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Not-For-Profit Organization for Interdisciplinary Research Regarding Private Sector Funding Alternatives for Long-Term Care

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SECURITIES FUNDING OF LONG-TERM CARE: A STEP TOWARD A PRIVATE SECTOR SOLUTION

*Dana Shilling**

It is a truth universally acknowledged that a person in possession of a good fortune who needs long-term care is likely to end up in want.¹

I. Introduction

Improvements in medicine and public health have lengthened the average lifespan of Americans, and greatly increased the percentage of the population over age 65, especially the “old old” who have reached the age of 85 or older.² Nonetheless, it has not been possible to eliminate disease and debility. Although not every person over 65 suffers from physical or mental impairment, or will develop a disabling condition before death, many senior citizens have at least one illness or limiting condition, or need assistance with one or more Activities of Daily Living (“ADLs”) such as eating, dressing, and bathing.³ As the year 2000 approaches, the financing of nursing home care will pose an increasingly complex problem, mandating public and private sector cooperation.

Long-term care (“LTC”) represents an enormous industry. It comprises acute medical care, chronic care, rehabilitation services, support services, and social services for the elderly and disabled.⁴

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1. This sentiment is reminiscent of the opening line of a well-known English novel. See *JANE AUSTEN, PRIDE AND PREJUDICE* 1 (Donald J. Gray ed., W.W. Norman & Co., Inc. 1966) (1813).

2. Employee Benefits Research Institute, *Issues Concerning the Financing and Delivery of Long-Term Care*, ISSUE BRIEF 86, at 3-4 (January 1989) [hereinafter EBRI]. (“The elderly, those aged 85 and older in particular, are the fastest growing age group in the U.S. population. . . Over the next 23 years—before the baby-boom generation begins to enter the ranks of the elderly—the number of persons aged 65 or older is projected to increase 1.7 percent per year, while the population aged 85 and older is projected to increase at more than twice that rate, 4.1 percent per year.”). See also UNITED STATES GENERAL ACCOUNTING OFFICE, *LONG-TERM CARE FOR THE ELDERLY: ISSUES OF NEED, ACCESS, AND COST*, GAO/HRD-89-4, at 8 (Nov. 1988) [hereinafter GAO I].

3. GAO I, *supra* note 2, at 2-4.

4. *Id.* at 8.

Although most people think of nursing homes when they think about providers of LTC, a high volume of services are also performed in the elderly person's home and are known as home care or home and community-based services.⁵ Not surprisingly, in 1988, estimates placed expenditures on LTC at \$57.8 billion, with \$44.3 billion allocated to nursing home care.⁶ Unfortunately, however, these expenditures fell well short of the LTC demand, suggesting that an expansion of LTC services may be necessary to alleviate the difficulties elderly people currently face in their lives.

The problem, on both an individual and a societal level, is that LTC is very expensive. For example, the yearly cost of a nursing home stay in 1988 averaged about \$25,000 a year.⁷ Costs in some East and West coast urban areas, particularly those offering a high staff-to-patient ratio, often exceeded \$75,000 a year and in some cases, exceeded \$100,000 a year. Home care can be equally expensive, or even more costly, than institutionalization in a nursing home because it may be necessary to hire three shifts of unskilled workers as well as retaining the occasional services of several health care professionals.

Clearly, few families can make such large payments out of current income. In many cases, the family's accumulated assets and the next generation's expected inheritance can be decimated by the cost of long-term health care. Although private LTC insurance is now beginning to play a significant role in financing long-term care, the thesis of this Article is that such LTC insurance is unlikely to become a major financing source because it lacks long-range viability as a product.⁸

In response to this health care crisis, this Article proposes a new system of funding long-term care that contemplates the issuing of securities. This mechanism is designed to supplement or supplant pri-

5. *Id.* at 3. These services are often provided on an unpaid basis by friends and family members.

6. CONGRESSIONAL BUDGET OFFICE, POLICY CHOICES FOR LONG-TERM CARE (June 1991) (report requested by the House Committee on the Budget) summarized at Commerce Clearing House (CCH) Medicare/Medicaid Guide ("MMG") ¶ 39,479. The Congressional Budget Office further estimated that private individuals paid \$27.5 billion for LTC in 1988 (\$21.5 billion for nursing home care, nearly all of it paid out of pocket rather than reimbursed by private health insurance, and \$6 billion for home care, again primarily paid out of pocket). The federal government financed \$18.3 billion, \$13.3 billion for nursing homes, and \$5 billion for home care. Medicare paid for about half the federal share of home care, but very little of the nursing home cost; Medicaid assumed almost the entire federal participation in nursing home care. States contributed a further \$9.5 billion to the overall cost of nursing home care, almost entirely through the state share of Medicaid costs; states also paid \$2.6 billion for home care, and \$1.1 billion in Medicaid cost-sharing, \$1.5 billion for other programs.

7. GAO I, *supra* note 2, at 4.

8. See discussion *infra* part II.C.1.

vate insurance and to enable the private sector to play a more significant role. Part Two of this Article considers the current funding alternatives for nursing home care, and specifically explores the types of facilities already in existence to serve the elderly in need of nursing home services. The limitations of Medicare and Medicaid, and the private sector funding alternatives for persons entering nursing homes are also discussed. Part Three introduces the concept of a health care consortium and outlines how such a program could be implemented. Part Four considers various legal implications of the plan including the consortium's tax status, antitrust ramifications, and problems that might arise in connection with Certificate of Need ("CON") laws.⁹

In the final analysis, the question is not whether one funding mechanism should supplant all others, but rather, whether consumers have adequate choice of funding mechanisms that in turn will permit them to obtain affordable high quality care. This Article contends that existing funding mechanisms are not sufficient, and should be supplemented with the securities plan. It further argues that the proposed plan represents a positive solution to the existing system because it contains no element of compulsion, expands competition and free choice, and promotes equity by permitting individuals to pay for their own care, leaving Medicaid funds available to those with fewer resources and lower incomes.

II. The Current Health Care System

A. The Nursing Home Universe

In order to succeed, the proposed plan must appeal both to health care providers and consumers. To predict the needs and predilections of both groups, certain information is required. The size of the senior citizen population; the degree of disability and need for care of the population; and the types of facilities already in existence would all be relevant factors in the plan's implementation.

1. *Defining The Nursing Home Population*

In 1990, more than 12 percent of the U.S. population, over 30 million people, were aged 65 or older.¹⁰ Predictions estimate that there will be more than 64.5 million Americans over 65 years old in 2030.¹¹

9. The implications arising out of state Certificate of Need issues will be important in any proposal that involves the construction of nursing homes. See discussion *infra* part IV.C.

10. See EBRI, *supra* note 2, at 4, Table 1.

11. *Id.*

In conjunction with this growth, demand for nursing home care is likely to increase, particularly since the population of the "old old," those over 85, is increasing faster than the percentage of all elderly individuals over 65.¹² Although only about one percent of the overall U.S. population, and five percent of the population of senior citizens, are institutionalized, more than *eighteen percent* of the over-85 population lived in institutions in 1985.¹³ In fact, it has been estimated that there is at least one equally disabled person residing in the community for each nursing home resident, suggesting there is a vast unmet need for nursing home beds.¹⁴ Collectively, the statistics show that the proportion of the population that is most in need of nursing home care is increasing the fastest, indicating that more nursing home beds will be needed in the future.

Counting people who are actually in nursing homes and analyzing their characteristics is reasonably simple. A more challenging task involves predicting the risk of institutionalization for a group or a particular individual. Even if it were possible to predict the age to which a particular person would live, issues such as his or her state of health and risk calculation factors such as finances, availability of uncompensated care from family and friends, and availability of beds complicate risk assessment. Recognizing the difficulty of making such calculations, various studies have defined risk of institutionalization figures at some point in a senior citizen's life as ranging anywhere from 39% to 63%.¹⁵ In addition, uncertainty over the correct definition of the term "nursing home" makes it difficult to reconcile statistics from different sources. A distinction is often drawn between "nursing homes" which offer some degree of medical care, in addition to personal care, and "residential facilities" that provide *only* personal or supervisory care with no medical component.¹⁶

12. *Id.* at 3.

13. *Id.* at 5, Table 3. In 1985, 88.2 percent of all nursing home patients were over 65. Of these, only 14.2% were aged 65-74, 34.1% were between 75 and 84, and 39.9% were over 85. *Id.*

14. The nursing home population in 2020 has been projected at 4.2 million, with more than 10 million elderly people in the community needing assistance with everyday tasks. See GAO I, *supra* note 2, at 17.

15. See EBRI, *supra* note 2, at 6.

16. Nearly two-thirds of the facilities fell into the "nursing home" category (16,388 nursing homes versus 9,258 residential facilities). Because nursing homes were larger, averaging 92 beds to 22 beds in residential facilities, they had nearly eight times as many beds (1,507,400 versus 201,800). Nursing homes also had a higher occupancy rate: a nationwide average of 91.7%, as compared to the 85.4% occupancy rate for residential facilities. See U.S. DEPARTMENT OF COMMERCE, BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 112 (No. 176. Nursing and Related Care Facilities - Selected Characteristics: 1986) [hereinafter Statistical Abstract].

2. Comparing The Nursing Home Population To Nursing Home Availability

According to U.S. government statistics for 1986, the last year for which complete statistics have been tabulated, the U.S. contains 25,646 nursing homes, with approximately 1,553,000 residents.¹⁷ A large majority of these residents are age 65 or older.¹⁸ In recent years, the AIDS epidemic appears to have increased the number of younger nursing home patients, altering the balance somewhat from 1986 levels.

U.S. Government figures demonstrate a dearth in the supply of nursing home beds. The lowest occupancy rate of 76.9% is found among the comparatively few large residential facilities (14 facilities with 300-499 beds).¹⁹ The highest occupancy rate of 95% is found among facilities (both residential and nursing homes) with more than 500 beds.²⁰ The small number of existing vacancies means that those entering a nursing home may have to make compromises if there is a long waiting list at a preferred facility. It also means that advocates for the elderly and federal and state regulators face a practical limitation on their enforcement powers. In other words, the threat to close down a facility, or to move patients elsewhere, becomes an empty one (even if there were no risk of harming the patients themselves through transfer trauma)²¹ when there is no superior or even equivalent alter-

17. *Id.* at 104 (No. 162. Hospitals and Nursing Homes — Summary Characteristics: 1971 to 1986). About 80% of these homes were proprietary (20,223 proprietary versus 4,378 nonprofit-owned and 1,045 government-controlled (e.g., Veterans' Administration facilities)). About 40% of the nursing homes had fewer than 25 beds; about 20% had 25-74 beds; and about 40% had more than 75 beds (9,613; 6,605; and 9,428, respectively). *Id.*

18. In 1986, a nationwide average of 90.4% of all nursing home residents were senior citizens, with 9.3% aged 22-64. U.S. Dep't of Health and Human Services, Public Health Service, Centers for Disease Control/National Center for Health Statistics: Vital and Health Statistics: Nursing Home Characteristics: 1986 Inventory of Long-Term Care Places, Series 14: Data from the National Health Survey No. 33, at 24, Table 25 (March 1989) [hereinafter Inventory].

19. *Id.* at 11, Table 4. Another survey divides facilities into "nursing homes," "hospital-based facilities," and "residential facilities," and finds a nationwide average occupancy rate of 91.8% for nursing homes, 92.1% for hospital-based facilities, and 85.4% for residential facilities, with noticeable state-to-state variations. Residential facilities are operating at full capacity in Montana, but only 69.9% of capacity in Indiana; the overall occupancy rate in Rhode Island is 96.2%, but only 84.9% in New Mexico. Inventory, *supra* note 18, at 11, Table 4.

20. Statistical Abstract, *supra* note 16, at 112 (No. 176 Nursing and Related Care Facilities-Selected Characteristics: 1986).

21. "Transfer trauma," also known as "relocation trauma," has been identified as a cause of harm or even premature death of nursing home residents. See, e.g., Collette I. Hughes, *Liberty From Transfer Trauma: A Fundamental Life and Liberty Interest*, 9 HASTINGS CONST. LAW QUARTERLY 429 (Winter 1982); *Stitt v. Manor Care of Wil-*

native facility available. One objective of the securities funding plan²² is to increase the number of facilities, and decrease average occupancy rates, precisely so that facilities would be forced to compete to keep their own patient census high.

Another issue of concern is the level of care offered which is related to participation in the Medicaid/Medicare program. In 1986, 2,968 of the 16,399 nursing homes were not certified by the Medicare or Medicaid programs.²³ A non-certified facility may choose to forego public-sector reimbursement in exchange for less interference. However, approximately half the nursing homes in the U.S. (8,045) were certified as Medicare/Medicaid skilled nursing facilities ("SNFs").²⁴

The 1990 Statistical Abstract's *Inventory* analysis excludes hospital-based and residential facilities, but gives useful details about the medically-oriented facilities that are usually described as nursing homes.²⁵ The survey shows that the Midwest is the region with the largest number of nursing homes (5,393); the South is next, with 5,008 homes, compared to the Northeast which has only 2,948.²⁶ About

loughby, Inc., MMG ¶29,409 (N.D. Ohio 1978); *Bracco v. Lackner*, 462 F. Supp. 436 (N.D. Cal. 1978); *Newland v. Kizer*, 209 Cal. App. 3d 647, 257 Cal. Rptr. 450 (1989); but see *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980).

22. Assuming it can be accomplished consonant with the Certificate of Need laws. See discussion *infra* part IV.C.

23. Statistical Abstract, *supra* note 16, at 112 (No. 176. Nursing and Related Care Facilities - Selected Characteristics: 1986).

24. *Inventory*, *supra* note 18, at 20, Table 18. Recent statistical findings demonstrate an increasing trend in the numbers of SNFs. There were 7,262 SNFs in 1987, and 7,507 in 1988, so at least the number, though not necessarily the percentage of the total, of SNFs is increasing. Statistical Abstract, *supra* note 16, at 111 (No. 175. Nursing and Related Care Facilities: 1971 to 1988). Their average bed-count was 122 (for a total of 984,100 beds) and average occupancy rate was 92.9% (i.e., above the national average of 91% for all facilities). Facilities certified by Medicaid as intermediate-care facilities numbered 5,375 in 1986; these facilities provided a total of 411,500 beds to an average of 77 patients, and had an average occupancy rate of 90.3%. *Id.* at 112 (No. 176. Nursing and Related Care Facilities - Selected Characteristics: 1986) Note that, as a result of the Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330-268 § 4211(g) (1987), Medicaid has eliminated the distinction between Skilled Nursing Facilities and Intermediate Care Facilities; Medicaid regulations now refer merely to "nursing facilities," "NFs." However, the distinction is still meaningful for Medicare purposes, because Part A nursing home benefits are payable only for skilled, not intermediate care.

25. Very small nursing homes were also somewhat uncommon. Only 8.2% of nursing homes nationwide had 3-9 beds (although nearly one-fifth—18.8%—of Western nursing homes fit this description). Nationwide, 6.5% of nursing homes had 10-24 beds (ranging from 5.5% in the South and 5.6% in the Midwest, through 7.2% in the West and 9.3% in the Northeast); corresponding figures for 25-49 bed nursing homes are 12.6% nationwide, 15.6% Northeast, 13.3% Midwest, 9.5% South, 13.5% West. Facilities with 50-74 beds, and 75-99 bed facilities (medium-sized facilities) represented 18.5% and 14.3% of facilities, respectively. See *Inventory*, *supra* note 18, at 16, Table 10.

26. See generally, *Inventory*, *supra* note 18.

three-quarters of the nursing homes in this survey were proprietary.²⁷ The survey also demonstrates that nursing home size can vary significantly.²⁸

A nursing home's ownership status is another distinguishing attribute that varies from state to state and must be considered prior to implementation of the plan. The proposed consortium would consist of proprietary facilities, so success of the plan depends on the availability of a large number and wide variety of proprietary facilities. As the majority of United States nursing home facilities are proprietary, this should pose little problem in most states. A breakdown by states, however, demonstrates that the number of beds in proprietary facilities varies according to location.²⁹ For example, in California, more than 85% of the beds were in proprietary nursing homes; the figure for Oklahoma and Texas was near 88%. In contrast, New York has an unusually low proportion of proprietary facilities, with only about half of the nursing home beds located in proprietary facilities.³⁰ In order to be successful, the security financing plan must meet the needs of the proprietary sector at the varying state levels, while taking into account the fact that, in certain states, the nonprofit sector may play a major role.

There are also significant state-by-state differences in the size of the over-65 population,³¹ and in the percentage of the over-65 population residing in nursing homes.³² The connection between the two figures

27. *Id.* at 16, Table 10. The most common size for nursing homes was the 100-199 bed range, representing one-third of homes nationwide (but regional differences are especially significant here: only 22.1% of Western nursing homes fit this pattern, but 40.4% of the Southern homes came within this category, compared to 32% of those in the Midwest and 35.5% in the Northeast). Very few nursing homes (1.7% nationwide) had more than 300 beds; only 4.9% had 200-299 beds.

28. *Id.* Most nursing homes have somewhere between 25-199 beds; more than half of all nursing homes have fewer than 99 beds, and nearly two-thirds of all nursing homes have more than 50 but fewer than 200 beds.

29. *Id.* at 19, Table 16.

30. *Id.* In New York, provisions are made for not-for-profit and "limited profit" corporations to receive grants and issue debentures for nursing home project costs and to borrow from the state's housing finance agency, medical care facilities agency, and revolving nursing home development fund. NEW YORK PUB. HEALTH LAW ART. 28-A (McKinney 1985). The statutory purpose for permitting "limited profit" corporations is that the need for nursing home beds for low-income people "cannot readily be provided by the ordinary unaided operations of private enterprise. . . ." *Id.* §§ 2851, 2853(2).

