America's Long Term Care Crisis and Solutions

Stephen J. Wesolick

Author Note

All materials have been prepared for general information purposes only and to permit you to learn more about our firm, our services and our experience. The information presented is not legal advice, is not to be acted on as such, may not be current and is subject to change without notice.

This report adapts and draws heavily from the background, demographic and economic discussion, along with proposed reforms to public policy, that are provided in the following policy papers:

The Bipartisan Policy Center's *America's Long-Term Care Crisis: Challenges in Financing and Delivery* (April 2014), and

The Bipartisan Policy Center's *Initial Recommendations to Improve the Financing of Long-Term Care* (February 2016).

A helpful tip for the reader: This report is an attempt to distill a mountain of complex information into a few key concepts. Inevitably, such an effort is destined to result in confusion and omissions that affect the understanding of some. That is to be expected and is solely the fault of the author rather than the reader. Some readers may want a more comprehensive survey of the Medicaid landscape or to drill down into the minutiae contained in Pages 4-11. Other readers may simply wish to **jump ahead to Page 12** to take a quick look at individualized planning solutions that are available now through the assistance of a qualified Medicaid planner, with the goal of preserving hard-earned assets and complying with Medicaid eligibility rules sooner. Either way, it is hoped that the reader will gain new perspectives or find some answers that are beneficial.

Abstract

America's elderly and disabled members face a looming crisis. A gathering storm approaches. And it centers on the ever-increasing costs of providing care to those who are unable to care for themselves. For decades, the nation's politicians, policymakers and economists, along with leaders in the insurance industry, have known that our changing demographics – initiated by our aging Baby Boomers – were leading America toward a Long Term Care (LTC) financing crisis of enormous magnitude. Yet, our leaders have done nothing to ensure that a viable, affordable path exists for retirement security and dignified aging. Instead, millions of our citizens are forced to go broke, spending down their hard-earned life's savings and selling their homes, to pay for nursing home or other LTC expenses. This special report will examine the magnitude of this crisis, and will present for consideration:

(a) various aspirational public policy proposals currently being made to reform the nation's LTC financing system, and

(b) practical solutions that are available on an individual basis for those who choose to engage in planning strategies under current Medicaid regulations to help pay for LTC expenses while preserving their hard-earned assets.

America's Long Term Care Crisis and Solutions

What is Long Term Care and Long Term Services and Supports?

This is a great question because of the misinformation and confusion that exists over this complex topic. Long Term Care (LTC), otherwise known as Long Term Services and Supports (LTSS), is defined as assistance with 1) Activities of Daily Living (ADLs) for self-care, including bathing, dressing, eating, transferring, walking, personal grooming and toileting; and 2) Instrumental Activities of Daily Living (IADLs), including meal preparation, money management, house cleaning, medication management, transportation, shopping, telephone use and other communications. This type of assistance is provided to older people and adults with disabilities who are unable to perform these functions independently due to a physical or cognitive condition or chronic health condition that is expected to last for an extended period, usually 90 days or more. Long Term Care assistance is provided by personal assistance, technology tools, and care coordination, in an institutional setting (e.g., nursing home), residential community or even one's own home. Long Term Care also includes support provided by family members and other unpaid caregivers.

Demographic Challenges and Utilization of LTC

An estimated 12 million Americans are currently in need of LTC – defined as institutional or home-based assistance with ADLs. In the next two decades, the U.S. health care system will face a tidal wave of aging Baby Boomers. This, among many other factors, will create an unsustainable demand for LTC in the coming years. Fewer family caregivers, increasingly limited personal financial resources, and growing strains on federal, state, and family budgets will further complicate efforts to organize and finance services. Although there is tremendous variation in what is, or will be, needed, fully 70 percent of people who reach the

age of 65 will require some form of LTC at some point in their lives, with women aged 65 and over needing services for an average of 2.5 years compared with about 1.5 years for men. The number of Americans needing LTC at any one time is expected to double from 12 million today to 27 million by the year 2050.

