] Perhaps demonstrating this overconfidence, one nationwide survey revealed that 60 percent of employed persons in the general population believe that their long-term care needs will be met by loved ones.[84] However, while the majority of long-term care services is provided by loved ones in the home,[85] many individuals will require institutional care when their needs become more pronounced. Furthermore, few middle-aged persons can definitively declare that loved ones will meet their long-term care needs, since many variables can alter this expectation.

Finally, some studies suggest that although the majority of Americans desire in-home care provided by loved ones, many do not actually trust their children to provide it without practical or financial incentives.[86] As a result, some consumers perceive the advance purchase of long-term care insurance as an impairment of the more desirable option,

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Consequences of Markets and Other Economic Institutions, 36 J. ECON. LITERATURE 75 (1998). Similarly, a subfield of behavioral economics has evolved to study the influence of cultural variables on the formation of deeply-rooted preferences. *See, e.g.*, Justin D. Levinson & Kaiping Peng, Valuing Cultural Differences in Behavioral Economics (April 28, 2006) (unpublished manuscript), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=899688.

83 Sometimes, individuals intend to rely on care from a loved one, only to find that their anticipated caregiver has predeceased them. For instance, a poll of 461 Massachusetts residents, conducted in 2002, found that over half of respondents expressed a preference for in-home care, provided by a spouse. UNIV. OF MASS. LOWELL POLL, MAY 5-MAY 9, 2002, at 3, *available at* http://www.uml.edu/umasspoll/previous/data/pdf/2002_May5_May9.pdf. However, as the federal government's long-term care insurance program's promotional literature explains, "one of the most common long-term care scenarios is for wives to become the primary caregivers for their husbands, only to find that they lack a source of care when their own long-term care needs arise." Website of the U.S. Office of Personnel Management, Federal Long Term Care Insurance Program, "Did You Know?" . . Long Term Care Facts, http://www.opm.gov/insure/ltc/snippets.htm (last visited February 3, 2007).

84 LIFEPLANS, INC., *supra* note 75, at 27.

85 *See infra* Part II.B.1.

86 This argument was posited in Mark V. Pauly, *The Rational Nonpurchase of Long-Term Care Insurance*, 98 J. POL. ECON. 153, 163 (1990). A subsequent article published by two economists developed a statistical modeling of the "moral hazard" effect within the long-term care insurance market; the authors confirmed that an individual choosing whether to purchase long-term care insurance will often recognize that the presence of such an insurance policy will reduce the likelihood that adult children will provide informal care within the home setting. Peter Zweifel & Wolfram Struwe, *Long-Term Care Insurance in a Two-Generation Model*, 65 J. RISK & INS. 13, 14 (1998).

since adult children might be less inclined to provide in-home care if a pre-financed alternative exists.[87]

2. Unique Time Functions in Long-Term Care Planning

In addition to the preferences described above, the long-term care planning market is unique in that consumers must make choices over an extended period. This not only means that different consumers will confront the initial planning decision at varying life stages, but also that each consumer may revisit the initial plan at later points in life. Moreover, since long-term care planning implicates one's final years, these preferences will be highly sensitive to the consumer's evolving attitudes toward the prospect of aging. The following subsections describe three unique time functions that can cause rational actors to process long-term care choices in unexpected ways.

i. *Time Function 1: Long-term Care Planning as an Initial Proxy for Financial Interests, and as an Evolving Proxy for Emotional Interests*

Although rational actors assign values to alternatives using objective measures—such as pecuniary worth—these objective measures are sometimes used as proxies for subjective values that the rational actor finds even more desirable than the objective value.[88] In the arena of long-term care, the rational actor may initially perceive long-term care planning as a proxy for financial interests. In fact, a recent nationwide survey found that 57 percent of long-term care insurance policyholders initially purchased their policies to advance financial motives.[89]

However, the initial focus on financial utility appears to be a momentary one, which is ultimately subsumed by much more deeply emotional considerations. As consumers approach the threshold of old age, long-term care planning is increasingly perceived as a means to obtain comfort, security, and positive surroundings. Once planning becomes a proxy for these emotional interests, the consumer may decide to aban-

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87 *See id.*

88 One early behavioral work noted that the acquisition of wealth and money also represent another motivation for most humans: social approval. *See* GEORGE HOMANS, SOCIAL BEHAVIOUR: ITS ELEMENTARY FORMS (1961).

89 LIFEPLANS, INC., *supra* note 74, at 28. This figure represents the combined results for the following three rationales: "Protect Assets/Leave an Estate," (31 percent), "Guarantee Affordability," (14 percent), and "Protect Living Standards" (12 percent). *Id.*

don the original plan if it is unlikely to advance these new subjective proxies.

In light of this shifting focus, abandonment of one's financial plan is entirely conceivable. In fact, a consumer might maximize his utility by abandoning a long-term care plan if he develops a fear of institutional care in response to widespread stories of neglect and abuse in nursing homes,[90] or if he adopts the more common preference for in-home care provided by loved ones. The latter preference evolution has been identified in at least one empirical study: a poll conducted in New York found that while younger respondents tended to include professionals among their desired long-term care providers, older respondents were more likely to omit professional caregivers and favor care provided only by loved ones.[91]

ii. *Time Function 2: The Tendency to Disproportionately Value Current Costs and Benefits Over Future Costs and Benefits*

Even within the subset of consumers that choose to make the initial planning decision based purely on objective measures, the *overall* values assigned by actors do not always correspond with these objective calculations.[92] For instance, although pecuniary interests are based on objective measures, the costs and benefits one associates with monetary transactions are often highly subjective: "[I]ndividuals do not consider all money fungible and, instead, establish different 'mental accounts' for different classes of goods and services."[93] Individuals have different "discount rates," and therefore assign different values to present and future benefits.[94] Furthermore, rational actors do not have stable prefer-

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90 *See, e.g.*, Mary H. Hayes, *2003 Survey of Rhode Island Law: Cases: Health Care Law*, 9 ROGER WILLIAMS U. L. REV. 816, 820-21 (2003) ("[C]ases of elder abuse, nursing home neglect, and violence against seniors [are] being publicized in the media on an increasingly regular basis."); Lisa Nerenberg, *Abuse in Nursing Homes*, NAT'L CTR. ON ELDER ABUSE NEWSLETTER (Wash., D.C.), May 2002, *available at* http://www.elderabusecenter.org/default.cfm?p=abuse innursinghomes.cfm.

91 BRIDGES, *supra* note 76, at 2 (finding that "[y]ounger members are most likely to say they would prefer to have long-term care provided at home, with help from family, friends, *and* homecare professionals (55 percent [for ages fifty through sixty-four] vs. 40 percent [for ages sixty-five and over])" while "older members more often than younger members say they would prefer to receive this care at home, with help from just family and friends (19 percent [for ages sixty-five and over] vs. 10 percent [for ages fifty through sixty-four])").

92 *See* Korobkin & Ulen, *supra* note 51.

93 *Id.*, at 1103.

94 *See, e.g.*, George Ainslie & Nick Haslam, *Hyperbolic Discounting*, *in* CHOICE OVER TIME 59, 59-71 (George Loewenstein & Jon Elster eds., 1992).

ences because discount rates are usually higher for benefits that will arise in the distant future.[95]

When actors are asked to value future costs or benefits, they first consider the statistical probability that various outcomes will occur in their own lives, and continuously "'update' (adjust) this 'base rate' with any available particularized information about a specific situation."[96] Specifically, the "representativeness heuristic," which leads rational actors to undervalue certain base rates and overestimate other correlations,[97] is a fluid and ever-changing bias which can change significantly over time—particularly as the consumer grows older and as emotional considerations are increasingly implicated. For instance, a recent poll of Massachusetts residents found that 41 percent of consumers under the age of twenty-five believe they will not require long-term care services.[98] However, among those over sixty-five, only 4 percent expressed this belief.[99] Thus, the anticipated need for long-term care services is highly susceptible to the representativeness heuristic. Consequently, the perceived value of long-term care planning will change as the consumer updates the statistical probability that he will require such services.

iii. *Time Function 3: The Problem of the "Future Incapacitated Self" as a "Non-Self" or an "Impossible Self"*

Behavioralists observe that unlike the traditional economist's model of a single rational actor, each individual may in fact comprise "multiple selves": a "forward-looking self that plans to invest . . . [and a] present-oriented self that changes course and decides to spend."[100] The present-day self tends to use a paradigm to order preferences and value alternatives that is unique to its time frame, while making decisions that affect other "selves."[101] Thus, for instance, the rational actor must often

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95 *See supra* notes 72 and 73 and accompanying text. Discount rates are also discussed in Daniel A. Farber and Paul A. Hemmersbaugh, *The Shadow of the Future: Discount Rates, Later Generations, and the Environment*, 46 VANDERBILT L. REV. 267 (1993).