31. See EBRI, *supra* note 2, at 19-20, Table 7.

32. See Inventory, *supra* note 18, at 17, Table 12. The elderly population in nursing homes is 4.3% nationwide, with a low of 1.3% in Hawaii and a high of 7.4% in Minnesota. Contrary to expectations, Florida ranked quite low, with 2.2% of its elderly population in nursing homes. *Id.*

is the availability of nursing home beds per 1,000 persons over 65.³³ This ratio masks very large discrepancies in availability and balance between the facilities in the various states.³⁴

3. Nursing Home Costs and Funding Sources

In 1985, about half of the funds for the care of nursing home residents over 65 came from the residents themselves or their families.³⁵ This figure tended to vary depending on the age of the resident.³⁶ Statistics also indicate that Medicare did not play a major role in paying for nursing home care, which left Medicaid to assume nearly half the burden.³⁷ The Congressional Budget Office's figures for all long-term care for fiscal year 1985 are slightly different.³⁸

In 1986, overall nursing home costs had increased to \$38.1 billion³⁹

33. *Id.* at 17, Table 11. In 1986, 60.6 beds were available nationwide for every thousand people over 65 (51.6 of them in nursing homes, 6.9 in residential facilities, and 2.1 in hospital-based facilities).

34. *Id.* While the common belief that Florida has a large elderly population is true, the perception that Florida retirees flock to nursing homes is incorrect. Minnesota, Nebraska, North Dakota, and Wisconsin had a very high level of capacity (all above 85 beds per 1,000 elderly citizens; Nebraska had 95.3 beds per thousand). Availability was lowest in Nevada (33.6 beds per thousand) and in Southern states such as Alabama (47.5 per thousand), Mississippi (45 per thousand), South Carolina (45.1 per thousand), and amazingly low in Florida (34 per thousand). *Id.*

35. See Statistical Abstract, *supra* note 16, at 113 (No. 177. — Nursing Home Residents — Living Arrangements Prior to Admission, Source of Payment and Dependency Status, By Age and Sex: 1985).

36. The "young-old" (65-74) provided 38.1% of the total paid for their care; the figure was much higher, at 51.2% and 53.5% respectively, for those 75-84 and 85 and over. *Id.*

37. *Id.* Medicare assumed 5.3% of the overall bill (5.5%, 5.7% and 4.8% respectively for the three age groups). Medicaid assumed 13.6% of the total spent on SNF care (nearly uniform through the three age groups) and 25.7% of the cost of ICF care (31.9% for those 65-74, 24.8% for those aged 75-84, and 24.3% for over-85 nursing home residents). Virtually no long-term care insurance was available in 1985; certainly no appreciable benefits were collected in that year.

38. See GAO I, *supra* note 2, at 34. This report indicates that 45% of costs came from patients and their relatives (a total of \$16.2 billion). Other private sources (e.g., insurance) paying 2%, Medicare paying 7%, and Medicaid paying 41% of the total (\$17.2 billion, or 90% of public funds expended for nursing home care; of this amount, \$9.5 billion came from the federal government, \$7.7 billion from the various states).

One explanation for the discrepancy is the different definition of long-term care, here including home care as well as institutional care. Approximately \$9 billion was spent for home care, versus \$36 billion on nursing care. *Id.*

39. Alan L. Otten, *States, Alarmed by Outlays on Long-Term Care, Seek Ways to Encourage More Private Coverage*, WALL ST. J., Feb. 11, 1988, at 58. \$19.4 billion private out-of-pocket costs by patients and their families, \$0.3 billion from private insurance, \$0.6 billion from Medicare, \$15.9 billion from Medicaid, the balance from all other public and private sources. *Id.* See also Glenn Ruffenach, *Nursing-Home Care as a Work Benefit*, WALL ST. J., June 30, 1988, at 25; U.S. Dep't of Health and Human Services news

as compared to home care costs which remained stable at \$9 billion. The figures for 1987⁴⁰ also show an overall increase to \$40.6 billion for nursing home expenses.⁴¹ In short, unless LTC insurance becomes a major payment source for nursing home care, or unless the Medicare program is expanded to cover custodial care, neither of which seems likely, the Medicaid system will have to cope with cost increases associated with the unavoidable increases in both the number of nursing home patients and the extent of their dependency.⁴²

To date, much of the financing to construct and operate nursing homes has been debt financing, taking the form of mortgages on the facilities. Before the Deficit Reduction and Fiscal Responsibility Act (DEFRA) took effect, nursing homes had access to tax-free debt financing, but Section 2314 of DEFRA terminated this option.⁴³ To compound the problem, the credit market, in turn, views nursing homes as rather risky borrowers, in part because they are so heavily dependent on Medicaid, and also because owners are unable to control the level of Medicaid reimbursement.

Because of the high costs of debt financing, nursing homes must rely heavily upon Medicaid funds to cover infrastructure and operating costs. Additionally, compliance with stringent Medicaid requirements can preclude facilities from ejecting a non-paying patient.⁴⁴

release, Mar. 29, 1988, reprinted in *Medicare/ Medicaid Guide* (CCH) Last Report Letter #552, at 8.

40. See EBRI, *supra* note 2, at 7, Chart 1.

41. *Id.* The percentage of out-of-pocket payments increased to 49%; other private sources such as insurance paid 2% of the total, Medicare and other government sources paid 5%, leaving Medicaid with 44% of the cost burden.

42. A General Accounting Office study of the period September 1988-1989 reports that:

Historically, about 40 percent of elderly nursing home residents enter as Medicaid recipients, about 50 percent as private payers, and the remaining 10 percent under private insurance, Medicare, or other public programs. Some of those who enter a nursing home as private payers, however, subsequently become Medicaid-eligible. One recent study found that about 11 percent of those entering as private payers spent down to Medicaid eligibility levels during their stay. Overall, about two-thirds of nursing home residents are receiving Medicaid assistance at any point.

UNITED STATES GENERAL ACCOUNTING OFFICE, NURSING HOMES: ADMISSION PROBLEMS FOR MEDICAID RECIPIENTS AND ATTEMPTS TO SOLVE THEM, GAO/HRD-90-135, at 10 (Sept. 1990) [hereinafter GAO II]. See also Korbin Liu, Pamela Doty, and Kenneth Manton, *Medicaid Spenddown in Nursing Homes*, 30 THE GERONTOLOGIST 7-10 (1990).

43. Deficit Reduction and Fiscal Responsibility Act ("DEFRA"), Pub. L. No. 98-369, 98 Stat 494 § 2314. See also LONG TERM CARE AND THE LAW 26, (The National Health Lawyers Association Tenth Annual Symposium) (Thomas C. Fox ed. 1986).

44. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330-268 § 4211 (1987). There are also state laws forbidding Medicaid discrimination in

Nursing homes can avoid this "problem" of complying with the Medicaid rules by avoiding participation in the program; however this course of action would cut them off from a major source of funds.⁴⁵ Moreover, what would a non-Medicaid-certified facility do in the very common situation in which a patient depletes all assets by paying privately for care? True, there is no outright federal prohibition of discharge of patients because they are Medicaid-eligible if the facility does not participate in Medicaid, but if the facility can evict the patient without violating state law, the choices are finding another placement that does accept Medicaid (a difficult task), or literally throwing the patient out on the street. The latter is hardly good public relations for a facility that seeks to attract private-pay patients.

When a nursing home does issue bonds, rating agencies seldom rate the debt highly enough to make it attractive to institutional investors such as pension funds. A lower rating means that the nursing homes must pay a higher interest rate, making it even more likely that they will default on their obligations. Health-care chains, for whom conventional stock issues are an option, have had a history of poor stock performance even in a bull market.

Despite the tremendous need for more nursing home beds, and for capital and staffing improvements in existing facilities, it seems very unlikely that the capital markets will be responsive to nursing homes. The securities plan has the advantage of creating a significant pool of new capital from individual investors to be used by the nursing home industry. Implementation of the plan is necessary to compartmentalize the need for nursing home financing given the unresponsiveness of more traditional financing mechanisms.

nursing homes, or forbidding transfers or discharges of patients motivated solely by the change of payment mechanism from private payment to Medicaid. *See, e.g.*, CAL. WELF. & INST. CODE § 14124.7 (West 1990); CONN. GEN. STAT. ANN. § 19a-533 (1986 & Supp. 1990); FLA. STAT. ANN. § 400.17(5) (West 1986 & Supp. 1990); GA. CODE ANN. § 31-8-108(a)(3) (Michie 1991); IOWA CODE ANN. § 135C.31 (West 1989 & Supp. 1990); KY. REV. STAT. § 205.560(9) (Michie 1991); LA. REV. STAT. § 40:2010.8 (West Supp. 1990); ME. REV. STAT. ANN. tit. 22, § 7925 (Supp. 1990); MD. HEALTH-GEN. § 19-345 (1990); MICH. STAT. ANN. § 333.21773 (1980 & Supp. 1991); MINN. STAT. ANN. § 144.651 (West 1989); NEBRASKA REV. STAT. § 71-6023.01 (West 1990); N.H. REV. STAT. ANN. § 167.17-b(h) (1990); N.J. STAT. ANN. § 10:5-12.2 (1988 & Supp. 1990); N.D. CENT. CODE § 50-24.4-19 (Michie 1989); OHIO REV. CODE ANN. tit 51, § 5111.31 (Page 1989); OKLA. STAT. ANN. tit. 63, § 1-1918(c) (West 1984 & Supp. 1990); R.I. GEN. LAWS § 23-17.5-19 (Michie 1989); S.C. CODE ANN. § 44-7-88 (Law. Co-op. 1985 & Supp. 1989); TEX. HUM. RES. § 102.003(f) (Vernon 1990).

45. As noted above, very few patients are able to remain in private pay status throughout their stay in the nursing home.

B. A Critical Look at Medicaid and Medicare

The close relationship between nursing home financing and public funding programs mandates a careful examination of the Medicare and Medicaid programs. Medicare provides benefits similar to those provided by private Blue Cross/Blue Shield insurance to persons over 65.⁴⁶ For example, when a senior citizen suffers a heart attack, is hospitalized for a few days, and then immediately discharged to the care of a physician, the patient pays comparatively little of the eventual bill. On the other hand, the program does little to address the medical, social and housing needs of impaired older persons and the chronically ill. Furthermore, the statutes and regulations are administered in an extremely restrictive manner, similarly limiting the practical availability of Medicare funds. Thus, although Congress intended for Medicare to provide comprehensive health care for the poor, the high cost of LTC, along with Medicare's limited LTC provisions, have combined to force the Medicaid system to take a major role in LTC financing.

Unlike private insurance, which is available regardless of income or assets, Medicaid-eligibility is restricted.⁴⁷ To qualify for Medicaid

46. Congress enacted Medicare as Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc (1983). Part A of Medicare provides extensive benefits for hospitalization, and limited benefits for up to 100 days of care in a skilled nursing home for recuperation subsequent to hospitalization. Certain home care benefits are also available to individuals who are diagnosed as home-bound. 42 U.S.C. § 1395d (Supp. 1990) Part B provides payment for care rendered by physicians and certain other health professionals to Medicare beneficiaries. 42 U.S.C. § 1395l (Supp. 1990) Part A benefits are available automatically to all recipients of Social Security checks. Senior citizens must make an affirmative election to receive Part B benefits, and must pay a monthly premium for the benefits.

The Medicare Catastrophic Coverage Act, Pub. L. No. 100-360, §§ 101-429, 102 Stat. 683 (1988), somewhat expanded Medicare hospitalization and skilled nursing home benefits, added coverage of prescription drug expenses and limited beneficiaries' out-of-pocket expenses for services covered by Part B of the Act. The Act was politically unpopular, however, and was subsequently repealed by the Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, 103 Stat. 1979 (1989).

47. See 42 U.S.C. § 1396 (1988). Medicaid is a joint federal/state program under which the federal government pays at least half of an eligible individual's health care costs and the states pay the remainder. Federal law sets the basic parameters of the Medicaid system, but states have extensive discretion in administering the program. Accordingly, the availability of Medicaid services varies greatly from state to state.

In 1980, Congress attempted to set standards for state reimbursement of health care costs by passing the Boren Amendment. See 42 U.S.C. §§ 1396a(a)(13)(A). The amendment required Medicaid reimbursement rates under state Medicaid plans to be reasonable and adequate in light of the cost of operating a facility efficiently. The amendment gives providers a substantive federal right enforceable by § 1983. See *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510 (1990). See also *Ohio Academy of Nursing Homes, Inc. v. Barry*, 56 Ohio St. 3d 120, 564 N.E.2d 686 (1990); *Michigan Hosp. Ass'n v. Babcock*, 1991 U.S.

benefits, an individual must meet the state's definition of "indigent," a concept which takes into account both income and assets.⁴⁸ Under present conditions, Medicare, Medicaid, and other federal, state and public sector programs pay approximately two-thirds of the cost of LTC.

By getting legal and financial advice about Medicaid planning, individuals with moderate or even large assets can qualify for Medicaid although they are not "indigent" in the ordinary sense of the term. As practiced by elder law attorneys, "Medicaid planning" includes making gifts before a penalty period begins; transferring assets to irrevocable trusts; creating convertible trusts that become irrevocable when a Medicaid application is made; and structuring ownership and investments to conform to Medicaid rules.⁴⁹ The elder law attorney must acknowledge the tax as well as Medicaid consequences of these transactions. For example, trusts must be drafted with special care in order to insure that the planner's goals of providing income to the elderly grantor and/or spouse can be met without jeopardizing Medicaid eligibility.⁵⁰

"Spend-down" is also an important factor in Medicaid eligibility. In order to spend-down, a person enters a nursing home as a private-

Dist. Lexis 2058 (W.D. Mich. 1991); *Temple University v. White*, 941 F.2d 201 (3d. Cir. 1991) (all involving successful rate challenges by providers). *But see* *Capitol Hill Hosp. v. District of Columbia*, 769 F. Supp. 16 (D.D.C. 1991) (courts withheld approval of disputed Medicaid rates in the District of Columbia pending review by the Department of Human Services Office of Health Care Financing).

48. Generally, individuals with low income, higher income offset by high medical expenses, and very limited assets over and above those assets that would be exempt for Medicaid purposes, may qualify as "indigent."

49. See JOHN J. REGAN, *TAX, ESTATE & FINANCIAL PLANNING FOR THE ELDERLY* (1982); PETER J. STRAUSS, ROBERT WOLF & DANA SHILLING, *AGING AND THE LAW* 332-37 (CCH 1990 & Supp. 1992). For recent developments in the area of Medicaid planning, see generally THE PROCEEDINGS OF THE NAELA 3RD ANNUAL SYMPOSIUM ON ELDER LAW (1991); Louis A. Mezzullo, *Advice On Planning For Medicaid Qualification*, 130 TRUSTS & ESTATES 8 (July, 1991); Ruth Longenecker, *Planning For Medicaid Eligibility*, 15 TAX MGMT ESTATES, GIFTS & TRUSTS JOURNAL 131 (July-August 1990).

The entire process of Medicaid planning has been criticized on ethical and public policy grounds. See, e.g., Jane Bryant Quinn, *Do Only Suckers Pay?*, NEWSWEEK, Dec. 18, 1989, at 52; Stephen Moses, *The Fallacy of Impoverishment*, 30 THE GERONTOLOGIST 21 (1991).

50. See 42 U.S.C. § 1396a(k) (1988). The corpus of a "Medicaid qualifying trust" set up by a person or a person's spouse will be considered an available asset that limits or precludes Medicaid eligibility to the extent that the trustee has discretion to invade the corpus. The maximum permissible invasion will be considered an available asset, regardless of whether or not invasion actually occurs. Medicaid imposes transfer restrictions when an individual applies for nursing home benefits, but not when the application is for certain forms of home care benefits; however, the availability of Medicaid home care benefits is limited. *Id.*

pay patient and pays several thousand dollars a month until all non-exempt assets over and above the permitted Medicaid level, typically \$3,000 or less, are exhausted.⁵¹ A spend-down can occur either voluntarily, as part of a plan to qualify for Medicaid, or involuntarily, if the individual is unaware of the full cost of LTC or the rules of the Medicaid system. An unplanned spend-down is much more painful and destructive of family financial security than a planned spend-down which could occur as part of a plan dealing with other needs of family.⁵²

In addition to ethical questions, practical limitations can affect Medicaid planning. Not all forms of care are available under the Medicaid program, and not all the care provided is of the highest quality.⁵³ Medicaid beneficiaries are especially vulnerable to the problem of quality control because the program's reimbursement rates are much lower than private-pay rates. Additionally, state regulators have very few personnel to inspect nursing homes, and monitoring the quality of care provided in a person's home can be difficult. Indeed, the assumption that all providers will deliver first-rate care to the vulnerable elderly under conditions where reimbursement rates are low and supervision is limited, is unrealistic.⁵⁴ Furthermore, the Medicaid program is a tremendous and increasing burden on the federal and state treasuries. These financial and practical constraints make it unlikely that the public sector will be able to expand the Medicaid

51. See Medicare/Medicaid Guide (CCH) ¶ 15,500-660 (containing charts which list the permitted asset levels and exempt resources for each state). The typical exemptions are a homestead, home furnishings, an automobile, and a burial fund.

52. See EBRI, *supra* note 2, at 8-9. The EBRI study performed in Massachusetts in 1988 found that 57% of married institutionalized individuals had spent-down and qualified for Medicaid within one year of entering the facility. In addition, 83% of single individuals who were not entitled to make use of Medicaid's spousal protection provisions and higher asset limits for married couples had spent-down within a year, and 74% had spent down within 6.5 months of private payment for nursing home care. A model constructed with EBRI's own research shows that, as a result of the expanded spousal protection provisions of the Medicare Catastrophic Coverage Act, 30% of married institutionalized elderly persons could spend-down to Medicaid levels within one year. Thirteen percent of single men and 23% of single women could spend down within six months. Half of the women could spend-down within 18 months; 53% of men could do so within two years. The gender differences derive from men's higher earnings and asset levels.

53. For a discussion of quality control issues in healthcare, see, e.g., William D. Spector & Margaret L. Drugovich, *Reforming Nursing Home Quality Regulation: Impact on Cited Deficiencies and Nursing Home Outcomes*, 27 MEDICAL CARE 789 (Aug. 1989).