The Federal-State Medicaid Partnership

Medicaid is most commonly thought of as the government's medical-welfare system for the poor. It is often confused with Medicare, which is the health insurance program for individuals aged 65 and older. In contrast with Medicare, the Medicaid program provides both acute care services and LTC for a broad range of individuals, including children, pregnant women, and people eligible for cash assistance such as Supplemental Security Income (SSI) and Temporary Assistance for Needy Families (TANF).

Medicaid is a state-federal program, which means that it was initiated by the federal government but is implemented and administered at the state level by state agencies. In South Dakota, that state agency is the Department of Social Services (DSS). Funding comes from both the federal and state governments. Also, the rules and regulations that control Medicaid are adopted, in combination, by the federal and state governments, and those rules and regulations are extremely complex.[1] The federal government does not directly interact with the individual recipient but primarily serves as a regulator over the state Medicaid programs and a source of funding for those programs. In South Dakota, the program interface with the public and providers is provided by DSS. The federal statutory and administrative rules essentially establish basic minimum requirements for the states to implement with *broad* discretion to the states in certain areas, including income and asset eligibility requirements. Therefore, it has been said that Medicaid law for LTC is a patchwork of 50 sets of regulations, comprised of the unique

regulatory scheme of each state. Additionally, the rules governing Medicaid are constantly changing.

Political and Fiscal Challenges

The Centers for Medicare and Medicaid Services (CMS) estimates that Medicaid spending on LTC will grow by an average of 6 percent annually from 2012 to 2021, far faster than the nation's Gross Domestic Product (GDP). The CMS expects that the Baby Boomer generation, when they begin to exceed the age of 85 in the 2030s, will start to drive even faster growth in Medicaid LTC spending. Policymakers seeking to address the challenge of financing and delivering LTC for an aging population will be looking for reforms that will reduce the rate of growth in spending over the long term through *greater efficiency in public programs* (nebulous concept, such as it is) for those who need them and an *increased reliance on privately funded solutions* (e.g., more personal resources) to limit the need for public funding of LTC services.

Over the years, there have been numerous policy proposals to address and reform LTC financing, yet many stumbling blocks have prevented progress on reforms. Consider, for example, the ongoing partisan divide over the government's role and participation in the financing of Americans' LTC needs within the context of ever-increasing public debt. As will be discussed below, it is a reasonable assumption that in the foreseeable future there will <u>not</u> be any meaningful reform of public (government) or insurance funding sources of Americans' LTC needs. And, accordingly, there will not be a viable, affordable path toward retirement security and dignified aging for any but the most affluent among the millions of Baby Boomers who will need assistance.

Cost of Long Term Care

LTC services are provided in institutional settings, which include nursing facilities and residential facilities, and through Home and Community-Based Services (HCBS). However, Medicaid LTC funding was originally designed with a built-in bias toward institutionalization – nursing facilities – over home care or other residential settings. And that continued bias is evident in the rules of many states, although it is changing. Regardless of the setting, the cost of services is significant, which is why many state and federal policymakers have been reluctant to take on the issue of financing LTC. In 2014, the average annual cost for a home health aide was approximately $45,800,[2,3] the cost for community-based adult day care centers was on average $16,900 per year,[4] and the average annual cost to live in a nursing facility was approximately $87,600 . . . or $7,300 per month. In 2013, national spending for formal LTC (i.e., services from a paid provider) was about $310 billion, with Medicaid spending accounting for about $123 billion (51 percent) of this amount.[5] Formal LTC spending for older Americans (65 years and up) was approximately $192 billion in 2011.[6]

The cost of providing services is estimated to rise, taking up a larger portion of federal and state budgets under the Medicaid program, and will significantly impact families' savings. According to the Congressional Budget Office, spending by the federal government, states and individuals on formal LTC for those aged 65 and older will increase from 1.3 percent of GDP in 2010 to 3 percent in 2050.[7]