96 Korobkin & Ulen, *supra* note 51, at 1085.

97 *Id.* at 1085-87.

98 Caro, *supra* note 75, at 1.

99 *See id.*

100 Korobkin & Ulen, *supra* note 51, at 1121.

101 *Id.* at 1123 n.286 (suggesting that "each individual may be viewed as a collection of competing preference orderings," leading to "a collective action problem in aggregating the contemporaneous preferences of these multiple selves").

find a way to force the present-oriented self to make sacrifices that are likely to bring future benefits.[102]

These findings are clearly relevant in the area of long-term care. Some consumers may feel that any use of today's income to finance something so far in the future would be unwise. Likewise, since long-term care is provided at the end of life, often when mental and physical capacity is significantly diminished, the present-oriented self may perceive long-term care as something that would be provided to a distant, future incapacitated self, or even a "non-self" or an "impossible self."[103] Some individuals will simply hope that the incapacitated self never materializes;[104] others will treat this self as a ghost or apparition which should be willed away with positive thoughts.[105] Still others will actively resent this self, and reward the present-day self more in comparison to the perceived disappointments that the incapacitated self will introduce.[106] Thus, for consumers who carry any of these inclinations, it may seem absurd to make present-day sacrifices to support the needs of the incapacitated self.

In summary, consumers who approach long-term care planning must grapple with these unique preferences and time functions. The

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102 *Id.*

103 This argument was eloquently developed in MCGREW, *supra* note 81.

> The failure or refusal to imagine a frail/impaired possible self with at least some degree of specificity is functionally different from imagining an unwanted or feared self . . . . [B]oth hoped-for and unwanted/feared selves guide behaviors and decisions. On the other hand, unimagined, or impossible, frail/impaired selves obstruct a perception of vulnerability. The effect of this is to render related behaviors and decisions irrelevant.

Id at 7.

McGrew's poignant remarks summarize findings from a comprehensive qualitative study, in which participants expressed these tendencies quite clearly in response to interview questions. Participant statements include: "This is something that I just never wanted to put my thoughts on," and "I just kind of flush it out of my mind." *Id. See also* Pauly, *supra* note 86 (explaining that there may never be adequate demand for long-term care insurance because some consumers will probably perceive the main benefit of planning as an increase in the policyholder's testamentary estate).

104 One survey participant explained, "I am trying not to think about it too much. I'm hoping it won't [happen]. That's all." MCGREW, *supra* note 103, at 8.

105 Another respondent in McGrew's study explained, "You just sort of hold your breath and, you know, thinking if you don't recognize it, it will go away." *Id.* at 7.

106 *Id.* at 8. One survey respondent in McGrew's study explained, "[E]very time I start to think of it a little bit I start imagining myself being more decrepit than I am right now . . . and I avoided it." *Id.* Another explained, "I get tired of hearing about assisted living and this and that and what to do in your old age. You know, I take it one day at a time. It's so important to live in the now." *Id.*

following sections discuss and evaluate whether, in light of these consumer motivations, current tax and economic incentives are likely to address the long-term care financing crisis.

II. TAX AND ECONOMIC POLICY RESPONSES TO THE MEDICAID CRISIS

In response to the looming Medicaid fiscal crisis, lawmakers have identified a critical need to replenish Medicaid coffers through sources other than tax revenues, while also reducing the total number of program beneficiaries. Current law manifests a two-pronged approach: the federal and state governments seek to discourage reliance on public assistance for long-term care through Medicaid estate recovery programs, while simultaneously encouraging reliance on private resources—such as long-term care insurance policies and informal home care. As the following sections reveal, although these government incentives do have some limited application, they are unlikely to have a sufficient impact on consumer behavior.

A. *Government Initiatives to Discourage Reliance on Public Assistance for Long-Term Care: Medicaid Estate Recovery Programs*

Although Medicaid is a means-tested program and beneficiaries cannot legally retain large amounts of wealth, spend down provisions do permit applicants to keep their principal residence.[107] Thus, one way to help preserve the financial health of the Medicaid program is to recover the principal residence—or any other assets—from decedent recipients, up to the value of Medicaid long-term care benefits received.

The Omnibus Budget Reconciliation Act of 1993 ("OBRA 93")[108] amended the Social Security Act to mandate recovery of the value of long-term care benefits from the estates of decedents who received Medicaid benefits beyond the age of fifty-five.[109] OBRA 93 also authorizes each state to define "estate" to include:

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107 *See* 42 U.S.C. § 1396p (2000) (codifying Medicaid spend down provisions).

108 Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312 (1993) (codified at 42 U.S.C. § 1396p) (2004).

109 *Id.* at § 1396p(b)(1)(B). Section 1396a, which establishes the Medicaid portion of the Social Security Act, conditions state receipt of funding on "compl[iance] with the provisions of section 1917 [42 U.S.C. § 1396p] with respect to liens, adjustments and recoveries of medical assistance correctly paid . . . transfers of assets, and treatment of certain trusts." *Id.* at § 1396a(a)(18). In provisions specifically dealing with Medicaid estate recovery, the Act provides, in pertinent part, "In the case of an individual who was fifty-five years of age or older

> . . . any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign[ee] of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement.[110]

Thus, OBRA 93 not only mandates estate recovery, but also significantly expands the range of property from which states may recover assets.

Today, while estate recovery programs are still being developed and refined, the trend is toward more systematic enforcement.[111] Policy-makers hope that estate recovery programs will discourage reliance on Medicaid by middle-class persons who have the means to procure long-term care insurance.[112] However, this goal assumes that consumers make a deliberate choice to rely on Medicaid, when in fact the behavioral model suggests that a significant number of consumers arrive unwittingly on Medicaid rosters because they avoided planning altogether, expected to receive in-home care from loved ones, or simply never believed they would require long-term care.[113] Thus, the impact of estate recovery on initial consumer choice is likely to be minimal since many consumers do not believe such programs will ever reach them.

Furthermore, estate recovery programs are unlikely to provide perfect replenishment for Medicaid coffers. Aside from the transaction costs inherent in the recovery process, and apart from the continuously rising costs of care, the simplest reason is that a large number of beneficiaries will not leave behind recoverable assets. In recognition of this reality, policy-makers have developed a second response to the Medicaid crisis: government incentives that seek to encourage widespread reliance on private support for long-term care.

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when the individual received such medical assistance, the State *shall* seek adjustment or recovery from the individual's estate." *Id.* at § 1396p(b)(1)(B) (emphasis added).

110 42 U.S.C. § 1396p(b)(4)(B).

111 *See, e.g.*, Zieger, *supra* note 32, at 374-75.

112 *See* Belshe v. Hope, 33 Cal. App. 4th 161, 173, 175 (Cal. Ct. App. 1995) (emphasizing that the California legislature's goals in enacting its Medicaid program are consistent with Congress' goal of discouraging "non-poor elderly persons" from "using estate planning to avoid applying their wealth to the costs of long-term care services for the purpose of having Medicaid pay for their care").

113 *See supra* INTRODUCTION.

B. *Government Initiatives to Encourage Reliance on Private Payer Sources for Long-Term Care*

If mandatory estate recovery is intended, at least in part, to discourage reliance on Medicaid for long-term care financing, then more recent government initiatives may be viewed as the means by which policy-makers seek to make private funding sources appear more attractive.[114] Specifically, federal and state laws establish tax expenditures[115] and other economic incentives to encourage families to provide informal, in-home care for loved ones and promote the purchase of long-term care insurance policies. These measures are discussed below.

1. Additional Personal Exemption for Caregivers

Although discussion often focuses on the burgeoning costs of professional care, lawmakers also recognize that a large portion of long-term care is provided informally within families, without any direct cost to the government.[116] Loved ones provide an estimated 80 percent of long-term care, typically within the home.[117] A study released in 2002 found that approximately forty-five million Americans provide some form of long-term care to friends or relatives.[118] The value of such care was most recently estimated to be $196 billion in 1997;[119] given the rise

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114 *See, e.g.*, Karin C. Ottens, Note, *Using Tax Incentives to Solve the Long-Term Care Crisis: Ineffective and Inefficient*, 22 VA. TAX REV. 747, 749 (2003).

