Long Term Care Coverage: The Role of Advocacy

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ARTICLES

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Anthony Szczygiel*

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He organized and chairs the coalition of Medicaid Advocates (COMA), an organization of over 225 attorneys, paralegals, and other advocates from public interest organizations and the private bar, who represent Medicaid-eligible clients. The coalition serves as an information exchange on developments in health care law. The quarterly COMA newsletters he writes update members on the developments in health law and policy.

His publications include What Every Lawyer Should Know About Medicare Coverage of Long Term Care, 64 N.Y. ST. B.J. 40 (1992) and Beyond Informed Consent, 21 OHIO N.U. L. REV. 171 (1994).
I. INTRODUCTION

This article analyzes the access to and payment for long term care services in the United States, from the point of view of a consumer advocate. I will examine the coverage of home care, nursing home care, and related services promised by three sources of insurance: Medicare, the Department of Veterans Affairs (VA), and private health insurance contracts. What we will see is an uncoordinated, overlapping, hole-ridden conglomeration of programs. Each insurer promises selective coverage to selected beneficiaries. When we move past the promises to performance, the findings are even less encouraging. Having insurance coverage does not mean that all needed health care is available and paid for, and that is especially true for long term care services. The complexity of the programs, combined with perverse incentives for insurers and care providers, denies access to and payment for long term care that is vitally important.

These three sources, along with Medicaid, are the key to providing access to long term care services. The limited income and resources of most individuals in need of long term care services do not permit them the option of buying the care. Commercial long term care is expensive. For example, the average cost for a day in a nursing home more
than doubled from 1983 to 1993, reaching $106.\(^2\) Most nursing home residents are impoverished by the cost of their care within six months to one year. For the aged, the life savings built up during the 1940s, '50s, and '60s are rarely a match for the escalating long term care costs of the 1990s. Younger disabled individuals have had less opportunity to build up their wealth, because they cannot engage in substantial, gainful employment.

The complexity of each insurance program and the lack of coordination between the programs makes it very difficult for individuals to define their access to, and personal liability for, commercial long term care services. The eligibility criteria defining the individuals covered by Medicare, the VA and private insurance are idiosyncratic, but relatively easy to administer. Among the critical factors determining an individual's coverage package are age, marital status, where she lives, for whom she has worked, and whether she has served in the military. The categorical nature of each program makes it dangerous to assume that the services provided to one person are available to anyone else with similar needs or even that the covered individual will remain in the beneficiary class should a critical factor, such as employment status, change. Many individuals qualify for more than one insurance program. When they try to cumulate the promised coverage, they often find that the whole is less than the sum of the parts.

The value of a person's coverage depends on how well the benefit package fits the needs of the particular individual at various points in time. We know less about the "best medicine" for chronic care than for acute care. Furthermore, because long term care providers have no duty to treat,\(^3\) access to care is limited to that which the individual can afford and the provider chooses to provide. The patchwork of programs provides no guarantee that a person can get the most appropriate care at an affordable cost.

Much less is covered by each insurer than is promised in the contract or legislation establishing the agreement. The contract obligation establishes a ceiling on the types of care covered and the extent of coverage. A number of factors limit individual access to something less than that ceiling. Access to many of the coverage benefits requires an understanding of what is available and how to get it. Each insurer, however, has a formal, often vague, description of the benefit package and the exclusions from benefit coverage. Subjective qualifiers such as "medically necessary" or "skilled care" further cloud the issue.


\(^3\) See generally BARRY R. FURROW ET AL., HEALTH LAW 612-16 (2d ed. 1991).
addition, access is hindered by the delays and frustrations of each system.

Each program has a unique administrative process and delivery system, deriving in part from its distinctive model of insurance. The variety includes social insurance (Medicare), socialized care (VA), contract coverage (private insurance), and need-based coverage (Medicaid). Each insurer is funded differently. They all, however, face increasing medical care costs and a limited stream of revenue. This has led to cost controls of various forms. Most encouraging are the efforts to raise the standard practices in medicine through outcome studies, science-based practice guidelines, and improved utilization review. On the other hand, all paying sources have discovered that it may be easier to shift costs out of their budget rather than to try to improve the care for which they pay. Each insurer has developed unique ways of discouraging individuals from even asking for coverage. There are also subtle ways of avoiding liability if initial efforts are taken to ask for coverage.