A significant number of people receive *unpaid* LTC from caregivers who are family members or friends. While many people who engage in caregiving consider it rewarding, caregiving takes a toll on the caregiver in terms of physical and mental health, missed work time, and forgone retirement savings.[8] Because of a lack of measurable statistics, valuing unpaid care

is difficult and inherently uncertain. However, some estimates put the total economic value of unpaid caregiving at about $470 billion in 2013.[9]

Amount and Distribution of LTC Spending per Person

Approximately 6 percent of individuals will have expenditures greater than zero but under $10,000; about 27 percent will have LTC costs of at least $100,000 over the course of their lifetimes, and costs will exceed $250,000 for about 15 percent. [10]

Individuals and their families pay for about 53 percent of their total LTC expenses out-of-pocket. The states and the federal government pay for about 34 percent of total LTC expenditures through the Medicaid program. Other public programs, such as benefits available to veterans, cover about 10 percent of total LTC expenditures, and private Long Term Care Insurance accounts for *less than 3 percent* of expenditures.[11]

Private Long Term Care Insurance

Long Term Care is an insurable risk yet the private Long Term Care Insurance (LTCI) market covers a decreasing portion of Americans. Many carriers have stopped issuing new policies. The LTCI take-up rate[12] is stalling because policies are too expensive, distribution is too limited, and the traditional design is not sustainable for insurance companies. Today, private LTCI accounts for a small portion of LTC spending. The origin of this problem is that insurers made incorrect assumptions when establishing premiums in the early 2000s and found them to be unprofitable without substantial rate increases. Many insurers left the market due to continued uncertainty about whether the product will ultimately be profitable. There are about a dozen companies actively selling in the individual market, down from more than 100 in the early 2000s, and fewer than eight selling in the group market.[13]

Consumer purchase of private LTCI has been low for a variety of reasons, including the high cost of premiums, the need to pass medical underwriting, the complexity of LTCI benefit design, and limited opportunities to purchase coverage. Even though slightly more than half of Americans entering retirement age will eventually experience the need for LTC at a level that would be covered by most private-market LTCI policies, few Americans feel that obtaining LTCI is possible or beneficial under their circumstances.

Proposals to Reform LTC Financing (Public Policy)

Various proposals from a public policy perspective for reforming the delivery and financing of LTC include:

Improving Affordability and Availability of Private LTCI

1. Stabilizing and expanding the private Long Term Care Insurance market by offering a newer, streamlined and lower-cost policy, known as a "retirement LTCI." Such policies would be standardized, with a few basic designs and having limited options for customization. The lower-cost product would cover two to four years of LTC needs, after a deductible or exclusion period is met, and includes coinsurance. Notably, these policies will reduce, but not eliminate: (1) the use of personal and retirement savings for out-of-pocket spending for paid services; and (2) the reliance on friends and family members to provide unpaid care.

2. Allowing employees aged 45 and older in defined-contribution retirement plans, such as 401(k) and 403(b) plans, to take distributions from the plan solely for the purchase of retirement LTCI for themselves or a spouse. Distributions for the purchase of retirement LTCI from tax-deferred plans would be subject to income tax but exempt from the 10 percent early withdrawal penalty.

3. Providing employers incentives to *automatically* enroll employees as plan participants in LTCI retirement policies. Although automatically enrolled, an employee would retain the right to opt out of the plan.

4. Allowing retirement LTCI policies to be sold through existing channels on state and federal health insurance marketplaces, like the process for health insurance policies under the Affordable Care Act.

These proposals, while well intentioned, are modest at best and fail to offer LTCI to a broad enough segment of the American population to bring the costs of coverage down or otherwise make the LTCI an attractive, yet alone available, option for most people. However, any improvement in the private LTCI market over the current conditions – a market contraction – is worthy of consideration.

Expanding Options at Home and in the Community

5. Create incentives for states to expand the availability of Home and Community-Based Services (HCBS) by streamlining and simplifying existing authorities under current law waivers, and extend federal financing to encourage states to do so.