54. All state Medicaid plans must include nursing home services, but states have wide discretion in determining how much home care and ADL assistance they will provide. See Ellice Fatoullah, *Medicaid and Elder Law, 1991 Legislative Update*, N.Y.L.J., Oct. 25, 1991, at 1.

program to meet the needs of the large "baby boom" generation for long-term care in the next few decades.⁵⁵ Conversely, a private sector solution can harmonize these concerns by creating a mechanism which allows for affordable saving for one's own eventual care and the care of family members, thereby reducing the risk of impoverishment.

C. Existing and Proposed Financing Alternatives

It would not be an accurate picture of long-term financing to depict a stark opposition between private payment, leading to complete depletion of resources, and Medicaid, conditioned on a prior depletion of resources. The variety of alternatives already in place include long-term care insurance and reverse mortgages. In addition, many government agencies and organizations have responded with legislative changes or proposals for improved financing mechanisms.

1. Private LTC Insurance

Private LTC insurance ("LTC") is a well-accepted mechanism for risk planning. Most senior citizens have one or more Medi-Gap⁵⁶ policies to supplement their Medicare coverage and there is an increasing consumer interest in purchasing LTC policies. Although LTC policies are sometimes thought of as "nursing home" policies, there is an increasing trend towards policies which cover home care as well as institutional care. Furthermore, insurers are showing greater interest in providing such policies. In 1987, an industry survey found a total of 17 insurers to be engaged in the selling of LTC policies.⁵⁷ In 1988, 43 companies sold LTC policies to individuals and 11 sold policies to groups, including employers purchasing insurance as an employee benefit. By 1989, group LTC coverage could be purchased from 19 companies providing individual consumers seeking an LTC policy

55. See, e.g., Howard L. Schneider & Jack M. Guralnik, *The Aging of America: Impact on Health Care Costs*, 263 JAMA 2335 (1990); Regina E. Herzlinger, *Healthy competition: a third approach to the medical-insurance crisis; Proposal to enable Americans to shop competitively for their own health insurance policies*, THE ATLANTIC MONTHLY, August 1991, at 69.

56. Medi-Gap policies cover deductibles, coinsurance, and a certain number of items excluded from Medicaid. They do not cover long-term care. Insurers are forbidden to sell Medi-Gap policies in anything other than ten standard forms prescribed by the National Association of Insurance Commission (NAIC). Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508 §§ 4351-61, 104 Stat. 1388 (1987) (effective July 1, 1991). For a history of Medi-Gap policies and their regulation, see Carol Olson, *Review of Medicare Supplement Insurance After Repeal of the Medicare Catastrophe Coverage Act*, (NAIC 1990). See also CBO says Medigap Policies Can Curb Enrollees' Acute Care Out-Of-Pocket Costs, 18 BNA PENSION REPORTER No. 33, August 19, 1991 at 1515.

57. Chuck Jones, *LAN's 3rd Annual Long-Term Care Survey*, LIFE ASSURANCE NEWS, May, 1989, at 76.

with a choice of 52 insurers.⁵⁸ The Health Insurance Institute of America (HIAA) estimates that, as of June, 1990, 1.65 million policies, written by 134 insurers, were in force.⁵⁹

At first glance, LTC insurance appears to provide a simple solution to the needs of the middle-class elderly. Indeed, in 1989, there were 1.1 million LTC policyholders.⁶⁰ To protect policyholders against insurer abuse, the Health Insurance Association of America's Board has drafted a comprehensive and consumer-oriented set of guidelines for LTC policies.⁶¹ Many states have since followed suit by adopting related statutory controls on LTC policies.⁶² The great advantage of LTC insurance is that it does not limit elderly purchasers' financial planning options. That is, if purchasers are adequately insured, they can make gifts or retain property based on personal preference, tax and estate planning objectives, without worrying about the effect of Medicaid-eligibility requirements on asset transfers.

While LTC insurance may appear to be the solution to the problem of insuring long-term care for the elderly, it is problematic when compared to more traditional life and health insurance policies. While it is possible to predict both the number of deaths in an entire population and the incidence of disease throughout the population, it is not possible to predict an individual's lifespan or the morbidity he or she will suffer. Thus, the smaller the group in question, and the less "average" its composition, the less valid are the conclusions and predictions made about the group. In addition, LTC insurance is a new product with little past history to draw upon. Furthermore, because only about one of every 250 Americans owns such a policy, the policyholders are a small and unrepresentative group.

Compared to LTC insurance, life insurance and health insurance are popular and broadly owned products with a great deal of actuarial information available for use in setting premiums and for the insurers' own financial planning and projected claims. A plausible explanation exists for the limited growth of LTC insurance. The fundamental problem appears to be that LTC insurance may not offer returns that are attractive enough to constitute a viable product for insurance providers.⁶³ In other words, if the insurance is attractive only to a

58. *Id.*

59. Susan Van Gilder & Diane Johnson, *Long-Term Care Insurance: A Market Update*, HIAA RESEARCH BULLETIN 4-5 (1991).

60. Jennifer Landes, *Supply and Demand for LTC Grows*, NATIONAL UNDERWRITER, June 5, 1989, at 3.

61. *Id.*

62. *Id.*

63. The return provided by such policies must cover current claims, a reserve for

small, elderly population at a high risk of institutionalization in the near future, it will be very unattractive to the insurers who must pay claims of indefinite duration and amount shortly after the receipt of premiums. Individual consumers, many of whom are retired and have low incomes, buy LTC insurance with after-tax income, after paying living expenses and life and Medi-Gap insurance premiums. Thus, unlike employers who consider buying insurance one of the costs of doing business, these consumers are more sensitive to price increases making it difficult for insurers to increase returns by raising prices.

Some of the insurers' problems could be solved by broadening the base of policyholders. With more policyholders and with wider age range, insurers would have more time to earn income on the premiums before paying them out as policy benefits. Unfortunately, barriers to selling LTC insurance to young and middle-aged buyers include general ignorance regarding whether Medicare will pay for custodial care, denial that they will ever grow old, and an absence of disposable income to cover premiums. Perhaps insurers can overcome these marketing problems and sell enough LTC policies to make the product economically viable; however, controlling doctor's bills and hospital care costs pose additional problems.

Furthermore, a built-in paradox complicates selling LTC to younger buyers. LTC policies usually offer a level premium throughout the life of the policy, so buying the policy at an earlier age locks in a lower premium. But what benefits does the premium purchase? If the policy provides a certain level of benefits (e.g., \$120 a day), and the policy is kept up for many years, \$120 may prove to be only a small fraction of the actual private-pay cost when the insured person is institutionalized. In other words, policies with fixed benefits are beneficial to the insurer (which can at least make some realistic plans), and can be affordable for the younger buyer—but are unlikely to be attractive to the younger buyer because of inflation and inability to foresee a need. On the other hand, the policy can include meaningful inflation protection, but only at the cost of increasing the risk assumed by the insurer and the premiums.

Several elder law specialists⁶⁴ have pointed out that LTC insurance costs can be reduced by using the policy as a "hedging" mechanism. The maximum Medicaid penalty period is 30 months. If a person

future claims, which are very difficult to estimate, marketing and administrative expenses for the policies themselves, and a contribution toward the overall expenses of the insurer. It is unclear whether, in the long run, LTC insurance will succeed as a product.

64. E.g. Ezra Huber, Esq. through personal communications with the author.

planning to make transfer who has purchased an LTC policy is institutionalized before the penalty period elapses, the policy is available to pay for nursing home care until the person becomes eligible for Medicaid. Once Medicaid benefits are granted, the policy can be dropped. However, this strategy depends on a person who is at high risk of institutionalization being able to buy a policy as underwriting guidelines can be so strict that only healthy people qualify. The financial value of this strategy may further be limited if a deductible period of several months is imposed by the particular policy.

This discussion has assumed that anyone who wants an LTC policy can get one, that insurers make policies available at all price levels, and that, once purchased and maintained, the policy will in fact provide benefits when needed. In reality, economic factors preclude many willing buyers from purchasing LTC insurance as well as many insurers from offering LTC insurance. A recent Families USA study casts doubt on all of these assumptions by illustrating the affordability problem elderly people currently face⁶⁵ and the assumptions inherent in the belief that private LTC provides a solution that can encompass a significant percentage of the elderly population.⁶⁶

65. Families USA Foundation Report, *The Unaffordability Of Nursing Home Insurance*, January, 1990, at 2.

This study examined widely-sold LTC policies offered by nine insurers with A+ or A rating from A.M. Best—that is, insurers of the highest quality and stability. The study focused on a basic LTC policy, defined as one meeting these criteria: benefits available for at least two years; deductible period (during which the newly-admitted nursing home resident pays the entire bill out-of-pocket, unless Medicare SNF benefits are available) of no more than 90-100 days; a daily benefit of at least \$110 per day—or at least \$80 per day with an “escalator clause” to provide protection against inflation; availability of benefits even if the insured person enters the nursing home directly from the community, without prior hospitalization; no “step-down” clause: that is, the insured can get the level of treatment appropriate for his or her needs, with no requirement of receiving skilled care before receiving intermediate-level or custodial care. *Id.*

66. *Id.* According to the Families USA study, a policy of this type actually falls below the minimum level of coverage recommended by Consumer Reports in its May, 1988 survey of LTC insurance. *Who Can Afford a Nursing Home?*, CONSUMER REPORTS, May, 1988, at 300. Consumer Reports recommends at least four years of benefit coverage and a deductible of 20 days or less, so the “basic” policy is therefore significantly less expensive than the Consumer Reports-recommended type of policy. Yet the average premium for the basic policy was unaffordable for 84% of senior citizens aged 65-79; even the lowest price policy meeting the basic standards was unaffordable for 73% of Americans aged 65-79. The older the senior citizen, the less likely that he or she could afford a basic policy. “Affordability” was defined as medical expenses (including LTC premiums) of not more than 10% of income. However, the definition of income included a “spend-down” by assuming that the individual’s assets would be liquidated at a constant rate, leaving no estate. According to a 1988 study by United Seniors Health Cooperative, a prior hospitalization requirement would prevent 54% of nursing home residents from receiving insurance benefits. The repeal of the Medicare Catastrophic Coverage Act of 1988 reimposed the prior-hospitalization requirement on the Medicare Part A SNF bene-

It is certainly conceivable that other studies, using different methodology, would conclude that a higher percentage of senior citizens would be able to afford LTC insurance. Nonetheless, spending hundreds or thousands of dollars a year on LTC insurance premiums will remain a strain for many elderly households. Furthermore, at least some LTC policyholders will purchase and maintain coverage that proves unsuitable for their actual needs.⁶⁷

2. Reverse Mortgages

While LTC insurance is a valuable adjunct to some financial plans, it is not the whole answer to the problem of funding long-term care for the middle class. Reverse mortgages provide what can be viewed as an alternative supplement to LTC insurance. This type of mortgage operates under the assumption that cash-poor senior citizens are often "house-rich."⁶⁸ For example, an elderly person or couple with a low income and few other assets may own a mortgage-free home that has appreciated significantly since its purchase.⁶⁹ A reverse mortgage is a way to "liquify" the homeowner's equity without selling the house. In particular, reverse mortgages have been recommended as a private-sector method for financing the cost of long-term care.⁷⁰

Under a reverse annuity mortgage ("RAM"), the senior citizen homeowner receives a lump sum which is used to buy an annuity. Various types of "equity kickers" may be granted so that the lender receives a share in the appreciation in home value after the home's eventual sale. A simpler alternative is for the elderly person to secure

fit, so no one entering a nursing home from the community can get Part A benefits either. The same United Senior Health Cooperative study showed that 46% of nursing home residents wouldn't get coverage under a policy that contained a step-down requirement.

67. Examples might include a person who enters a nursing home without having first been hospitalized who has a policy with a prior hospitalization requirement; or a person with low income and few other assets who has a policy with a two-year maximum benefit, which runs out early in the person's seven-year stay in the nursing home.

68. For instance, in 1985, Medicaid recipients in the eight states selected for study owned real property with an average value of \$30,712 per recipient. See UNITED STATES GOVERNMENT ACCOUNTING OFFICE, MEDICAID: RECOVERIES FROM NURSING HOME RESIDENTS; ESTATES COULD OFFSET PROGRAM COSTS, GAO/HRD 89-56, at 20 (March 1989).

69. In 1983, for instance, 17.8 million senior citizens were homeowners; 80% of them owned their homes free and clear, without mortgage. ALICE M. RIVLIN & JOSHUA M. WIENER, CARING FOR THE DISABLED ELDERLY: WHO WILL PAY? 131 (1988).

70. See, e.g., Bruce Jacobs & William Weissert, *Using Home Equity to Finance Long-Term Care*, 12 J. OF HEALTH POLITICS, POLICY AND LAW 77 (1987). (An econometric model is used to show that 48% of the senior citizens who are at a 10% or greater risk of institutionalization could use reverse mortgages to pay for home care in lieu of being institutionalized; they also show the greatest benefits from reverse mortgages accruing to the most vulnerable elderly).

an ordinary home equity credit line, and keep it in reserve for medical costs.⁷¹ The basic terms of a reverse mortgage involve a bank or other lender making a loan, usually limited to 80% of the appraised value of the home. Instead of the homeowner then making monthly payments to the lender, the lender makes payments to the homeowner. These payments can be used to supplement retirement income, including one spouse's nursing home care while the other spouse continues to reside in the home. The annual payments usually range between \$6,000 and \$7,800.⁷²

At the end of the loan term, or if the senior citizen dies or is institutionalized during the loan term, the senior citizen homeowner owes the amount of the mortgage or, in some cases, may have the option to refinance. Generally, this "balloon payment" is made by selling the home. This makes the selection of the loan term crucial. The longer the loan term, the smaller each payment to the senior citizen will be, making it less likely that the extra income will affect a recipient's lifestyle. Yet, maximizing income by shortening the loan term creates a risk of losing the house altogether. To make matters worse, reverse mortgages seldom contain refund provisions. Thus, the lender takes the risk that the sale proceeds from the home will not be large enough to satisfy the mortgage. The borrower takes the risk that he or she will die long before the loan term expires, so that, in effect, the lender "buys" the home for a small number of payments.

One effect of the reverse mortgage is to make it very unlikely that the house will remain in the family after the death of the homeowner. This objection is insuperable for some families and trivial in others, where estate planning requires removal of a major asset from the estate. This is usually the case where all the children are already homeowners and do not want to inherit the "family home," or where the elderly individual has never married, has no children, or has no desire for children to inherit the house.⁷³ Finally, reverse mortgages do not interfere with Medicaid planning. This is because a reverse mortgage is considered a debt of the aged homeowner, not a source of income,

71. RIVLIN & WIENER, *supra* note 69.

72. *Id.* at 292.

73. A small four-year HUD demonstration project for home equity conversions for the elderly was created under the Housing and Community Development Act of 1987. Pub. L. No. 100-242 §§ 1-706, 101 Stat. 1815 (1988). In October, 1990 the ABA recommended that the program be expanded from 2,500 mortgages to 25,000. Several states regulate reverse mortgages. *See, e.g.*, CAL. CIV. CODE §§ 1917.320 - 1917.714 (West 1985 & Supp 1991); ILL. ANN. STAT. ch. 17 ¶ 312 (Smith-Hurd 1981 & Supp 1991); IOWA CODE ANN. §§ 528.1 - 528.9 (West Supp 1990); N.Y. REAL PROP. LAW § 280 (McKinney 1989).

and therefore will not affect eligibility.⁷⁴

3. *Continuing Care Retirement Communities (CCRCs)*

For many senior citizens who do not require institutionalization, the family home is no longer a suitable residence. It may be too large, too hard to clean and care for, too expensive to heat, in need of extensive renovation, in a dangerous neighborhood, or inaccessible to shopping, recreation, and medical care.

One alternative for fairly affluent senior citizens is to move to a life-care community or continuing care retirement community ("CCRC"). Depending on the definition used, and the survey methodology employed, anywhere from 100,000 to 200,000 elderly Americans live in CCRCs.⁷⁵ The CCRC combines living accommodations suitable for the elderly with the availability of nursing home care on the premises or nearby.

There are three general types of CCRCs. In an "all-inclusive" community, the fees paid by the residents cover both housing and medical care; under a "modified" CCRC contract, the resident pays some of the cost of transferring from ordinary housing to the community's nursing home. In a "fee-for-service" community, residents are guaranteed access to nursing home care, but must pay for it on a per diem basis. About one-third of CCRCs fall into each category.⁷⁶

Entering a CCRC calls for a sizable entry fee, often equivalent to most of the entrant's assets, in addition to a monthly maintenance charge.⁷⁷ Thus, entering a CCRC in some ways resembles buying a co-op apartment or condominium unit. The important difference is that the CCRC resident does not have an equity interest in the housing unit in which he or she lives. In 1984, it was estimated that only 13% of the population, aged 75 or older, could afford to enter a CCRC.⁷⁸

In addition to affordability problems, a person who can pay the

74. This is not necessarily true for state programs that supplement Social Security, or for state programs that provide home care and housekeeper service.

75. See GAO I, *supra* note 2, at 41. (The American Association of Homes for the Aging provided the 200,000 figure).

76. See EBRI, *supra* note 2, at 12.

77. See RIVLIN & WIENER, *supra* note 69, at 85-86. In 1987 dollars, the median fee paid by a single person for a one bedroom apartment was estimated at \$47,927; a 1986 survey gave a median monthly cost of \$756 per CCRC resident. *Id.*

78. See RIVLIN & WIENER, *supra* note 69, at 92. Compare the model used in EBRI Issue Brief, *supra* note 2, at 16 in which it was estimated that 11% of the total population over 65 could afford to pay an entry fee of \$64,226 (and still retain \$10,000 in cash or other assets), and pay a monthly fee of \$1,300 while still retaining 60% of their income while only 9% of the over-75 population could afford to do this.

costs necessary to enter a CCRC may not wish to do so because of certain drawbacks. The CCRC environment is admittedly restrictive, and the entry fee is hardly inexpensive. Similarly, it is difficult or impossible for a CCRC resident to move out. This inability to relocate exists, in part, because alternative CCRC accommodations are scarce with many communities having waiting lists longer than the life expectancy of their clientele.