Perhaps most troubling is the fact that individuals must frequently rely on the long term care providers for coverage information. These providers are being thrust into critical screening roles in an increasingly cost-conscious health care system. The incentives for these stakeholders often influence their answer as to what constitutes medically necessary care, as well as to what is payable under a contract or statute. This conflict will increase as managed care and other reimbursement techniques continue to transform providers into the "gatekeepers" for long term care. For example, a recent study suggests that managed care will reduce long term care costs, but doing so will produce inferior outcomes.

A. The Growing Need for Long Term Care

Long term care consists of a variety of health-related services spanning the range between acute care in a hospital and the periodic physical exam done for a person living independently in her own residence. Such needs do not fit the common medical model of a professional care giver assisting an otherwise healthy person through a short term acute care episode. The health problems are lengthy and

4. Medicare has kept the rate of increase of its hospital payments under the rate of medical care inflation. PROSPECTIVE PAYMENT ASSESSMENT COMM'N, MEDICARE AND THE AMERICAN HEALTH CARE SYSTEM 20-21 (1995). Medicare payment now covers less than 90% of the cost of care. Id. The shortfall has been made up by higher reimbursements from private insurers. Id.

often incurable. Appropriate medical, health, and social care can avoid or cure complicating medical conditions and also improve the quality of life for these individuals. Two major categories of long term care are home care and nursing home care, but a spectrum of services is needed.\textsuperscript{6} Many of the required services fall into the category of assistance with activities of daily living and do not need to be provided by medical professionals. Development of new services has been slowed by the conflict with the medical model of care-giving that is the focus of the insurance programs.

Commercial long term care services supplement family and community caring for infirm individuals. Studies estimate that families and other unpaid care givers provide about 85\% of long term care services.\textsuperscript{7} Demographic and economic changes guarantee that over the next thirty years, the level of unpaid care-giving, while still high, will prove inadequate in significant ways for the growing segment of the population that is disabled. The age group with the greatest need for long term care services, those age eighty-five and over, is the fastest growing part of the U.S. population.\textsuperscript{8} Quick deaths from a heart attack or a stroke have declined dramatically over the last forty years. New research suggests that individuals now entering old age are in better health than previous generations.\textsuperscript{9} Still, for many, old age means living with lingering afflictions such as arthritis, Alzheimer’s disease, and chronic heart problems.\textsuperscript{10} At the same time, more care givers are now busy with their careers and families, live away from home, or suffer from their own disabilities.\textsuperscript{11} Thus, long term care needs are growing while informal systems for providing care are not.

Accompanying these demographic changes are technological developments that have allowed greater flexibility in the situs of advanced care. These developments have led to an increase in outpatient and home care services.\textsuperscript{12} Budget-driven health care reform

\textsuperscript{6} The social and supportive services include such items as adult social day care, Meals on Wheels, and a wider range of barrier-free housing, often with congregate meals.

\textsuperscript{7} See Home Care in the 1990s, 263 JAMA 1241, 1243 (1990); FAMILIES USA FOUNDATION, THE HEAVY BURDEN OF HOME CARE 10 (1993).


\textsuperscript{9} Gina Kolata, New Era of Robust Elderly Belies the Fears of Scientists, N.Y. TIMES. Feb. 27, 1996. at A-1.

\textsuperscript{10} The death rate from diseases of the heart has been halved and the 1990 death rate from cerebrovascular disease is about 30\% of the 1950 rate. NATIONAL CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 1992 64-67 (1993).

\textsuperscript{11} See HOUSE SELECT COMM. ON AGING, 100TH CONG., 1ST SESS., EXPLODING THE MYTHS: CAREGIVING IN AMERICA 11-12 (Comm. Print 1987).

