LEVERAGING FILIAL SUPPORT LAWS UNDER THE STATE PARTNERSHIP PROGRAMS TO ENCOURAGE LONG-TERM CARE INSURANCE

JAMIE P. HOPKINS,* THEODORE T. KURLOWICZ,** & CHRISTOPHER P. WOEHRLE***

TABLE OF CONTENTS

* Jamie Hopkins, Esquire is Assistant Professor of Tax at the American College and the Associate Director of the New York Life Center for Retirement Income. He received his B.A. in political science from Davidson College in 2007, his J.D. from Villanova University in 2010, and his M.B.A. from Villanova in 2011.

** Theodore T. Kurlowicz, Esquire is Professor of Tax at the American College and holds the Charles E. Drimal Professorship in Estate Planning. He received his B.S. from the University of Connecticut, M.A. from University of Pennsylvania, J.D. from Widener University School of Law, and LL.M. in Taxation from Villanova University.

*** Christopher P. Woehrle, Esquire is Assistant Professor of Tax at the American College and The Guardian/Deppe Chair in Pensions and Retirement Planning. He received his B.A. from Cornell University in 1979 and his J.D. (1982) and LL.M. in Taxation (1985) from Villanova University.

ABSTRACT

As thousands of the United States' baby-boomers retire each day, people live longer, families disperse, and the population ages. Financing long-term care needs has become an increasingly important focal point in both civilian and government budget discussions. In order to reduce reliance on government provided long-term care funding programs such as Medicaid, states can leverage the often unenforced filial responsibility laws and State Long-Term Care Partnership Programs. Through the enforcement of existing filial responsibility laws, states can provide the proverbial "stick" to incentivize people to purchase long-term care insurance by increasing their personal liability for their family members' long-term care expenditures. Furthermore, by offering liability protections from filial responsibility laws under the state's long-term care insurance partnership program, states will be able to offer a "carrot" to encourage participation in the long-term care insurance market. Ultimately, by leveraging these two existing legal structures, states can incentivize the purchase of long-term care insurance and reduce reliance on government provided long-term care financing programs.

I. INTRODUCTION

As thousands of the United States' baby-boomers retire each day, people live longer, families disperse, and the population ages. Financing long-term care needs has become an increasingly important focal point in both civilian and government budget discussions.[1] The increased demand and rising costs associated with long-term care place a tremendous amount of strain on existing long-term care funding sources.[2] Traditionally, there have been three main sources for financing long-term care expenditures: (1) government aid (i.e., Medicaid, and to a lesser extent, Medicare); (2) long-term care insurance; and (3) self-funding.[3] However, as both federal and state budgets become overwhelmed with long-term care financing, many have begun to question who should be responsible for paying long-term care expenditures and how long-term care should be funded.[4] Recently, through the proliferation of State Long-Term Care Insurance Partnership Programs,[5] enabled by the Deficit Reduction Act of 2005, and the passage of the Community Living Assistance Services and Supports Act (CLASS Act), the government has demonstrated a strong desire to shift long-term care costs away from publicly funded programs, such as Medicaid and Medicare, and instead place the financial responsibility of financing long-term care onto the long-term care recipient and his or her family.[6] Furthermore, both the State Partnership Programs and the CLASS Act were specifically designed to increase individual ownership of long-term care insurance as a way to pay for long-term care expenditures, thereby easing reliance on government financed long-term care programs.[7]

Even with existing state and federal provided incentives, such as favorable tax benefits, marketing campaigns to raise awareness of the need, and Medicaid asset protections, long-term care insurance ownership has remained extremely low; there are only eight million individually owned private long-

---

1. Mark Twigg, *The Future of Retirement: A new reality*, HSBC 5, 20 (2013), http://www.hsbc.bm/1/PA_ES_Content_Mgmt/content/bermuda/pdfs/future_of_retirement.pdf (discussing the impacts of increased lifespans and changing family dynamics on retirement).

2. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-05-564T, LONG-TERM CARE FINANCING: GROWING DEMAND AND COST OF SERVICES ARE STRAINING FEDERAL AND STATE BUDGETS 2-3 (2005) [hereinafter LONG-TERM CARE FINANCING], *available at* http://www.gao.gov/assets/120/111594.pdf (statement of Kathryn G. Allen, Director, Health Care—Medicaid and Private Health Insurance Issues).

3. *Id.* at 4 (breaking down long-term care costs by private and public sources).

4. *Id.* at 1 (stating that retiring baby boomers will nearly double the strain on public funding sources for long-term care such as Medicare, Medicaid, and Social Security by 2035).

5. For brevity purposes, this paper will often refer to the State Long-Term Care Insurance Partnership Programs as merely "State Partnership Programs."

6. *See* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 8002, 124 Stat. 119, 828 (codified at 42 U.S.C. § 300ll (Supp. V 2012)) (adding sections 3201 through 3210 to title 42 of the United States Code setting forth Title VIII of the Affordable Care Act, also known as the CLASS Act, which was signed into law by President Obama on March 23, 2010) (repealed by the American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 642, 126 Stat. 2313, 2358).

7. *Id.* (setting forth the CLASS Act as a voluntary long-term care insurance program).

term care insurance policies in the United States, representing a meager 2.5% of the United States. population and covering slightly less than 10% of those aged sixty-five and older.[8] Participation in the private long-term care insurance market is disappointingly low compared to other mature economies. For example, France has over 25% long-term care insurance coverage for those aged sixty-five and older.[9] Unfortunately, the repeal of the CLASS Act and limited success of the State Partnership Programs have left the government without a wealth of financially sound options for improving participation in the private long-term care insurance system.[10] However, the recent application of the relatively unknown filial support laws,[11] which can impose financial liability for unpaid long-term care debt onto the care recipient's family members, provides the government with a unique opportunity to leverage two existing systems, the filial support laws and State Long-Term Care Insurance Partnership Programs, in order to provide increased incentives to purchase long-term care insurance.

This article examines the need for long-term care and the current system in place for funding long-term care expenditures. It also delves into the issues plaguing the long-term care insurance industry and reviews the government's recent push to incentivize the purchase of long-term care insurance. More specifically, it describes some of the tax benefits available, the repealed CLASS Act, and the long-term care commission's potential role in overhauling long-term care financing. Next, the article reviews state long-term care insurance partnership programs, describing the model statute and the requirements that must be satisfied in order to benefit from the programs. The next section describes filial support laws and their potential impact on long-term care financing. Lastly, the article concludes by recommending how the government can ease reliance on Medicaid and Medicare by leveraging filial support laws and State Partnership Programs to increase private long-term care insurance participation.

---

8. AM. ASSOC. LONG-TERM CARE INS., THE 2012-2013 SOURCEBOOK FOR LONG-TERM CARE INSURANCE INFORMATION 40-41 (2012) [hereafter AM. ASSOC. LONG-TERM CARE INS.] (listing the total amount of outstanding individual long-term care insurance policies at roughly 8 million in 2012). *See also* Howard Gleckman, *Long-Term Care Financing Reform: Lessons from the U.S. and Abroad*, THE COMMONWEALTH FUND 3 (Feb. 2010), http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Feb/1368_Gleckman_longterm_care_financing_reform_lessons_US_abroad.pdf (setting forth long-term care insurance coverage by country).

9. *See* Gleckman, *supra* note 8, at 3, 5, 15 (noting the high rate of long-term care insurance coverage in France).

10. *See* AM. ASSOC. LONG-TERM CARE INS., *supra* note 8, at 38 (publishing the results of a study by America's Health Insurance Plans on "Who Buys Long-Term Care Insurance," which surveyed the main reasons for buying long-term care insurance, finding that only 1% of long-term care purchases stated they purchased insurance because of a State Partnership Program).

11. *E.g.*, 23 PA. CONS. STAT. ANN. § 4603 (West 2010) (setting forth Pennsylvania's filial support obligations under the subheading "Relatives' liability").

II. THE LONG-TERM CARE "CRISIS"

A. Defining Long-Term Care

In order to understand the problems associated with funding long-term care expenses, long-term care must be clearly defined. Long-term care is distinct from other types of health care services designed to "prevent, diagnose, treat, or cure a medical disease or condition."[12] Instead, long-term care is any service that assists an individual with the execution of activities of daily living, often for an expected time period of more than ninety days.[13] Activities of daily living (ADLs) are defined as: (1) eating; (2) toileting; (3) transferring; (4) bathing; (5) dressing; and (6) continence.[14] Assistance with ADLs can vary from mere verbal reminders, to full physical assistance with some or all physical movements.[15] Long-term care services may also come in the form of assistance with instrumental activities of daily living (IADLs).[16]

While long-term care is provided in a wide range of settings and through a variety of services, including home care, adult day care centers, nursing homes, and assisted living facilities,[17] the majority of long-term care is provided by family members.[18] For example, family members provide roughly 70% of all long-term care services, mostly provided in the form of informal and unpaid care in the care recipient's home.[19] Additionally, nearly 78% of people who need long-term care reside at home, but more than two million people still need long-term care in an institutional setting each year.[20] Most people who

---

12. 42 U.S.C. § 3002(34)(C) (2006) (describing the differences between long-term care and other types of care services); *see also* Gunson v. James, 364 F. Supp. 2d 455, 458 (D.N.J. 2005) ("Long term care is not health insurance, nor is it acute care. Long term care is chronic care that an individual may need for the rest of his or her entire life. Health insurance may cover some of the skilled medical services an individual may need when unable to care for himself after an illness or injury. However, such coverage is usually for a limited period and only as long as the individual shows medical improvement. Health insurance plans typically do not cover ongoing chronic care such as extended stay in an assisted living facility or a continuing need for a home health aide to help the individual in day to day living tasks.").

13. 42 U.S.C. § 3002(34) (defining long-term care services).

14. 26 U.S.C. § 7702B(c)(2)(B) (2006) (describing and defining activities of daily living for purposes of long-term care).

15. 42 U.S.C. § 3002(9) (defining the term "at risk for institutional placement").

16. 29 C.F.R. § 825.122(d)(1) (2013) (describing activities of daily living).

17. *The Next Step: A Kiplinger Workbook to Help You Plan Ahead for Long-Term Care*, KIPLINGER'S PERSONAL FIN. 1 (2009), http://www.johnhancockltc.com/individual/ltc-document-kiplingers-ltc-planning-booklet.aspx (noting the variety of long-term care settings and services available).

18. *Id.* (stating the majority of long-term care is provided by family members in the form of unpaid services in the care recipient's home).

19. *See* Lee Thompson, *Long-term Care: Support for Family Caregivers*, GEORGETOWN UNIV. LONG-TERM CARE FIN. PROJECT 3 (Mar. 2004), http://ltc.georgetown.edu/pdfs/caregivers.pdf (articulating the impact of family caregivers on long-term care services) (account required) (on file with Widener Law Review).