In a very counter-intuitive manner, Medicaid LTC funding was designed with a built-in bias toward institutionalization – nursing facilities – over home care or other residential accommodations. Over time, many states have seen the benefits of receiving waivers from Medicaid to allow for LTC services, provided through HCBS to be paid for through Medicaid. While there has been significant movement toward this outcome, many states have yet to implement such reforms. Most people want to stay in their homes if they can. They should not be forced into an institution to receive Medicaid benefits. It is generally accepted that care

provided in an alternative setting will reduce overall expenditures. This reform proposal will go a long way toward improving delivery of LTC and reducing its cost.

Addressing the Needs of Americans with Extraordinary LTC Needs Through a Mandatory Public Insurance Program

6. Developing a *public* catastrophic insurance program, broadly covering Americans of all ages and complementing private-market LTCI, if any, with a dedicated payroll-tax financing option (like Social Security or Medicare Part A). This program would help pay only for expenses of a limited percentage of individuals having higher or "catastrophic" LTC expenses, such as those more than $250,000. Under this plan, while a broad swath of the public will contribute to the program, only a small percentage of Americans would ultimately receive benefits.

7. An alternative would be a "general-funding" approach, which would be offset through changes to the tax system, such as broadening income or consumption-tax bases or increasing tax rates, adjustments to Medicare and Social Security, or a combination of both.

These models involve substantial uncertainty because the cost projections are sensitive to assumptions, such as the duration of services needed by claimants. It is unlikely that such a program would have the support of either the public or congressional leaders since only about one-third of retirees would receive benefits and there is a likelihood that the public debt will increase.

INDIVIDUALIZED SOLUTIONS, PLANNING STRATEGIES AVAILABLE RIGHT NOW

This is "Rocket Science"

While politicians, policymakers and the insurance industry dawdle over the very complicated issues addressed above, the average American believes he or she has very few options to adequately address the financial train wreck that they are about to encounter should they need Long Term Care for themselves, a spouse or other loved one. Everyone has been told their entire lives to work hard to save for their retirement or to pass a little something down to their children. And most have abided dutifully to that ethic only to realize that as they approach or enter their retirement years everything … literally everything … is at risk of being lost to pay for LTC expenses because of spiraling costs combined with lack of action on the part of those in whom trust has been placed to fix this mess.

In most cases, the reader who took the time to read the material presented in Pages 4-11, will likely have experienced confusion, perhaps anxiety, about what planning for LTC means for his or her family. There is no way that anyone, other than a very few experts and professionals qualified in this type of planning, can successfully navigate the rules and processes known as Medicaid law for elders. Yet, while this involves very special and sophisticated legal planning strategies, there *are* solutions to address one's concerns and protect his or her family.

One cannot overemphasize the importance and benefits of utilizing private LTCI to fund or at least partially fund the cost for Long Term Care. A qualified insurance professional should certainly be consulted to help determine if LTCI is a viable option. If LTCI is acquired and it is part of the State's incentivized Partnership Program then an additional benefit is received by the policy holder through reduction of the spenddown amount for the total aggregate policy payout, which could be a sizable asset protection outcome. LTCI might be considered on its own or, in

combination with legal planning, as part of a comprehensive strategy to maximize asset preservation. On the other hand, LTCI simply might not be available or an attractive option.

It is important to note that eligibility for Medicaid LTC benefits is determined on a "snapshot" date based on the income and assets of the applicant. The applicant can have no more than $2,205 in monthly income ("income cap") and can own no more than $2,000 in non-exempt assets (or countable resources). If the applicant's monthly income exceeds the income cap, an easy remedy exists: a "qualified income trust" or QIT (otherwise known as a Miller trust), through which the excess income is funded. A QIT can be prepared by an attorney to allow the applicant to qualify. Concerning the asset cap, if the applicant is married then there are certain exemptions applied to assets, such as the primary residence, and the non-applicant spouse can keep a certain amount of additional non-exempt assets (or countable resources), but no more than $120,900. The non-applicant spouse's income is not used to determine the applicant spouse's eligibility. These are, of course, only very general statements on the income and asset eligibility rules. Quite a bit of planning involves looking for opportunities to properly spend down the countable resources to a level that will allow the applicant to qualify for Medicaid benefits. Caution is required here, however, because of Medicaid's "lookback period" of five years / 60 months prior to the application date. Improper transfers – those for less than fair market value – made during the lookback period will result in DSS imposing a "penalty period" during which the applicant will not receive benefits. And the manner in which the penalty period is applied is especially punitive.