115 The argument that a tax deduction is a governmental expenditure typically goes as follows: "'[t]ax expenditures are revenue losses resulting from Federal tax provisions that grant special tax relief designed to encourage certain kinds of behavior by taxpayers or to aid taxpayers in special circumstances. These provisions may, in effect, be viewed as spending programs channeled through the tax system.'" Roberta F. Mann, *The (Not So) Little House on the Prairie: The Hidden Costs of the Home Mortgage Interest Deduction*, 32 ARIZ. ST. L.J. 1347, 1353 n.25 (2000) (quoting S. COMM. ON THE BUDGET, 105TH CONG., TAX EXPENDITURES: COMPENDIUM OF BACKGROUND MATERIAL ON INDIVIDUAL PROVISIONS, (Comm. Print 1998)). For a more thorough discussion, see STANLEY S. SURREY & PAUL R. MCDANIEL, TAX EXPENDITURES (1985).

116 *See* Rosalie A. Kane & Joan D. Penrod, *In Search of Family Caregiving Policy: General Considerations, in* FAMILY CAREGIVING IN AN AGING SOCIETY: POLICY PERSPECTIVES 2, 2 (Rosalie A. Kane & Joan D. Penrod eds., 1995) (discussing the prevalence of informal, in-home care by family members).

117 COLEMAN, *supra* note 39, at 1.

118 THE HENRY J. KAISER FAMILY FOUNDATION, THE WIDE CIRCLE OF GIVING: KEY FINDINGS FROM A NATIONAL SURVEY: LONG-TERM CARE FROM THE CAREGIVER'S PERSPECTIVE 6 (2002), *available at* http://www.kff.org/kaiserpolls/upload/The-Wide-Circle-of-Caregiving-Chart-Pack.pdf.

119 *See* Peter S. Arno et al., *The Economic Value of Caregiving*, HEALTH AFFAIRS, Mar.-Apr. 1999, at 182, 184.

in long-term care costs during the past ten years, and the steadily growing population, this figure is likely to be significantly larger today.

These figures suggest that although the cost of institutional care is crippling the Medicaid budget, public coffers are in fact only supporting a fraction of all long-term care. Private resources are already shouldering a significant portion of the nation's long-term care needs, albeit through the direct provision of services to loved ones rather than through the outlay of cash to a professional caregiver.[120] Although in-home care is generally less expensive than institutional care, the obligation to support a loved one nonetheless imposes a significant economic burden on a family.[121]

Policy-makers believe that if government initiatives somehow discourage this form of private care giving, or fail to promote it in conjunction with other solutions, then the costs of long-term care could rise dramatically. Thus, the Internal Revenue Code offers a $3,200 personal exemption for taxpayers who pay for or directly provide long-term care services to qualified dependent family members living in the taxpayer's home.[122] State governments also provide income tax benefits to support informal, in-home care. For instance, the state of California provides a $500 income tax credit for caregivers.[123]

Although these initiatives provide incentives for families to provide care, they do not appear to impact the consumer choices of those who *receive* such care. Given the stable preference for in-home care provided by loved ones, and given that this preference is often viewed by consumers as a reason *not* to engage in formal financial planning for long-term

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120 *See, e.g.* White House Press Release, The President Triples His Long-Term Care Tax Credit and Urges Congress to Pass a Long-Term Care Initiative in 2000 (Jan. 19, 2000), *available at* http://clinton4.nara.gov/WH/New/html/20000119_4.html ("[T]he economic value of care giving for families ranges from $4,800 to $10,400 per caregiver.").

121 For a moving depiction of the pressures family caregivers face, see CAROL S. ANESHENSEL ET AL., PROFILES IN CAREGIVING: THE UNEXPECTED CAREER (1995).

122 26 U.S.C. § 151 (2004). The amount of the exemption is adjusted annually for inflation. For 2005, the personal exemption amount is $3,200. *See* Rev. Proc. 2004-71, I.R.B. 2004-50, 970. The exemption was announced as part of President Clinton's health care proposal. *See* Joshua M. Wiener, Commentary: Pitfalls of Tax Incentives for Long-Term Care, http://www.urban.org/url.cfm?ID=900205 (last visited February 3, 2007). Former President Clinton explained the reasons for the initiative: "We cannot expect that every older American will be able to fend for himself or herself . . . . [The long-term care tax exemption] would help to offset the direct cost of long-term care . . . as well as the indirect costs, like unpaid leave some caregivers must take." *Online NewsHour: Long-Term Care* (PBS television broadcast Jan. 4, 1999).

123 *See* Franchise Tax Board, State Gives $500 Tax Credit for Qualified Caregivers, http://www.ftb.ca.gov/aboutFTB/press/archive/2003/03_17.html.

care, the provision of a tax incentive to family members appears unlikely to impact initial consumer planning choices in appreciable ways.

Furthermore, informal, in-home care cannot be counted on as a primary source of assistance. Although this form of care is ultimately provided to some degree within most families, individuals simply cannot predict whether they will in fact receive care from loved ones, or if such care will be available to support advanced stages of care.[124] Thus, to better protect governmental resources, federal and state initiatives must encourage formal financial planning for long-term care among those who have the means to achieve such planning. Most of the incentives presently designed to accomplish this task encourage consumers to purchase long-term care insurance policies.[125] The following sections introduce these incentives.

2. Long-Term Care Insurance Partnership Programs

Policy-makers believe that the ever-increasing popularity of "Medicaid planning," which broadly denotes the creative use of estate planning to shield assets and qualify for Medicaid long-term care benefits,[126] confirms that many consumers prefer to receive public assistance for long-term care without having to initially "spend down" personal assets.[127] Lawmakers and insurance companies have sought to leverage this preference through the formation of long-term care insurance partnership programs ("partnership programs").[128] Partnership programs effectively shift the initial expenses of long-term care to private resources

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124 *See supra* note 83 and accompanying text.

125 *See supra* Part I.

126 One article provides: "[Medicaid estate planning] involves legal and financial approaches to satisfying financial eligibility requirements for Medicaid, coverage for nursing home care. More specifically, an individual's assets are sheltered with the intention of precluding consideration of such assets in determining Medicaid eligibility." L. Curry, C. Gruman, & J. Robison, *Medicaid Estate Planning: Perceptions of Morality and Necessity*, 41 GERONTOLOGIST 34 (2001).

127 Medicaid spend down provisions are explained *supra*, note 29.

128 *See* Joshua M. Wiener, Jane Tilly, & Susan M. Goldenson, *Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance*, 8 ELDER L.J. 57, 90 (2000). However, while insurance companies initially supported partnership programs, there is some evidence that insurers find these programs potentially harmful to their overall marketing strategies. *Id.* (explaining that insurance companies initially supported the concept but ultimately receded because, "[f]rom the insurer's perspective, a long-term care partnership is unattractive because . . . [l]ong-term care insurance is sold primarily by stressing that Medicaid is a 'terrible' program with inferior access to poorer quality facilities").

while allowing individuals to rely on public assistance for the balance of their long-term care needs.[129]

Under the typical partnership program, a person who purchases a designated long-term care insurance policy and uses the benefits of that policy to pay for at least the minimum duration of care will be permitted to receive Medicaid benefits for all remaining long-term care costs without having to meet Medicaid asset spend down requirements.[130] In essence, a partnership policy provides the direct benefit of long-term care coverage from the insurer, as well as the indirect benefit of a preferential Medicaid eligibility standard.[131]

Some commentators criticize the formation of partnership programs as a "flawed" policy solution.[132] These critics maintain that partnership programs reach more affluent persons, who might have been inclined to purchase long-term care insurance policies notwithstanding

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129 Jan Ellen Rein, *Misinformation and Self-Deception in Recent Long-Term Care Policy Trends*, 12 J.L. & POL. 195, 293 (1996).

> The goal of partnership programs is to lessen the strain on public funds while providing more individuals with adequate coverage. The operating principle is that people are encouraged to buy insurance. The incentive offered is that should the insurance benefits run out, the State will cover the remaining expenses without the purchaser needing to spend-down assets . . . .

Id.

130 *See* Thomas Day, About Medicaid Long Term Care, http://www.longtermcarelink.net/eldercare/medicaid_long_term_care.htm (last visited Feb. 3, 2007).

> If you buy a long-term care insurance policy under the Partnership program, and you use three years of nursing home care, or six years of home care, or some combination of the two, you may apply for New York State Medicaid benefits and still retain all your assets. You will, however, have to contribute your income to the cost of your long-term care.

Id.

131 The New York State Partnership for Long-Term Care program website explains this two-pronged benefit in more detail:

> Like other long term care insurance policies, Partnership policies help you to remain in control of your own assets, to increase your chances of receiving your preferred choice of long term care and to maintain your own sense of independence and dignity. In addition, Partnership policies—uniquely—enable you to directly control your assets while shielding them from the Medicaid requirement that they be used to pay for care. A Partnership policy preserves your possible future eligibility for Medicaid payments for your long term care and other needs if you are income eligible at that time.