20. Christine Benz, *40 Must-Know Statistics About Long-Term Care*, MORNINGSTAR (Aug. 9, 2012, 6:00 AM), http://news.morningstar.com/articlenet/article.aspx?id=564139; *The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation: Report to Congress*,

enter a nursing home or similar long-term care facility will spend the remainder of their life in that institution. Almost 65% of people die within the first year of admission to a nursing home.[21] However, the length of stay varies significantly, as the average stay in a nursing home is 835 days[22] and nearly 10% of those admitted will spend five or more years in the nursing home.[23] Additionally, changing family dynamics, increased longevity, and rising health care costs are impacting the way people fund and receive long-term care.[24]

B. Who Needs Long-Term Care?

Predicting one's long-term care needs with any certainty is muddled by an array of unpredictable risks, such as how much care will be required, when the care will be needed, where the care will take place, and how long care will be provided. While all of these risks are difficult to predict on an individual level, most people will need long-term care at some point, with the majority of long-term care coming after age sixty-five and lasting for an average of 1,040 days.[25] Roughly 70% of those who reach age sixty-five will need long-term care, and nearly 50% of the general population will need long-term care.[26] Nine million people age sixty-five and older needed long-term care in 2012, a number that is expected to reach twelve million by 2020.[27] In 2005, there were thirty-seven million Americans age sixty-five or older, and by 2050, it is projected there will be roughly eighty-one million Americans age sixty-five or older.[28]

The need for long-term care, along with its duration and cost, are influenced by a variety of factors. For example, women need significantly longer care on average than men—3.7 years versus 2.2 years, respectively.[29] Chronic illnesses such as diabetes or a permanent disability also increase the

---

U.S. DEP'T OF HEALTH & HUMAN SERVS. 5-6 (May 14, 2003), http://aspe.hhs.gov/daltcp/reports/ltcwork.pdf (discussing where the majority of people reside when receiving long-term care services).

21. Benz, *supra* note 20.

22. *See* AM. ASSOC. LONG-TERM CARE INS., *supra* note 8, at 20 (citing U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CDC REPORT (PHS) 2009-1738 (2009)) (articulating the average stay in a nursing home).

23. *See* Benz, *supra* note 20.

24. Sandra R. Levitsky, *"What Rights?" The Construction of Political Claims to American Health Care Entitlements*, 42 LAW & SOC'Y REV. 551, 554 (2008).

25. *See Long-Term Care Insurance Facts—Statistics*, AM. ASSOC. FOR LONG-TERM CARE INS. (2013), http://www.aaltci.org/long-term-care-insurance/learning-center/fast-facts.php (noting the average length of long-term care services based on 2011 data).

26. *Medicare & You*, U.S. DEP'T OF HEALTH & HUMAN SERVS. 127 (2014), http://www.medicare.gov/pubs/pdf/10050.pdf (detailing how many people will need long-term care and at what ages long-term care is more likely); *Compare Cost of Care Across the United States*, GENWORTH FIN. (Oct. 31, 2013), https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html (listing the cost of long-term care by state and the likelihood of needing long-term care).

27. Benz, *supra* note 20.

28. *Id.*

29. *How Much Care Will You Need?*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://longtermcare.gov/the-basics/how-much-care-will-you-need/ (last visited Mar. 24, 2014).

likelihood of needing long-term care.[30] Alzheimer's disease is the leading cause for long-term care,[31] and the likelihood of being impacted by Alzheimer's increases with age. For example, Alzheimer's disease impacts one in eight people over age sixty-five, but half of people over age eighty-five.[32] Further, the United States Census Bureau predicts the number of those aged eighty-five or older will more than triple in size from 2010 to 2060, from 5.9 million to 18.2 million.[33] Consequently, the total number of people needing long-term care due to Alzheimer's will drastically increase as the baby boomers age, enhancing strains on long-term care services. As such, the need for long-term care is expected to significantly increase in the coming years, exacerbating the financial burden of funding long-term care expenditures.

C. The Financial Burden of Long-Term Care

The financial burden of long-term care is being amplified by an ageing United States population. In 2003, the total public and private long-term care expenditures totaled $183 billion, or roughly 13% of all health care expenditures.[34] By 2011, however, long-term care expenditures reached nearly $210.9 billion, growing by almost twenty billion dollars in eight years.[35] Furthermore, national long-term care expenditures are expected to continue to multiply, reaching $379 billion by 2050.[36]

Long-term care costs vary significantly by the length of time in which care is provided and by the type of care facility. The costs associated with private nursing home care, non-skilled home care, and adult daycare centers are remarkably different, but all have experienced recent cost increases. "For example, in 2008 the median annual rate for a private nursing home room was $67,525, compared with the 2013 median annual rate of $83,950[,] . . . represent[ing] a 4.45 percent compound annual growth rate over that

30. *Who Needs Care?*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://longtermcare.gov/the-basics/who-needs-care/ (last visited Mar. 15, 2014).

31. *See* AM. ASSOC. LONG-TERM CARE INS., *supra* note 8, at 36 (listing the primary reasons for needing long-term care).

32. *Issue Paper: Alzheimer's Disease*, N.M. AGING & LONG-TERM SERVS. DEP'T 1 http://www.nmaging.state.nm.us/uploads/FileLinks/93d89f60b10b4732be44e6c31f403060/Policy_Advisory_Committee_Issues_Paper_on_Alzheimer%E2%80%99s_Disease.pdf (last visited Mar. 24, 2014).

33. *U.S. Census Bureau Projections Show a Slower Growing, Older, More Diverse Nation a Half Century from Now*, U.S. CENSUS BUREAU (Dec. 12, 2012), https://www.census.gov/newsroom/releases/archives/population/cb12-243.html ("According to the projections, the population age 65 and older is expected to more than double between 2012 and 2060, from 43.1 million to 92.0 million. The older population would represent just over one in five U.S. residents by the end of the period, up from one in seven today. The increase in the number of the 'oldest old' would be even more dramatic—those 85 and older are projected to more than triple from 5.9 million to 18.2 million, reaching 4.3 percent of the total population.").

34. LONG-TERM CARE FINANCING, *supra* note 2, at 4.

35. *The Basics: National Spending for Long-Term Services and Supports (LTSS), 2011*, NAT'L HEALTH POL'Y FORUM 1 (Feb. 1, 2013) https://www.nhpf.org/uploads/announcements/Basics_LTSS_02-01-13.pdf.

36. LONG-TERM CARE FINANCING, *supra* note 2, at 13.

period."[37] However, non-skilled home care has remained relatively flat from 2008 until 2013, representing only 1% compound annual growth rate over this period.[38] Further, adult day health care services increased 6.56% from 2012 to 2013,[39] while nursing home and assisted living care costs experienced slightly more than 4% compound annual growth rates since 2008.[40] Despite the differences in care facilities and the fact that an individual's long-term care costs will depend in part on the type and length of care, all long-term care remains incredibly expensive.

D. Financing Long-Term Care Expenditures

The financial burden of funding long-term care expenses is attributable to a combination of private and public sources which vary based on the patient's individual circumstances. There is a combination of private payment and government funded long-term care options available. However, the current strategy for funding the costs of long-term care expenses has resulted in disparate treatment of families and an unsustainable burden on both state and federal government budgets.

1. Long-Term Care Coverage Under Medicare

A common misconception for those individuals lacking significant experience with how to finance long-term care expenses is that Medicare provides significant coverage for nursing homes and other long-term care facilities. Medicare coverage for long-term care expenses is, in fact, quite limited. Under specified conditions, for example, Medicare will provide for the cost of a skilled nursing facility if the patient needs skilled nursing or skilled rehabilitation services and not merely custodial care.[41] Admission to the skilled care facility must occur within thirty days of discharge from a covered hospital stay of at least three days.[42] The first twenty days of care are provided without cost to the patient, and the next eighty days are provided to the patient with a co-payment.[43] Further, this coverage is not necessarily

37. *Genworth 2013 Cost of Care Survey*, GENWORTH FIN. 5 (10th ed. Mar. 22, 2013), https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032213_Cost%20of%20Care_Final_nonsecure.pdf (setting forth annual growth rates of long-term care services).

38. *Id.* at 5. (noting the price only rose fifty cents per hour over this timeframe from $18.50 to $19.00).

39. *Id.* at 4.

40. *Id.*

41. *See* 42 C.F.R. § 409.32(a) (2012) (defining "a skilled service" as a "service . . . so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel[ ]").

42. *Id.* at § 409.30(a)-(b).

43. *Your Medicare Coverage: Skilled nursing facility (SNF) care*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.medicare.gov/coverage/skilled-nursing-facility-care.html#1423 (last visited Mar. 15, 2013) (explaining the co-pay for days 21 through 100 was $148 per day in 2013).

guaranteed for the full-time period. Medicare coverage will be eliminated if the long-term care patient no longer needs skilled nursing care or has plateaued with respect to his or her rehabilitation services and is no longer improving.[44] The bottom line is that Medicare coverage is not the long-term solution for funding long-term care services.

Additionally, Medicare does provide some limited home-care benefits. These services are contingent on the care recipient needing the services, and most services must begin to occur within thirty days immediately following a Medicare covered hospitalization for a minimum of three days.[45] Such care can be provided even if the beneficiary is not entirely homebound.[46] Although the home health services are limited under Medicare, coverage is worth investigating because, in some states, these expenses will not be covered under Medicaid and it can provide at least some financial relief for funding long-term care services.[47]

2. Long-Term Care Coverage Under Medicaid

Medicare and Medicaid represent nearly 69% of all long-term care funding.[48] Because of the limitations discussed above, Medicaid is the primary source of long-term care funding, with roughly one-third of its total budget—approximately $129.3 billion in 2010—expended ongoing to long-term care.[49]

---

44. *See Medicare Benefit Policy Manual*, CTRS. FOR MEDICARE & MEDICAID SERVS., § 110.2(3), at 28, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf. Medicare coverage for rehabilitation services in the facility is routinely terminated under the determination that the patient is no longer improving; however, improvement is not necessarily required by the statute or regulations. In fact, it is possible to receive continued rehabilitation if the treatment is preventing the patient's condition from worsening. C.F.R. § 409.32(c).

45. 42 C.F.R. § 409.30(a). Under the Social Security Act, "[t]he term 'home health services' means . . . services furnished to an individual, who is under the care of a physician, by a home health agency or by others . . . and periodically reviewed by a physician, which items and services are . . . provided on a visiting basis in a place of residence used as such individual's home—(1) part-time or intermittent nursing care . . . ; (2) physical or occupational therapy . . . ; (3) medical social services under the direction of a physician; (4) . . . part-time or intermittent services of a home health aide . . . ." 42 U.S.C. § 1395x(m) (2006).

46. *Medicare Home Health Agency Manual*, CTRS. FOR MEDICARE & MEDICAID SERVS. § 204.1.A, at 14 (Dec. 17, 2001), http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R298HHA.pdf (stating beneficiary is allowed to have absences from the home primarily for healthcare purposes but also for limited special occasions).

47. *See Your Guide to Choosing a Nursing Home or Other Long-Term Care*, CTRS. FOR MEDICARE & MEDICAID SERVS. 11-12 (Dec. 2013), http://www.medicare.gov/pubs/pdf/02174.pdf.

48. LONG-TERM CARE FINANCING, *supra* note 2, at 4 ("About 69 percent of expenditures for long-term care services were paid for by public programs, primarily Medicaid and Medicare.").