With these comments in mind, the following is a brief discussion of some unique planning strategies that can be considered for Medicaid LTC eligibility situations, whether that need is immediate ("crisis") or, instead, longer out into the future ("proactive"). These strategies

should be considered only with the careful guidance of a qualified planning professional, such as the Wesolick Law Firm. Great caution is advised against proceeding on one's own without such guidance. The potential disastrous consequences are very real.

Individualized Planning Solutions to Take Control of Your Future

Know the Numbers, Know Your Spenddown

Any analysis of one's situation and solutions begins with one very simple exercise, understanding the general asset and income eligibility rules. At the time application for Medicaid benefits is made, all income and every asset, otherwise known as a resource, owned by the applicant and, if married, the spouse must be disclosed to DSS, even if that ownership is partial or joint. DSS categorizes resources as either "exempt" (or "non-countable") toward the spenddown or "countable" toward the spenddown. There are many exempt assets, some of the more common of which are: homestead (within limits), primary vehicle, personal items and furnishings, limited cash value of life insurance policies, certain business and non-business assets, specific types of annuities that comply with Medicaid regulations, limited and segregated accounts for burial expenses or irrevocable pre-paid funeral contracts, and burial plots owned by the applicant or spouse for themselves and other family members.

Remember that the applicant can have no more than $2,205 in monthly income and can own no more than $2,000 in non-exempt assets (or countable resources). Where both spouses are applying for or are receiving aid, the limit is $3,000. Medicaid rules for the treatment of income and resources of married couples when one spouse requires nursing home care and the other remains living at home are intended to prevent the impoverishment of the spouse remaining in the community. Before the applicant spouse's money is used to pay for the cost of institutional care, a minimum monthly maintenance needs allowance is deducted for bringing the income of

the spouse living in the community up to a moderate level; and a State-determined level of resources is preserved.

The basic asset/resource calculation for a single applicant (or where both applicants are married and are receiving care in a facility at the same time) is to inventory all assets, determining which assets are exempt and which are countable. Here is an example:

Step 1:		Total Asset Inventory	$160,000
	-	Exempt Assets	15,000
	=	Countable Assets	$145,000
Step 2:		Countable Assets	$145,000
	-	Individual Countable Resource Allowance (ICRA)	2,000
	=	Spenddown Amount	$143,000

In the situation of a married couple, the applicant spouse is referred to as the "Institutionalized Spouse" (or IS) and the non-applicant spouse is referred to as the "Community Spouse" (or CS). The basic formula for the protected resource amount that the Community Spouse can keep is demonstrated as follows:

Step 1:		Total Asset Inventory	$465,000
	-	Exempt Assets	215,000
	=	Total Countable Assets	$250,000
Step 2:		Determine the Community Spouse Resource Allowance (CSRA) 50% of Countable Resources, maximum of $120,900	
Step 3:		CSRA	$120,900
	+	ICRA	2,000
	=	Total Protected Countable Resources	$122,900

Step 4:		Net Countable Assets	$250,000
	-	Total Protected Countable Resources	122,900
	=	Spenddown Amount	$127,100

There are many more details or factors that come into play in determining income and asset eligibility, which is why it is crucial to seek the guidance from a qualified planning professional. But, hopefully, the examples shown above provide some idea of how the planning process begins.

Basic Asset Eligibility Strategies

A key concept in Medicaid planning is the "spenddown" amount. To most people, this means the amount of countable resources that must be spent on LTC. However, there is no actual requirement to spend down such amount on nursing home care. The concept of "spend" is broader than that and can mean any manner of transfer or conversion of assets from countable to non-countable until the total amount of the countable resources is less than or equal to the protected amount.