See New York State Partnership for Long Term Care, http://hiicap.state.ny.us/ltc/nys05.htm (last visited September 27, 2004).

132 *See, e.g.*, Jonathan Roos, *Senate OK's Long-Term Care Incentive*, DES MOINES REGISTER, Mar. 11, 2004, at 4B (discussing reactions and criticisms when the Iowa Senate approved a bill that would authorize partnership programs).

these incentives; such persons should not be permitted to receive Medicaid benefits and retain their privileged financial circumstances.[133] Furthermore, in light of the behavioral motivations described above, partnership programs only appeal to persons who: 1) choose to confront long-term care planning; 2) can accept that they may require long-term care; and 3) do not mind the possibility of institutional care. Thus, partnership programs may only be useful in speeding up the purchase of long-term care insurance by individuals who probably would have paid privately for nursing home care or eventually purchased long-term care insurance policies without government incentives. Notwithstanding these criticisms, partnership programs are likely to become more widespread. In fact, President Bush's 2006 budget proposal contains a provision that enables states to develop new partnership programs.[134]

3. Federal Income Tax Deductions for the Costs of Long-Term Care Insurance

While partnership programs are currently available in only a handful of states, many more Americans—and their employers—can obtain federal income tax benefits for the purchase of long-term care insurance policies. The Internal Revenue Code allows employers to deduct the cost of long-term care insurance policies when such policies are provided to employees, and also allows individuals to deduct costs associated with the purchase of individual policies if their employer does not reimburse this expenditure. The Internal Revenue Code's current deductions, along with a proposed version, are discussed below.

i. *The Business Deduction for the Cost of Employer-Sponsored Long-Term Care Insurance Policies*

The overwhelming majority of employers in this country decline to offer employer-sponsored long-term care insurance policies.[135] Some

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133 *See id.*

134 The 2006 budget proposal "includes a proposal to encourage the purchase of private long term care insurance. The proposal would eliminate the existing statutory ban on new Partnership for Long Term Care programs." *See* OFFICE OF MGMT. AND BUDGET, EXEC. OFFICE OF THE PRESIDENT, MAJOR SAVINGS AND REFORMS IN THE PRESIDENT'S 2006 BUDGET 191 (2005).

135 One report notes that only 0.2 percent of all U.S. employers with ten or more employees offer group long-term care insurance policies, and only 8.7 percent of large employers offer such plans. *See* JEREMY PINCUS, EMPLOYEE BENEFIT RESEARCH INST., ISSUE BRIEF: EMPLOYER-SPONSORED LONG-TERM CARE INSURANCE: BEST PRACTICES FOR INCREASING SPONSORSHIP 1 (2000).

authors surmise that most employers fail to see any logic in offering a novel form of insurance if the benefits are only likely to materialize for employees at a very distant point in the future.[136] To reverse the private market's reluctance to offer long-term care insurance benefits, the Internal Revenue Code provides an income tax expenditure for employer-subsidized long-term care insurance policies.[137] Employers may deduct the costs of employer-sponsored long-term care insurance policies from taxable income. Thus, the Code treats the employer's contributions in the same manner that it treats any other deductible business expense.[138] Additionally, the federal government and many state governments currently offer group long-term care plans to their employees.[139]

Yet despite the public sector's lead, group insurance programs may never become a universal long-term care payer source. Even when private employers do provide group plans and employees are willing to pay their portion of premiums, these insurance policies would only provide the anticipated pay out if the employee retains the policy until long-term care needs arise; given the mobility of the modern worker, perhaps only a small portion of the group policies purchased today will continue to be in force when the policyholder's long-term care needs arise.

Thus, long-term care financing via group insurance plans will likely remain the exception, not the norm. In possible recognition of this reality, policy-makers have also introduced tax benefits to encourage Americans to purchase long-term care insurance policies on their own. These initiatives are discussed below.

ii. *The Current Individual Deduction*

In 1996, the federal government began offering a deduction from taxable income for unreimbursed expenses associated with the purchase of individual long-term care insurance policies.[140] Taxpayers may deduct a portion of the cost of long-term care insurance purchased for the

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136 Wiener et al., *supra* note 128, at 73.

137 *See* 26 U.S.C. § 7702B(a)(3) (2004) (explaining that "any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage").

138 *See* 26 U.S.C. § 162 (2004) (permitting deductions for all "ordinary and necessary" expenses incurred in the operation of a taxpayer's business).

139 *See* Wiener et. al., *supra* note 128, at 73-74.

140 26 U.S.C. § 213(d)(10) (2004). If the taxpayer receives reimbursement for any of these expenses, he or she must reduce the total amount deducted by the amount that was reimbursed. *See* INTERNAL REVENUE SERV., PUB. NO. 502, MEDICAL AND DENTAL EXPENSES 17 (2003).

taxpayer, the taxpayer's spouse, and the taxpayer's dependents, to the extent that the total cost of all medical expenses exceeds 7.5 percent of total adjusted gross income.[141] The amount of the deduction is limited, with graduating caps based on the taxpayer's age. Presently, the taxpayer may deduct $260 if he is younger than forty; $490 if he is from forty to fifty years of age, $980 if he is from fifty to sixty, $2,600 if he is from sixty to seventy, and $3,250 for age seventy and over.[142]

While income tax deductions can be viewed as a means of encouraging an overall shift of long-term care costs from public to private resources, these initiatives carry significant attendant costs.[143] For instance, it is estimated that the individual income tax deduction for long-term care insurance policies will cost the federal government over $28 billion in lost tax revenue in the years 2004–2013.[144] While this amount is small in comparison to total anticipated tax revenues during the same period, it nonetheless represents a governmental expenditure in an amount that, if spent elsewhere, might have greater utility.

The federal government has targeted these incentives at individuals who have the means to afford private long-term care insurance. The current "below-the-line" deduction has a greater impact on middle- and upper-class taxpayers because these more affluent Americans are more likely to have enough other deductions—such as a home mortgage interest deduction—to justify itemizing on their returns.[145] In fact, one

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141 26 U.S.C. § 213.

142 *Id.* at § 213(d)(10); *see also* INTERNAL REVENUE SERV., *supra* note 140. Under § 213(d)(10) (B), these amounts are adjusted annually for the percentage increase in the medical-care component of the consumer price index. 42 U.S.C. § 213. The figures provided above are for 2004. Rev. Proc. 2003-85, 2003-49 I.R.B. 1184.

143 The tax deduction for long-term care insurance is arguably a "'subsidy' because it reduces the cost of acquiring [long-term care insurance] by reducing the tax burden of [long-term care insurance purchasers]." Mann, *supra* note 115, at 1353 n.24 (analyzing the home mortgage interest deduction).

144 *Treasury Releases Blue Book Detailing Tax Proposals in White House Budget*, TAX NOTES TODAY, Feb. 4, 2003, at ¶ 174, 181.

145 *See id.* This argument is often made with respect to income tax deductions. *See, e.g.*, Mann, *supra* note 115, at 1353 n.28.

> A major criticism of the home mortgage interest deduction is that it primarily benefits middle to upper income taxpayers . . . . Such inequitable subsidies are defensible as instruments for improving housing quality only if the national goal is to encourage the relatively well-to-do to buy even better housing than they would buy without a subsidy.

Id. (quoting HENRY J. AARON, SHELTER AND SUBSIDIES: WHO BENEFITS FROM FEDERAL HOUSING POLICIES? 163 (1972)) (citations omitted).

analyst reported that only 28 percent of taxpayers with an adjusted gross income below $100,000 itemize deductions.[146]

Thus, the federal government's tax expenditure, which subsidizes long-term care insurance, targets individuals who probably have the resources to assume the entire cost of long-term care through the procurement of private insurance without the subsidy, but have declined to do so for some other reason—such as a preference for in-home care provided by loved ones, or a belief that they will not require long-term care.[147] As the following section reveals, a proposed above-the-line deduction would substantially increase the breadth of the federal government's attempts to promote the purchase of long-term care insurance.

iii. *The Proposed Above-the-Line Deduction*

Beyond the presently allowable deduction, a more generous deduction has been included in recent budgetary and legislative proposals.[148] President Bush's 2004 budget proposal would have allowed a deduction for certain costs associated with the purchase of long-term care insurance without reference to the taxpayer's total medical expenses.[149] This "above-the-line" deduction would permit individuals to receive the benefit of a deduction even if they do not itemize on their returns.[150] As a result, greater numbers of taxpayers could deduct the costs of long-term care insurance from taxable income, and the government would be called upon to subsidize a greater number of insurance policies.[151]

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146 One author found that "IRS 2000 Statistics of Income data show that over 90 percent of individuals with [adjusted gross income ("AGI")] of $100,000 or more itemized their deductions, whereas only about 28 percent of individuals with AGI under $100,000 did." Leandra Lederman, *The Entrepreneurship Effect: An Accidental Externality in the Federal Income Tax*, 65 OHIO ST. L.J. 1401, 1460 (2004).