49. *Who Pays for Long-Term Care in the U.S.? (Updated)*, THE SCAN FOUND. 2 (Jan. 2013), http://www.thescanfoundation.org/sites/thescanfoundation.org/files/who_pays_for_ltc_us_jan_2013_fs.pdf.

Furthermore, Medicaid is roughly 23.6% of all state budgets.[50] In 2005, the United States Government Accountability Office stated that "[w]ithout fundamental financing changes, Medicaid . . . can be expected to remain one of the largest funding sources, straining both federal and state governments."[51] As such, the impact of long-term care financing through Medicaid on state budgets cannot be overstated.

Although Medicaid coverage for long-term care facilities and other related long-term care expenses is extensive, this public option requires the recipient to qualify under both categorical[52] and means-based testing.[53] For most individuals, long-term care eligibility under Medicaid requires impoverishment under rules provided by both the federal and individual state statutes. However, the means-based qualification testing will vary depending on whether the applicant is an unmarried individual[54] or married with a "community spouse."[55] When qualifying under the means-based test, potential Medicaid beneficiaries often have to spend down their assets to meet the maximum allowable asset limit for Medicaid eligibility.[56] In addition, any of the individual or couple's assets that were not expended on long-term care services are subject to estate recovery to reimburse the State's Department of

---

50. NAT'L GOVERNORS ASS'N & NAT'L ASS'N OF STATE BUDGET OFFICERS, THE FISCAL SURVEY OF STATES 1, 28 (2011), *available at* http://www.nasbo.org/sites/default/files/2011%20Fall%20Fiscal%20Survey%20of%20States.pdf.

51. LONG-TERM CARE FINANCING, *supra* note 2, at 3.

52. 20 C.F.R. § 416.1100 (2012); *id.* at § 404.1512 (categorically requiring individuals to be aged, blind or disabled).

53. *Fact Sheet: 2013 Social Security Changes*, U.S. SOCIAL SECURITY ADMIN., http://www.socialsecurity.gov/pressoffice/factsheets/colafacts2013.htm (last visited Mar. 15, 2014). Technically, the rules for Medicaid eligibility first require the ability to qualify under Supplemental Security Income (SSI). 20 C.F.R. § 416.1100. In many states, qualification for one dollar of SSI benefits is a ticket into Medicaid eligibility. There are two components to the eligibility test based on financial status. First, the applicant cannot have more than a threshold level of income, which was $710/month in 2013. *Fact Sheet: 2013 Social Security Changes*, *supra*. Not all of the Medicaid applicant's income will be counted for the purposes of this threshold. *Id.* For a more thorough description of the income test, see *Understanding Supplemental Security Income SSI Income -- 2013 Edition*, U.S. SOCIAL SECURITY ADMIN. (2013), http://www.socialsecurity.gov/ssi/text-income-ussi.htm (last visited Mar. 15, 2014). In addition, there are resource limitations for the purposes of SSI and Medicaid qualification. *Id.* The income tests are applied first. *Id.* The basic resource allowance is $2000 for an individual and $3000 for a married couple. *Fact Sheet: 2013 Social Security Changes*, *supra*. The resource limitations contain many exceptions for resources that are not treated as countable assets for this purpose. *Understanding Supplemental Security Income SSI Income -- 2013 Edition*, *supra*.

54. The 2013 Minimum Monthly Maintenance Needs Allowance (MMMNA) provides a minimum of $1,891 and up to a maximum of $2,898. *2013 Elder Law Numbers*, ROTHKOFF LAW GROUP (Dec. 9, 2012), http://rothkofflaw.com/2013-elder-law-numbers/.

55. The 2013 Community Spouse Resource Allowance (CSRA) ranges from a minimum of $23,184 to a maximum of $115,920. *Pennsylvania Medicaid Numbers and Elder Law Statistics*, GERHARD & GERHARD, http://paelderlaw.net/library/Pennsylvania_Medicaid_Numbers.asp (last updated Aug. 12, 2013).

56. *See* Keith Lyman, *Safe Ways to Spend Down Your Assets to Qualify for Medicaid*, NOLO, http://www.nolo.com/legal-encyclopedia/safe-ways-spend-down-your-assets-qualify-medicaid.html (last visited Mar. 15, 2014).

Welfare for expenses provided by Medicaid.[57] This means the State can collect assets from the deceased Medicaid beneficiary's estate to reimburse the State for any Medicaid money spent to pay for the individual's long-term care expenses. However, as discussed later, some assets might be exempt from State recovery.[58]

Although long-term care expenses are reimbursed under Medicaid, this public option requires the impoverishment of an individual or a married couple when one or both of the spouses will receive benefits from Medicaid. In addition, as we have discussed above, the public option of Medicaid has placed the states and federal government in an untenable position to continue to provide such benefits.[59]

3. Private Funding for Long-Term Care Expenses

Even though Medicaid provides the majority of public funding for long-term care expenditures, family members provide the majority of long-term care through informal channels, which makes measuring the full economic value of this care difficult.[60] However, it is estimated that the annual cost of replacing this informal family care is between $45 and $94 billion.[61] While this paints a partial picture regarding the cost of family provided long-term care services, there is a deeper cost: the health and well-being of the family caregiver.[62] Half of all family long-term caregivers have full-time employment.[63] On average, they provide nineteen hours of care a week in addition to their full-time jobs.[64] This care-giving takes an emotional and physical toll on the family caregiver, as 69% of people report that providing long-term care services for family members negatively impacted their own health.[65] Providing long-term care can also negatively impact the caregiver's employment due to decreased hours, early retirement, giving up work

57. *See, e.g.*, 55 PA. CODE § 258.3 (2002).

58. *See infra* pp. 182-83.

59. *See supra* notes 48-51 and accompanying text.

60. *See* KIRSTEN J. COLELLO, CONG. RESEARCH SERV., RL34123, FAMILY CAREGIVING TO THE OLDER POPULATION: BACKGROUND, FEDERAL PROGRAMS, AND ISSUES FOR CONGRESS 14 (2007) (discussing the issues with determining exact numbers of family caregivers or good estimates as to the economic impact).

61. Colello, *supra* note 60, at 17 ("Annual cost of replacing informal caregiving with paid home care at $45 billion to $94 billion. Imputed value of informal caregiving at $168 billion (18.7 billion hours of caregiving at $9 per hour).").

62. *Caregiving in the U.S*, NAT'L ALLIANCE FOR CAREGIVING 18-19 (2005), http://assets.aarp.org/rgcenter/il/us_caregiving_1.pdf.

63. *Caregiving in the U.S.: A Focused Look at Those Caring for the 50+*, NAT'L ALLIANCE FOR CAREGIVING 57 (2009), http://assets.aarp.org/rgcenter/il/caregiving_09.pdf.

64. *Id.* at 26 (setting forth the average number of long-term care service hours provided by middle-aged family caregivers).

65. *Evercare Study of Caregivers in Decline: A Close-up Look at the Health Risks of Caring for a Loved One*, EVERCARE & NAT'L ALLIANCE FOR CAREGIVING 11 (Sept. 2006), www.caregiving.org/data/Caregivers%20in%20Decline%20Study-FINAL-lowres.pdf (reporting 15% of caregivers say their health has declined "a lot" because of the care and 44% say it has become "moderately worse").

completely, lost wages, lost benefits, lower savings, and decreased job performance.[66] Family members shoulder a serious amount of the long-term care burdens, and while not always a large financial burden, providing long-term care can lead to significant physical and emotional challenges.

In addition to government funding and informal family care expenditures, out-of-pocket funding plays a crucial role in long-term care. Out-of-pocket expenditures for long-term care were estimated to be roughly $64 billion in 2006.[67] Furthermore, out-of-pocket expenditures typically represent between 20% and 28% of the total annual funding for long-term care.[68] While self-funding plays an important role, the majority of people do not set funds aside specifically earmarked to pay for long-term care expenditures. Only 8% of people age forty to fifty-four have done any planning for long-term care.[69] Additionally, 60% of people expect family members to step up and provide some care, even though they never have these conversations with family members.[70] However, available out-of-pocket financing for long-term care expenditures is going to be limited as the United States faces a retirement savings shortfall of up to $14 trillion over the next forty years.[71]

4. Long-Term Care Insurance

The fourth long-term care financing option is long-term care insurance. While long-term care insurance seems like the natural fit for funding long-term care expenditures, participation in the private long-term care insurance system has been limited. Currently, there are roughly eight million outstanding long-term care insurance policies,[72] which pay for only 7% of all long-term care expenditures a year,[73] totaling $14.9 billion in paid claims a year.[74] More

---

66. *See Fact Sheet: Selected Caregiver Statistics*, FAMILY CAREGIVER ALLIANCE (Nov. 2012), http://caregiver.org/selected-caregiver-statistics ("70% of working caregivers suffer work-related difficulties due to their dual caregiving roles.").

67. *Long-Term Care --- an Essential Element of Healthcare Reform*, THE SCAN FOUND. 18 (Dec. 2008), http://thescanfoundation.org/sites/thescanfoundation.org/files/ChartBook_121808_2.pdf.

68. *See id.*

69. Jennifer Agiesta & Lauran Neergaard, *Americans in denial about long-term care*, NBC NEWS (Apr. 24, 2013), http://vitals.nbcnews.com/_news/2013/04/24/17895542-americans-in-denial-about-long-term-care.

70. Agiesta & Neergaard, *supra* note 69.

71. *See* Nari Rhee, *The Retirement Savings Crisis: Is It Worse Than We Think?*, NAT'L INST. ON RET. SEC. 1 (June 2013), http://www.nirsonline.org/storage/nirs/documents/Retirement%20Savings%20Crisis/retirementsavingscrisis_final.pdf ("The collective retirement savings gap among working households age 25-64 ranges from $6.8 to $14 trillion, depending on the financial measure.").

72. *See* AM. ASSOC. LONG-TERM CARE INS., *supra* note 8, at 40-41.

73. *Long-Term Care --- an Essential Element of Healthcare Reform*, *supra* note 67, at 18.

74. *National Spending for Long-Term Care*, GEORGETOWN UNIV. LONG-TERM CARE FIN. PROJECT (Feb. 2007), http://ltc.georgetown.edu/pdfs/natspendfeb07.pdf (account required) (on file with Widener Law Review); *see also* AM. ASSOC. LONG-TERM CARE INS., *supra* note 8, at 25 (stating the total number of long-term care insurance claims paid a year).

disconcerting is that only 8% of people age forty-five and older have a long-term care insurance policy.[75]

In addition to low participation rates, long-term care insurance has recently suffered through drastic premium hikes, raising concerns about affordability.[76] More importantly, the price of premiums is cited as the number one reason people do not buy long-term care insurance.[77] People simply do not see the financial gain in paying between $2,200 and $3,200 a year for long-term care insurance.[78] As such, the long-term care insurance market has been criticized "for being unaffordable, inaccessible to people with diagnosed chronic diseases, and unreliable in delivering benefits to those who had actually obtained policies."[79] Many people also view "long-term care insurance as an ineffective tool for addressing the kinds of care crises that they routinely confront[ ]."[80]

Many people rely on government programs and out-of-pocket expenditures to fund their long-term care expenditures instead of purchasing long-term care insurance.[81] This planning, or lack of planning, is leaving the majority of people unprepared to pay for long-term care expenditures in retirement.[82] Furthermore, with possible reductions to government benefits looming, "a diminish[ed] pool of private resources could worsen the long-standing funding gap between long-term care need and available financing."[83] Ensuring proper funding of long-term care expenses is crucial to ensuring the United States' elderly receive the care they need.