Furthermore, CCRCs are vulnerable to financial problems or even bankruptcy.⁷⁹ In the past, the unscrupulous have used CCRCs as a means to prey on the vulnerable elderly through deceptive schemes. CCRCs have also been plagued by failure due to poor management skills.⁸⁰

Consumers can protect themselves by getting professional advice, and also by taking advantage of the extensive disclosure provisions imposed on CCRCs by many states.⁸¹ Although a well-run, financially sound CCRC can provide a very agreeable place for a senior citizen to live, with assurances that medical and nursing services will be available when necessary, a number of drawbacks keep the CCRC from being a complete solution to the problem of care for the middle-class elderly. For example, to enter a CCRC, both members of a married couple must qualify for entrance to the facility. More specifically, they must both want to live there, which means, in effect, leaving the community and restricting most daily contacts to other

79. See GAO I, *supra* note 2, at 41 citing RIVLIN & WIENER, *supra* note 69, at 89.

80. Non-profit organizations sometimes may be more oriented to their charitable mission than to effective management. In 1988, 95% of CCRCs were operated by nonprofit organizations, according to Sheldon Goldberg, president of the American Association of Homes for the Aging. See Louise Saul, *Interest Grows in Continuing-Care Communities for Elderly*, N.Y. TIMES Aug. 28, 1988, at 1.

81. See, e.g., ARIZ. REV. STAT. ANN. §§ 20-1801-12 (1990) (This statute expires Jan. 1, 1991 unless renewed); CAL. HEALTH & SAFETY CODE §§ 1770-93 (West 1990 & Supp. 1991); COLO. REV. STAT. §§ 12-13-101-19 (1985); CONN. GEN. STAT. ANN. §§ 17a-360-75 (West 1988 & Supp. 1991); FLA. STAT. ANN. §§ 651.001-134 (West 1984 & Supp. 1990); IDAHO CODE § 67-2750-64 (1989); ILL. ANN. STATS. ch. 1111/2, para. 4160-1-12 (Smith-Hurd 1988 & Supp. 1991); IOWA CODE ANN. § 523D.1-10 (West Supp. 1991); LA. REV. STAT. ANN. §§ 2171-88 (West Supp. 1991); ME. REV. STAT. ANN. tit. 24A, §§ 6201-26 (West 1990); MD. ANN. CODE art. 70B, §§ 7-23 (1988 & Supp. 1990); MASS. ANN. LAWS ch. 93, § 76 (Law. Co-op. 1985); MO. ANN. STAT. §§ 376.900-50 (Vernon Supp. 1991); N.J. STAT. ANN. § 52:27D-330-60 (West Supp. 1991); N.M. STAT. ANN. §§ 24-17-1-18 (Michie Supp. 1991); N.Y. PUB. HEALTH LAW §§ 4600-20 (McKinney Supp. 1991); OHIO REV. CODE ANN. § 173.13 (Anderson 1990); PA. STAT. ANN. tit. 40, §§ 3201-25 (Supp. 1990); R.I. GEN. LAWS §§ 23-59-1-17 (1989); TENN. CODE ANN. § 4-3-1305 (Supp. 1991); VA. CODE ANN. §§ 38.2-4900-17 (Michie 1990); WASH. REV. CODE ANN. § 70.38.025 (West Supp. 1991). See also STRAUSS, WOLF & SHILLING, *supra* note 49; Lisa Stearns, Ellen Netting & Cindy Wilson, *Continuing Care Retirement Communities*, 8 ST. LOUIS U. PUB. L. REV. 245 (1989).

elderly community residents, and limiting daily activities to only those offered by the CCRC. In addition, they must have sufficient funds to make the initial payment and continuing monthly payments and be willing to devote the necessary proportion of their resources to this purpose. The chosen CCRC, therefore, must meet the standard of both being suitable for its residents' needs and having sound financial prospects. Additionally, because there are fewer than 1,000 CCRCs nationwide, some senior citizens may not be able to find a suitable CCRC in their desired geographic area.⁸²

4. *Proposals For Reform*

The need for new funding mechanisms for long-term health care is widely acknowledged, and various proposals have been developed in an attempt to meet this need. One such proposal was set forth by the U.S. Bipartisan Commission on Comprehensive Health Care (the "Pepper Commission"). In its September 25, 1990 final report, the Commission recommended a hybrid approach to long-term health care financing.⁸³ The approach contemplated the existence of social insurance providing full coverage of community-based home care, but did not suggest expanding the Medicare program to provide all forms of long-term care without income or asset limitations.⁸⁴

Under the Pepper Commission's recommendations, the U.S. Government would cover the first three months of nursing home care to all individuals meeting a test of disability.⁸⁵ For longer stays, the plan calls for a combination of federal and state funding, with subsidies for low-income nursing home residents. In addition to allowances for spousal income, personal needs, and maintenance of the homestead, nursing home residents would be allowed to retain \$30,000 in assets over and above the value of the homestead, with couples getting an asset allowance of \$60,000.⁸⁶

Some legislators and policy-makers believe that tax incentives,

82. Charles P. Sabatino & Christopher D. Rolle, *CCRCs and Assisted Living: Counseling Prospective Residents*, Proceedings 1991 NAELA Symposium #11, at 1 (estimating that there are 700 CCRCs nationwide).

83. *Sen. Rockefeller, Rep. Waxman To Introduce Bills Based On Pepper Commission Proposal*, 18 BNA PENSION REPORTER No. 21, May 27, 1991, at 910-11.

84. See Pepper Commission's Final Recommendations Issued Medicare/Medicaid Guide (CCH) Last Report Letter #632, at 2-3 (Oct. 4, 1990).

85. *Id.* The test for disability includes either limitations in three out of the five Activities of Daily Living; a cognitive impairment that mandates constant supervision; or dangerous or disruptive behavior that mandates constant supervision.

86. *Id.* Although current Medicaid rules do permit states to grant spousal resource allowance of up to \$60,000 (adjusted for inflation), the \$30,000 resource allowance for single people greatly exceeds current standards.

rather than direct government funding, are preferable. Favored tax status could be granted to "Individual Medical Accounts," ("IMAs"), which, like IRAs, are intended to increase the savings rate in the United States by inducing taxpayers to open special accounts. Under the system, the appreciation on the IMA would be tax-deferred until withdrawals were made to finance medical care. Other proposals call for a tax deduction for contributions made to the IMA. Many of these proposals were made before 1986, when deductibility of conventional IRA contributions was severely limited. Responding to this proposal, commentators point out that funding long-term care would require substantial annual IMA contributions.⁸⁷ Assuming a low rate of inflation, a 30-year-old saver would have to put more than \$600 in the IMA each year to fund 22 years of nursing home care. With a higher inflation rate, the saver might have to make IMA contributions in excess \$1,000 a year.⁸⁸

Another proposal is "Social Health Maintenance Organizations" ("S/HMOs"), now the subject of small demonstration projects.⁸⁹ A S/HMO expands the standard HMO to include a program of long-term care and nursing home services in addition to the acute care services already provided by the traditional HMO. As a result, a S/HMO participant could receive care through the same organization throughout his or her life.

Under one proposal, a S/HMO member would pay monthly premiums, plus co-payments for certain services.⁹⁰ Like other LTC policies, the fiscal health of the plan would be threatened by an "adverse selection" process. Joining a S/HMO is a voluntary decision, based on a belief that the S/HMO offers the best available investment of the health care dollar.⁹¹ A S/HMO would be most attractive to people who believe that they are likely to need home care or nursing home services, and least attractive to people who believe they will not need such care, therefore overall costs are likely to be inflated.

Several strategies have been proposed to limit adverse selection. For example, the enrollment materials for S/HMOs could downplay

87. RIVLIN & WIENER, *supra* note 69, at 112.

88. *Id.*

89. The Deficit Reduction and Fiscal Responsibility Act of 1984 (DEFRA), Pub. L. No. 98-369, 98 Stat. 494 (1984), included provisions for four S/HMO demonstration projects; one each in New York, Oregon, Minnesota, and California. The Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 98-369, 101 Stat. 1330-268 (1987) extended the funding of the demonstration project until 1992.

90. In the four DEFRA demonstration S/HMOs, 10-20% copayments were required for home care services.

91. For a discussion of adverse selection, see EBRI, *supra* note 2, at 12-13; RIVLIN & WIENER, *supra* note 69, at 101-02.

the availability of long-term care.⁹² However, state disclosure statutes might require a full explanation of all services offered by the plan, and advocacy organizations for the elderly would similarly inform their members of a new source of long-term care. The demonstration S/HMO projects, which are subject to regulation by the Health Care Financing Administration ("HCFA"), are allowed to limit the percentage of their enrollment subject to existing disabilities—but this would probably not be permitted in a broadly marketed plan because of the competitive nature of the current insurance market. To attract enrollment and premiums, S/HMOs must highlight their distinctive features, while attempting to control the number of disabled members.

Several states have adopted Public/Private Initiative programs, which are at various stages of planning and implementation, to encourage the purchase and use of private long-term care insurance.⁹³ Already in operation, Indiana's program offers citizens who have adequate private insurance the ability to obtain Medicaid coverage without depletion of assets, and without the need to make transfers to qualify for Medicaid.⁹⁴ The program, which is administered by the state's Department of Health, requires interested senior citizens to apply to the Department and receive counseling about the availability of Medicare benefits and private LTC insurance. If these individuals buy and maintain LTC insurance that provides at least a year of benefits, and if they do become institutionalized but encounter nursing home costs that are not reimbursed by insurance, they will automatically be granted Medicaid benefits for the non-reimbursed care, regardless of their income, assets, or transfers.

The development of public/private programs is not an entirely new concept. Since 1987, eight states have been given grants to create these systems intended to serve as a model for a nationwide program.⁹⁵ Connecticut was the first state to bring a program to the testing stage.⁹⁶ Another grantee state, New York, is in the process of

92. See RIVLIN & WIENER, *supra* note 69, at 101-02.

93. See, e.g., IND. CODE ANN. § 12-1-25-3-7.6 (Burns Supp. 1991).

94. *Id.* at § 12-1-25-5-7.6.

95. See *supra* notes 93-94 and accompanying text.

96. See Matthew Schwartz, *Conn. LTC Plan Called 1st In nation*, THE NATIONAL UNDERWRITER COMPANY; LIFE & HEALTH/FINANCIAL SERVICES EDITION, September 9, 1991, at 3; Editorial Comment, *Connecticut's LTC Crucible*, THE NATIONAL UNDERWRITER COMPANY; LIFE & HEALTH/FINANCIAL SERVICES EDITION, September 16, 1991, at 18. The program, "The Connecticut Partnership," insulates, for Medicaid purposes, assets equal to their LTC coverage: that is, \$50,000 in insurance would render \$50,000 in assets Medicaid-exempt. See also Kirk Johnson, *Connecticut to Sponsor Nursing Home Insurance*, N.Y. TIMES, Dec. 19, 1991, at A1.

developing a demonstration project for the sale of state-approved private LTC policies. It was anticipated that New York would sell its first policies in early 1991, but implementation was delayed.⁹⁷

Programs that enhance the attractiveness of private LTC insurance are an important step toward protecting the middle class against impoverishment when long-term care is required. The securities plan would be an excellent complement to these programs. By providing a competing system, a consumer would be given a choice between insurance and securities funding that could act as a check on insurance premiums, and would build flexibility into the existing system by allowing consumers to combine the two according to personal finances, investment strategies, and beliefs about the personal risk of institutionalization or need for extensive home care.

III. The Proposed Securities Plan

This Article proposes a new funding mechanism that will rely upon the private sector and virtually eliminate the need for government funding for those who use it. The proposed system will utilize proprietary for-profit providers of long-term care and suggest that they combine voluntarily into a consortium. Once formed, the consortium would issue securities to the public that would be used by consortium members to solve the current funding system's inability to provide adequate care.

97. Under the projected plan, participants will be Medicaid-eligible once the policy benefits are exhausted and will be responsible for a copayment, but will be Medicaid-eligible regardless of asset level or transfers made during what would otherwise be the penalty period before nursing home admission.

It is estimated that the annual premium for the guaranteed-renewable, state-approved policy, purchased at age 65, will fall between \$1,200-\$1,500 range, depending on the options and riders chosen. If the policy is purchased at a younger age, the premiums will be less expensive. In addition, the policies will be subject to state-mandated minimum requirements. The requirements include the following:

No prior hospitalization or step-down requirement

Uniform eligibility requirements with other state-approved policies

A minimum loss ratio (i.e., the insurer must pay out at least a certain percentage of the premiums it receives in the form of benefits)

No exclusion of Alzheimer's Disease or other dementias

Home care coverage, with a minimum benefit of \$50 per day; nursing home coverage with a minimum benefit of \$100 per day

A benefit period of at least six years of home care, three years of institutional care, or some combination of the two

For home care patients, respite care must be provided for the family or other unpaid care giver.

See NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES, [AFFORDABLE FINANCING FOR LONG-TERM CARE] (INFORMATIONAL MATERIALS).

A. How the Plan Works

A consortium of proprietary providers of long-term care could solve many of the problems faced by health care providers and their patients. In forming this consortium several factors should be considered, including the selection of the securities and products which would be issued.

1. *Formation, Structure and Operation of the Consortium*

The first step in the plan would be the organization of the consortium. Prospective members would sign a contract detailing their rights to receive funds from the consortium and setting forth their obligations to provide care meeting high quality and objective standards, in exchange for the surrender of securities.

Membership would be open on a voluntary basis, both to small facilities with a few beds and to large facilities operated by nationwide chains. The consortium should include as many nationwide care providers as possible so that security holders have a wide choice of facilities which vary by geographic location, type of facility, religious affiliation, and other characteristics. Nationwide participation is particularly important to reassure the consumer that shares purchased in Wisconsin would still be usable for retirement in a "sunbelt" state. Since about three-quarters of nursing homes in the United States are proprietary,⁹⁸ there should be a broad choice available in most geographic regions to meet this concern.

Other considerations should be addressed in identifying the consortium's membership criteria. For example, membership should be open without discrimination provided that interested facilities meet state licensing requirements. To ensure continued compliance with these requirements, the membership agreement should provide for expulsion of members who lose their operating license, and perhaps for censure (and fines payable to the consortium) for members who receive sanctions for poor performance. The consortium could also ensure a minimum uniform performance standard by requiring all consortium members to meet the standards set by Medicare and Medicaid, even if a facility did not seek certification by these programs.

To document and define its membership, the consortium should draft a "membership agreement" for participating facilities, which would not only regulate the relationship of members within the consortium, but would also satisfy public and regulatory demands for

98. See *supra* note 27.

quality assurance in participating facilities.⁹⁹ Vital terms would include: (1) membership qualifications; (2) the extent to which all members will share in the costs of the initial public offering of securities and any subsequent offerings;¹⁰⁰ (3) provisions for facilities to join the consortium after it begins operations, as well as provisions for quitting the consortium;¹⁰¹ (4) an arbitration mechanism under which residents or their families could bring complaints about the quality of care in participating facilities;¹⁰² and (5) provisions for access to a non-compulsory central purchasing system.¹⁰³

Once membership concerns have been addressed and identified, the consortium would make an Initial Public Offering (IPO) of securities to the public. This function of the consortium represents the essence of the proposed financing plan — that investors must be assured of a store of value. In order to meet this objective, the securities must be completely fungible and completely marketable, which in turn mandates registration.¹⁰⁴ While there are some scenarios under which securities are exempt from registration,¹⁰⁵ this discussion assumes that

99. See *supra* notes 53-55 and accompanying text.

100. It seems most equitable to calculate cost-sharing based on a member's market share before joining the consortium.

101. The agreement must specify the extent to which existing members must provide refunds of money already received. Perhaps most critically, it should outline the consortium's responsibilities toward those who have already used securities to obtain residence at the facility and wish to leave the consortium.

102. The use of arbitration could be attractive to the nursing home industry. Many industries have willingly adopted self-regulation, regarding it as a better alternative to enhanced government regulation. Nonetheless, the consortium would have to develop a means to ensure objectivity in the course of arbitration proceedings. One possible solution is to mandate inclusion of consumer representatives, as well as representatives of advocacy organizations, on the arbitration panels.

103. This membership feature would allow a "mom and pop" facility that needs two cases of a particular supply to share in some of the cost savings. To avoid accusations of the "tying" forbidden by antitrust laws, the central purchasing system should stock various brands of a particular commodity, and should respond to members' requests for particular brands, rather than selecting a single brand. Furthermore, members must be permitted to purchase as much or as little as they like of any item or any mix of items. The price structure for purchasing supplies must be based strictly on the size of individual order.

104. See Securities Act of 1933 § 5, 15 U.S.C. § 77e (1988). For purposes of registration, federal law defines the term "security" quite broadly. See 15 U.S.C. § 77b(1).

105. See, e.g., Securities Act § 3(a)(3) (exempting short-term commercial paper); Securities Act § 3(a)(2) (exempting securities issued or guaranteed by government instrumentalities); Securities Act § 3(a)(11) (exempting issues limited to one state). 15 U.S.C. § 77c. This latter exemption clearly will not apply because the consortium plan depends on its nationwide scope. Similarly, § 3(b) of the Securities Act and its implementing Regulations A and D permit small issues of securities to be made without registration, but the consortium plan would require a larger issue. 15 U.S.C. § 77c; 17 C.F.R. §§ 230.251-262, 230.501-703(T) (1990). Finally, § 4(2) of the Securities Act exempts

the securities issued by the consortium would be registered.¹⁰⁶

The differing investment and care needs of potential purchasers mandate that more than one type of security be offered. In light of this need for diversity, the consortium should offer three types of securities:¹⁰⁷ annuities,¹⁰⁸ common stock,¹⁰⁹ and zero-coupon bonds.¹¹⁰ These securities should be issued with the consortium itself as the issuer and registrant.¹¹¹ The distinctive feature of the consortium securities is that each would contain a "put" provision, enabling the

deals which do not involve any public offering. 15 U.S.C. § 77d. The consortium offering would emphatically be public and would preclude a 4(2) exemption.