After the stage that a protected amount has been determined, such as through a DSS resource assessment, there are simple consumer transactions that can be taken to direct countable resources into exempt or protected resources to meet the spenddown. These could include:

- making renovations or upgrades to the primary residence
- purchasing a new home
- purchasing new appliances, furniture, clothes or other personal property
- upgrading the primary vehicle
- pre-pay funeral and burial expenses

Advanced Strategies for Asset Eligibility
Gifting or Divestment

In addition to the basic consumer transactions for the conversion of countable resources, more complex strategies exist that could prove beneficial in the planning process to preserve assets for a spouse or future generations. These are often used in pre-planning or proactive planning, that require more steps and must be carefully considered in the context of possible drawbacks. Some examples are:

- making an exempt transfer of the home to a person recognized by Medicaid
- entering into a legal, written and prospective service contract or caregiver agreement with a family member to receive compensation, including a lump sum, for the applicant's non-custodial or non-medical care needs, companionship and transportation; care must be taken because Medicaid ordinarily considers such services for family members to be gratuitous
- purchasing or converting property into income-producing property, in particular, a second home to rental property; care must be taken to satisfy net rental revenue guidelines
- purchasing a life estate in the home of another
- transferring the applicant's primary residence while retaining a life estate
- converting assets into income streams, in the forms of annuities and promissory notes; these are specifically tailored to meet the requirements of Medicaid regulations
    - to qualify, an annuity must be irrevocable, non-commutable, non-assignable, and actuarially sound, provide payments in equal amounts, must be a single-premium immediate annuity, and must name the State as the primary beneficiary to the extent of LTC benefits paid
    - likewise, a promissory note must be actuarially sound, provide payments in equal amounts with no balloon payments or deferral, must not allow the cancellation of the balance upon the death of the lender, should be unchangeable and non-assignable to qualify as "lesser than market value" or non-negotiable
- carefully engaging in strategic divestment or gifting of countable resources – either outside the lookback period or within – sometimes combined with other

strategies to intentionally trigger and pay for a penalty period imposed by the State

- implementing and funding an irrevocable trust with special recognition under Medicaid rules, which creates no further rights in or to the assets of the trust and, perhaps, the income of the trust

- utilizing other trusts, revocable or irrevocable, to accomplish very specific strategies, such as increasing the CSRA or benefitting a disabled child

- acquiring "unavailable" assets, such property or stock owned jointly with others (not a spouse) that cannot be liquidated unless all joint owners agree; or "unsellable" assets, such as real property that cannot be sold within a reasonable period

These strategies, individually or in some combination, provide outstanding opportunities to qualify for Medicaid benefits to pay for LTC while preserving assets and protecting families. As can easily be seen, these are not a one-size-fits-all strategy, each client's plan is uniquely tailored under the careful guidance of our professionals to his or her circumstances and objectives to achieve the desired outcome. But, as with most things in life, acting early ensures the best possible protection while delay results in lost opportunities.

Conclusion

As discussed in this report, the prospect for many of enjoying a secure retirement and aging with dignity is quickly becoming an illusion, a prospect that will never come to pass, because of the gathering storm known as America's Long Term Care crisis. It is certainly a laudable effort by our nation's leaders and policymakers to take up structural Medicaid and LTC reforms, and changes will inevitably come. Yet those changes will result in an increased shifting of the burden to retirees (or their unpaid caregivers) rather than provide meaningful benefits through public programs or private insurance. As the crisis grows, options are lost. Each of us is faced with two choices. Either do nothing and wait for the impending financial train wreck that is

quickly approaching or, instead, take charge of our family's financial security and determine our own future. There are real and immediate solutions to the crisis. It is simply a matter of choice.