III. GOVERNMENT FOCUS ON RELIEVING LONG-TERM CARE FINANCING STRAIN

As the United States government attempts to balance its budget and free itself of unwanted liabilities, management of its expenditures on long-term care must be part of the discussion. As previously mentioned, long-term care

75. Agiesta & Neergaard, *supra* note 69.

76. *See* Ari Houser, *A New Way of Looking at Private Pay Affordability of Long-Term Services and Supports*, AARP PUB. POLICY INST. 5 (Oct. 2012), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/private-pay-affordability-ltss-insight-AARP-ppi-ltc.pdf.

77. *Id.* at 5.

78. AM. ASSOC. LONG-TERM CARE INS., *supra* note 8, at 32.

79. Levitsky, *supra* note 24, at 574-75.

80. *Id.* at 575.

81. *Long-Term Care --- an Essential Element of Healthcare Reform*, *supra* note 67, at 18 (stating out-of-pocket funding and government programs cover the majority of long-term care expenditures).

82. *See Long-Term-Care Insurance Industry Snapshot*, SOC'Y OF ACTUARIES 17 (2005), http://www.soa.org/library/proceedings/record-of-the-society-of-actuaries/2000-09/2005/june/rsa05v31n216pd.aspx.

83. *Filling in the Long-Term Care Gaps*, KAISER COMM'N ON MEDICAID & THE UNINSURED 7 (June 3, 2009), http://www.aging.senate.gov/events/hr210dr.pdf (testimony of Diane Rowland, Executive Vice President, Henry J. Kaiser Family Foundation before the United States Senate Special Committee on Aging) (stating a variety of financial issues are creating a serious long-term care funding problem).

funding represents a significant portion of Medicaid's budget.[84] Furthermore, the government has had open congressional conversations regarding its desire to reform the way long-term care is funded, including easing the burden placed on public programs. The government has supported a variety of initiatives aimed at relaxing the costs shouldered by public long-term care funding programs, namely by encouraging individuals to purchase long-term care insurance. Since 2000, the federal government has rolled out a long-term care insurance program for federal employees, created a federal long-term care commission, passed the CLASS Act, and dramatically expanded the availability of the Long-Term Care Insurance State Partnership Program.

A. Federal Long-Term Care Insurance Program

In 2000, the Long-Term Care Security Act (LTCSA) was passed by Congress.[85] It was enacted to secure the availability of long-term care insurance for federal employees[86] and, by doing so, create "affordable options for dealing with the catastrophic expenses of nursing home care, home care, assisted living, and other forms of long-term care services."[87] As such, the Office of Personnel Management (OPM) was granted the authority to establish a partnership with insurance companies in order to create a program through which federal employees could obtain long-term care insurance.[88]

The OPM entered into contracts, referred to as Master Contracts, with qualified insurance carriers[89] and established the Federal Long-Term Care Insurance Program (FLTCIP).[90] The federal government does not fund long-term care insurance for federal employees under the FLTCIP, as each federal employee is required to pay 100% of his or her long-term care insurance.[91] Furthermore, nothing in the LTCSA requires universal coverage or guaranteed availability of long-term care insurance under the program.[92] The LTCSA "establishes minimal underwriting standards for master contracts, and delegates the establishment of further underwriting requirements to the

---

84. *See supra* notes 48-50 and accompanying text.

85. Long-Term Care Security Act, Pub. L. No. 106-265, 114 Stat. 762 (2000) (codified at 5 U.S.C. §§ 9001-9009).

86. Metro. Life Ins. Co. v. Conger, 474 F.3d 258, 260 (6th Cir. 2007) (describing the LTCSA).

87. Gunson v. James, 364 F. Supp. 2d 455, 458 (D.N.J. 2005) (citation omitted).

88. 5 U.S.C. §§ 9002(a), 9003(a) (2012).

89. *Id.* at § 9003(a)-(b) (requiring a competitive bidding process to become a qualified insurance carrier for purposes of the FLTCIP).

90. *Gunson*, 364 F. Supp. 2d at 458-59.

91. *Id.* at 458 (noting each participant must pay all of his or her premiums); *see also* 5 U.S.C. § 9004(a) (setting forth the requirements of the program).

92. 5 U.S.C. § 9002(e)(3) ("Nothing in this chapter shall be considered to require that long-term care insurance coverage be guaranteed to an eligible individual."); *Gunson*, 364 F. Supp. 2d at 458 (suggesting Congress avoided guaranteed long-term care insurance coverage because "the costs of issuing polices on a guaranteed basis [would] increase premiums substantially for all enrollees." (citation omitted)).

qualified carriers and OPM."[93] The LTCSA requires "each master contract contain the following: (a) a detailed statement of the benefits offered, including any maximums, limitations, exclusions, and other definition of benefits; (b) the premiums charged; (c) the terms of the enrollment period; and (d) such other terms and conditions agreed to by OPM and the carrier."[94] When a federal employee applies for long-term care insurance coverage, the carrier "has discretion to accept or reject the application in accordance with the terms of the master contract."[95] As such, it is the qualified insurance carrier that determines which employees are eligible for long-term care insurance.[96] The insurance carrier's determination, however, is in part driven by the OPM provided guidelines.[97] The program became available in 2001, and by 2011, the FLTCIP reached over 270,000 enrollees, making it the largest employer sponsored group long-term care insurance program in the country.[98]

B. The CLASS Act: Increased Long-Term Care Insurance Participation?

The passage of the LTCSA allowed hundreds of thousands of federal employees to apply for and obtain affordable long-term care insurance policies. However, to further increase the availability of long-term care insurance coverage and alleviate the financial stress placed on government funded long-term care programs by spreading long-term care costs across a variety of sources,[99] the federal government passed the Community Living Assistant Services and Supports Act (CLASS Act) as part of the health care reform bill in 2010.[100] The CLASS Act was designed to be "a national, voluntary insurance program that offer[ed] working individuals some protection against the cost of paying for long-term services and supports."[101] As such, the program was expected to save the government billions of dollars

---

93. *Gunson*, 364 F. Supp. 2d at 458 (citing 5 U.S.C. § 9002(e)).

94. *Id.* (citing 5 U.S.C. § 9003(b)).

95. Rouse v. Berry, 848 F. Supp. 2d 4, 6 (D.D.C. 2012) (citing 5 U.S.C. § 9003(c); *id.* at § 875.407).

96. *Gunson*, 364 F. Supp. 2d at 458 (citing 5 U.S.C. § 9002(e)).

97. *Id.*

98. *OPM Announces Federal Long Term Care Insurance Program Open Season Results*, OMP.GOV (Sept. 22, 2011), http://www.opm.gov/news/releases/2011/09/opm-announces-federal-long-term-care-insurance-program-open-season-results/ (stating the 2011 open season saw an increase in 45,000 new members, a 20% increase).

99. Donna N. Miller, *The Effect of Medicaid Reform and Expansion on the Future of Long-Term Service and Supports in Illinois*, 22 ANNALS HEALTH L. ADVANCE DIRECTIVE, Fall 2012, at 130, 138 ("This innovative program illustrated an attempt to spread the responsibility of paying for long-term care between multiple payers, instead of relying primarily on Medicaid, and could have created an option for adults to plan for their long-term care needs.").

100. Jeffrey R. Brown & Amy Finkelstein, *Insuring Long-Term Care in the United States*, J. ECON. PERSP., Fall 2011, at 119, 136 (discussing the impact of the CLASS Act).

101. *Health Care Reform and the CLASS Act*, THE HENRY J. KAISER FAMILY FOUND. 2 (Apr. 2010), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8069.pdf (providing an overview of the CLASS Act).

by reducing reliance on government funded long-term care programs.[102] However, the CLASS Act was only expected to be a partial solution as it was forecasted to have minimal participation when compared to the entire population; the Congressional Budget Office predicted "only 4 percent of the adult population would have enrolled in the CLASS Act program by 2019."[103]

Before its implementation, the CLASS Act was required to be deemed actuarially sound for a seventy-five year period.[104] In 2011, it was determined that the program could not meet its statutory requirements of solvency, delaying its implementation.[105] Furthermore, in 2013, as part of the fiscal cliff deal, the CLASS Act was officially repealed.[106] Thus, all of the CLASS Act program's details were never fully developed.[107] However, the program was going to allow individuals to purchase long-term care insurance directly from the federal government through payroll deductions.[108] Additionally, there was going to be a minimum benefit amount and a required participation period before benefits would be payable.[109] However, with the demise of the CLASS Act, the government will need to explore other avenues to reduce reliance on Medicaid by increasing long-term care coverage to Americans through other sources.[110]

C. The Long-Term Care Commission

While the CLASS Act was repealed in 2013, the government did not abandon all notions of long-term care reform. Rather, the government wasted little time passing new long-term care reform oriented legislation, as the same legislation repealing the CLASS Act contained a section authorizing the creation of a national long-term care commission.[111] The Commission on Long-Term Care ("the Commission") was tasked with developing

> a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the

102. *See* Brief for Center for Constitutional Jurisprudence et al. as Amici Curiae in Support of Respondents, U.S. Dep't of Health & Human Servs. v. Florida, *renamed* Nat'l Fed'n of Indep. Buss. v. Sebelius, 132 S. Ct. 2566 (2012) (No. 11-398), 2012 WL 484070, at *20 (arguing the projected savings were a gimmick to ensure healthcare reform was passed).

103. Brown & Finkelstein, *supra* note 100, at 137.

104. *See Health Care Reform and the CLASS Act*, *supra* note 101, at 2 (discussing the actuarial requirements for the CLASS Act program).

105. *See* Brown & Finkelstein, *supra* note 100, at 136 (noting the CLASS Act was abandoned in 2011 after it failed to satisfy the statutory solvency requirements).

106. American Taxpayer Relief Act of 2012, Pub. L. 112–240, § 642, 126 Stat. 2313, 2358 (repealing the CLASS Act).

107. *See* Brown & Finkelstein, *supra* note 100, at 136.

108. *Id.*

109. *Id.*

110. *See Health Care Reform and the CLASS Act*, *supra* note 101, at 3; *see also* Stephen A. Moses, *The CLASS Act and the Future of Long-Term Care Financing*, SOC'Y OF ACTUARIES 8 (2011), http://www.soa.org/library/monographs/life/living-to-100/2011/mono-li11-1a-moses.aspx.

111. American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 643, 126 Stat. 2313 (creating the Commission on Long-Term Care).