106. The registration requirement exacerbates the already lengthy, complex, and expensive process of making an IPO for a single corporation. For instance, the focus of securities registration is financial disclosure; however, before the IPO, the consortium would have no significant financial assets, no past financial statements to be disclosed, and no track record. Other problems, such as routine SEC reporting requirements and disclosures to security owners, would develop once the securities were issued.

The logical solution would be to require disclosure not of the consortium's financial affairs, but of the nursing home industry as a whole, making the consortium a kind of "pass-through" entity with administrative but not operating functions. In effect, then, the securities would be guaranteed by the full faith and credit of the nursing home industry. Although it is quite plausible that a particular facility might go out of business or become insolvent, it is hard to imagine that *all* nursing homes would do so simultaneously.

Another interesting issue is whether, in addition to the disclosure requirements of the Securities Act, and the normal Blue Sky process, the consortium securities would be subject to additional disclosure requirements that many states impose on Continuing Care Retirement Communities. This problem could be addressed by including a provision in the consortium contract to the effect that all participating facilities must submit current disclosure documents to the consortium and then by including a provision in the prospectus to the effect that disclosure documents for all participating facilities are available on request from the consortium.

107. See discussion *infra* part III.A.2.

108. Under § 3(a)(8) of the Securities Act, some insurance and annuity contracts issued by companies subject to state banking or insurance regulation are exempt from registration. 15 U.S.C. § 77c. An exemption under this section might be available for consortium annuities, but it seems more practical to register all consortium securities rather than encounter state insurance regulation.

109. Registration of stock and annuities would probably have to be made on the SEC's "long form" registration statement, Form S-1. Shorter registration forms are available for issuers with a "track record," but a new issuer or an issuer that has not been subject to the reporting requirements of the Securities Exchange Act of 1934 for at least three years must use Form S-1.

110. It is assumed that zero-coupon bonds would be subject to the Trust Indenture Act and registered as such. 15 U.S.C. §§ 77aaa-bbbb (1988).

111. See John D'Alimonte, *Underwriting Documents: Their Purpose and Content*, in MECHANICS OF UNDERWRITING 1989, at 99-100 (Practicing Law Institute, Corporate Law & Practice Course Handbook Series #656 (1989)).

In acting as the issuer, the consortium must furnish each purchaser with a prospectus as required by the Securities and Trust Indenture Acts. It would be helpful to purchasers to draft the prospectus in a manner that also conforms to federal and state consumer protection regulations and regulation of LTC insurance and Medicare.

security holder to surrender the security in exchange for LTC at the consortium facility of the security holder's choice. Although pricing issues would have to be resolved, the initial proposal contemplates that ownership of one share of stock would entitle the holder to one month of care. As for the other securities, a zero-coupon bond could be redeemed at a certain date for \$25,000 in cash or \$25,000 worth of care (and could be sold on the secondary market at any time before that date). Similarly, an annuity would promise payments of \$600 a month in cash or \$600 worth of care, for example, starting on a certain date.

A successful IPO would raise millions of dollars. It is recommended that a portion of the proceeds be distributed immediately to consortium members in proportion to their market share or investment before implementation of the plan. The consortium should also make annual distributions of investment income based on the proportion of securities actually redeemed at a particular facility. That is, the more stockholders, bondholders, and annuitants that the facility could induce to become residents in that facility, the more income the facility would receive from the consortium.

In the first few years of consortium operation, few redemption payments would be made because there would not be many stockholders redeeming their securities. Thus, the consortium would have a large pool of capital which would then be made available for borrowing by the members, at competitive or perhaps below-market rates, in order to construct new facilities or upgrade physical plant or staffing in existing facilities. This continued access to immediate payments usable for facility operations would be one incentive for facilities to join the consortium.

The remainder of the proceeds would be retained by the consortium. These funds, and the corresponding investment income, could operate as a revolving loan fund within the industry. Each year a distribution could be made to consortium members, in proportion to the extent to which security holders actually "put" their securities to the facility. Facilities that attracted a larger number of security holders to use their securities for care in those facilities would be entitled to more money. In this regard the plan would be pro-competitive, providing an incentive for facilities to engage in active competition in quality to convince security holders to select their facility.

Security holders would not be required to surrender their full complement of securities when they enter a consortium facility. The typical entrant could pay a month at a time, or a few months in advance. If the entrant is dissatisfied with a facility, she could simply leave, and

use her remaining securities in exchange for care in another participating facility. Although transfer trauma¹¹² still poses a risk, the problem is less severe when the residents have more control over their placement.¹¹³ Most importantly, the transfer will be at the instance of the resident who will have a full menu of choices available.

Once the IPO of consortium securities is launched, the next question is whether the IPO will succeed in the market. The criteria for a successful IPO have been described in the following way:

In addition to meeting certain financial guidelines, a high quality initial public offering candidate should possess some proprietary capability or technology, be a member of a growing and viable industry, have good relationships with both customers and suppliers, and have a competent management team.¹¹⁴

Although the proposed consortium has neither proprietary capability nor technology, it would be the only organization offering securities for nursing home care. In addition, demographics indicate that the nursing home industry is likely to expand as the size of the elderly population increases.

An additional question remains as to who would invest in the securities offered by the consortium. Although this hypothesis must be tested by the market, middle-class people who are already securities investors might perceive the advantages of buying the consortium's securities. In addition, the securities would be an attractive investment for mutual funds that specialize in socially progressive issues. They would also appeal to union pension funds, because retirement security, including post-retirement health benefits, is a major concern of these funds. In a climate in which employers are seeking to reduce employee and retiree health benefits, the availability of an investment that promotes better health care for union retirees would probably have a broad constituency. In contrast, the securities probably would not be attractive to risk arbitrageurs because the reciprocal relation-

112. See *supra* note 21 and accompanying text.

113. Many nursing home residents, of course, are mentally incapacitated and cannot make choices about their own care. It might be useful for state conservatorship and guardianship statutes to be amended to specify that fiduciaries can properly invest in consortium securities, and that the fiduciary has the same power over the securities as the protected person would have if he or she were not incapacitated — powers including doling out the securities one month at a time, selling securities and applying proceeds in the best interests of the protracted person, and moving the protected person to a better facility.

114. Addison M. Levi, III, *Preparing for an Initial Public Offering*, in HOW TO PREPARE AN INITIAL PUBLIC OFFERING 95, 100 (Practising Law Institute, Corporate Law Practice Course Handbook Series #656 (1989)).

ship between private-pay fees paid in cash and the securities would set an upper limit on the securities' potential appreciation.

In principle, the consortium could be organized in several forms: a joint venture, a trade association, a not-for-profit corporation, or a for-profit corporation. Issuing stock is a corporate attribute, which seems to rule out the feasibility of the joint venture structure. In a sense, the consortium's objectives are similar to those for which many not-for-profit organizations are set up, such as operation of health care facilities and provision of care for the elderly. Nevertheless, the consortium would provide private profit opportunities to the owners of participating facilities, ruling out the use of a not-for-profit corporation.

In some ways, the proposed consortium resembles the "business league," a type of not-for-profit corporation organized under Internal Revenue Code Section 501(c)(6),¹¹⁵ and distinct from the 501(c)(3) charitable organization.¹¹⁶ Consortium members would have the requisite common business interest as providers of long-term care for the elderly. The consortium's activities would be directed toward improving conditions in one or more lines of business and improving nursing home care for the elderly. The Code forbids business leagues from carrying on a business that is ordinarily done for profit, but there is no existing profit-making business that channels capital to nursing homes. Nevertheless, the consortium's intended result of net income inuring to private shareholders or individuals would preclude 501(c)(6) treatment.

The producer's or consumer's cooperative is another structure that provides a somewhat useful analogy for determining what the tax status of consortium securities may be. The cooperative association, as recognized by the laws of many states, permits an association and its members to enter into an arrangement under which producers market their products, or consumers satisfy their purchasing needs, through the cooperative. Typical hallmarks of the cooperative include voting power for all its members; levying of assessments for shared purposes such as "image" advertising and management of the cooperative; and the distribution of economic benefits (sales proceeds, cost savings) to members either equally or on the basis of utilization. Properly constituted cooperatives are exempt from antitrust attack and dictum in

115. See generally Jerald A. Jacobs, *Association Law Handbook* (Bureau of National Affairs, Washington, D.C. 1986); Howard L. Oleck, *Non-profit Corporations, Organizations and Associations* 938-49 (5th ed., 1988 & Cum. Supp. 1990).

116. See Lynn Stevens Hume, *IRS Clarifies Policy on Granting 501(c)(3) Status to Nonprofit Health Care Entities*, THE BOND BUYER, August 5, 1991, at 2.

several cases suggests that the cooperative form is favored by the law.¹¹⁷

Because the consortium's objectives include enhancing a nursing home's image and improving the quality of care to attract private-pay patients, the consortium bears certain resemblances to the producer's cooperative model. In both the cooperative and the consortium, members would probably have to pay some type of assessment to cover administrative costs, especially in the early years of operation before the IPO proceeds have accumulated. Typically, producers who participate in a cooperative agree to give the cooperative exclusive marketing rights for their product. In this instance, consortium members would want to retain the right to attract private-pay patients who do not own consortium securities. Similarly, Medicare and Medicaid certified facilities would want the option of servicing patients whose care is paid for by public benefit programs.

Despite the desirable attributes of the cooperative and joint venture forums, the ordinary business corporation, which allows the most flexibility in issuing securities, presents the most feasible alternative.¹¹⁸

2. *Selection of Securities and Products*

Because the elderly are not a homogeneous group, the proposed plan should offer a variety of securities to accommodate the types of care required by the elderly population.¹¹⁹ By offering common stock, zero-coupon bonds, and annuities, the consortium is most likely to meet the needs of consumers.

The initial attraction of common stock is that single shares would probably trade at low enough prices to permit young and middle-aged people to buy at least one share a year and accumulate shares for future need. An additional advantage is that a securities market and the private pay nursing home rate would act as reciprocal checks on one another. In this way, an individual would pay no more than the discounted present value of anticipated future care for consortium se-

117. See Eric Mayer, *Cooperative Associations*, 18 AM. JUR. 2d 271-321 (1985 & Supp. 1990).

118. Because the consortium would have hundreds of stockholders, many of them corporations, a C Corporation would be most appropriate and an S Corporation election would be precluded. In selecting an incorporation state, the criteria of low taxes and favorable treatment must be balanced against other costs of doing business including rents and utility rates and convenience of communication with consortium members.

119. As stated several times throughout this Article, some members of the elderly population are completely healthy while others are completely debilitated. In addition, financial resources and systems of family and community support vary greatly.

curities, based on an assessment of the risk of needing LTC in the future, because of the assurance that the same care could be obtained for a smaller sum in cash. Similarly, no one would pay \$5,000 in cash for a month's worth of care if securities could be purchased on the open market for a lesser amount and then exchanged for the same care.

A common stock component is also attractive because corporate democracy gives rights to stockholders which help protect consumers. For example, stockholders can vote for the corporation's board of directors and, to a limited extent, place proposals on the corporate agenda for stockholder vote. Stockholders are also entitled to extensive disclosure through the corporation's annual and quarterly reports. Thus, a stockholder who expects to move into a nursing home at some time in the future will have every right, and significant incentive, to visit the facility to see that residents are well-fed and are receiving adequate care. Ideally, younger stockholders will act as advocates for elderly residents of consortium facilities and press for improvements in the quality of care.

The proposed plan calls for zero-coupon bonds as a complement to the common stock. The zero-coupon bond would be redeemable at maturity, either in cash (directly from the consortium) or in the equivalent amount of care provided by a participating facility of the bondholder's choice.¹²⁰ For instance, it might be possible to purchase a bond with a face value of \$30,000, with a fifteen year maturity, for about \$10,000, depending on prevailing interest rates, the bond rating, and other financial factors. At maturity, the owner would receive the \$30,000 in either cash or care through the bond's sale on the secondary market.

At first glance, it seems that an enormous variety of denominations and maturities would be required to fit the varying needs of purchasers. In practice only a few maturities, such as five, ten, fifteen, and twenty-year bonds, would suffice. The inclusion of stocks as well as bonds would be important because both securities offer a different risk structure. The stock, exchangeable for a month of care per share, effectively shifts some of the risk of cost increases to the facility, because a facility would be constrained from "charging" more than one share for a month's care. Regional cost differences might create a problem because the same share could not be exchanged on the same terms in high-cost and low-cost areas of the country.

120. Conventional "coupon" bonds are not included because the intention is to minimize the transfer of cash from the consortium to the public, in favor of maximizing the provision of nursing home services in exchange for securities.

Offering consortium stocks in conjunction with bonds has other advantages. It would allow the investor to choose the amount he or she wishes to invest, and the degree and type of risk that would be desirable for a particular purchaser. The intention is that both stocks and bonds would appeal primarily to middle-aged investors, who want to make a long-range plan for their own care or contribute to the cost of a parent's care, and who look to appreciation in stock prices and the built-in appreciation inherent in zero-coupon bonds to provide such care at a deep discount.

While it is arguable that stocks and bonds would be less attractive to the elderly investor, there may be ways to avoid this problem. For example, granting preferential Medicaid treatment, and thereby making it easier to qualify for Medicaid, could make these securities more attractive.¹²¹ If a Medicaid applicant owned securities, the securities would be a countable asset that ordinarily would impair Medicaid-eligibility; however, it would be in the interests of both the state and federal governments to amend the Social Security Act (and its accompanying Medicaid regulations) to permit consortium securities to be spent-down, without Medicaid penalty, before other assets were used. Eligibility for Medicaid benefits depends on asset level, on income, and on whether non-exempt transfers have been made once a penalty period has started to run. A financial transaction constitutes a transfer for Medicaid purposes only if it is gratuitous. A purchase for full market value is not a transfer and cannot trigger a penalty period. Because nursing home residents remain private-pay patients and defer their Medicaid application, the state and federal government will have to shoulder fewer months of care.

Typically, the elderly investor, who is already at risk of institutionalization in the near future, would not be attracted by the relatively insignificant short-term discount offered by purchasing a bond. Nevertheless, it is likely that the stocks and bonds would be attractive to a conservator or guardian faced with the likelihood of placing the protected person in a nursing home. Similarly, stocks and bonds would also appeal to a person who fears his or her own future incapacity, and wishes to take steps to ensure the availability of institutional care.

In addition to stocks and bonds, an annuity¹²² would be potentially attractive to a different niche of the elderly population. Offering an annuity component in the plan would accommodate the older inves-

121. States such as Indiana provide incentives for their citizens to maintain LTC insurance, by liberalizing Medicaid requirements for citizens who maintain at least a minimum of private insurance.

122. See I.R.C. §§ 61, 72 & 101 (1988 & Supp. 1989).

tor who would be likely to have a lump sum to invest, whether it be a lump-sum pension payout,¹²³ IRA or Keogh fund, or proceeds from the sale of a family home or insurance. An annuity component would permit elderly investors with a large sum to invest with the expectation of receiving continuing income, "backstopped" by the promise of receiving long-term care of equivalent value if the annuitant requires institutionalization.

Older investors often favor annuity investments for additional reasons. In planning, they avoid having to manage a large sum of money and receive safe, regular income. From a tax perspective, the Internal Revenue Service provides favorable treatment for deferred annuities.¹²⁴ For money invested in a deferred annuity, the appreciation in value of the annuity is not taxed until the owner begins to receive regular payments.¹²⁵ Thus, the consortium could provide annuities for middle-aged and older investors who seek regular income. Annuities tailored to produce no more than the amount of income that can be retained by a Medicaid applicant and his or her spouse would be especially attractive in elder care planning.¹²⁶

The annuity, like the bond, contains a factor of price risk. The fact that the monthly annuity payment may represent far less than the total cost of care should be emphasized in the prospectus and stressed by elder law attorneys and financial planners. By combining annuity

123. Elder law attorneys often advise clients who have this option to take their pensions in lump-sum rather than annuity form because Medicaid plans can be made to transfer part of the lump sum, or to transmute it into exempt assets (e.g., by buying a home, selling the homestead and buying a more expensive one, doing home repairs or making capital improvements that make the home more suitable for a disabled elderly resident.) There are no comparable planning possibilities for excess income deriving from annuity payments. Pensions cannot be anticipated; the recipient cannot assign future pension payments. Furthermore, although some of the states allow "income spend-down" — permitting Medicaid applicants whose income exceeds the limit to qualify for Medicaid by proving that they have spent the excess on Medicaid care — still others do not allow this option. Thus, applicants with excess income remain ineligible for Medicaid even if they devote their income to medical bills.

124. See I.R.C. § 72.

125. This favorable tax treatment is available only if annuity payments are delayed at least until the investor reaches age 59 1/2, which explains why older investors favor annuity investment. By contrast, younger investors seldom have the patience to wait twenty or thirty years before receiving annuity payments.

126. The attractiveness of this option would be enhanced in states such as Florida and New Jersey that disqualify Medicaid applicants if their income exceeds the limit. Purchase of such an annuity would convert excess assets into permissible income, and would not constitute a transfer giving rise to a penalty period because there is no gratuitous element. The strategy of combining consortium securities with Medicaid planning might be used by a person unable to afford enough securities to fully fund LTC, but with an asset level too high to qualify for Medicaid without some form of planning or spend-down.

purchases with a balanced investment program, the risk could be brought within tolerable limits.

With any security, no guarantee exists that a profit would be realized and it is unlikely that the securities would become worthless through bankruptcy. The full faith and credit of all consortium members, who might represent a large portion of the entire nursing home industry, not the credit of one nursing home or nursing home operator, would support the consortium's securities. If a particular facility went out of business, securities could still be redeemed at other facilities. In contrast, LTC insurance contains a significant risk that the purchaser of an LTC insurance policy will, in effect, surrender all insurance premiums and never collect any benefits. This is indeed true of other forms of insurance — for example, a homeowner who never suffers a fire never collects benefits from fire insurance — but LTC insurance premiums are often high enough to deter potential purchasers who are aware of this risk. For these potential purchasers, the securities plan offers reassurance.