References

America's Long-Term Care Crisis: Challneges in Financing and Delivery. Bipartisan Policy Center (April 2014). Available at: http://bipartisanpolicy.org/library/americas-long-term-care-crisis/

Initial Recommendations to Improve the Financing of Long-Term Care. Bipartisan Policy Center (February 2016). Available at: http://bipartisanpolicy.org/library/long-term-care-financing-recommendations/

Erica L. Reaves and Marybeth Musumeci (5/8/2015). *Medicaid and Long-Term Services and Supports: A Primer.* Kaiser Family Foundation. Available at: http://goo.gl/Uh5xv5.

Rising Demand for Long-Term Services and Supports for Elderly People. Congressional Budget Office (June 2013). Available at: http://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44363-LTC.pdf.

Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson. *Financing Long-Term Services and Support: Options Reflect Trade-Offs for Older Americans and Federal Spending.* Health Affairs. Vo. 34 Iss 12, 1. 2015. Doi: 10.1377/hlthaff.2015.1226. Available at: http://content.healthaffairs.org/content/early/2015/11/13/hlthaff.2015.1226.full.pdf + html.

Susan C. Reinhard et al. *Valuing the Invaluable: 2015 Update. Undeniable Progress, but Big Gaps Remain.* AARP Public Policy Institute (July 2015). Available at: http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf.

Long-Term Services and Supports for Older Americans: Risks and Financing. ASPE Issue Brief (July 2015). Available at: https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief.

Leslie Scism (May 2015). *Long-Term Care Insurance: Is It Worth It?* The Wall Street Journal. Available at: https://www.wsj.com/articles/long-term-care-insurance-is-it-worth-it-1430488733. And Marc A. Cohen (March 2014). *The Current State of the Long-Term Care Insurance Market.* Presented to the 14th Annual Intercompany Long-Term Care Insurance Conference. Available at: http://iltciconf.org/2014/index_htm_files/44-Cohen.pdf.

Endnotes

[1]The United States Supreme Court has described the Medicaid law as "among the most intricate ever drafted by Congress," with a "Byzantine construction" that is "almost unintelligible to the uninitiated." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981). Other federal courts have described the Medicaid rules as a "virtually impenetrable thicket of legalese and gobbledygook." *Lamore v. Ives*, 977 F.2d 713, 716 (5th Cir. 1992).

[2]Erica L. Reaves and Marybeth Musumeci (5/8/2015). *Medicaid and Long-Term Services and Supports: A Primer.* Kaiser Family Foundation. Available at: http://goo.gl/Uh5xv5.

[3]Cost was calculated using the rate of $20/hour, 44 hours/week.

[4]Cost was calculated using the rate of $65/day, five days/week.

[5]See reference cited in Endnote 2.

[6]*Rising Demand for Long-Term Services and Supports for Elderly People.* Congressional Budget Office (June 2013). Available at: http://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44363-LTC.pdf.

[7]See reference cited in Endnote 6.

[8]Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson. *Financing Long-Term Services and Support: Options Reflect Trade-Offs for Older Americans and Federal Spending.* Health Affairs. Vo. 34 Iss 12, 1. 2015. Doi: 10.1377/hlthaff.2015.1226. Available at: http://content.healthaffairs.org/content/early/2015/11/13/hlthaff.2015.1226.full.pdf + html.

[9]Susan C. Reinhard et al. *Valuing the Invaluable: 2015 Update. Undeniable Progress, but Big Gaps Remain.* AARP Public Policy Institute (July 2015). Available at: http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf.

[10]*Long-Term Services and Supports for Older Americans: Risks and Financing.* ASPE Issue Brief (July 2015). Available at: https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief.

[11]See reference cited in Endnote 10.

[12]The term "take-up rate" means the percentage of persons who are eligible for some benefit or compensation who take advantage of it.

[13]Leslie Scism (May 2015). *Long-Term Care Insurance: Is It Worth It?* The Wall Street Journal. Available at: https://www.wsj.com/articles/long-term-care-insurance-is-it-worth-it-1430488733. And Marc A. Cohen (March 2014). *The Current State of the Long-Term Care Insurance Market.* Presented to the 14th Annual Intercompany Long-Term Care Insurance Conference. Available at: http://iltciconf.org/2014/index_htm_files/44-Cohen.pdf.