> availability of long-term services and supports for individuals in need of such services and supports, including elderly individuals, individuals with substantial cognitive or functional limitations, other individuals who require assistance to perform activities of daily living, and individuals desiring to plan for future long-term care needs.[112]

The Commission was also specifically directed to examine at the interactions between Medicaid, Medicare, and private long-term care insurance.[113] As such, the Commission is expected to present recommendations to the President, House of Representatives, and Senate by the end of September 2013.[114] While the Commission could return with a variety of proposed solutions, the focus of the government in creating the Commission, the FLTCIP, and the CLASS Act remains to reduce government provided long-term care funding through Medicaid and Medicare by increasing participation in private or public long-term care insurance programs.

IV. STATE PARTNERSHIP PROGRAMS: A SHARED SOCIAL RESPONSIBILITY

A. What are State Long-Term Care Insurance Partnership Programs?

In a direct attempt to increase long-term care insurance ownership and decrease dependence on government long-term care financing, the federal government passed the Deficit Reduction Act of 2005. One of its primary goals is to incentivize the purchase of long-term care insurance and, thereby, reduce the middle class's consumption of Medicaid for long-term care services through the expansion of the State Long-Term Care Partnership Programs.[115] If a State enacts a State Long-Term Care Partnership Program, it is authorized to exempt a Medicaid recipient's assets from State recovery up to the amount of long-term care benefits paid from a qualified long-term care insurance contract.[116] A state with a State Plan Amendment (SPA), providing a qualified State Long-Term Care Partnership Program, can take advantage of such an exemption.[117]

---

112. American Taxpayer Relief Act of 2012 § 643(b)(1).

113. *Id.* at § 643(b)(2)(A) (listing specific areas for the Commission to focus its attention).

114. *See id.* at § 643(f).

115. THE ADVISOR'S GUIDE TO LONG-TERM CARE 104-105 (R. David Watros & Erik T. Reynolds eds., 2013) (noting the objective to curtail "use [of] Medicaid's safety net as an incentive for middle income Americans to purchase long-term care insurance and, by doing so, encourage them to financially prepare for the risk of needing long-term care[ ]").

116. Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6021(a)(1)(A)(iii), 120 Stat. 4, 68 (2006); *Qualified Long-Term Care Partnerships Under the Deficit Reduction Act of 2005*, CTRS. FOR MEDICARE & MEDICAID SERVS. 5 (July 27, 2006), http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/LTCEnclosure.pdf. The Deficit Reduction Act of 2005 is also commonly referred to as the Deficit Reduction Act of 2006, since it was passed by the Legislature in 2005 but was not finalized and signed into law until 2006. For purposes of this paper, we will refer to it as the Deficit Reduction Act of 2005.

117. Deficit Reduction Act of 2005 § 6021(a)(1)(A)(iii).

However, in order for a long-term care insurance policy to qualify under a State Long-Term Care Partnership Program the insurance contract must satisfy seven specific statutory requirements of the Deficit Reduction Act of 2005. The first two requirements are: (1) an insured under a qualified State Long-Term Care Partnership must be a resident of the state at time the coverage is effective,[118] and (2) the policy satisfies the definition of qualified long-term care insurance within the meaning of section 7702B(b) of the Internal Revenue Code of 1986 as amended.[119] The most noteworthy requirements under Internal Revenue Code section 7702B(b) for qualified long-term care insurance contracts include: (a) guaranteed renewal or noncancellability of the policy, (b) prohibitions on limitations and exclusions, (c) extension of benefits, continuation or conversion of coverage, (d) discontinuance and replacement of policies, (e) protection from an unintentional lapse, (f) disclosure, (g) prohibitions against post-claims underwriting, (h) minimum standards for home health and community care benefits, (i) inflation protection, and (j) prohibitions against pre-existing conditions, exclusions and probationary periods in replacement policies.[120]

In addition, there are five other requirements set forth by the Deficit Reduction Act with regards to State Partnership Programs. These requirements are: (1) the policy is certified by the adopting state as satisfying the requirements of the Model Long-Term Care Insurance Act and Regulations;[121] (2) the policy offers compound annual inflation protection of benefits for all individuals under age sixty-one at time of purchase, some level of inflation protection for those who have attained sixty-one but not yet seventy-four, and the option of inflation protection for those seventy-four and older;[122] (3) the Medicaid agency of the State adopting a long-term care program "provides information and technical assistance" to the State insurance department to assure the public that sellers of long-term care insurance will be able to evidence an understanding of how such policies relate to other public and private coverage of long-term care;[123] (4) any issuer of long-term care insurance provides regular reports to the Department of Health and Human Services regarding payment of benefits, termination of policies and "such other information as . . . may be appropriate to the administration of [state long-term care] partnerships;"[124] and (5) an adopting State cannot impose any requirement affecting the terms or benefits of a long-term care policy under the state partnership policy that is not imposed on all other long-term care policies.[125]

The Deficit Reduction Act's requirements are mostly designed to provide some consumer protection to long-term care insurance policy owners. For

118. Deficit Reduction Act of 2005 § 6021(a)(1)(A)(iii)(I).
119. *Id.* at § 6021(a)(1)(A)(iii)(II).
120. *Id.* at § 6021(a)(1)(B).
121. *Id.* at § 6021(a)(1)(B)(iii).
122. *Id.* at § 6021(a)(1)(A)(iii)(IV)(aa)-(cc).
123. *Id.* at § 6021(a)(1)(A)(iii)(V).
124. Deficit Reduction Act of 2005 § 6021(a)(1)(A)(iii)(VI).
125. *Id.* at § 6021(a)(1)(A)(iii)(VII).

instance, the Deficit Reduction Act requires all participating long-term care contracts to conform to the Model Regulations and contain inflation protection.[126] The drafting note to the Model Regulation states that the goal was to ensure "that meaningful inflation protection be provided. Meaningful benefit minimums or durations could include providing increase to attained age, or for a period such as at least 20 years, or for some multiple of the policy's maximum benefit, or throughout the period of coverage."[127] Without any meaningful inflation protection, younger consumers will be less motivated to buy long-term care insurance as the benefits might not be substantial in the future due to inflation's reduction in the purchasing power of promised benefits. However, the long-term care insurance market place has and will likely continue to consist of older consumers.

Additionally, the Deficit Reduction Act pushes the idea of financial transparency. Financial transparency enables consumers to make informed decisions when seeking to purchase long-term care insurance coverage. Consumers will need accurate information about the likelihood of needing long-term care, the costs associated with care, and also how a long-term care insurance policy could address such risks. These requirements also assure that long-term care policies under the SPA will be treated on equal footing with other policies predating the passage of the Deficit Reduction Act of 2005.[128] Ultimately, the thrust of the seven requirements promotes increased long-term care insurance ownership through better incentives, benefits, and consumer protections.

1. The Model Statute Explained

In addition to the Deficit Reduction Act's requirements, the consumer protection requirements under Internal Revenue Code section 4980C for qualified long-term care insurance contracts include provisions from both the Model Regulation and Model Act.[129] Requirements from the Model Regulation relate to application forms and replacement coverage, reporting requirements, filing requirements for marketing, standards for marketing, appropriateness of recommended purchase, standard format for outlining of the policy's coverage, and delivery of a shopper's guide.[130] The Model Act requirements include the right to return a policy, outline of coverage of a policy, certificates under group plans, policy summary, monthly reports on

126. Deficit Reduction Act of 2005 § 6021(a)(1)(iii)(III).

127. *Long-Term Care Insurance Model Regulation*, NAT'L ASS'N OF INS. COMM'RS 20 (Jan. 2010), http://www.naic.org/store/free/MDL-641.pdf. Additionally, the solvency of long-term care insurance premiums shares that of life insurance—that is, there must be long-term accumulation and investment of premiums to satisfy future costs. THE ADVISOR'S GUIDE TO LONG-TERM CARE, *supra* note 115, at 90.

128. That objective has been achieved. THE ADVISOR'S GUIDE TO LONG-TERM CARE, *supra* note 115, at 82 (citing market statistics that nearly 99% of long-term care policies sold are qualified long-term care insurance policies).

129. 26 U.S.C. § 4980C(c)(1)(A)-(B) (2006).

130. *Id.* at § 4980C(c)(1)(A).

accelerated death benefits, and incontestability period.[131] Again, the Model Act and Model Regulation provide significant levels of consumer protection, increasing confidence in long-term care insurance policies.

2. Asset Protection under the Model Act and Regulations

As mentioned earlier, to qualify for Medicaid benefits, an individual must divest or spend down assets to an indigent level of assets. An individual may typically keep an automobile, personal property up to reasonable limits, a burial plot, and a small amount of cash value life insurance.[132] However, purchasing a qualified long-term care insurance policy in a state with a qualified State Partnership Program could help protect an individual's assets, requiring the individual to spend down less in order to qualify for Medicaid coverage.

If a state adopts a qualified Long-Term Care Partnership Program, the benefits paid under a qualified long-term care policy create dollar-for-dollar protection for the insured against such Medicaid spend-down requirements.[133] Assets previously required to be spent down in order for the individual to be eligible for Medicaid coverage are now preserved for the insured or the insured's estate, to the extent of long-term care benefits paid or payable from the qualified long-term care insurance policy.[134] As such, the qualified Long-Term Care Partnership Program is designed to incentivize people to purchase qualified long-term care insurance by offering asset protections from the Medicaid's estate recovery and spend down qualification requirements. Conceptually, this process can be difficult to imagine. The following example helps illustrate both how the program works and how it benefits both Medicaid and the purchaser of long-term care insurance.

> Ann, a widower, has a qualified long-term care policy and enters a nursing home. The policy pays $150 a day for a maximum of two years for a total payout of $109,500 ($150/day x 365 days/year x 2 years). The total cost of Ann's nursing home care for the two years was $149,500. Ann paid the difference of $40,000 from her savings of $240,000, leaving her with $200,000. Because Ann had a Partnership policy that paid for $109,500 of her nursing home expenses, Ann is eligible for $109,500 of asset disregard, meaning that she is deemed to have only $90,500 in countable assets ($200,000 less $109,500). After

131. 26 U.S.C. § 4980C(c)(1)(B).

132. The Commonwealth of Pennsylvania outlines excludable assets for Medicaid counting. 55 PA. CODE §§ 178.66, 178.67, 178.69, 178.71 (2013) (outlining exclusion for household goods and personal effects, motor vehicles, life insurance policies, and burial spaces, respectively). The Commonwealth also explains circumstances that will make individuals ineligible for payment of long-term care services. 55 PA. CODE § 178.62a (2013) (home equity in a principal residence of $500,000 or less).

133. *See* Deficit Reduction Act of 2005 § 6021(a)(1)(iii).

134. 42 U.S.C. § 1396p(b)(1)(C)(ii)(I) (2006).

> she spends an additional $88,500 on her care, she will have only $2,000 of assets and should also be able to satisfy the income and asset eligibility requirements under Medicaid. Ann is permitted to retain $149,500 for her lifetime use or testamentary disposition to heirs.

The appeal of the State Partnership Programs to a potential long-term care insurance purchaser is the creation of the opportunity not only to preserve a portion of assets for distribution either during lifetime or at death, but also the ability to ensure greater levels of long-term care financing. Medicaid and state governments benefit because increased long-term care insurance coverage reduces the amount of state provided long-term care financing needed as people insure their own long-term care needs. As long-term care insurance policies begin to pay out benefits covering expenses otherwise paid by Medicaid, the financial burden on Medicaid is reduced. Ultimately, the government is offering asset protection to those who qualify for Medicaid if the individual purchases long-term care insurance in an effort to decrease financial reliance on government funded long-term care programs.