\textsuperscript{12} PROSPECTIVE PAYMENT ASSESSMENT COMM’N, supra note 4. at 19. Tables 1-6.
measures such as prospective payment systems for hospitals and managed care have accelerated this shift of care away from the most expensive cost centers, hospitals.13

These factors explain why individuals increasingly must rely on the purchase of long term care services to meet their needs. Nursing homes and home health care agencies are expanding.14 Hospice programs, which provide palliative care for terminally ill patients and their families, have become more widely available.15 Assisted living programs and community-based support services are being developed around the country.16

B. The Problems with Long Term Care

There are many unresolved questions regarding the developing area of long term care. Gerontologists, health planners, and advocates are not at all sure what is the right mix of services.17 Long term care service availability and capacity varies widely from state to state and often, within the state.18 Existing services may not be available at the time and place they are needed.19

Long term institutionalization can debilitate a patient. Increasingly, there are concerns regarding the autonomy of individuals in the long

13. Id.
14. Between 1960 and 1993, nursing home expenditures increased from $1 billion to almost $70 billion. These expenditures represented 3.7% of national health expenditures in 1960 and 7.8% in 1993. Levit. supra note 2, at 282, 284.
16. See David Abramowitz & Rebecca Plaut, Assisted Living for Low-Income Seniors, 5 J. of Affordable Housing & Community Dev. 63 (1995).
17. For example, the opinions of state health planning officials vary widely over what is an adequate supply of nursing home beds. Planners in Oregon and Arizona, with relatively low ratios of 328 and 350 nursing home beds per 1,000 persons age 85 and over, respectively, believe they have an oversupply of nursing home beds. In contrast, state health planners in Ohio and Montana report an undersupply of nursing home beds with ratios of 586 and 532 beds per 1,000 respectively. Richard DuNah, et al., Variations and Trends in the State Nursing Facility Supply, 1978-1993, 17 HEALTH CARE FINANCING REV. 183 (1995).
18. Newly identified levels of care, such as subacute care, may be no more than the opportunistic behavior of entrepreneurs trying to avoid regulation and maximize profits. See, e.g., Toby Edelman, The Changing Long-Term Care Industry: "New" Levels of Care, 28 CLEARINGHOUSE REV. 630 (1994).
19. For example, the national nursing home occupancy rate is 91%, but ranges as high as 99% in some states, such as New York. Id. at 193.
term care system. Medical providers find little glamour in the work of slowing down deterioration in the patients they serve. There is much we do not know about medical interventions and treatments for chronic aging-related conditions are among the least well understood. This uncertainty leads to significant practice variations.

Despite these problems, the most pressing concern for policy makers is restraining the growth of medical care spending by government and business. There is little support for new taxes or higher premiums to cover related health and social services. Third-party payers, both public and private, are also concerned about displacing “free” home care from family members with insurance benefits. The result has been limited government initiatives designed to displace more expensive care with less expensive care.

In a system with perfect knowledge and no transaction costs, the individual would know the appropriate coverage for her needs and risk...
tolerance. She would understand all the benefits she is entitled to from each insurer and how to access them. We live and die, however, in a far from perfect world. The supply and availability of long term health care services vary widely. Public and private insurers are selective about whom and what they will cover. The benefit packages available are not individually drafted, but have been characterized by many courts as standardized "contracts of adhesion." The coverage available from a particular insurer is rarely clearly defined. The statute or contract only outlines what is available and under what circumstances. The intent of the drafters may be very different from the understanding of patients and care givers at the point of service.

The individual will often have to make choices from among several imperfect service options. An understanding of the available coverage will be needed to make an informed choice. For example, a veteran is entitled to medical care from the VA, but generally this care is available only at VA facilities, or facilities that have contracts with the VA. HMOs and many other insurers restrict the choice of providers. Medicare home care benefits can only be obtained if an individual receives services from a certified home health agency (CHHA). Consumers of medical care rarely study the contract or statute applicable to their situation. The consumer usually relies on second- and third-hand interpretations of the original promise, filtered through intermediaries with varying interests and capabilities.