147 Lawmakers probably believe that more affluent individuals make a choice to rely on Medicaid because it provides full coverage with relatively few costs. Indeed, there is some social science support for this position. *See, e.g.*, Pauly, *supra* note 86.

148 The proposal initially appeared in the Ronald Reagan Alzheimer's Breakthrough Act of 2004, S. 2533, 108th Cong. § 305 (2004). The bill was described as containing "language long sought by the insurance industry." Steven Brostoff, *Reagan Memorial Bill Includes LTC*, NAT'L UNDERWRITER, June 21, 2004, at 8.

149 *See* OFFICE OF MGMT. AND BUDGET, EXEC. OFFICE OF THE PRESIDENT, ANALYTICAL PERSPECTIVES, BUDGET OF THE UNITED STATES GOVERNMENT FISCAL YEAR 2004, at 71 (2003) (describing the above-the-line deduction).

150 *See* Ottens, *supra* note 114, at 755-56.

151 An "above-the-line" deduction would allow approximately 70 percent of taxpayers—those who do not itemize deductions—to claim the benefit. Richard L. Kaplan, *Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, 2004 U. ILL. L. REV. 47, 74-75 (2004)

However, an income tax deduction—whether below or above the line—is unlikely to have a broad enough impact on aggregate consumer behavior. As an initial matter, deductions have no effect on those with the lowest incomes. Despite the rhetoric used by those who favor an above-the-line deduction, any type of deduction will ultimately have a greater affect on more affluent consumers. For example, economists have argued that approximately forty-four percent of the United States population reside in households that show no tax liability: for these individuals, a deduction would not provide additional benefits.[152] Second, even among taxpayers who are able to claim them, deductions reduce taxable income by an amount that varies based on the income bracket of the taxpayer: each dollar of a deduction will yield a ten cent benefit for somebody in the lowest tax bracket, and a thirty-five cent benefit for somebody in the highest bracket.[153] Of course, there is inherent logic in the use of a deduction to offset the cost of long-term care insurance: typically, only those with sufficient incomes will be able to purchase such a policy.

However, the impact of these provisions is questionable even with regard to their intended beneficiaries. Although policy-makers hope these incentives will motivate more affluent consumers to engage in financial planning for long-term care, the narrowly tailored emphasis on long-term care insurance policies runs counter to most of the unique behavioral motivations described above.[154] Long-term care insurance is typically used to finance institutional care rather than in-home care pro-

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(citing Scott M. Hollenbeck & Maureen Keenan Kahr, *Individual Income Tax Returns, 1997: Early Tax Estimates*, STATISTICS OF INCOME BULL., Winter 1998-99, at 132, 145-46).

152 Furthermore:

> [R]oughly fourteen million individuals and families will earn some income but not enough to be required to file a tax return. When these non-filers are added to the zero-tax filers, they add up to fifty-eight million income-earning households who will be paying no income taxes . . . . When all of the dependents of these income-producing households are counted, roughly 122 million Americans—44 percent of the U.S. population—are outside of the federal income tax system.

J. Scott Moody & Scott A. Hodge, *The Growing Class of Americans Who Pay No Federal Income Taxes*, THE TAX FOUNDATION (2004), *available at* http://www.taxfoundation.org/research/show/206.html.

153 GEORGETOWN UNIVERSITY LONG-TERM CARE FINANCING PROJECT, TAX CODE TREATMENT OF LONG-TERM CARE AND LONG-TERM CARE INSURANCE FACT SHEET, *available at* http://ltc.georgetown.edu/pdfs/taxcode.pdf (last visited Feb. 3, 2007).

154 *See supra* Part I.C.

vided by loved ones.[155] Also, it should be purchased at a fairly young age,[156] and it requires consumers to accept that they may need long-term care and that this risk is high enough to justify present-day sacrifices to purchase a rather costly insurance product. Therefore, tax incentives to purchase long-term care insurance will only affect consumers who have reached this level of awareness.

Although Congress never adopted the more generous deduction,[157] the proposal has not been set aside completely. Several prominent interest groups continue to advocate heavily for the more generous deduction.[158] In fact, as recently as March 2005, the "above-the-line" deduction was reintroduced in Congress as part of the Ronald Reagan Alzheimer's Breakthrough Act of 2005.[159] As the following section reveals, the push for more generous tax incentives has also had an impact on state-level income tax provisions.

4. *State-Level Income Tax Incentives for the Purchase of Long-Term Care Insurance*

Beyond the federal initiatives described in the preceding sections, numerous other tax incentives have been developed on the state level. In some states that levy income taxes, incentives mirror the federal tax deduction, so that a portion of the cost of long-term care insurance premiums may be deducted from taxable income if the total cost exceeds a certain percentage of total adjusted gross income.[160] Other

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155 *Thirty-Four Percent of Elderly Use Long-Term Care Insurance In-Home*, BALT. SUN, Feb. 7, 2007, *available at* http://www.baltimoresun.com/business/investing/bal-bz.ym.ltinsure04feb04,0,758017.story.

156 *See infra* note 174.

157 The above-the-line deduction was never added to the Internal Revenue Code, and it does not appear in the most recent budget proposal. *See* OFFICE OF MGMT. AND BUDGET, EXEC. OFFICE OF THE PRESIDENT, BUDGET OF THE UNITED STATES GOVERNMENT FISCAL YEAR 2006.

158 The American Health Care Association and the National Center for Assisted Living advocate for an above-the-line deduction. *See, e.g.*, AMERICAN HEALTH CARE ASSOCIATION, ISSUE BRIEF: UTILIZING TAX INCENTIVES TO PROMOTE PERSONAL RESPONSIBILITY AND CHOICE IN LONG-TERM CARE PLANNING (2004), *available at* http://www.schmalberg.com/ib_tax_credits.pdf.

159 S. 602, 109th Cong., § 305 (2005), *available at* http://www.ltcconsultants.com/agent/articles/reagan_alzheimers.shtml. Sen. Barbara A. Mikulski introduced the proposal on March 10, 2005. *Id.*

160 For a list of these states, see AARP PUB. POL'Y INST., STATES OFFERING TAX INCENTIVES FOR LONG-TERM CARE INSURANCE, 2002 (2003), http://www.aarp.org/bulletin/longterm/Articles/a2003-06-23-taxincentives-.html.

states have chosen to offer more generous deductions or credits to taxpayers that purchase qualified long-term care insurance policies.[161] For instance, Maryland allows taxpayers who are forty-one and older to claim a state income tax credit of up to $500 for each long-term care insurance policy purchased for the taxpayer or qualified members of the taxpayer's family.[162] Colorado also provides a state income tax credit, which is capped at the lesser of $150 or 25 percent of the amount paid for insurance premiums during the year.[163]

As these examples reveal, the federal government is not the only public entity investing tax revenues in the hopes that more Americans will turn to private insurance policies when long-term care needs arise. State governments are also joining in this venture. The following section discusses the impact these government incentives have had on the long-term care insurance industry, and investigates further whether these investments are likely to ease the long-term care financing crisis by modifying consumer behavior.

III. AN ANALYSIS OF LEGISLATIVE INTENT: THE PERCEIVED BENEFIT OF LONG-TERM CARE INSURANCE

In virtually all of the initiatives discussed above, the federal and state governments offer tax subsidies to encourage individuals to purchase private long-term care insurance.[164] Market performance reveals that the long-term care industry is growing significantly as a result of these incentives.[165] Although long-term care insurance has been available for over two decades,[166] this form of healthcare coverage has

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161 *See id.*

162 *See* Comptroller of Maryland: Information for Individual Taxpayers, Long-Term Care Insurance Credit, http://individuals.marylandtaxes.com/incometax/gtpitc/longterm.asp (last visited Feb. 3, 2007).

163 COLO. REV. STAT. § 39-22-122 (2006).

164 For a general discussion of long-term care insurance, see, e.g., BEN LIPSON, J.K. LASSER'S CHOOSING THE RIGHT LONG-TERM CARE INSURANCE (2002).

165 *See* CORONEL, *supra* note 59, at 15. One author contends that the long-term care insurance market is potentially very profitable because the aggregate risk during any given year is actually very low: "Though about one in four will reside in a nursing home at some point, fewer than 5 percent of our nation's elderly are in nursing homes at any one time." John A. Miller, *Voluntary Impoverishment to Obtain Government Benefits*, 131 CORNELL J.L. & PUB. POL'Y 81, 104 (2003).