B. State Partnership Program: Encouraging Long-Term Care Insurance

A number of the required provisions in qualified State Long-Term Care Partnership insurance policy offer incentives to individuals who purchase long-term care insurance. A purchaser of long-term care insurance through a State Partnership Program has assurance that his or her coverage will be portable; premium payments deductible; benefit payments potentially completely tax-free; and inflation-adjusted.[135] With insurers having the constrained ability to raise future premiums, insurers will most likely compete on the basis of more realistically established premiums at the initial underwriting.[136]

Let's examine in detail how a qualified long-term care policy works. First, portability from state to state is an important issue as many people relocate in retirement to a new state. A long-term care policy sold under the SPA must provide that policyholders who relocate to another state will be eligible to receive dollar-for-dollar asset protection as if they had not relocated.[137] Since thirty-nine states have adopted the Model Act and its requirement of reciprocity,[138] an individual can relocate with the assurance that long-term care benefits will be available if needed and that the asset protection will also follow them to most states. It is important to note, however, that there is not full portability between all states.

---

135. *See* Deficit Reduction Act of 2005 § 6021.

136. *See* Kelly Greene & Leslie Scism, *Long-Term-Care Insurance Leaves Customers Groping*, WALL ST. J., July 2, 2013, at A1.

137. Deficit Reduction Act of 2005 § 6021(b)(1).

138. States without long-term care partnership programs are Alaska, Delaware, Hawaii, Illinois, Massachusetts, Michigan, Mississippi, New Mexico, Utah, Vermont, and Washington. THE ADVISOR'S GUIDE TO LONG-TERM CARE, *supra* note 115, at 108.

Second, it is important to examine the deductibility of long-term care premium payments, as it will reduce the nominal cost of the premiums to an after-tax amount.[139] Premium payments for State Partnership qualified long-term care insurance policies are considered a deductible medical expense payment subject to the applicable federal income tax limitations.[140] Premium payments for long-term care insurance are deductible subject to the following limitations based on age:

- Age . . . 40 or under $370
- Age . . . above 40 not over 50 $700
- Age . . . above 60 not over 60 $1,460
- Age . . . above 60 not over 70 $3,720
- Age . . . above 70 $4,660[141]

However, for taxpayers age 65 and older, all eligible medical expenses (including long-term care) must exceed 7.5% of AGI.[142] For those not yet sixty-five, eligible medical expenses must exceed 10% of AGI.[143] The excess over the applicable floor will be treated as an itemized deduction.[144]

Thirdly, it is crucial to examine how received benefits are treated for purposes of taxation. Simply put, benefits paid for long-term care are excludable from gross income to the extent of the pure insurance amount.[145] Benefits received are generally treated as payments under a life and accident insurance plan[146] and excludible from income to the extent they are used for long-term care services as defined under section 7702B(c).[147] If benefits exceed the daily inflation-adjusted cap, the excess amounts are also excludible to the extent they cover actual costs for qualified long-term care services.[148] If not so used, the excess would be included in gross income.[149]

Fourth, the requirement of inflation-adjusted benefits plays a huge role in qualified State Partnership Program long-term care insurance policies.

---

139. Tax savings from the premium payments will be available to an itemizing taxpayer, but will not be available for the taxpayer who does not itemize and takes the standard deduction.

140. 26 U.S.C. § 213(d)(10)(A) (2006).

141. Rev. Proc. 2013-35, 2013-47 I.R.B. 537, 543, *available at* http://www.irs.gov/pub/irs-irbs/irb13-47.pdf (publishing at Section 3.24 eligible long-term care premiums for 2014).

142. 26 U.S.C. § 213(f) (Supp. V. 2012).

143. 26 U.S.C. § 213(a) (2006).

144. *Id.* at § 63(d)(1).

145. *Id.* at § 105(f).

146. *See id.* at § 105(b), (f).

147. *Id.* at § 213(d)(1)(C)

148. *See* Rev. Proc. 2013-35, 2013-47 I.R.B. 537, 544, *available at* http://www.irs.gov/pub/irs-irbs/irb13-47.pdf (publishing at Section 3.43 the amount of periodic payments received under qualified long-term care insurance contracts excluded under the per diem limitation for 2014 of $330). For 2014, an insured could receive $330 x 365 or $120,450 tax-free.

149. 26 U.S.C. § 105(b).

Individuals age 60 and younger must have annual compound inflation protection.[150] An adopting state may require at least 5% compounded; others 3% compounded.[151] Individuals age 61 to 75 must have some type of inflation protection, either a simple inflation or a guaranteed purchase option in addition to compound inflation.[152] Individuals 76 and older must be offered an option for inflation protection.[153] Inflation adjustments of future benefits helps reduce the likelihood that additional assets of the insured would be needed to help cover long-term care costs. A consumer may be attracted to make a multi-decade commitment for the payment of long-term care premiums if the promised future benefits are not eroded by inflation. However, one downside of requiring inflation protections is the fact that inflation protection increases the premium payments for long-term care insurance by 25% to 40%.[154]

Fifth, insurers are limited in their ability to raise premiums under the qualified policy rules.[155] When examining the Model Regulation's legislative history, there is a clear indication by the National Association of Insurance Commissioners (NAIC) to influence rate stability through rate caps and non-forfeiture options.[156] The problem arises when people buy long-term care insurance in their 50s, when it is affordable, but then have trouble keeping up with the premiums because they find rate increases have made it too expensive once they are in their 70s and 80s and actually need coverage.[157] While it is possible for insurers to raise premiums, the Model Regulation mandates 58% of the initial premium and 85% of the increased portion of the premium must be available to cover claims on a lifetime present value basis.[158] Insurers will be compelled to more accurately price premiums to avoid rate increases.

One of the main complaints regarding long-term care insurance has been the unpredictable and substantial premium hikes.[159] The State Partnership Program specifically attempts to address these issues. Furthermore, the program is designed to increase private long-term care insurance coverage and

---

150. *See* 26 U.S.C. § 7702B(g)(2)(A)(i)(X) (2006).

151. *See* Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6021(a)(1)(A)(iii)(IV), 120 Stat. 4, 68 (2006) (referencing the requirement of the state to provide some level of inflation protection without requiring a specified rate).

152. *Id.* at § 6021 (a)(1)(A)(iii)(IV)(bb).

153. *Id.* at § 6021(a)(1)(A)(iii)(IV)(cc).

154. Jay MacDonald, *Long-term care insurance lingo to know*, BANKRATE (Sept. 9, 2011), http://www.bankrate.com/finance/news/long-term-care-insurance-lingo-to-know.aspx.

155. 26 U.S.C. § 7702B(g)(4)(B)(ii) (2006).

156. *Long-Term Care Insurance Model Regulation*, *supra* note 127, § 6F, at 6 (citing to the Proceedings of the NAIC, 1992 Proc. IIB 695 and 1993 Proc. IB 851-852).

157. JEFF SADLER, THE ADVISOR'S GUIDE TO LONG-TERM CARE 58-59 (2012); *Who Buys Long-Term Care Insurance?: A 15-Year Study of Buyers and Non-Buyers, 1990-2005*, AMERICA'S HEALTH INS. PLANS 17 (Apr. 2007), http://www.ahip.org/LTC-Buyers-Guide/ ("[A]s age-specific premiums have increased, individuals over age 70, who tend to be on fixed incomes, may find the insurance too costly relative to perceived value.").

158. *Long-Term Care Insurance Model Regulation*, *supra* note 127, § 20C, at 27.

159. Deirdre Fernandes, *Rates for long-term insurance may double: Increases threaten retirees' ability to cover costs of nursing care*, BOSTON GLOBE, Sept. 6, 2013, at A1.

alleviate some of the financial burden placed on Medicaid. While the passage of the Deficit Reduction Act of 2005 and the proliferation of the State Long-Term Care Partnership Program indicate a governmental initiative to shift the burden of long-term care funding away from the government and onto individuals, these actions are not sufficient to solve the pending long-term care insurance financing problem facing both state and federal governments.

V. FLY IN THE OINTMENT OR FAMILY MOTIVATOR: FILIAL RESPONSIBILITY LAWS

A. Filial Responsibility Laws

With the failure of the CLASS Act and the limited success of the State Partnership Programs, the federal government continues to examine ways to incentivize private long-term care insurance purchases in order to alleviate government provided long-term care funding concerns. The enforcement of often-unknown filial support laws may result in meaningful personal liability of family members such that long-term care insurance will be re-examined as a means of managing the risk of possible six-figure care liability.

Filial responsibility laws require specified family members to provide for the financial needs of other statutorily specified family members.[160] While the legal obligation for a parent to support a minor child is well known,[161] filial laws extend family care responsibilities even further. Virtually every jurisdiction has requirements for parents to support children unemancipated and under the age of majority and for spouses to support each other.[162] This support obligation is viewed as so important that it receives extended multistate enforcement.[163] Furthermore, this parental support obligation is sometimes extended to claims by third parties against a minor child.[164] A majority of states,[165] however, also have more expansive responsibility

160. *E.g.*, 23 PA. CONS. STAT. ANN. § 4603(a)(1)(i)-(iii) (West 2010) (charging spouses, children, and parents with "the responsibility to care for and maintain or financially assist an indigent person, regardless of whether the indigent person is a public charge[ ] . . . .").

161. *See* N.Y. JUDICIARY LAW § 413 (McKinney 2008) (stating a parent's basic child support obligations).

162. *E.g.*, 23 PA. CONS. STAT. ANN. § 4321 (West 2010).

163. *E.g.*, *id.* at § 7101 cmt. ("Public policy favoring [reciprocity between states with respect to support orders enforcement] is sufficiently strong to warrant waiving any quip pro quo among the states.").

164. *E.g.*, *id.* at § 5502.

165. A total of 29 states currently have filial responsibility laws. Katherine Pearson, *Family (Filial) Responsibility/Support Statutes in the Unites States*, PENN ST. UNIV. DICK. SCH. L. (Mar. 5, 2012), http://law.psu.edu/_file/Pearson/FilialResponsibilityStatutes.pdf. The list (prior to an update) was published in a New York Times blog by Jane Gross. Jane Gross, *Adult Children, Aging Parents and the Law*, THE NEW OLD AGE (Nov. 20, 2008, 6:00 AM), http://newoldage.blogs.nytimes.com/2008/11/20/unenforced-filial-responsibility-laws/?_r=0. For perhaps the most thorough discussion of filial responsibility within the United States and abroad, see Katherine C. Pearson, *Filial Support Laws in the Modern Era: Domestic and International Comparison of Enforcement Practices for Laws Requiring Adult Children to Support Indigent Parents*, 20 ELDER L.J. 269 (2013) [hereinafter *Filial Support Laws in the Modern Era*].

statutory provisions, entitled filial support laws, which create a legal obligation for specified related parties to assist each other with financial support.[166] This rule is typically limited to assisting an indigent family member; however, it can expand familial support obligations significantly further than the commonly known parent-minor child relationship. While the term indigent is not often specifically defined by the filial statutes, its definition has apparently expanded from individuals who are completely destitute or on public assistance to include persons who have limited income and inadequate resources to provide for their care.[167] Ultimately, filial support laws can require a wide range of family members to provide financial support for the care and maintenance of a family member with limited resources.