C. Drafting Guidelines from College Savings Plans

While the proposed consortium would be entirely new in the health care field, a number of states have already enacted securities funding programs for higher education. This section will discuss how these programs have succeeded in uniting public and private providers and in issuing securities in order to assist families with the challenge of financing higher education.¹²⁷ While these programs are fairly new and it is too early to assess their success, they provide insight into the viability of a large scale securities plan similar to the proposed consortium.

The analogy between college savings plans and nursing home financing is not perfect. A college education is a much-desired outcome, whereas institutionalization is not an aspiration. The offspring of education-oriented families will usually go to college and enrollment will usually take place between the ages of eighteen and twenty-five, typically over a period of four years. In contrast, only a fraction of the elderly population will enter a nursing home.¹²⁸ Another critical difference is that college planning is usually done by parents for

127. See generally Peter Barton, *Paying for Your Child's College Education with New, Double Tax-Free Government Bonds*, 62 WIS. L. REV. 19 (1989); Douglas K. Chapman & Roger W. Anderson, *Ohio's College Savings Plan: Buyer Beware*, 21 U. OF TOLEDO L. REV. 131 (1989); David Williams II, *Financing a College Education: A Taxing Dilemma*, 50 OHIO ST. L.J. 561 (1989);

128. See *supra* note 13. Both the age at entry and the length of stay are unpredictable.

their children, while long-term care planning must be done by individuals for themselves, with the funds remaining after other family needs have been met. A high proportion of nursing home residents are widowed, divorced, or never married.¹²⁹ Many of these residents seldom receive visitors and are unlikely to receive substantial financial support from relatives.

In spite of these differences, the approaches that have evolved in response to the parental challenge of providing college tuition for one or more children are still informative. Many states have enacted college savings plans modeled after either the "Michigan Plan"¹³⁰ or the "Illinois Plan."¹³¹ An initial comparison of the two plans is necessary for the purposes of analysis. In the Michigan Plan, a family pre-pays tuition in advance at a discount, while the Illinois Plan tackles the problem by issuing college savings bonds.

In Michigan, the Michigan Education Trust administers the plan under the auspices of the board of trustees and includes a representative of Michigan's colleges as well as various government appointees. Under the plan, individuals can buy a contract priced in accordance with how long in advance it is purchased—the longer the term, the lower the contract price. The contract obligates the state of Michigan to pay the full tuition and fees for a "qualified beneficiary," typically, the payor's child. To create an incentive to purchase such contracts, the state makes the purchase price, payable in a lump sum or in installments, deductible on state income tax returns. The Michigan statute spells out the conditions on which refunds will be available, and whether interest will be paid on refunded moneys.

The Michigan Plan has been in operation only since the summer of 1988, so it is hard to tell how successful it will be either from the point of view of the parents of college students or the state operating the trust. A recent article criticizes the validity of the trust's actuarial

129. GAO I, *supra* note 2, at 35 ("In 1985, only 16% of the elderly entering nursing homes were married.").

130. MICH. COMP. LAWS § 390.1421-1444 (West 1988). Also adopted in: FLA. STAT. ANN. § 240.439-498 (West 1989 & Supp. 1990); IND. STAT. ANN. § 21-8-6-1 to -16 (West 1991); ME. REV. STAT. ANN. tit. 20-A, § 12601-12619 (West Supp. 1990); MO. ANN. STAT. § 166.207-260 (Vernon 1991); WYO. STAT. § 21-16-501 to -505 (Supp. 1991).

131. ILL. STAT. ANN. ch. 144, para. 2401-11 (1986 & Supp. 1991). Something similar also exists in: COLO. REV. STAT. ANN. § 23-15-110.5 (West 1990 & Supp. 1990-91); CONN. GEN. STAT. ANN. § 10A-221 to -245 (1982 & Supp. 1990); IOWA CODE ANN. § 262A.6A (Supp. 1991); MO. ANN. STAT. § 360.046 (Vernon Supp. 1991); N.C. GEN. STAT. § 116-209 (1987); OHIO REV. CODE ANN. § 3334.01-.12 (Anderson 1990); R.I. STAT. LAWS § 35-15-1 to -6 (1990); TENN. CODE ANN. § 49-7-901 to -907 (1990); VA. CODE ANN. § 23-38.72-.74 (Michie Supp. 1991); WASH. REV. CODE ANN. § 28B.106.005-.902 (Supp. 1991); 1989 WIS. LAWS 68.

assumptions, federal income tax status, and price setting mechanism for participation.¹³² Nevertheless, in 1989, the Hemar Corporation modeled a private-sector education financing plan after the Michigan Plan¹³³ and a handful of colleges currently offer guaranteed tuition programs similar to the Michigan Plan.¹³⁴

Compared to the Michigan Plan, the Illinois plan relies heavily on private sector securities financing. Under Illinois' "Baccalaureate Savings Act,"¹³⁵ the state issues triple-tax-exempt (federal, state, and local) zero-coupon bonds.¹³⁶ The interest rate on the bonds is set one-half percent higher if the bonds are redeemed for higher education purposes within the state, but there is no limitation on the use of the proceeds. Furthermore, the first \$25,000 of bond principal and interest is excluded from the determination of the student's financial-aid eligibility.

Following these initiatives, in September, 1989, Wisconsin adopted an enabling statute under which the Building Commission could sell

132. Jeffrey S. Lehman, *Social Irresponsibility, Actuarial Assumptions, and Wealth Redistribution: Lessons About Public Policy from a Prepaid Tuition Policy*, 88 MICH. L. REV. 1035 (1990). Lehman notes that, in the first year of program operation, \$6800 was charged to guarantee four years of tuition to a newborn infant; \$9200 for a child entering tenth grade in the fall of 1988. Although registration fees were paid to reserve a place in the program for 82,000 children, only 39,000 contracts were actually purchased. *Id.* at 1044. Lehman quotes April, 1986 testimony by MET treasurer Robert Bowman before the Michigan House of Representative's Colleges and Universities Committee: "This is a middle-income plan. But once investments are made, middle-income families should not need other scholarship monies as much, freeing these funds for poor families. Plus, the state could consider investing a portion of the funds it already spends on scholarships and grants into the program on behalf of the poorer students." *Id.* at 1060-61. If this argument is valid, it would operate even more strongly in favor of the securities plan: by permitting middle-income individuals to make affordable provision for their own care, it would free Medicaid funds for poorer people.

133. See David Williams, *supra* note 121, at 595 n.255. The Hemar plan has intriguing similarities to the plan for LTC financing described in this article. Hemar, a close corporation, supplemented its original business of buying and servicing college loans by developing a program under which colleges nationwide could join in a plan under which parents would purchase guaranteed tuition contracts redeemable at any participating school, with provisions for refund if the offspring in question failed to attend a participating institution. Hemar needed SEC clearance and IRS advice before the plan could be offered to the public.

134. These plans are limited to providing a discount on tuition at that specific institution, creating a problem if the student is unable to meet the admissions standards of the institution, or prefers to seek instruction somewhere else. The problem of a single-institution limitation is somewhat alleviated by Indiana University's offering of guaranteed tuition certificates redeemable at eight campuses to parents who are Indiana residents. In addition, the certificates can also be sold on a secondary market, with two banks acting as market-makers. Williams, *supra* note 121, at 595.

135. ILL. ANN. STAT. ch. 144, para. 2401-11 (Smith-Hurd 1987).

136. Christopher R. O'Dea, *Illinois to Sell \$90 Million Zero Coupon GO's Marketed as College Bonds*, THE BOND BUYER, January 11, 1988, at 4.

zero-coupon higher education bonds.¹³⁷ First sold in March, 1990, the state used tax incentives to spur sales. Under federal law, the bonds are tax free and under state law, the original issue discount on the bonds is excluded from taxable income providing that the bonds are purchased by an individual as opposed to a corporation or partnership.¹³⁸ The Wisconsin plan calls for non-callable bonds with varying maturities of six to twenty years. The longer the maturity, the lower the price of the bond. In other words, if the goal is to accumulate \$X in principal and imputed interest, the longer the term of the bond, the smaller the principal sum that need be invested to provide the desired fund. The non-callable feature is important because, if the bonds were callable, the issuer could redeem the bonds, depriving the bond holders of the benefit of a favorable change in interest rates. To a certain extent, parents can select a maturity in line with their children's actual age and expected college entrance and can make selections by price, according to what they can afford.¹³⁹

A third education based program, the Ohio Bond Program became effective October 2, 1989.¹⁴⁰ The program provides for the sale of zero-coupon bonds with a \$5,000 face value and a 15-year term. The length of the term permits a deep discount, reducing the sale price to approximately \$1,200 per bond. The program also includes the sale of two types of non-tax-exempt, "tuition credits" similar to the Michigan contracts. One type of credit is redeemable at the educational institution for tuition, the other type is paid directly to the student to pay fees, dormitory costs, and related non-tuition costs. The credits are sold in units whose denomination is one percent of the average yearly tuition in state-assisted Ohio schools.¹⁴¹

The long maturity structure of these educational plans may pose a practical limitation on their attractiveness to potential purchasers. Not all parents have the resources or the inclination to plan two decades ahead for a child's college education or for a projected offspring. To cope with this objection, the Illinois-type plan permits

137. See Williams, *supra* note 121; 1989 WIS. LAWS 68.

138. Original issue discount means the "interest" on the bonds is not paid periodically in cash as it would be on an ordinary bond; instead, the bond is sold at a deep discount.

139. A longer maturity means a lower price. When the plan was designed, it was projected that the initial issue of 20-year bonds would yield 6.95%, selling for \$255.02 per \$1,000 face value (the maximum denomination permitted by the plan).

140. OHIO REV. CODE ANN. § 3334.01-.12 (1989).

141. A legal question raised by the program, that has yet to be resolved, is who will be the "owner" of the credits—the purchaser, who retains the right to change the beneficiary of the credits, or the student on whose behalf tuition or other non-tuition-related expenses are paid?

colleges and other eligible post-secondary institutions¹⁴² to redeem the bonds prior to the maturity date—i.e., when the student is actually in college. To accomplish this end, the college could credit the “accreted value” of the bonds¹⁴³ to the bond holder’s account. An advantage of not redeeming the securities for cash would be to create a guarantee against a loss in value, that would insulate a bondholder against inflation in post-secondary tuition.

Additional concerns have been raised regarding the significant degree of interest rate risk inherent in making long-term financial commitments.¹⁴⁴ If the interest-rate climate is unfavorable to parent-investors, the bond program will have to make concessions to overcome an unwillingness to purchase bonds. From an equity perspective, the tuition plans, like the securities plan, are attractive to potential middle-class investors, but have little or nothing to offer low-income families. From an issuing state’s perspective, excessive returns could also threaten a bond program by leaving the state with obligations it may be unable to afford.

Implementing the proposed securities plan in the health care industry will raise a host of similar concerns. The tax questions raised in conjunction with state education securities plans provide a basis for analyzing the likely tax treatment for consortium securities and will be discussed in the following section.

IV. The Legal Implications Of The Proposed Plan

The proposed consortium’s implementation will raise a multitude of complex legal issues. The first section will discuss tax considerations that may affect a purchaser’s decision to buy consortium securities. The second section explores why the proposed combination of health care providers is unlikely to be vulnerable to antitrust challenge. Finally, the consortium’s interaction with the highly regulated nursing home industry will be considered. The focus will be on the limitations Certificate of Need Laws may impose on the consortium’s construction of new facilities.

142. The definition of post-secondary institutions explicitly excludes proprietary trade schools.

143. Accreted value of the bonds includes the original purchase price, plus an additional amount compounded semi-annually from the date of purchase, based on the yield prevailing at the time of purchase.

144. See Williams, *supra* note 121, at 595 (quoting Richard E. Anderson of the Forum for College Financing Alternatives).

A. Tax Issues

When an attorney or other advisor makes a plan providing for long-term care, it is important to choose the alternative that provides the best results and lowest after-tax cost to the senior citizen. Accordingly, the tax status of the securities to individual purchasers raises important questions, including what basis a purchased security will have upon redemption and whether the securities will be entitled to a tax preference. The health-care related nature of consortium securities, as compared to securities purchased for conventional investment purposes, might entitle them to preferential tax treatment. Basis rules and tax issues will affect the attractiveness of the consortium's securities to a prospective purchaser who must compare the after-tax return of consortium securities to other securities.

Tax preferences would reduce the effective tax rate that a security holder would have to pay in redeeming consortium securities. A 1988 change in the Internal Revenue Code¹⁴⁵ extends a limited tax preference to certain purchases of Series EE savings bonds.¹⁴⁶ Interest on such bonds purchased after December 31, 1989 is excluded from income if the bonds are redeemed in a year in which the purchaser incurs "qualified education expenses."¹⁴⁷ The exclusion is not available to grandparents, other relatives, or friends of the student, but is fully available to parents with qualifying adjusted gross incomes.¹⁴⁸ A simple measure that would benefit the elderly would be to extend similar tax benefits to individuals who redeem Series EE bonds for their own long-term care.

Optimally, the same treatment would also be extended to consortium securities, however this extension is less likely because of an IRS ruling on the federal tax consequences of the "Michigan Plan."¹⁴⁹ The ruling provides that the purchase of the contract is not an event subject to federal income tax. This implies that the consortium's se-

145. 26 U.S.C. § 135 (1988) (added by Technical and Miscellaneous Revenue Act (TAMRA), Pub. L. No. 100-647, tit. VI, § 6009(a), 102 Stat. 3688.

146. Series EE bonds are widely available, in small denominations, with no "load," and therefore are a suitable investment for families whose income level or lack of experience with financial services makes other investments unsuitable or undesirable. Consortium securities might also fit these criteria.

147. Tuition and fees only; not dormitory bills or other expenses that replace ordinary nondeductible living expenses for a dependent child.

148. See I.R.C. § 135(b)(2)(A). Subject to certain modifications, adjusted gross income must be less than \$40,000 (for a single or head-of-household return) or \$60,000 (for a joint return); reduced for parental incomes between \$40,000 and \$55,000 (single or head-of-household) and \$60,000-\$90,000 (joint return), and unavailable at higher income levels. These figures are indexed for inflation.

149. Priv. Ltr. Rul. 88-25-027 (Mar. 29, 1988).

curities would fail to qualify for gift tax exemption status.¹⁵⁰ Furthermore, the ruling found the gift to be a completed one, indicating that the purchase of a contract would deplete the purchaser's unified credit.¹⁵¹

Under Private Letter Ruling 88-25-027,¹⁵² when a student begins college, the student realizes taxable income equal to the excess of the fair market value of the educational services provided, over one-fourth of the student's basis in the contract. Because the consortium contemplates a contract's purchase far in advance at a deep discount, tax gains would be significant in most cases.

While letter rulings lack the precedential value of case law and while the consortium's objectives diverge from Michigan's education program, application of the ruling to the proposed consortium would discourage investors from purchasing the securities. A possible IRS position would be to interpret the disposition of consortium securities for health care as a barter transaction. In this interpretation, the security holder who exercises the put provision barter securities in exchange for long-term care.

Barter transactions receive rather unfavorable treatment because the Code forces each party to realize a gain on the fair market value of the item transferred rather than the excess of the fair market value of the property received over that of the property surrendered.¹⁵³ If, for instance, a sculptor and a furrier exchange a statue for a fur coat, each of them has taxable income equivalent to the FMV of the property received. Instead, if the fur-loving sculptor had sold 100 shares of stock and used the cash to buy the coat, she would be taxed only on the capital gain, the excess of the FMV over the basis of the stock. The trade-off is that barter improves the taxpayer's cash flow,¹⁵⁴ but increases his or her tax bill.

Under current law, the basis of the consortium securities in the

150. *Id.* Under the ruling, because the payment was made to the Michigan Education Trust, not directly to an educational institution as required by that Code Section, the gift would also fail to qualify for exempt status under the Internal Revenue Code. See I.R.C. § 2503(e)(2)(A).

151. See I.R.C. § 2503(b) (1988).

152. Priv. Ltr. Rul. 88-25-027 (Mar. 29, 1988).

153. See I.R.C. § 61. Interestingly, the Internal Revenue Code deals explicitly with the situation in which an employee or independent contractor receives securities in compensation for his or her services, but gives little guidance as to what happens when a recipient of services, such as health care, pays for them with securities.

154. See Treas. Reg. § 1.61-2(d)(6)(ii) (1960); Rev. Rul. 79-24, 1979-1 C.B. 60; Rev. Rul. 83-163, 1983-2 C.B. 26. Desired goods or services can be paid for with property; often property that the taxpayer would otherwise have trouble disposing of or would have to sell at a loss.

hands of their original purchaser would be the purchase price, subject to any adjustment mandated or permitted by the Code. The basis of inherited securities would be the fair market value at the time of the decedent's death.¹⁵⁵ The computation is more complex for securities that are the subject of gifts. For computing gain, the donee assumes the donor's basis. For computing loss, the basis is either the donor's basis or the fair market value of the property at the time of the gift, whichever is lower.¹⁵⁶

Consortium securities may raise other income tax issues. The Code does not wait until redemption to tax the appreciation of the zero-coupon bond. Instead, the Internal Revenue Code¹⁵⁷ taxes a bondholder on a proportionate share of the "original issue discount" (OID), which in effect is a substitute for the taxable interest on a conventional bond.¹⁵⁸ Consequently, the zero-coupon bonds included in the securities plan would generate OID and thus taxable income.

The gain on disposition of a market discount bond attributable to the discount constitutes ordinary interest income, not capital gain. This distinction would make a practical difference with respect to nursing home bonds purchased on the secondary market, not as part of the original issue, if the Tax Code were amended to reinstate significant preferential tax rates on capital gains.

Another significant question is the status of consortium securities vis-a-vis the medical expense deduction.¹⁵⁹ For life care communi-

155. I.R.C. § 1014 (1988). Somewhat similar considerations apply to the taxation of income received under an annuity, including an annuity issued by the consortium. I.R.C. § 72 permits the taxpayer to retrieve the capital invested in the annuity tax-free. The portion of each annuity payment that exceeds the "exclusion ratio," representing a return of capital, constitutes taxable income. For taxable "coupon" bonds, the interest paid periodically constitutes taxable income to the recipient. In the case of a "zero-coupon" bond, no periodic interest payments are made, but the maturity value is much higher than the bond's initial purchase price.