Getting the information needed to make an informed choice is difficult even for those whose job involves regular interaction with the programs, such as social workers and discharge planners. The criteria for each program are challenging to master. The recurring changes in coverage standards make information outdated at irregular intervals. In this context, the most prominent sources of payment for a service are often presented to an individual as the only options. For example, Medicaid and private payment cover about 85% of the national nursing home charges. Rarely will hospital discharge planners even mention the possibility of Medicare or private insurance coverage to patients being discharged to a nursing home. To make matters worse, the

24. See e.g., ROBERT E. KEETON, BASIC TEXT ON INSURANCE LAW § 6.3(a), at 350 (1971).
25. See generally DEP’T OF VETERANS AFFAIRS, FEDERAL BENEFITS FOR VETERANS AND DEPENDENTS (1995) [Hereinafter VA FEDERAL BENEFITS].
28. ROBERT E. KEETON & ALLEN I. WIDISS, INSURANCE LAW § 2.8(c), at 125 (1988).
29. See Levit et al., supra note 2, at 288.
nursing homes have little interest in processing the paperwork required for speculative coverage under these programs.

No one knows how much long term care coverage is promised in private insurance contracts. Policies, especially those issued on behalf of larger employers, sometimes contain long term care benefits in the basic contract or in riders. Typically, these plans use language identical to that used by Medicare. Due to lack of awareness, misconceptions, and lack of provider interest, Medicare and private health insurance are underutilized as sources of coverage for nursing home care.

Having coverage does not mean that all needed care is covered, especially in the context of long term care services. The individual’s protection depends on which insurers are involved, the promises that have been made, and the impediments to realizing the promised benefits. Overall, out-of-pocket payments for medical care have been steadily declining as a proportion of health care spending in the United States, decreasing from 55.9% in 1960 to 39.5% in 1970 and 20.1% in 1993. The insurers, each in its own way, have done a better job of avoiding responsibility for long term care services than they have done with hospital and physician expenses. For example, the level of out-of-pocket consumer payments for hospital and physician services (2.8% and 15.3%, respectively) is lower than for nursing home care and home health services (33% and 20.7%, respectively). Third-party payments for home care services become an even less significant factor if the total cost of home care includes the unpaid contributions of family members and other care givers.

The difference in insurance coverage by service category is not the result of a decision as to which service category is most appropriately insurable. Nor does it reflect a principled choice to use increased patient cost-sharing as a means of changing behavior or use of services. Rather, the difference mainly reflects the fact that hospital and physician coverage matured, while there was the societal commitment to expand access and share costs. The more recent growth in long term care, which has occurred in a period of concern about medical care costs, has spawned cost avoidance initiatives by insurers and providers.

30. Id. at 260.
31. This disparity is true despite the fact that 17.4% of individuals under 65 years of age were without any third-party insurance in 1992. EMPLOYEE BENEFIT RESEARCH INSTITUTE, SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED (EBRI Issue Brief 145:5, 1994).
32. Cf. PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY 89-91 (1985) (describing the peculiar features of medical malpractice which make it a particularly high, thus expensive, insurance risk).
33. Patient liability for hospital care is extremely low despite high costs and substantial excess capacity. Levit et al., supra note 2, at 259, 286-88, 291, Tables 15, 16, 17, 19.
Incentives to shift long term care costs from one insurer to another are endemic to our multi-payer system. At best these efforts result in cost-shifting between programs with little positive effect on the overall cost of the delivery system or the quality and continuity of care for those in need. For example, state Medicaid programs have discovered that a substantial amount of Medicaid nursing home coverage can be shifted over to Medicare. This shifting has helped to quadruple Medicare’s portion of the nation’s nursing home bill over the past eight years. Other strategies deprive individuals of intended benefits or access to care they need. For over fifteen years, Medicaid treated the VA Improved Pension payments of institutionalized veterans as a subsidy to Medicaid’s program, by siphoning off the benefits before they could be used for the veteran.

In addition, there have been less public but extremely effective means of discouraging claims for services and thus, access to care. For instance, many nursing homes in use when Medicare coverage became available in 1967 did not meet the program standards for Medicare certification. They violated fire and safety codes or were below the standard for staffing by nurses. Fear of bed shortages prompted a generous administrative interpretation of “substantial compliance” with federal requirements, thus authorizing Medicare participation. The nursing homes were quick to take advantage of the new funding stream. Medicare nursing home payments far exceeded budget projections. The response was not a revised set of certification requirements, but rather a “reinterpretation” of Medicare coverage standards. Intermediary Letter 371, dated April 1969, made it clear to the agents processing claims that they were to err on the side of denials rather than coverage. This mechanism avoided the unpleasantness of public notice necessary for a change in Medicare policy or regulations. It took advantage of the subjective coverage definitions to limit drastically the availability of Medicare coverage. The strategy had its intended effect.