The rule is inapplicable in some instances if the responsible assisting party does not have sufficient financial ability or is a child who was abandoned by an indigent parent for a period of ten years during the child's minority.[168] While the statutes do not provide a definition for the level of support that would be considered unreasonable, they often provide a limitation on the amount that can be imposed on a responsible family member.[169] Furthermore, the Pennsylvania statute provides that specified responsible parties must respond to financial obligations of certain indigent persons without setting forth any sort of priority between responsible family members or a right of reimbursement from other potentially responsible parties.[170] Other state statutes have been interpreted to create rights of reimbursement from other responsible family members.[171]

---

166. The filial responsibility laws in this context typically apply between parents and adult children. *See, e.g.*, S.D. CODIFIED LAWS § 25-7-27 (West, Westlaw through the 2013 Regular Session and Supreme Court Rule 13-17) (requiring that financially able adult children provide food, shelter or medical attendance for a parent who cannot provide for oneself); 23 PA. CONS. STAT. ANN. § 4603(a)(1)(i)-(iii) (charging spouses, children, and parents with "the responsibility to care for and maintain or financially assist an indigent person, regardless of whether the indigent person is a public charge[ ] . . . ."). However, other filial responsibility laws could extend to other relatives of the children of the indigent person if the resources of the children are insufficient. *E.g.*, UTAH CODE ANN. § 17-14-2 (West, Westlaw through the 2013 Second Special Session). *See also* Michael Lundberg, *Our Parents' Keepers: The Current Status of American Filial Responsibility Laws*, 2009 UTAH L. REV. 581, 583 (explaining the filial responsibility goes next (after the children) to the parents of the indigent family member, followed by siblings, grandchildren, and grandparents).

167. Matthew Pakula, *A Federal Filial Responsibility Statute: A Uniform Tool to Help Combat the Wave of Indigent Elderly*, 39 FAM. L.Q. 859, 862 (2005); Allison E. Ross, *Taking Care of Our Caretakers: Using Filial Responsibility Laws to Support the Elderly Beyond the Government's Assistance*, 16 ELDER L.J. 167, 169 (2008).

168. Ross, *supra* note 167, at 175-76.

169. *See id.* at 177. The Pennsylvania filial responsibility statute also provides an annual financial limitation on the responsibility of the liable family member limited to the lesser of: "(A) six times the excess of the liable individual's average monthly income over the amount required for the reasonable support of the liable individual and other persons dependent upon the liable individual; or (B) the cost of the medical assistance for the aged." 23 PA. CONS. STAT. ANN. § 4603(b)(2)(i)(A)-(B).

170. 23 PA. CONS. STAT. ANN. § 4603(a)(1).

171. Kirsten Wilson, *Filial Responsibility – A New Look at an Old Legal Concept*, N.H. BAR J., Dec. 1999, at 44, 44; s*ee also* Ketcham v. Ketcham, 29 N.Y.S.2d 773, 779 (N.Y. Fam. Ct.

Additionally, filial responsibility statutes vary as to the extent they provide standing for third party individuals or entities to bring a case against a responsible family member to collect financial support for the indigent person.[172] Some statutes provide for relatively expansive standing, allowing almost any party with a financial loss as a result of the indigent person, for the purpose of providing care, to seek repayment from the statutorily responsible family members.[173] As a practical matter, the entity or agency caring for the adult indigent person will generally initiate the action.[174] For example, a nursing home that is taking care of an adult indigent person could initiate the action to recover from the care recipient's responsible family members.

The imposition of filial responsibility beyond the obligation to support a spouse or unemancipated minor child has certainly received criticism.[175] In one instance, a state's filial responsibility statute was upheld against challenges that it violated rights to due process and the Equal Protection Clause.[176] Furthermore, the findings of the Medicaid Commission in 2005 led to sweeping changes to Medicaid in the Deficit Reduction Act of 2005.[177] These were accompanied by similar changes to state Medicaid law.[178] The Commonwealth of Pennsylvania put a spotlight on its filial responsibility law by re-codifying the law within the Domestics Relations Statute.[179] Ultimately, this led to the firestorm discussed below.

1941) (determining that obligation can be unequal and based on the ability of the responsible parties to afford to support).

172. *Filial Support Laws in the Modern Era*, *supra* note 165, at 275-76 (noting third-party creditors use filial support laws to compel payment form adult children for their indigent parents' care).

173. 23 PA. CONS. STAT. ANN. § 4603(c) (providing that "[a] court has jurisdiction in a case under this section upon petition of: (1) an indigent person; or (2) any other person or public body or public agency having any interest in the care, maintenance or assistance of such indigent person.").

174. *See Filial Support Laws in the Modern Era*, *supra* note 165, at 293.

175. Michael Rosenbaum, *Are Family Responsibility Laws Constitutional?*, 1 FAM. L.Q., Dec. 1967, at 55, 59.

176. Swoap v. Superior Court, 516 P.2d. 840, 852 (Cal. 1973). "It seems eminently clear that the selection of the adult children is rational on the ground that the parents, who are now in need, supported and cared for their children during their minority and that such children should in return now support their parents to the extent to which they are capable." *Id.* at 851.

177. *See Report to the Honorable Secretary Michael O. Leavitt, Department of Health and Human Service and The United States Congress*, MEDICAID COMM'N 9 (Sept. 1, 2005), http://www.aafp.org/dam/AAFP/documents/advocacy/coverage/medicaid/ES-MedicaidReformCommission-090105.pdf (recommending cutting $11 billion from the Medicaid program over the next five years).

178. *See Medicaid State Plan Amendments*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html (last visited Mar. 16, 2014) (listing states that submitted amendment plans to the CMS for review and approval).

179. 23 PA. CONS. STAT. ANN. § 4603 (West 2010).

B. The Pittas[180] Decision – When Has $93,000[181] Meant so Much to so Many?

Although the filial responsibility laws would appear on their face to be very powerful weapons, case law has been historically thin with respect to enforcement of these laws. In fact, eleven states have not enforced their statute at any point in time.[182] When the statutes have been enforced, however, they have garnered a lot of attention. For example, in *Health Care & Retirement Corp. of America v. Pittas*, the Health Care Retirement Corporation of America (HCR) brought a civil suit against the defendant for reimbursement of expenses incurred as a result of his mother's treatment in their skilled nursing facility.[183] The defendant's mother suffered injuries in a car accident and was transferred to the skilled nursing facility for treatment that lasted about six months.[184] During her brief stay, the mother racked up a substantial amount of long-term care expenditures and was unable to pay.[185] While an application for Medicaid was initiated for the mother, it was still pending at the time of trial.[186] Eventually, after leaving the facility, the defendant's mother relocated overseas.

Following arbitration and a non-jury trial, the lower court held for the plaintiff, enforcing Pennsylvania's filial support laws and finding the defendant responsible for his mother's long-term care bill. In examining the facts, the trial court determined that the son had not met the burden of proving that his right is discharged from his duty to provide for his mother's expenses.[187]

The defendant appealed the decision to the Pennsylvania Superior Court.[188] On appeal, the defendant raised three issues:

1) Did the trial court commit reversible error or abuse its discretion in determining the burden of proof was on the [Appellant] to prove his inability to support his "indigent" mother?
2) Did the trial court commit reversible error or abuse its discretion in not considering alternate sources of income to satisfy the alleged support obligation?
3) Did the trial court commit reversible error or abuse its discretion in deciding [Appellant's mother] was indigent, without competent evidence to do so?[189]

---

180. Health Care & Ret. Corp. of Am. v. Pittas, 46 A.3d 719 (Pa. Super. Ct. 2012).

181. *Id.* at 720 (noting that the actual judgment was $92,943.41).

182. Ross, *supra* note 167, at 168.

183. *Pittas*, 46 A.3d at 720.

184. *Id.*

185. *Id.*

186. *Id.* at 723.

187. *Id.* at 722 ("[H]e did not provide a specific statement as to all of his finances, income, expenses, assets, liabilities and things of this nature. This, together with his very general responses to questioning, causes the [trial court] to find him of low credibility and, therefore, we find none of his testimony to be truthful.") (alteration in original).

188. *Id.* at 720-21.

The Superior Court found that HCR had the burden to establish the defendant had the financial ability to support his indigent mother.[190] The appellate court found that the plaintiff met this burden, even though the defendant had limited financial resources compared to the substantial long-term care bill his mother accumulated.[191] While the appellate court was sympathetic to the son's contention that the trial court failed to consider his mother's other sources of income, similar support obligations of her husband and two other grown children, and a pending appeal for Medicaid assistance, it held that nothing in the plain language of the filial support statute required such consideration.[192] In regard to the third issue on appeal, the appellate court found the common law definition of indigence to be applicable: "[T]he indigent person need not be helpless and in extreme want . . . . Indigent persons are those who do not have sufficient means to pay for their own care and maintenance."[193] Furthermore, the appellate court found that the trial court had not abused its discretion in determining that Appellant's mother was an indigent pursuant to the filial responsibility statute.[194] Ultimately, the Pennsylvania Supreme Court denied the defendant's appeal, refusing to hear the case and further review the decision.[195]

C. The Impact of the Pittas Decision on Long-Term Care Planning

The *Pittas* decision ought to (1) have a chilling effect on baby boomers with parents with assets insufficient to provide for medical or custodial care and (2) be a significant motivator to plan for how an individual will pay for his or her long-term care costs. The appellate court's holding has been well discussed by a pre-eminent legal scholar[196] on the subject of filial responsibility laws. Furthermore, the popular press similarly did not ignore the result and potential impact of the *Pittas* decision.[197] Despite some media recognition and scholarly

---

189. *Pittas*, 46 A.3d at 721.

190. *Id.* at 722.

191. *Id.* at 723. HCR presented the son's S corporation joint tax returns and elicited testimony from him that his net income was in excess of $85,000. *Id.* at 722.

192. *Id.* at 723. The court noted that the son had failed to join his mother's husband and two other adult children, which he was permitted to do. *Id.* In addition, the Medicaid appeal filed by his mother would relieve his burden if successful. *Id.*

193. *Id.* at 723-24 (quoting Savoy v. Savoy, 641 A.2d 596, 599-600 (Pa. Super. Ct. 1994)).

194. *Id.* at 724. The lower court had the mother's bank statement and admissions sheet for the skilled nursing facility in evidence. *Id.* She had only $1000 a month of income and no other notable assets. *Id.*

195. Health Care & Ret. Corp. of Am. v. Pittas, 63 A.3d 1248 (Pa. 2013).

196. *Filial Support Laws in the Modern Era*, *supra* note 165, at 295.