156. I.R.C. § 1015 (1988).

157. I.R.C. § 1273(b) (1988).

158. Under I.R.C. § 1272(a) (1988), certain amounts are not considered OID: the discount on U.S. Savings Bonds or tax-exempt bonds; short-term obligations with a term under one year; obligations created by natural persons no later than March 2, 1984; and loans of less than \$10,000 where both borrower and lender are natural persons, and there is no tax-avoidance intent.

159. Under I.R.C. § 213, unreimbursed medical expenses are deductible to the extent that they exceed 7.5% of an individual's adjusted gross income. Because a nursing home resident lives in the nursing home, and a portion of the cost of institutionalization represents a substitute for ordinary living costs, no medical expense is available for a "rest home" or other facility that does not offer medical or nursing care. But if medical care is the principal reason for placement in a nursing home, the entire nursing home bill (above the 7.5% "floor") is deductible without allocation. See *Robinson*, 51 T.C. 520 (1968), *aff'd without opinion* (9th Cir. 1970). Treas. Reg. § 1.213-1(e) sets the line of demarcation between a nursing home placement with a primary motivation of obtaining medical

ties,¹⁶⁰ the Tax Court held a portion of the entry fee to be deductible.¹⁶¹ In *Klappenbach*, a taxpayer was denied a charitable deduction for a donation made to a corporation which solicited "sponsorship gifts" proportionate to the size of the unit, to build retirement homes.¹⁶² With regard to a CCRC, the IRS has permitted a deduction of 30% of the entry fee for a CCRC because the taxpayer proved that 30% of the facility's budget was devoted to medical and nursing care.¹⁶³ If the facility ceased to provide lifetime care and paid a rebate to the 78-year-old taxpayer, the recipient would have to include that portion of the rebate which generated a tax benefit.

Finally, section 121 of the Internal Revenue Code may have an indirect impact on the securities plan.¹⁶⁴ This section exempts the proceeds from the sale of a home that is the principal residence of a

care, where all costs would be deductible (even costs that substitute for ordinary living costs) and placement motivated by other considerations. In the latter case, only the medical component of the nursing home bill is deductible.

See also *Counts*, 42 T.C. 755 (1964), in which a deduction was permitted for the amount a taxpayer paid for his father's nursing home care, including the lump-sum "maintenance" charge that was assessed over and above itemized charges for certain medical services. The father's institutionalization was held to have a primary purpose of securing medical care for his high blood pressure and gall bladder illness, while nursing care was necessary for his extensive impairment in performing daily activities.

160. A life care community or CCRC is a hybrid between a retirement community, offering suitable living accommodations for the active elderly, but no medical facilities, and a medically-oriented nursing home. See *supra* notes 76-83 and accompanying text.

161. *Estate of Smith*, 79 T.C. 313 (1982) (allowing the portion allocable to days of care provided in the community's nursing center without additional charge to be deductible).

162. The Tax Court's rationale was that Mr. Klappenbach was in fact paying his mother's rent by paying the necessary sum, not making a real charitable contribution. See 52 T.C.M. (CCH) 437 (1986).

163. Rev. Rul. 75-302, 1975-2 C.B. 306.

164. With regard to the one time exclusion for the sale of a permanent residence by a taxpayer over the age of 55, most elder law attorneys would advise clients to forgo this election, and to remain in the family home or to "trade up" to a more expensive home and take advantage of the I.R.C. § 1034 election. Under Medicaid law, the family home is an exempt asset and purchase of even an expensive residence will not affect Medicaid eligibility. Certain transfers of the family home can also be made without affecting eligibility, including: transfers to a spouse, to a sibling who already has an equity interest, or to a minor or disabled child.

Originally, IRC § 121 was drafted to cope with an ordinary home sale, not a situation where the nursing home resident is forced to concede that he or she will never return home, causing the home to lose its homestead status. In fact, as originally drafted, § 121 mandated that the property for which exclusion of gain was sought must have been the taxpayer's principal residence for at least a total of three years out of the five years ending with the sale or exchange of the property. Recently enacted, § 121(d)(9) permits the exclusion to be taken by an individual, "physically or mentally incapable of self-care," who used the property as a principal residence during at least one of the five years prior to the sale, on condition that the disability occurred during the five-year period, and that the taxpayer spends the time *not* in the principal residence in a licensed facility suitable for his or her condition.

taxpayer over age 55. Although Medicaid is not bound by tax concepts, the principal residence is also likely to be a "homestead" for Medicaid purposes.¹⁶⁵ Once the home loses its homestead status,¹⁶⁶ it becomes an ordinary, non-exempt asset and the Medicaid beneficiary may be required to sell it in order to meet Medicaid's maximum asset requirement. By making non-Medicaid funds available for private payment of nursing home costs, the securities plan would allow an elderly person's decision to retain or sell the home to be premised on financial and tax considerations, with no need to consider Medicaid implications. The cruel need to sell the former homestead would be averted.

A Private Letter Ruling¹⁶⁷ has deemed the use of Internal Revenue Code Section 1034¹⁶⁸ in connection with the purchase of a life care contract. The IRS' rationale was that the taxpayer did not purchase an equity interest in the community, only the right to live there. Under this theory, senior citizens who use home sale proceeds to buy consortium securities would almost certainly be deemed the benefit of section 1034 treatment, because the security-holder does not have an equity interest in the real property of the participating consortium facilities.

Implementing the consortium's securities plan might necessitate the seeking of a ruling, or even an amendment to the Code itself, to the effect that nursing home care paid for by securities would receive tax treatment on a parity with nursing home care privately paid in cash. Parity with LTC insurance would not be necessary, because care compensated by insurance is not deductible. Unless the Code is amended, or a favorable ruling is obtained, this provision would not be available to insulate a gift of nursing home securities made to a person at risk of institutionalization, because the consideration for the securities is paid to the consortium, not directly to the health care provider.¹⁶⁹

B. The Antitrust Implications of the Proposed Consortium

Section I of the Sherman Act forbids all contracts and combinations, in the form of a trust or otherwise, and conspiracies in restraint

165. 42 U.S.C. § 1396(p) (1989); 42 C.F.R. § 433.36.

166. See STRAUSS, WOLF & SHILLING, *supra* note 49, at 303-07.

167. Priv. Ltr. Rul. 88-37-022 (June 14, 1988).

168. I.R.C. § 1034 (1988) provides for nonrecognition of gain where a principal residence is sold and a more expensive residence is purchased.

169. A gift tax exclusion is available without regard to amount, for amounts paid directly to an educational institution or health care provider for the benefit of another. For example, a grandparent may pay a child's private school tuition and a child may pay the bill rendered by a parent's cardiologist. See IRC § 2503(e)(2) (1991).

of trade.¹⁷⁰ This section considers whether the consortium would run afoul of these prohibitions. Antitrust violations may potentially occur whenever competitors engage in some form of concerted action that has an effect on prices.¹⁷¹ In such instances, attention must be paid to the possibility of price fixing;¹⁷² group boycott; attempted monopoly; minimum *or* maximum price schedules;¹⁷³ dividing the market; allocating services; or attempting to prevent new entries into the market.¹⁷⁴ The mere fact that an acquisition has been authorized by a Certificate of Need statute will not insulate it from antitrust scrutiny.¹⁷⁵

Indeed, the proposed consortium will impose a degree of price uniformity, because all holders of common stock would be entitled to a month of care in return for each share "put" to the participating facility. However, the facilities would be free to set their private-pay prices for non-shareholders at any level they choose. Similarly, they would be able to key the redemption of zero-coupon bonds or annuity payments to any private-pay price.

Furthermore, health facilities already agree to accept insurance reimbursement, which imposes a degree of uniformity to the extent that the insurer has a payment schedule. In general, agreements between a health care provider and an insurer to set the prices charged to patients have been held not to violate the antitrust laws.¹⁷⁶ By asserting

170. 15 U.S.C. § 1 (Supp. 1991).

171. Agreements to allocate markets by product, location, or customers are *per se* antitrust violations. See *Timken Roller Bearing Co. v. U.S.*, 341 U.S. 593, 597 (1951).

172. See, e.g., *American Medical Ass'n v. F.T.C.*, 94 F.T.C. 701, *aff'd*, 638 F.2d 443 (2d Cir. 1980), *aff'd*, 455 U.S. 676 (1982), (affirming a consent order to stop a trade association from price fixing and discouraging its members from advertising, despite the truthful nature of the advertisements).

173. *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982) (the agreement between members of foundation for medical care to set maximum fees for care held illegal *per se* under § 1 of the Sherman Act).

174. See, e.g., *United States v. Sealy, Inc.*, 388 U.S. 350 (1967) (holding that an owner of a trademark agreement with licensed manufacturers to produce and sell under a territorial allocation system *per se* illegal under § 1 of the Sherman Act); *United States v. Topco Assoc.*, 405 U.S. 596 (1972) (holding agreements between owners/stockholders of retail supermarkets not to stock brands other than their own brand products without permission of other owners to constitute horizontal price-fixing because of territorial restrictions on competition).

175. *North Carolina v. P.I.A. Asheville Inc.*, 740 F.2d 274 (4th Cir. 1984), *cert. denied*, 471 U.S. 1003 (1985). See also *Nat'l Gerimedical Hosp. & Gerontology Cntr. v. Blue Cross of Kansas City*, 452 U.S. 378 (1981) (federal health care planning legislation does not have the effect of repealing the antitrust laws as they apply to health care facilities).

176. See, e.g., *Brillhart v. Mutual Medical Ins.*, 768 F.2d 196 (7th Cir. 1984) (agreement between doctors and a doctor-managed insurer with respect to reimbursement levels was not *per se* illegal); *Kartell v. Blue Shield of Mass.*, 749 F.2d 922 (1st Cir. 1984)

that the consortium's activities are analogous to insurers such as Blue Cross/Blue Shield, the consortium could withstand antitrust challenge.

Further arguments to insulate the consortium from an antitrust challenge might focus upon the indirectness of the consortium's effect on the pricing of its securities. Any issuer of securities has only an indirect effect on pricing in the secondary market. Once the consortium makes an initial public offering, the price of LTC securities would be determined by investors, not by the consortium. Therefore, the consortium would play a minimal role in setting prices. Market demand and the overall availability of nursing home services would be much more influential on prices.

The Fourth Circuit recently held that separate corporations constituting a cooperative may be treated as parts of a single enterprise, thus making a "conspiracy," which requires at least two actors, impossible.¹⁷⁷ Another bulwark against private suits is the principle that the antitrust laws were enacted to protect competition, not the other competitors,¹⁷⁸ thus requiring a potential plaintiff to demonstrate antitrust injury in order to have standing to sue.¹⁷⁹ The question then remains as to who would suffer antitrust injury from the activities of the consortium. As long as the consortium is operated in good faith, and makes membership open on a voluntary basis to all facilities that meet objective standards of quality, no facility providing adequate care would be denied membership. Furthermore, facilities that chose *not* to join could not complain if the consortium offered its members certain advantages.¹⁸⁰

Antitrust complications might also be avoided if consortium activities are treated as favorably as those of a "trade association."¹⁸¹ A

(prohibition of billing in excess of the insurer's reimbursement level is not a per se price fixing violation); *Royal Drug Co. v. Group Life & Health Ins.*, 737 F.2d 1433 (5th Cir. 1984), *cert. denied*, 469 U.S. 1160 (1985) (agreement by pharmacies to limit prescription prices for insured individuals to a fixed amount did not constitute illegal horizontal price fixing).

177. See *City of Mount Pleasant v. Assoc. Elec. Co-Op*, 838 F.2d 268 (8th Cir. 1988) (The Robinson-Patman Act, like the Sherman Act, is designed to protect competition and it should not reach activity that has no economic consequence).

178. See *Brunswick Corp. v. Pueblo Bowl-o-Mat*, 429 U.S. 477 (1977) (injury must be causally linked to an illegal presence in the market).

179. *Cargill, Inc. v. Monfort of Colorado, Inc.*, 479 U.S. 104 (1986).

180. See *North Carolina*, 740 F.2d 274. These advantages might include: cost-sharing by bulk orders of drugs, over-the-counter medications, and supplies; advertising by the consortium; and access to loans for improvements to the facilities.

181. See, e.g., *Kreuzer v. American Academy of Periodontology*, 735 F.2d 1479 (D.D.C. 1984) (analyzing a periodontology association's activities under the rule of reason, because the practice of predicting membership on the full-time practice of peri-

long history of "coalitions" in health care planning suggest useful guidance for the consortium's operations. In describing the fundamental characteristics of a health care planning coalition,¹⁸² one commentator has noted that the crucial issue in assessing collaboration among competing health care providers is whether the collaboration is "output enhancing,"—whether it creates a new product or new way of delivering services.¹⁸³ This determination clearly embraces the proposed securities financing plan.

A genuinely new product would be one that: offers significant controls on costs and utilization review; permits segmented marketing; uses a new mode of delivery of services, such as satellite television for health education; and attracts bidders by offering a simplified, common, uniform system of administration.¹⁸⁴

Furthermore, current trends in antitrust enforcement suggest an intent to create an exception for health care networks. A past chairman of the Federal Trade Commission, advocated a policy of non-interference with pro-competitive joint ventures.¹⁸⁵ In 1987, the FTC proposed a consent decree indicating the dimensions of a bona fide joint venture in the health care area:

"integrated joint venture" means a joint arrangement to provide prepaid health care services in which physicians who would otherwise be competitors pool their capital to finance the venture by themselves or together with others, and share substantial risk of adverse financial results caused by unexpectedly high utilization

odontology was held to be acceptable, because there was no anti-competitive intent and no unreasonable restraint of trade).

182. See Arthur F. Southwick, *Antitrust Law: Applications to the Health Care Industry*, in THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 222 (1988).

183. See generally Clifford D. Stromberg, *Health Care Provider Networks: Antitrust Issues and Practical Suggestions*, in DEVELOPMENTS IN ANTITRUST HEALTH CARE LAW 73, 73-113 (Phillip A. Proger et al. eds., 1990).

184. *Id.* at 75.

185. More specifically, health care professionals in a truly competitive market should be able to do the following:

- (1) Health care professionals should be able to offer, without unjustified restrictions, any service that they are licensed and qualified to provide;
- (2) They should be able to join other providers in a group or clinical practice, and participate in HMOs and PPOs, without having to endure burdensome government regulations or unlawful retaliation from competing providers; and
- (3) Health professionals should be able to use truthful, non-deceptive advertising to inform patients and potential patients about their services, qualifications, prices, and all other relevant aspects of their practice.

Daniel Oliver, *The Role of the Federal Trade Commission in the Health Care Area*, in DEVELOPMENTS IN ANTITRUST HEALTH CARE LAW 243, 244-45 (Phillip A. Proger et al. eds., 1990).

costs of health care services.¹⁸⁶

The securities proposal seems even less vulnerable than the joint venture described in the proposal, because the various health facilities participating in the consortium would continue at all times to be competitors, and would have to compete more vigorously than if the consortium did not exist. Access to consortium funds will permit participants to expand and upgrade operations and their marketing to the public. The expansion itself would force facilities to compete on the basis of quality for referrals and in the context of placement choices. To cite the approving language of *In the Matter of Brunswick Corporation*,¹⁸⁷

The joint venture is in some respects a "quasi-merger" where cooperation between formerly independent companies often acts to benefit and sprout competition. The combined capital assets or know-how of two companies may facilitate entry into new markets and thereby enhance competition, or may create efficiencies or new product capacity that would otherwise be difficult to achieve.¹⁸⁸

Group purchasing to reduce costs is a technique with obvious practical advantage, but one that must be carefully scrutinized under the Robinson-Patman Act.¹⁸⁹ This statute forbids sales "in commerce," (so that intrastate transactions are not regulated) by a seller of commodities that grants a discriminatory price to a buyer who knowingly benefits by the price discrimination. Under this statute, volume discounts corresponding to cost savings for the manufacturer are permissible, as are differences in price granted in good faith to meet a competitive price. Furthermore, a specific exemption applies to nonprofit institutions when they purchase supplies for their own use.¹⁹⁰

In addition to Robinson-Patman Act problems, a group purchasing agreement is subject to challenge under Sherman Act section II as a

186. Proposed Consent Agreement with Preferred Physicians Inc.; Analysis to Aid Public Comment, 52 Fed. Reg. 45,970 (1987) (to be codified at 16 C.F.R. pt. 13) (proposed Dec. 3, 1987).

187. 94 F.T.C. 1174 (1979), *aff'd sub nom.* Yamaha Motor Co. v. F.T.C., 657 F.2d 971 (8th Cir. 1981).

188. *Id.* at 1265.

189. 15 U.S.C. §§ 12-13b.21(a), amending Clayton Act § 2 (1988).

190. The Nonprofit Institutions Act provides: "Nothing in the [Robinson-Patman Act] shall apply to purchases of supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit." 15 U.S.C. § 13c (1988). *See, e.g.,* Under De Modena v. Kaiser Found. Health Plan, 743 F.2d 1388 (9th Cir. 1984) (exemption extended to an HMO, but not to a hospital operated by a government agency); Jefferson County Pharmaceutical Ass'n Inc. v. Abbott Laboratories, 460 U.S. 150 (1983) (exemption not to be extended to whatever new venture the nonprofit hospital finds attractive); Southwick, *supra* note 182, at 240-42.

monopoly or attempt to monopolize.¹⁹¹ Guidelines for an acceptable joint-purchase program can be found in a Michigan case involving a group-purchase program developed by a for-profit corporation organized to render services to a group of not-for-profit hospitals.¹⁹² The corporation entered into an agreement with a company that was, at that time, the largest supplier of hospital, medical and surgical supplies in the United States.

The Sixth Circuit held that this arrangement did not demonstrate an attempt to monopolize local single-product markets; instead, the court determined that the national market for supplies must be analyzed.¹⁹³ The court reasoned that within the national market, competitive forces mandate the development of cost-effective mechanisms for selling hospital supplies.