34. Medicare was covering 1.5% of the national aggregate of nursing home costs in 1987. For 1993 it covered 8.8%. Id. at 288, Table 17.
35. See infra Part III(B).
37. Id.
38. Id.
39. The chief actuary of the Social Security Administration projected that a $25 to $50 million net increase in funds for extended care would be spent on nursing homes in the first year of Medicare coverage (after allowing for reductions in hospital stays), but almost $275 million was spent. STAFF OF SENATE COMM. ON FINANCE, 91ST CONG., 2D SESS., MEDICARE AND MEDICAID: PROBLEMS, ISSUES AND ALTERNATIVES 33-36 (Comm. Print 1970).
40. VLADeCK, supra note 36, at 57.
The Medicare denial rate on nursing home claims increased from 1.5% in 1968 to 8.2% in 1970. Moreover, the negative impact on access was multiplied by the reaction of the providers. Nursing homes were scared away from billing Medicare. By 1971 the number of Medicare-covered nursing home days was one-third of the 1967 totals. Bruce Vladeck, currently the Administrator of the Health Care Financing Administration (HCFA), concluded that “[f]rom the time of Intermediary Letter 371 on, Medicare was no longer a significant factor in the nursing home industry.” That conclusion, appropriate in 1980, is no longer valid. The nursing home industry, however, did not begin to overcome the trauma of the 1969 transmittal until almost twenty years later. Nursing homes were brought back into the Medicare program by the determined efforts of patient advocates and Medicaid programs.

The strategy of informally restricting coverage standards to discourage claims submission was repeated with the Medicare home care benefit in the mid-1980s. A series of informal policy changes without amendments to the statute or regulations caused the denial rate for home health care services to rise from 2.5% in 1984 to 7.9% in 1988. This increase severely restricted home health care availability because certified home care agencies became more conservative in taking on new clients and in assessing the needs of those individuals. A group including home care clients and agencies sued Medicare over the change in standards. The U.S. District Court for the District of Columbia held that new written guidelines were necessary. In April 1989, the guidelines were issued in the form of an updated Medicare Home Health Agency Manual, more commonly known as HIM-I1. The impact of the informal policy lingers, however, because home care agencies are cautious when exploring the coverage possibilities opened by the new guidelines.

41. Id. (citing Glenn R. Markus, Nursing Homes and the Congress: A Brief History of Developments and Issues 79-85 (1972)).
43. Vladeck, supra note 36, at 57.
44. Medicare is emerging as a significant player once again in the nursing home industry. The proportion of nursing home costs that Medicare covers has increased from 1.5% in 1987 to 8.8% in 1993. See Levit et al., supra note 2, at 288.
45. See infra Part II(B)(2).
48. Id. at 1514.
49. See 1 Medicare & Medicaid Guide (CCH) 206 (Feb. 1, 1996) for revised provisions of the Medicare Home Health Agency Manual, also known as HIM-I1.
The opportunities for insurers to influence the level of care provided to individuals are also growing. Medical providers, with a strong managed care emphasis, are moving toward integrated networks of medical professionals, institutions, and support personnel. The administrators of these groups, attuned to the financial implications of capitation and limited budgets, are taking a more noticeable role in setting the parameters for individual care plans. The one-on-one interaction with an independent practitioner is no longer representative of most medical care interactions. Patients now have to deal with hospitals that are part of a regional or national chain, physicians in a managed care enterprise, or a home health aide supplied by an agency.

This restructuring of the medical care industry has had a negative impact on the patient advocacy that can be expected from the providers. In the past, physicians could be counted on for solid support of broad access to care. The professional stature of physicians gave their opinions an authoritative impact. The changing role of physicians is reducing their ability to advocate on behalf of an individual’s claim for coverage. For example, a recent decision by New York’s highest court recognized a private cause of action based on a physician’s duty to provide truthful information to the patient’s insurance company.