166 Dina Shapiro Frenkel, *Planning Ahead—Be Prepared For Long-Term Care*, DAILY RECORD (Balt.), April 12, 2004 ("[L]ong-term care insurance has been around for longer than twenty years.").

been virtually ignored by consumers until very recently.[167] Over the past two decades, the industry has enjoyed average annual growth of 21 percent.[168]

Only a small portion of today's seniors carry long-term care insurance.[169] However, increasing numbers of consumers plan to draw upon such policies when nursing home care becomes necessary. By the year 2002, there were over nine million long-term care policies in force in the United States.[170] While the percentage of policies purchased through employer-sponsored plans is increasing, the majority of in-force policies were purchased on an individual basis.[171]

Although these figures suggest that the tax and economic incentives described above are having some effect on consumer behavior, it is important to carefully consider the legislative intent behind government incentives that promote long-term care insurance. In developing tax and economic incentives, federal and state legislators assume that, in most cases, a long-term care insurance policy purchased today will pay out by assuming the cost of the insured's ultimate long-term care needs.[172] However, in arriving at this long-term result, the initial consumer choice to purchase a long-term care insurance policy is only the first step: the consumer must subsequently choose to renew, maintain, and draw upon the policy.

Although insurers generally view insurance policies as annual agreements that indemnify the insured when trigger events occur *in that year*, the pay out envisioned by policy-makers is a cumulative benefit of protection over the insured's *lifetime*.[173] To help ensure the availabil-

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167 In 1995, just one year before the federal government enacted the individual income tax deduction for long-term care insurance, only 7.5 percent of nursing home costs were paid by private insurance plans. NAT'L CTR. FOR HEALTH STATS., REPORT ON HEALTH: U.S. 2001, at 333, Table 118 (2001).

168 Thomas Day, About Long-Term Care Insurance, http://www.longtermcarelink.net/about_insurance.html (last visited Feb. 3, 2007).

169 According to a 2002 report, "less than 15 percent of all individuals over sixty-five and fewer than 5 percent of those under sixty-five have these policies." MARC A. COHEN, HEALTH INS. ASS'N OF AMERICA, BENEFITS OF LONG-TERM CARE INSURANCE 5 (2002).

170 CORONEL, *supra* note 59, at 15.

171 *Id.* at 21.

172 These expectations are also reflected in insurance industry reports. *See* COHEN, *supra* note 169, at 5 (explaining that long-term care insurance policies will reduce Medicaid expenditures by approximately $5,000 per policyholder, but relying on a calculation which does not take lapses into account).

173 *See* STEPHEN F. ROWLEY, THE CONSUMERS' GUIDE TO LONG TERM CARE INSURANCE *passim* (2004).

ity—and in some cases the affordability—of such lifetime risk protection, consumers should purchase long-term care insurance at a fairly young age.[174] Although the actual risk of long-term care needs arising during these early years is insignificant for most insured persons, policyholders pay premiums to maintain coverage until they are technically "uninsurable" due to illness, disability, or old age—at which point the policy would begin to pay for needed services. In this manner, long-term care insurance provides a dual benefit: an annual policy that provides financial risk protection for long-term care needs that are triggered by events occurring *in that year*, and a renewal option, which provides continuous protection against the risk of becoming a greater actuarial risk over time.[175] Only when a policy remains in force, and ultimately assumes the insured's *lifelong* financial risk of long-term care, can it be said that the policy abolished the insured's need to turn to Medicaid for long-term care financing.

As a result, even if government incentives are encouraging growing numbers of individuals to purchase long-term care insurance, the likelihood that these policies will ultimately provide the desired lifelong risk protection is highly susceptible to intervening events. Most obviously, the insurer or the insured may discontinue the policy ("lapse") at some

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174 A 1999 report found that "a typical policy with inflation protection would cost $649 a year for a forty-year-old, $1,802 a year for a sixty-five-year-old and $5,895 a year for a seventy-nine-year-old." *Thinking Ahead: Long-Term Care*, S.F. CHRON., May 15, 2005, at E1 (citing a 1999 Kaiser Family Foundation report). One article summarized the predicament of the typical long-term care insurance ["LTCI"] purchaser thus:

> The timing of an LTCI purchase is important as age is the primary factor in determining its cost . . . . [T]he insurance industry encourages the purchase of LTCI when the insured is young and healthy. This can be risky, however. Someone who buys LTCI at age forty is unlikely to need the services for thirty-five years or more, and predicting the circumstances thirty-five years in the future is obviously impossible.

Clofine & Kiersz, *supra* note 38, at 149. Yet despite these uncertainties, younger consumers are still in a better position to avoid insurer denials based on allegedly preexisting conditions. *See, e.g.*, Victoria Colliver, *Consumers' Worry—Will Insurer Pay If They Need Care?*, S.F. CHRON., May 15, 2005, at E1 (describing recent litigation between a seventy-seven-year-old Alzheimer's patient and an insurer, where the insurer argued that the insured "knowingly concealed symptoms of memory loss when he bought the policy ten years ago" because, although diagnostic testing at that time revealed no abnormalities, the patient had complained about memory loss).

175 For a discussion of this dual nature of long-term care insurance policies, see Amy Finkelstein, Kathleen McGarry, & Amir Sufi, *Dynamic Inefficiencies in Insurance Markets: Evidence from Long-Term Care Insurance* 1 (Nat'l Bureau of Econ. Research, Working Paper No. 11039), *available at* http://www.nber.org/papers/w11039 ("In a dynamic framework, risk averse individuals benefit not only from period-by-period 'event' insurance, but also from insurance against becoming a bad risk and being reclassified into a higher risk group with a concomitant increase in premiums.").

point between the first year and the year in which the insured's long-term care needs arise.[176] When a lapse occurs, the now uninsured individual may turn to Medicaid if long-term care needs arise.

A recent poll of insurance companies revealed that 72 percent of long-term care insurance policies ever sold were still in force in December 2002.[177] However, a closer review suggests that these figures may reflect the newness of the market rather than the durability of policies. At the time the report was published, approximately half of all long-term care insurance policies had been purchased within the preceding five years.[178] In fact, another study released in 2002 reported that, each year, policyholders deliberately cancel approximately 7 percent of in-force policies.[179] Thus, as the market matures, the in-force ratio will likely decline.

Recent studies attempt to explain annual lapse rates based on traditional insurance theories, such as emerging risk awareness and adverse selection.[180] However, such efforts decline to consider behavioral motivations such as those described above.[181] The likelihood of lapses—or, indeed, any intervening events that stand to frustrate legislative intent—should be considered and studied through a variety of academic and theoretical lenses. As the following section reveals, the behavioral model provides a more sophisticated modeling of long-term care consumer choice, and reveals that current tax and economic incentives have a much more limited application than insurance market growth suggests.

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176 Clofine and Kiersz further explain that although a younger insurance purchaser will have the benefit of lower premiums initially, they are more at risk of having inadequate coverage once long-term care needs arise, or of having their premiums increased once they are already on a fixed retirement income. Clofine & Kiersz, *supra* note 38, at 149.

177 CORONEL, *supra* note 59, at 23.

178 *Id.* at 21.

179 SOCIETY OF ACTUARIES, LONG-TERM CARE EXPERIENCE COMMITTEE INTER-COMPANY STUDY: 1984-1999, at 35 (2002), *available at* http://www.soa.org/ccm/content/areas-of-practice/special-interest-sections/long-term-care-insurance/actuarial/papers-presentations-research-resources/1984-1999-long-term-care-experience-committees-intercompany-study/.

180 A recent paper argues that these lapse rates reflect the fact that consumers constantly revalue their risk for long-term care and allow the policy to lapse once they determine that the cost of maintaining the policy outweighs their continued risk for financial exposure. *See* Finkelstein et al., *supra* note 175, at 12. The authors reach this conclusion by correlating lapses with subsequent nursing home admission. *Id.* at 8-9. Finding that those who allow policies to lapse are significantly less likely to enter a nursing home, the authors conclude that those who lapse believe they have a reduced risk of long-term care. *Id.* at 11.

181 *See supra* Part I.C.

IV. A DYNAMIC MODEL OF LONG-TERM CARE PLANNING

Once behavioral motivations are factored into the analysis, it seems that the long-term care consumer decision is comprised of five distinct choices. Each choice should be understood as an incremental level, upon which a rational consumer may choose to remain without going any further in the decision-making process.