A 1982 *Business Review Letter* issued by the Antitrust Division of the Department of Justice¹⁹⁴ sheds further light on problems that might arise in the pricing process. The letter concerned the 160 non-profit hospitals in Ohio that had centralized their purchasing by using the services of eight local purchasing groups. The purchasing groups, in turn, organized themselves into a consortium which compiled a single list for ordering each supply for all 160 hospitals, and then submitted the list for competitive bidding. The consortium recommended the low bidder to the individual hospitals, but the actual purchasing was done by the local group or the individual hospital, which retained the ultimate authority for making decisions. The Justice Department did not challenge the consortium arrangement, finding that there was no unreasonable restraint of trade, and further that the entire arrangement was a good-faith attempt to cut hospital costs by buying in volume at the best possible price.

In addition, *Broadcast Music v. Columbia Broadcasting System*,¹⁹⁵ the seminal Supreme Court opinion, affords additional assurance that the consortium's operations would not violate antitrust prohibitions. The case involved a challenge by a broadcasting organization to the "blanket licenses," issued by ASCAP and BMI to regulate the use of copyrighted musical compositions and to administer the collection and distribution of copyright royalties.¹⁹⁶

191. See *White & White, Inc. v. Am. Hosp. Supply Corp.*, 723 F.2d 495 (6th Cir. 1983).

192. *Id.* at 498.

193. *Id.* at 500-04.

194. See *Antitrust Division Won't Attack Hospital Group Purchasing Program*, 42 ANTI-TRUST & TRADE REG. REP. (BNA) No. 1070, at 1321 (July 24, 1982).

195. 441 U.S. 1 (1979).

196. Under the blanket license, the licensee paid a fee to ASCAP or BMI for the privi-

The blanket license survived the challenge. The Supreme Court also noted in the course of its opinion that ASCAP and BMI had been the subject of "rather intensive antitrust scrutiny."¹⁹⁷ Because the Copyright Act of 1976 actually refers to blanket licenses and other similar practices, the court held that the blanket license was not a *per se* Sherman Act violation.¹⁹⁸

The *BMI* decision suggests that the consortium can operate in consonance with the current interpretation of the antitrust laws, and furthermore, that it would not be challenged because it would have pro-competitive, rather than anti-competitive effects. Nor would there be antitrust injury to potential plaintiffs. Centralized purchasing could probably be carried out without violating the Robinson-Patman Act.

C. Certificate of Need Issues

The failure of the private sector to build nursing homes reflects legal limitations, imposed by both federal and state laws, on the construction of health facilities. These laws require advance permission and make it unlikely that a builder would take the risk of constructing a nursing home without first obtaining the necessary licensing. This regulatory system has arisen because of the traditionally large role that the public sector has taken in the financing, construction, and operation of health facilities. Initially, Medicare reimbursement was made on a "cost-plus" basis, giving health care providers an incentive to incur *higher* costs in order to secure a higher level of reimbursement.

Traditionally, the public sector paid for the bricks, mortar, and CAT scanners and opted to limit the number and scope of facilities as a cost-cutting approach.¹⁹⁹ Outright price controls were tried briefly,

lege of using any and all copyrighted compositions licensed by that organization. CBS challenged the blanket licensing system as monopolistic; its fees as price-fixing and tying arrangements; and its operations as a concerted refusal to deal with non-licensees. *Broadcast Music v. Columbia Broadcasting System*, 441 U.S. 1.

197. *Id.* at 10.

198. *Id.* at 19. The court distinguished the contract from the simple horizontal arrangements contemplated by the Sherman Act, and characterized it as a response to the serious problem of collecting and monitoring performance royalties. Thus, it had a purpose other than preventing competition. The case was remanded to the Second Circuit for further analysis under the rule of reason.

199. See UNITED STATES GENERAL ACCOUNTING OFFICE, NURSING HOMES—ADMISSION PROBLEMS FOR MEDICAID RECIPIENTS AND ATTEMPTS TO SOLVE THEM, GAO/HRD-90-135, at 2 (Sept. 1990) [hereinafter GAO III]. Two ways that states can control increased Medicaid nursing home spending are restricting the supply of nursing home care. States can restrict the bed supply by limiting construction of nursing homes or by limiting the number of beds the states will certify for Medicaid payments. Restrict-

then removed in 1977.²⁰⁰ Responding to these controls, providers voluntarily reduced cost increases to avert the threat of further federal price controls. During the 1970s, a number of states implemented their own cost containment programs, often including a change in reimbursement methodology. Instead of being reimbursed for their costs, hospitals received "prospective payments"—that is, the amount to be paid was determined in advance, based on factors that were not limited to the hospital's costs.²⁰¹

In the early 1980s, voluntary efforts at cost control proved unavailing, and in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA),²⁰² Congress moved away from cost-based reimbursement for Medicare hospital charges, and adopted an interim system that later led to the Diagnosis Related Group (DRG) system of prospective payment for hospitals under Medicare.

In 1974, Congress mandated that the states adopt another cost-cutting approach. Until its repeal in 1986, the National Health Planning and Resources Development Act of 1974,²⁰³ ordered states to adopt Certificate of Need statutes or lose federal funding.²⁰⁴ This law further required states to create health planning agencies responsible for approving all proposals for capital investment over \$150,000 by any hospital or nursing home. The goal was to ensure that the facilities, whether public, not-for-profit, or proprietary, met state and federal quality standards.

ing the supply of beds, in turn, can create a situation in which demand for nursing home care exceeds the supply of available beds.

200. *E.g.*, the Economic Stabilization Act of 1970 91 Pub. L. No. 379, 84 Stat 799 The Act provided for its own expiration on April 30, 1974; its price controls were terminated in 1974. See Margaret G. Farrell, *Legal and Ethical Issues in the Regulation of Health Care*, in 1 *BIO*LAW 333, 364 (1986).

201. *Id.* at 367-370.

202. Pub. L. No. 97-248, 96 Stat. 324 (1982)

203. Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. § 300q et seq.) (1991)

204. *See, e.g.*, ARIZ. REV. STAT. ANN. §§ 36-409 (Supp. 1991); CAL. GOV'T CODE § 15438.1 (West 1980 & Supp. 1991); CAL. HEALTH & SAFETY CODE §§ 438 et seq. (West 1990); CONN. GEN. STAT. ANN. § 19a-155 (West 1986 & Supp. 1991); FLA. STAT. ANN. § 381.701 et seq. (Supp. 1991); GA. CODE ANN. § 31-6-2 (1991); ILL. ANN. STAT. ch. 111 1/2, para. 1151 (West 1988 & Supp. 1991); KAN. STAT. ANN. § 65-4801 (1986); KY. REV. STAT. ANN. §§ 216B.061 (1991); ME. REV. STAT. ANN. tit. 22 § 301 et seq. (1980 & Supp. 1990); MASS. ANN. LAWS ch. 111 § 25B (Law. Co-op. 1985 & Supp. 1991); MISS. CODE ANN. § 41-7-187—201 (1981 & Supp. 1991); MO. ANN. STAT. §§ 197.300 et seq. (Vernon 1983 & Supp. 1991); N.J. STAT. ANN. §§ 26:2H-1 et seq. (West 1987 & Supp. 1991); VA. CODE ANN. § 32.1-102.1 et seq. (1985 & Supp. 1991). Many of the states have retained their CON laws even after repeal of the federal statute, although some have raised the amount of capital expenditure that is permissible without state review.

In particular, under the federal Certificate of Need statute, "only those services, facilities and organizations found to be needed shall be offered or developed in the State."²⁰⁵ Criteria for the decision included: a population's perceived need for the proposed services; the availability of less costly or more efficient means of delivering the same services; and the likely effect the proposed construction would have on the applicant's cost of providing services.²⁰⁶

Compliance with the statute was accomplished in a two-step process. First, local health service agencies performed an initial evaluation of the applications using the criteria of the federal or state statute. As a second step, state health planning agencies evaluated the health service agency recommendations and made a final decision, which could be reviewed administratively at the request of an applicant whose request was denied.²⁰⁷

A further regulatory step could also be imposed by the Medicare and Medicaid "Section 1122 Program." This program required state agencies to advise the secretary of Health and Human Services whether a proposed capital expenditure satisfied the "necessary and appropriate" requirement as a condition for the receipt of federal reimbursement. A negative evaluation from the state agency would lead to denial of the requested federal funds.

As would be expected, the tension between state regulatory schemes and the private sector has produced litigation. For example, *National Gerimedical Hospital and Gerontology Cntr. v. Blue Cross of*

205. See *supra* note 202.

206. See *State of North Carolina ex rel. Morrow v. Califano*, 445 F. Supp. 532 (E.D.N.C. 1977) (the court found the legislation to be a reasonable Congressional response to the need to assure that federal grant money did not have the effect of increasing medical costs).

Several cases hold that a statutory requirement that CON applicants show a need for the proposed facility is proper as a valid exercise of the state's police power. See, e.g., *People v. Casa Blanca Convalescent Homes, Inc.*, 159 Cal. App. 3d 509, 206 Cal. Rptr. 164 (1984); *Boswell, Inc. v. Harkins*, 230 Kan. 738, 640 P.2d 1208 (1982), *app. dismd.*, 459 U.S. 802; *New Jersey Ass'n of Health Care Facilities v. Finley*, 83 N.J. 67, 415 A.2d 1147, *cert. denied*, 449 U.S. 944; *Merry Heart Nursing & Conv. Home v. Dougherty*, 131 N.J. Super. 412, 330 A.2d 370 (1974); *Levine v. Whalen*, 39 N.Y. 2d 510, 384 N.Y.S.2d 721, 349 N.E.2d 820 (1976); *Attoma v. State Dep't of Social Welfare*, 26 A.D.2d 12, 270 N.Y.S.2d 167 (4th Dept. 1966) (such regulation is a valid exercise of police power even when the facility or proposed facility being regulated is a private one that receives no public funds); *State v. Hudson Home for the Aged*, 62 A.D.2d 1121, 405 N.Y.S.2d 319 (3d Dept. 1978). See also John P. Ludington, Annotation, *Licensing and Regulation of Nursing or Rest Homes*, 53 A.L.R. 4TH 689 (1987 & Supp. 1989).

Even a contrary result would have little practical impact: remember that about three-quarters of nursing homes receive at least some Medicaid funds. See *supra* note 23.

207. See Farrell, *supra* note 200, at 365.

*Kansas City*²⁰⁸ demonstrates the interrelation between the CON system and the antitrust laws. The CON statutes made no distinction between proprietary and other facilities. Therefore, private facilities that were in competition were forced to cooperate to a certain extent, both by sharing information and by refraining from adding competitive facilities whose construction was barred by the CON laws. Ironically, at the time the case arose, the domicile state, Missouri, had not even enacted a CON statute. Missouri did have a health services agency, which found that there was a surplus of hospital beds in the Kansas City area, and subsequently refused to allow any institution to add more acute-care beds. Blue Cross had also refused (as a cost-control measure) to accept new hospitals as Blue Cross participants in its program unless these applicants could show that there was a clearly evident need for additional hospital beds in the service area.

The plaintiff hospital in *National Gerimedical* obtained a state license and opened its facility despite the lack of local planning approval. The conflict arose when the hospital's attempt to participate in Blue Cross was denied because of this failure to procure approval.²⁰⁹ The hospital responded to this denial by bringing an antitrust suit against Blue Cross, charging violations of Sections 1 and 2 of the Sherman Act. In its defense, Blue Cross unsuccessfully alleged that the National Health Planning and Resources Development Act ("NHPRDA") had implicitly repealed the antitrust laws in the context of new health facility construction.²¹⁰ The Supreme Court refused to accept this argument, however, finding that there was no clear repugnancy or explicit repeal of the antitrust laws and the NHPRDA.

Why then, did the NHPRDA fail? One theory is that the regulators were unduly influenced by regulated industries, and despite their inefficiency, allowed the existing facilities to stay in business, by keeping new competitors out of the market. Additionally, the CON program had failed to contain costs, stemming from a failure to impose a ceiling on the total amount of new capital expenditures permitted in any one state or region.²¹¹

208. 452 U.S. 378 (1981).

209. *National Gerimedical*, 452 U.S. at 381.

210. *Id.* at 382.

211. Health planning, then, was not an exercise in allocating finite, scarce resources; the pie to be divided by the agencies was limited only by the inclination of the private sector to make investments in health care. Thus, there was no conceptual reason why the local planning bodies could not approve every application for a CON—indeed, there was even an incentive to do so, since disapprovals might have produced lawsuits and eventual reversals. . . . [T]o the

As is clear from *National Gerimedical*, the question of competition is intimately related to the question of quality. The assertion of this Article is that increasing the number of nursing homes, especially the number of nursing homes in the proprietary sector, will increase competition and force them to compete on the basis of quality. But this is not necessarily true, especially since few nursing home placement decisions are made after leisurely consideration by well-informed parties and that factors other than quality have an important effect on choice of a nursing home.

A provocative 1982 work²¹² illustrates how the CON regulatory system, by keeping nursing home beds scarce, enables nursing homes to select patients, rather than the converse:

Entry controls through certificate-of-need laws and the 1122 program have made it nearly impossible in many communities for patients to choose a home suitable for their needs, since they are frequently lucky to get any bed at all; indeed if this is not the case, the certificate-of-need agency can be accused of not doing its job of tightening supply to force rationing of beds.²¹³

Under those circumstances, nursing homes, like airlines, engage in "load management," seeking the most profitable way to fill a seat or a bed. But there are plenty of discount airfares, but no discount nursing home beds, because airlines have a lot more empty seats than nursing homes have empty beds. The economics of nursing homes differ significantly from those of hospitals, and Havinghurst suggests that competition is both more beneficial and more feasible for nursing homes than for hospitals.²¹⁴

Havinghurst has also expressed concern²¹⁵ that increasing the *supply* of nursing home beds would simultaneously increase the *demand* for such services ("induced demand" or "induced utilization"). The problem of induced demand is most serious when public funds are

extent that regulation restricts the choices otherwise available in the marketplace it limits individual autonomy in favor of collective determinations of distributive justice. And, to the extent that competition determines whether a proposal for private capital investment is ever placed before a planning body for its approval, it significantly limits the effectiveness of the regulatory process in achieving equitable distribution of health care resources. It might be that regulation of investment and market competition for health services can coexist, but that neither can be fully effective in achieving its objectives because of the other.

See Farrell, *supra* note 200, at 367.

212. CLARK HAVINGHURST, DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION 352-63 (1982).

213. *Id.* at 355.

214. *Id.* at 357.

215. *Id.* at 359-62.

involved, least serious when consumers spend their own money for long-term care. The intended effect of the proposed securities funding plan is to induce the building of new facilities, with funds derived from the issuance of the securities, and to induce consumers to spend their own funds on securities with a view to eventual long-term care.

Efficiency and equity concerns should dictate the continued use of utilization review,²¹⁶ rather than artificially limiting the supply of beds as a clumsy indirect form of utilization review. Induced demand consists both of people who have always needed the service, which is only now being made available, as well as those who do not need the service. In any case, the fact remains that people are much more likely to avoid nursing homes despite a real need than to manufacture a need in order to gain admittance.

State CON laws may make it difficult for facility operators to use funds from the proposed securities plan to make capital improvements, or to build new facilities, and may make it particularly difficult for entrepreneurs to enter the nursing home field. Full implementation of the securities program may require modification of some CON laws to allow upgrading and increased bed capacity in the interest of competition. If such modification cannot be obtained, it may limit the attractiveness of the securities in those states.

V. Conclusion

The proposed securities plan will enable the private sector to assume a significant role, both in the management of proprietary facilities and in health care financing. In fact, the public and private sectors have important and complementary roles to play in the provision and financing of long-term care for the elderly.

The benefits of the proposed plan are apparent. To a prospective patient, the securities plan offers an opportunity to save and invest for care needs, while maintaining a store of value that would be accessible in the event that LTC is not required. Ordinarily, Medicaid planning is complex, expensive, and requires that the recipient surrender con-

216. Utilization review, which is required in some form by the Medicare and Medicaid programs as well as by private insurers, can take several forms. In order to be reimbursed, a patient may have to receive prior approval for non-emergency care. Medicare Peer Review Organizations review the admissions and discharges of Medicare patients for appropriateness. See Social Security Act, 42 U.S.C. § 1320a (1989); Lee P. Jedziniak, *Regulation of Utilization Reviews: One State's Approach*, HEALTH INSURANCE UNDERWRITER 16 (Feb. 1991); Glenn Kramon, *Medical Second-Guessing—In Advance*, N.Y. TIMES, February 24, 1991, at F12. See also Omnibus Reconciliation Act of 1987, Pub. L. No. 100-203 §§ 4091-4097, 101 Stat. 1330-268; Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508 § 4205, 104 Stat. 1388.

trol over assets and accept a financially compromised lifestyle. For example, a Medicaid plan may call for conversion of income-producing investments to non-productive forms. Under the securities plan, security holders would have complete control over their investments and complete discretion over their financial choices.

To state and federal governments, the proposed plan would shift a great part of the burden of caring for the non-indigent away from the taxpayer. More of the Medicaid budget could be allocated to help those who cannot afford to buy insurance or invest in securities. Reducing government involvement in the planning and administration process offers the additional efficiencies inherent in a private-sector solution. Similarly, to the proprietary LTC facilities, the proposed plan would offer an immediate access to capital which could be used to improve operations, expand bed capacity, and build new facilities subject to the amendment of Certificate of Need laws.

This Article represents a preliminary step in the research process designed to further the creation of more and better alternatives for meeting the ever-increasing need for the growing elderly population. Yet, several important questions remain unanswered. For example, what types of services would be desired by LTC consumers and potential consumers? Should the securities concept be expanded beyond nursing home care to include home care and specialized housing for the elderly? How should consortium facilities price their services and securities? While the economic impact of the securities plan on the LTC market remains unclear, the underlying need to reduce government health care expenditures and to individualize health care planning suggests that a securities plan could provide a viable solution.