The patient’s treating physician had continuously certified, over a six year period, that she needed twenty-four hour-a-day nursing care. The insurer reevaluated the patient’s nursing care needs and reduced authorization to six hours of nursing care per day. The patient sued to enjoin the reduction in coverage. The plaintiff’s physician gave deposition testimony and later signed an affidavit, prepared and unilaterally presented to him by the insurance company’s attorneys, stating that the plaintiff required skilled nursing care for only six hours per day. On the eve of trial, the physician recanted the prior testimony, saying that he signed the insurance company’s affidavit only to avoid having to testify. Allegedly, the conflicting medical opinions led to a settlement of the coverage reduction lawsuit on terms very favorable to the insurance company. A second suit resulted, with the

50. See generally U.S. GEN. ACCOUNTING OFFICE, MANAGED HEALTH CARE: EFFECT ON EMPLOYERS’ COSTS DIFFICULT TO MEASURE (1993).
51. Id.: see also PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 430-36 (1982).
53. Id. at 402.
54. Id. at 402-03.
55. Id. at 403.
56. Id.
57. Id.
58. Id.
physician as defendant. The second suit raised the issues of whether the physician owed the plaintiff a duty and whether there was a private cause of action to redress a violation of that duty. The court held that:

[I]iability may arise where a duty obtains, if one speaks at all, to provide truthful information. Thus, we conclude that because the defendant treating physician stands in a relationship of confidence and trust to his patient, he owed plaintiff in this case a duty to speak the truth about her medical condition.

Increasingly, the cost of care is a factor in defining the "truth" regarding a patient's condition and the appropriate care.

C. Countering Avoidance

These developments demand that patient advocates play an increasing role with respect to long term care coverage. Access to, and payment of, long term care is being redefined by the self-interest of insurers and providers. In order to promote a client-centered care system, advocates must approach the problems of access and payment for long term care in a broader fashion than is currently the practice. They must resist the temptation to let the coverage dictate the choices of care. First, the advocate should determine what kind of assistance, medical or otherwise, an individual will need to live life in the style he desires. Second, the advocate should try to find a way to access those services. Informal supports and private payment may provide all that is needed. Patching together the available insurance coverage may extend the period of maximum independence, but this approach is not easy because of the complex, categorical approach to coverage.

Advocacy can bring the provider's performance closer to the promise. Education of the client, the providers, and the various information providers is an ongoing task. The appeals process for each program offers another means of education as to the extent of coverage possible.

D. A Note on Medicaid

No discussion about long term care coverage would be complete without consideration of the need-based Medical Assistance programs. Medicaid is the largest single source of nursing home coverage in the United States and is responsible for over half of the expenditures for nursing home care. Medicaid also covers a significant amount of

59. Id. at 404.
60. Id.
61. See 42 U.S.C. §§ 1396-1396s (1994) and applicable state law.
62. Levit et al., supra note 2, at 260.
home care, personal care, and related long term care services. I will not, however, address the program in detail for three reasons. First, Medicaid, as the payer of last resort, represents the worst case scenario in terms of preserving choices and assets for the individual with long term care needs. Second, Medicaid is a program with which providers are familiar, so it is not likely to be overlooked. This is not to suggest that there is no room for advocacy regarding eligibility and coverage. The Medicaid rules are complex and ever-evolving. The programs must be monitored to assure compliance with federal as well as state requirements. Noncompliance will often work to the detriment of applicants or recipients. Third, detailing the Medicaid programs is virtually impossible, unless it is done on a state-by-state basis. The United States has fifty-six distinct Medicaid programs. Federal law sets minimum standards as to who may participate, on what terms, and for what benefits. In addition, each state program has its own mixture of add-ons to, as well as variances from, those minimum standards. States can add specific categories of participants and


64. This number includes the Arizona Health Care Cost Containment System (operated as a Medicaid demonstration project), the District of Columbia, the Commonwealth of Puerto Rico, and the U.S. territories of American Samoa, Guam, the Northern Mariana Islands, and the Virgin Islands. See 3 Medicare & Medicaid Guide 6501 (Mar. 11, 1993) (listing of state programs). American Samoa, Puerto Rico, and the Virgin Islands provide all Medicaid services through public health facilities. Id. at 15,553, 15,634, 15,650. There is no individual eligibility determination made under the American Samoa program. Id. at 15,553. The Northern Mariana Islands government provides most medical services and operates the only hospital, but a small private sector participates in Medicaid. Id. at 15,625. Given their unique delivery systems and small populations, I will not discuss Puerto Rico and the territories in the remainder of this section.