A. *Choice 1: To Plan or Not to Plan*

At Choice 1, many consumers simply choose not to even think about long-term care planning because overall utility is significantly diminished by any serious reflection on the topic.[182] Therefore, the rational consumer who fails to plan and ultimately turns to Medicaid probably never actually evaluated the question of how to pay for long-term care, but rather exercised rational decision-making with regard to the question of whether to think about long-term care planning at all.[183] In essence, the rational actor chooses to "satisfice" with regard to all remaining choices,[184] and rationally declines to gather information, rank preferences, or evaluate alternatives about various long-term care financing options.

As many as one-fifth of consumers decline to go any farther than Choice 1. In a nationwide survey, individuals over the age of fifty-five were asked how they plan to pay in the event that long-term care needs arise. Twenty percent declined to select options reflecting personal, familial, or governmental sources of support, and responded that they "don't know."[185] Consumers in this category are unlikely to respond to financial incentives to purchase long-term care insurance unless the benefits are overwhelming.

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182 *See supra* Part I.C.1.i.

183 This rationale seems to be reflected in the findings of a recent AARP survey of over 1,000 members residing in the state of New York. When asked why they do not own long-term care insurance, 16 percent of respondents said they "never considered it," and another 8 percent of respondents answered that they "don't know." In contrast, only 1 percent responded that they "will rely on State/Medicaid." BRIDGES, *supra* note 76, at 2.

184 *See supra* note 69 and accompanying text.

185 LIFEPLANS, INC., *supra* note 74, at 22. Respondents were also given the option to respond, "Medicaid or Medicare," "Other Health Insurance," or "Self or Family." *Id.* The fact that the survey was conducted on a mailed, paper-based form is significant because it suggests that respondents were given an opportunity to consider each option before making a final selection. *Id.*

B. *Choice 2: Develop a Financial Plan, or Rely on Informal Care at Home*

At Choice 2, among consumers who opt to think about long-term care needs, many will ultimately choose not to develop a formal plan because they receive greater utility from the continuation of a present belief that family members will someday provide care.[186] There is a corollary explanation: even among decision-makers that approach this choice with a desire to advance economic interests, some will choose informal, in-home care because they genuinely believe that this type of care will provide greater practical and financial utility in the future. Consumers in this category are so deeply biased by custom and tradition, or by a fear of institutional care, that data or statistics on the costs of—or need for—professional care will have little impact. Furthermore, among consumers who prefer informal, in-home care but believe family members will decline to provide it if the consumer has purchased long-term care insurance, purchasing such a policy would defeat the consumer's primary goal. Consequently, tax or economic incentives are unlikely to motivate such consumers.

C. *Choice 3: Assuming the Consumer Does Not Prefer Informal, In-Home Care, How Costs and Benefits Should be Weighed When Developing a Financial Plan*

Among those consumers who do not have a preference for informal, in-home care provided by loved ones, the behavioral economics model is instrumental in demonstrating *how* rational actors assign utility to financial values and make decisions among various planning devices. Currently, most middle- to upper-class consumers who are open to the possibility of institutional care can choose between three options: they can plan to pay privately from personal assets, they can plan to pay privately through a long-term care insurance policy, or they can choose to rely on public assistance.[187] While less fortunate persons can plan to rely on Medicaid simply by allowing their financial circumstances to remain as they are, most middle- to upper-class consumers who choose the latter option must take proactive steps to divest assets long before the relevant lookback period is likely to commence.[188]

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186 *See supra* text accompanying notes 78 and 79.

187 *See* sources cited *supra* notes 23-25 and accompanying text.

188 *See* Miller, *supra* note 31, at 81.

In weighing these options, immediate costs or benefits will often have a more pronounced impact on utility, and more remote costs or benefits will have considerably less influence.[189] For some consumers, the "multiple selves" phenomenon may lead to significant detachment between the present-oriented self, who must make an immediate financial sacrifice, and the future self, who might benefit from careful planning.[190] Some consumers believe that the future incapacitated self is so removed from the present self, almost feeling like a "non-self" or an "impossible self," that any benefits received by this future self should not be factored into utility calculations.[191]

Thus, consumers may undervalue future benefits to such a significant degree that they ultimately choose to forego the opportunity to purchase long-term care insurance or engage in other planning techniques. When long-term care needs arise, such consumers will be required to spend down assets, enroll in Medicaid, and expose their principal residence to estate recovery.[192] This negative outcome could have been prevented by the purchase of insurance, so the initial failure to do so appears irrational. However, the prospective purchaser may believe that the risk will never materialize in his own lifetime, but would rather affect the incapacitated "non-self."[193] Alternatively, consumers in this category may disproportionately value immediate interests as well as the future interests of their descendants, and engage in Medicaid planning to protect their immediate financial interests and their descendants' access to their wealth upon death.[194] Among those consumers who believe the future incapacitated-self is a "non-self," it appears to be irrelevant that this plan exposes the future self to all of the risks associated

189 *See supra* Part I.C.

190 *See supra* text accompanying note 103.

191 *See id.*

192 *See supra* Part II for a description of Medicaid eligibility requirements.

193 *See supra* Part I.C.2.iii.

194 The following anecdote captures the apparent irony in such decisions:

> When the agent learned we had [no company that would provide long term care insurance for a man in his nineties], he thought they could do some Medicaid planning instead. I gasped and said, "Why in the world do that? . . . Here we have an individual who is coming into the final phase of life, who has accumulated over his ninety plus years a tidy sum of a half a million dollars. Why wouldn't we want these last years to be the very best for him and his family? I don't believe Medicaid planning . . . will do that for him, but his own money will!"

Timothy L. Takacs & David L. McGuffey, *Revisiting the Ethics of Medicaid Planning*, NAELA Q. Summer 2004, 29, 29 (2004).

with complete reliance on public assistance during a vulnerable life stage.[195]

D. *Choice 4: Once Costs and Benefits are Weighed, Assuming the Consumer Wishes to Provide for the Future Incapacitated Self, What to Include in the Long-Term Care Plan*

At Choice 4, assuming the consumer does not prefer informal, in-home care, and assuming the consumer wishes to provide for the future incapacitated self, then most middle- to upper-class consumers would probably plan to pay privately for long-term care, rather than rely on public assistance by spending down assets and exposing the principal residence to estate recovery. Since current federal and state laws provide immediate financial benefits that help offset the costs of long-term care insurance, the regulatory scheme in most states probably tips the balance toward purchasing such a policy.[196] Perhaps demonstrating this, authors of an attitudinal study of long-term care insurance buyers compiled responses and classified buyers as "planners,"[197] who are primarily concerned with financial well-being.

E. *Choice 5: Whether to Maintain the Initial Plan*

Although policy-makers have primarily focused on how to influence consumers when they make their initial set of decisions regarding long-term care, all forms of private planning also require some type of affirmative, ongoing action to maintain the choice until long-term care needs arise. For instance, to maintain a long-term care insurance policy, a consumer must agree to renew the insurance contract, pay premiums, and seek care in accordance with contract terms. As a result, policy-makers cannot ignore the crucial Choice 5: whether to maintain the initial plan in the face of ever changing emotional, behavioral, and pecuniary needs.

Most importantly, the preferences and time functions described above can surface and even resurface at any point. For instance, if a consumer reaches Choice 4 and makes the initial decision to purchase

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195 One risk associated with complete reliance on Medicaid is that the beneficiary may not be able to reside in a nursing home of his choice, since not every facility accepts all forms of public assistance. *See* CTRS. FOR MEDICAID & MEDICARE SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., GUIDE TO CHOOSING A NURSING HOME 36 (2002), *available at* http://www.feddesk.com/freehandbooks/1216-4.pdf.

196 *See supra* Part II.B.

197 CORONEL, *supra* note 59.

long-term care insurance based largely on tax and economic incentives, the consumer might not yet have confronted or factored in other motivations. Similarly, a consumer who ultimately arrived at Choice 4 in his mid-fifties will abandon the policy in his late-sixties if he unexpectedly rethinks Choice 2 and determines that in-home care would be superior to institutional care of any sort.

Furthermore, where tax and economic incentives are a primary motivation, consumers will be enticed to rethink their long-term care plan once they cross over into retirement. Fixed income retirees may no longer have sufficient income to pay premiums, and they may no longer benefit significantly from income tax incentives.[198] Yet ironically, the transition into retirement is a vulnerable point in person's life, when consumers are particularly susceptible to the emotional and behavioral motivations described above. For instance, as an age cohort crosses into retirement and no longer benefits appreciably from income tax incentives, and as the desire for in-home care and the fear of institutional care becomes more pervasive in that cohort,[199] then the immediate and future benefits of maintaining long-term care insurance will be outweighed by emotional interests. Correspondingly, as the consumer watches friends and loved ones become incapacitated, her ability to think in purely financial terms about planning will likely decline as her need for comfort and reassurance will rise. A consumer who begins to fear institutional care, or who desires to begin "living in the moment"[200] rather than fixating on her own possible incapacitation might find that her utility is maximized by canceling what may have grown to be a rather costly insurance policy.