197. Kelly Greene, *Are You on the Hook for Mom's Nursing-Home Bill?*, WALL ST. J. (June 22, 2012, 3:35 PM ET), http://online.wsj.com/news/articles/SB10001424052702303506404577446410116857508; Bernard A. Krooks, *Filial Responsibility Law Makes Son Liable for Mom's Nursing Home Bill*, FORBES (May 24, 2012, 10:05 AM), http://www.forbes.com/sites/bernardkrooks/2012/05/24/filial-responsibility-law-makes-son-liable-for-mothers-nursing-home-bill/. *See also* Beth Baker, *Paying for Mom: Little-Known Laws Force Families to Fund Parents'*

efforts, the potential impact of *Pittas* remains largely unknown to financial advisors, attorneys, and the general public.[198]

The potential exists for health-care providers to become emboldened by the success of the plaintiff in *Pittas*. This might result in more legal actions seeking reimbursement from statutorily obligated family members when the indigent family member is unable to pay bills for medical or skilled nursing home expenses.[199] What has not been widely discussed is the potential for the filial support laws to require a parent to pay for medical care for an indigent adult child. This potential action is clearly supported by the statutes in most states.[200] Additionally, in some states, brothers and sisters could be held liable for each other's costs under the filial responsibility laws.[201] This extension of legally enforceable family responsibilities could have a devastating effect on the estate, financial well-being, and retirement planning of one's family members.

The appropriateness of filial responsibility laws and corresponding enforcement is certainly questionable in modern family culture in the United States. While there is a certain degree of pragmatism that must be invoked with respect to health care costs of indigent family members, there is also a real question as to whether or not financially secure family members are better suited to shoulder these support costs than is the government. If suits for unreimbursed healthcare costs become routine, the cost will ultimately be passed down to the indigent's family member, burdening them with additional long-term care costs. Furthermore, if there is a trend to invoke filial responsibility laws, it could incentivize more care providers to seek indemnity from family members. This would place a higher burden on individuals to have long-term care insurance or risk burdening their family with long-term care expenditures.

There have been both critics[202] and proponents[203] of the use of filial responsibility laws to reimburse providers of healthcare to indigent family

---

Care, AARP (Jan. 2009), http://www.aarp.org/relationships/caregiving/info-01-2009/paying_for_momlittle_known_laws_force_families_to_fund_parents_care_.html.

198. During our presentations to financial service professionals discussing the impact on families concerning long-term care financing, by and large, the audience generally expresses shock and disbelief when hearing about the *Pittas* decision.

199. Robert Fleming, *"Filial Support" Laws: Making Children Pay for Their Parents' Nursing Home*, FLEMING & CURTI PLC (July 30, 2012), http://issues.flemingandcurti.com/2012/07/28/filial-support-laws-making-children-pay-for-their-parents-nursing-home/.

200. *E.g.*, 23 PA. CONS. STAT. ANN. § 4603 (West 2010).

201. Bill Boushka, *Editorial: Filial Responsibility Laws: The next iceberg for GLBT people?*, DO ASK DO TELL (Aug. 11, 2005), http://www.doaskdotell.com/controv/filial.htm (noting that a few states include siblings under filial responsibility laws).

202. Ross, *supra* note 167, at 185 (noting that although filial laws have been held constitutional, they have not reached their potential for alleviating financial difficulties for elders).

203. *See* Andrew R. Fischer, *Elder Abuse: A Private Problem That Requires Private Solutions*, 8 J. HEALTH & BIOMED. L. 81, 92 (2012) (suggesting filial responsibility statutes "may curb elder abuse and improve long-term care affordability by imposing legal obligations on an adult child to financially provide for a parent who cannot afford necessities").

members. This criticism of filial responsibility laws has not been totally ignored by state legislatures. One state has recently repealed its statute.[204] As a result of pressure brought about by the *Pittas* decision, bills have been introduced in Pennsylvania to repeal the filial responsibility statute.[205] At the very least, state statutes need clarification in the following areas: clearer definition of indigency; covered expenses under the required financial assistance; clear definition of the financial capability of obligated family members; and allocation of expenses among obligated family members and rights to contribution by the family member(s) affected by the statute.

VI. RECOMMENDATION: LEVERAGING FILIAL LAWS

The imposition of filial laws should frighten individuals as an indigent family member's long-term care costs might be passed along to unprepared family members. Additionally, filial laws highlight the need for a new system of long-term care financing as state governments cannot keep funding the cost and individuals are not prepared for the costs. Furthermore, the enforcement of existing filial support laws represents a unique opportunity for governments looking to enact long-term care funding changes. Enforcement of filial laws represents the "stick" to be applied to those without long-term care insurance. The State can also provide the "carrot" for purchasing long-term care insurance by providing liability protection to family members from filial support laws. States with filial laws must clarify for family members the magnitude of their potential liability under filial support laws and how long-term care insurance could mitigate this risk. This will put family members on notice regarding the massive and frightening amounts of money they might have to pay on behalf of a family member needing long-term care services.

Additionally, States can leverage existing filial laws by offering asset protections similar to those offered under the state long-term care insurance partnership programs. Essentially, the state could allow those individuals who purchased a qualified long-term care insurance policy for themselves or for the indigent family member to protect a certain amount of their assets from filial responsibility liability. Such an allowance enables the state to reduce the exposure of Medicaid and would reduce the potential liability to an individual under the filial law based on a dollar to dollar basis for any State Partnership qualified long-term care insurance benefits paid on behalf of the indigent family member or on behalf of the individual. This approach incentivizes both the indigent to purchase long-term care insurance to protect his or her family members and encourages responsible family members to be pro-active

---

204. *E.g.*, 2011 Idaho Sess. Laws 412 (repealing IDAHO CODE ANN. § 32-1002, Idaho's filial responsibility law).

205. *See* H.B. 224, 2013 Gen. Assemb., Reg. Sess. (Pa. 2013) ("An Act [a]mending Title 23 (Domestic Relations) of the Pennsylvania Consolidated Statutes, in support of the indigent, repealing provisions relating to relatives' liability."); S.B. 70, 2013 Gen. Assemb., Reg. Sess. (Pa. 2013) ("An Act [a]mending Title 23 (Domestic Relations) of the Pennsylvania Consolidated Statutes, repealing provisions relating to the relatives' liability.").

and purchase long-term care insurance for indigent family members. If the population is educated concerning the risks associated with long-term care costs and the potential for such costs to be passed to family members under the filial responsibility statutes, the long-term care insurance premiums may appear attractive to the entire family as a method of protecting both the indigent family member's remaining assets and the assets of other financially responsible family members.

By leveraging the renewed enforcement of existing filial support laws with coordination of its State Long-Term Care Partnership Programs, state governments can both increase long-term care insurance participation and lower the reliance on Medicaid as a long-term care funding option. Essentially all of the laws and infrastructure are in place. However, specific legislation providing asset protection against filial law liability is needed to incentivize people to purchase long-term care insurance under a State Partnership Program. While this potential partnership between two existing laws would likely not solve the entire long-term care funding problem, it could be a step in the right direction for states seeking to shift the financial responsibility of providing long-term care away from the government and onto individuals. Additionally, states with both State Partnership Programs and existing filial laws would not need to spend a lot of time or effort in creating this combined asset protection program as the majority of the required statutes and processes are already in place.

Furthermore, leveraging filial laws to increase long-term care insurance participation and decrease Medicaid spending perfectly aligns with the recently stated government goals on limiting long-term care expenditures. For instance, on August 2, 2012, the Medicaid Long-Term Care Reform Act of 2012, H.R. 6300 (112th), was introduced to the House of Representatives and referred to the Committee on Energy and Commerce.[206] The bill had five sponsors: Representatives Mr. Boustany, Mr. Gingrey, Mrs. Blackburn, Mr. Tiberi, and Mr. Westmoreland.[207] The bill detailed findings regarding the state of the United States health care system and the burden long-term care puts on government budgets.[208] The bill also noted the expansion of the State Long-Term Care Partnership Program, indicating this program was specifically designed to lower reliance of Medicaid's long-term care funding.[209] Furthermore, the bill proposes that the CLASS Program be repealed (which has occurred), and that federal and state governments should "work to reduce the number of middle-income individuals in the United States who will rely on Medicaid to finance their long-term care needs[.]"[210] The bill argues this could be accomplished by making long-term care insurance more affordable, by

206. Medicaid Long-Term Care Reform Act of 2012, H.R. 6300, 112th Cong. (2012), (introduced August 2, 2012, and noting the procedural history of the bill).

207. *Id.* (listing the authors and sponsors of the bill).

208. *Id.* at § 2 (describing problems with the long-term care funding system currently in place).

209. *Id.* at § 2(17) (articulating the reasons behind the bill).

210. *Id.* at § 3(2) (discussing reasons why the government needs to push forward long-term care funding changes).

better educating middle-income Americans on long-term care issues, and by "making the long-term care insurance partnerships . . . more effective by increasing enrollment among middle-income individuals in the United States in long-term care insurance policies[.]"[211] Ultimately, the merger of filial responsibility with qualified State Long-Term Care Partnership Program insurance policies to provide filial law asset protection can help incentivize long-term care insurance purchases and decrease Medicaid's long-term care funding burden, satisfying multiple governmental goals.

VII. CONCLUSION: CHANGES ON THE HORIZON?

Some of the Deficit Reduction Act of 2005's goals were to increase long-term care insurance coverage and awareness of the need for proper long-term care funding. While some progress was made, the fact remains that Medicaid is still burdened by long-term care expenditures. Furthermore, most Americans will need long-term care at some point, and this risk is greater than many other risks people commonly insure, but long-term care insurance is still not widely owned.[212] Until individuals are encouraged to participate in the long-term care insurance market, either by a "stick" (filial liability) or a "carrot" (favorable tax treatment and liability protections), people will continue to rely mostly on government funding.

As the United States seeks to reform the current system for financing long-term care by encouraging more individuals to purchase long-term care insurance, some relatively simple modifications to existing filial laws can be leveraged to incentivize further participation in the private long-term care insurance system. By encouraging more people to purchase long-term care insurance, Medicaid's financial burden will be eased. Furthermore, long-term care insurance ownership diminishes the risk of invading a retirement portfolio at suboptimal market prices, which would reduce the individual's retirement security. However, with the limited success of State Partnership Programs and the CLASS Act to increase private long-term care insurance participation, the government must look to new avenues in order to decrease the dependence on government funded long-term care expenditures. The recently applied filial laws offer the government an excellent opportunity to incentivize people to purchase private long-term care insurance. Ultimately, leveraging filial support obligation laws with State Long-Term Care Partnership Program insurance policies by providing asset protection against the filial liability collection process could play out to be an extremely valuable decision for increasing private long-term care insurance ownership and decreasing reliance on

---

211. Medicaid Long-Term Care Reform Act of 2012 § 3(2)(C) (noting the long-term care insurance partnerships can be leverage to increase long-term care ownership).

212. *See A Special Report on Long-Term Care Insurance Protection*, AM. ASS'N FOR LONG-TERM CARE INS., http://www.aaltci.org/subpages/resources/claimsreport.pdf (last visited Mar. 18, 2014) (reporting statistical probability of becoming "activities of daily life disabled" before age 65 is 72% for women and 44% for men, whereas probability of experiencing major house fire is only 2.6% and 2.2% for men and women respectively, and probability of suffering a major car accident is only 18% and 15.5% for men and women respectively).

government programs.