Congress has specified 27 categories of needy individuals who must be allowed to participate in Medicaid if they apply. 3 Medicare & Medicaid Guide (CCH) ¶ 14,231 (Mar. 30, 1995). Nineteen other groups identified as categorically needy can be covered at the option of the state. 42 U.S.C. §§ 1396a(a)(10)(A)(ii), 1396d(a) (1994).

66. For example, the federal Supplemental Security Income (SSI) program provides cash benefits to low income individuals who are aged, blind, or disabled. 42 U.S.C. § 1381 (1994). When SSI was legislated in 1972, most states coordinated the Medicaid eligibility definitions with those of the SSI program. SSI recipients are automatically enrolled in Medicaid in 38 states and the District of Columbia. In the other 12 states, some aged, blind, or disabled SSI recipients can be denied Medicaid. Section 209(b) of the Social Security Amendments of 1972 provided each
services to those listed as basic requirements. 67 Fifteen states, with less than 18% of the U.S. population, limit their Medicaid coverage to the “categorically needy.” 68 Categorically needy Medicaid participants qualify because of their poverty, whether or not they have current medical needs. 69 Thirty-six states have chosen to cover “medically needy” individuals, who are defined as having too much income or resources or both to be categorically eligible. 70 Medically needy individuals qualify for Medicaid when their medical expenses, left uncovered by other insurance programs such as Medicare, the VA, and private insurance, threaten to impoverish them. 71 Another example of state variation is the special budgeting rules for individuals who fit the definition of an “institutionalized spouse.” 72 The law was designed to prevent spousal impoverishment caused by the cost of nursing home care or equivalent services. State programs vary widely in the amount of resources protected for the non-applying, state with the option of retaining provisions of their 1972 Medicaid program that were more restrictive than SSI eligibility criteria. Pub. L. No. 92-603, § 209(b), 86 Stat. 1329, 1381-82 (1972) (currently codified at § 1396a(f) (1994); 42 C.F.R. § 435.121 (1995)). The 12 209(b) states use lower resource levels in most instances. For example, the Connecticut resource allowance is $1,600 rather than the SSI level of $2,000. 3 Medicare & Medicaid Guide (CCH) ¶15,566 (Oct. 5, 1995). Other, often minor, differences have also been retained. See Furrow et al., supra note 3 at 568-70. For a listing of the 209(b) states, see 3 Medicare & Medicaid Guide (CCH) ¶15,504 (Feb. 9, 1995).

67. The states have a good deal of latitude within the parameters of the basic program. In addition, HCFA can waive certain federal requirements to allow state demonstration programs. See 42 U.S.C. §§ 1315(a), 1396n(a) (1994). The first waiver category, referred to as section 1115 waivers, has been used to conduct state-wide experiments that rely on mandatory managed care enrollment to contain costs or expand coverage or both. There is a role for advocacy in the development and implementation of these programs. Jane Perkins & Michele Melden, The Advocacy Challenge of a Lifetime: Shaping Medicaid Waivers to Serve the Poor, 28 Clearing-House Rev. 864, 865 (1994).

The second type of waiver, referred to as section 1915 waivers, allows states to develop special packages of benefits for specific populations. They may do so without making the same services available to all Medicaid recipients, as the statewideness and comparability requirements mandate. 42 U.S.C. §§ 1396n(c)(3), (d)(3) (1994). The District of Columbia and all states except Arizona have home- and community-based waiver programs for individuals age 65 and over and individuals who are mentally retarded or developmentally disabled. 42 U.S.C. §§ 1396n(c)(1), (d)(1) (1994); 42 C.F.R. §§ 440.180-181, 441.301-310, 441.350-365 (1995). Most states also have other special programs for specific populations. As of March 1995, there were 218 home- and community-based waiver programs in 49 states. Medicaid Waiver Fact Sheet (Mar. 15, 1995) reprinted in 3 Medicare & Medicaid Guide (CCH) ¶14,625.35-.55 (Aug. 17, 1995).