V. DISCUSSION: TAX AND ECONOMIC POLICY IMPLICATIONS

Based on the foregoing model of the five choices faced by long-term care consumers, lawmakers can use tax and economic policies to influence consumer behavior at Choice 4. Choice 4 is the only level upon which most consumers approach the decision with sufficient def-

198 A survey of AARP members in New York found that younger age cohorts appear to value income tax incentives more than their older, retired peers. BRIDGES, *supra* note 76, at 2 ("Younger members and working members also say they would be more likely to buy a long-term care policy if the State offered larger tax credits for the amount of premiums paid (65 percent [ages fifty to sixty-four] vs. 40 percent [ages sixty-five and over]; 62 percent working vs. 46 percent not working).").

199 *See supra* Part I.C.1.i.

200 *See supra* text accompanying note 106.

erence to pecuniary concerns, since they do not appear to be driven by unique long-term care preferences and time functions. Yet most consumers who arrive at Choice 4 would probably be motivated to purchase long-term care insurance without considerable new incentives, since long-term care insurance is an attractive option under current Medicaid estate recovery laws and asset spend down requirements.[201] At best, tax and economic incentives may expedite consumer arrival at Choice 4, but only among those who process preferences and time functions in ways that would have enabled them to arrive at Choice 4 in due course.

However, it is unclear whether consumers who have already reached Choice 4 are immune to these other influences, or if they simply have not yet confronted them. It is quite plausible that those consumers who have reached Choice 4 were simply wearing the hat of a comprehensive financial planner, and have not yet given significant consideration to the broader reaches of this particular decision-making arena. Thus, even where tax and economic incentives have successfully motivated a consumer to progress through the first four choices and ultimately purchase a long-term care insurance policy, continuous revaluing and reweighing over time can cause the consumer to allow a long-term care insurance policy to lapse.[202] Once returned to the state of non-planning, the consumer is again prone to each of the behavioral motivations described above.[203] As the consumer progresses once more through the first four levels of long-term care consumer choice, several outcomes are possible: he may choose to avoid any reconsideration of future long-term care needs, he may develop a preference for in-home care, or he might choose to rely on Medicaid. Thus, despite a significant governmental expenditure to support alternative private payer sources,[204] there is simply no guarantee that federal and state governments will not be called upon to provide indemnification for consumers in the area of long-term care. The potential for intervening action, and particularly consumer-initiated lapses, is too great.

As these contingencies reveal, long-term care planning is an area where typical tax and economic incentives may not be a dependable solution. When consumer choice cannot be sufficiently modified to achieve the desired governmental outcome, a compulsory program may

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201 *See supra* Part II.

202 *See supra* Part IV.E.

203 *See supra* Part I.C.

204 *See* Ottens, *supra* note 114, at 749.

be necessary. While federal and state legislatures will ultimately need to develop the appropriate solution, various commentators have posited a variety of appealing options.[205] For instance, Medicaid can continue to provide a means-tested long-term care benefit, but a separate wage tax would support the expense.[206] Likewise, a mandatory savings plan can be implemented, whereby Americans redirect some portion of income into a tax-preferred investment account.[207]

As a further option, states can develop compulsory programs whereby all adults are required to pay an annual amount into a state-administered reserve fund.[208] Amounts owed could be collected through employer withholdings or by direct assessments on individuals. Individuals may be exempted from payment of the tax if they can show that their current asset and income levels enable them to *presently* qualify for Medicaid.[209] Medicaid would continue to operate in virtually the same manner, but state-level compulsory programs would pay out benefits for long-term care needs arising in persons over the age of sixty-five.[210]

To protect the financial health of these programs, they can be modeled after partnership programs.[211] For example, a state-level compulsory program could assume the costs of enrollees' first three years of long-term care, and Medicaid would assume the remainder of costs based on the preferential eligibility standard typically applied in partnership programs.[212]

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205 *See* sources cited *infra* notes 206 and 207.

206 *See, e.g.*, Kaplan, *supra* note 151, at 74-75 (recommending that the Medicare program assume payments for nursing home care, while all other forms of long-term care should be privately financed); Kazutoshi Miyazawa, Panos Moudoukoutas, & Tadashi Tagi, *Is Public Long-Term Care Insurance Necessary?*, 67 J. RISK & INS. 249 (2000) (recommending a universal, public insurance program for long-term care).

207 HEARING BEFORE THE S. SPECIAL COMMITTEE ON AGING, 106th Cong. (2000) (statement of Allan Kanner, Kanner & Associates, Tulane Law School) (recommending that Congress reform regulations governing privately held medical savings accounts so that these funds could be used to finance long-term care needs).

208 A plan of this sort was proposed in Hawaii. The Hawaii model was passed by the state legislature but ultimately vetoed by the governor. *See, e.g.*, Helen Altonn, *Coalition for Long-Term Care Disbands*, HONOLULU STAR-BULLETIN, Dec. 4, 2003.

209 In this manner, the program would render "Medicaid planning" very difficult, since individuals would be assessed based on present-day asset and incomes.

210 Since the incidence of long-term care needs among persons under the age of sixty-five is much lower, Medicaid could still be used to support this expense.

211 Partnership Programs are described *supra*, Part II.B.2.

212 *See supra* note 130.

A program of this sort would provide a number of benefits.[213] First, the compulsory nature would stimulate participants to make present-day sacrifices for the future incapacitated self, without requiring participants to progress through the first four choices. Thus, the program would overcome many of the behavioral tendencies noted above.[214] Second, since the risk would be spread over a much wider population and over a larger range of age cohorts versus private long-term care insurance policies, premiums could be significantly lower than those offered in the private market. Finally, to preserve informal, in-home care as a viable option for families, states could explore ways to support family care giving.

CONCLUSION

Policy-makers must reevaluate tax and economic initiatives that encourage private planning for long-term care. While these programs appear to have limited success with encouraging consumers to more rapidly reach Choice 4, these initiatives do not address the potential for adverse outcomes at all other levels of consumer choice. For example, tax and economic incentives have no bearing on those who prefer in-home care from loved ones and do not wish to jeopardize the likelihood of receiving such care by purchasing a private insurance policy; nor do they affect consumers who significantly underestimate their future need for long-term care. Similarly, current tax and economic incentives do not address the potential for lapses, particularly as consumers grow older and retire, and as long-term care planning increasingly becomes a proxy for emotional interests. If policy-makers have not anticipated the poten-

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213 Of course, not all observers agree that these programs are a good idea. Stephen Moses, of the Center on Long-Term Care Financing, explained that the Hawaii program's one year limitation on benefits would not sufficiently insulate the Medicaid budget from long-term care expenses. Furthermore, the program would impair the private insurance industry's growth "by reducing the public's sense of urgency regarding long-term care risk and cost," and "reward irresponsible health and lifestyle behaviors and punish healthy behaviors by charging all participants the same 'premium' regardless of the level of risk they bring into the risk pool." Interestingly, these critiques are based on a very different view of consumer choice in the long-term care insurance market. Moses appears to believe that consumers can and will make financial and health-related choices to advance the needs of the future, incapacitated self. *See* STEPHEN MOSES, GRASSROOT INSTITUTE OF HAWAII, IN PURSUIT OF . . . HAWAII'S CAREPLUS PROGRAM: REPORT ON HAWAII'S PROPOSED CAREPLUS MANDATORY LTC INSURANCE PROGRAM 1 (2002), *available at* http://www.grassrootinstitute.org/Publications/InPursuit/InPursuit200211.pdf.

214 *See supra* Part II.

tial for outcomes that are adverse to legislative intent, then the baby boomer generation has the sheer numbers to turn miscalculations into budgetary disaster.[215]

While legislation premised on consumer choice theory can produce outcomes that replicate a compulsory regime,[216] policy-makers must recognize that long-term care planning requires much more than an initial choice. Indeed, long-term care planning is actually comprised of a set of fluid and lifelong consumer choices, each of which is highly susceptible to behavioral tendencies. By studying these levels of consumer choice through a behavioral economics framework, policy-makers can enrich current policies and improve our system of long-term care financing. A rigorous and comprehensive review of the current legal milieu is necessary, since reliance on unsophisticated theoretical conceptions is a dangerous dance with fire. Even one failed prediction can become the final spark to the Medicaid powder keg.

215 *See Hearing on Baby Boom Generation*, *supra* note 35.

216 For examples, *see* Korobkin & Ulen, *supra* note 51, at 1123-24.