68. 3 Medicare & Medicaid Guide (CCH) ¶15,504 (Feb. 9, 1995).


70. See supra note 65; see also Furrow et al., supra note 3, at 569.


healthy spouse (defined in the law as the "community spouse"). After that allocation is made, the institutionalized spouse is reviewed for eligibility based on all remaining resources and her own income, measured against the state’s eligibility standards. If eligible, she must contribute toward care the amount of income not needed by her, her spouse, or other dependent family members. These levels also vary among the states.

States vary considerably in the scope of services covered by Medicaid. For example, personal care services were only recently given explicit recognition as a category of service to be covered at the state’s option. Thirty-two states provide this coverage, but there is no formal definition of what is included in “personal care services.” Some states cover personal care only when provided in the individual’s home, while others authorize coverage when services are provided in other settings. Such variations make it impossible to generalize about Medicaid’s role in long term care coverage.

E. The Overview of Long Term Care Coverage

In an effort to understand better the complex system for providing access to and payment for long term care, I will examine the three primary sources of long term care coverage and compare the coverage promised with the coverage provided. The coverage system is summarized by the following chart. The sources are listed in the order that most individuals would use them if they had the coverage. Few individuals will have all the sources of coverage listed, but many individuals will have more than one. The VA and Medicare are normally the primary payers when they are involved. Veterans who choose to receive their care at a VA facility are opting out of Medicare

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73. 42 U.S.C. § 1396r-5(e) (1993). States must allow the community spouse to have half the couple's resources at the time of institutionalization (the spousal share) or a higher minimum amount set by the state. Id. The minimum resource allowance can be between $14,964 and $74,820 (1995 figures). Special circumstances or needs will allow an upward adjustment of that figure.

74. The personal needs allowance for the institutionalized person varies from $30 per month to $90 per month, depending on the state involved and the source of income. See 42 U.S.C. § 1396a(q)(1) (1994). The community spouse income allowance brings the community spouse’s monthly income up to a state-selected amount, between $1254 plus an excess shelter allowance, and $1870.50 (July 1, 1995 figures). 42 U.S.C. § 1396r-5(d) (1994). These figures are adjusted every July 1 for inflation. A court order of support or a fair hearing decision may require a higher allowance. 42 U.S.C. §§ 1396r-5(d)(5), (c)(2)(B) (1994).


77. Id.
coverage for the period of time in which they receive the VA services. Conversely, veterans using a non-VA hospital or doctor effectively choose Medicare as the primary insurer rather than the VA.

### LONG TERM CARE COVERAGE OVERVIEW

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II. COVERAGE OF LONG TERM CARE SERVICES UNDER MEDICARE

A. Introduction to Medicare

Congress created the Medicare program in 1965 to provide federal medical insurance for "the aged," defined as U.S. residents age sixty-five and older. Medicare enrollment is now almost universal for this group. Congress grafted the new benefit system onto the Social Security system that provides retirement, survivors, and disability benefits to individuals based on their own employment record or that of a qualifying family member.

In the 1970s Congress broadened the Medicare eligibility criteria to include two groups of individuals under age sixty-five: individuals who have received twenty-four months of Social Security disability (SSD)
benefits and individuals who are medically determined to have end-stage renal disease (ESRD). Currently Medicare insures approximately one out every seven U.S. residents. The number of persons covered by Medicare has grown steadily since 1965. The increase is due in part to the graying of America. The number of U.S. residents age sixty-five and older has been increasing and will continue to increase as the post World War II baby boom generation begins to reach age sixty-five. There also has been a steady increase in the number and percentage of disabled Medicare enrollees since their inclusion in the program in 1973. Individuals under age sixty-five now constitute more than 10% of Medicare enrollment.


82. 42 U.S.C § 426-l (1994). ESRD is “that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life.” 42 C.F.R. § 406.13(b) (1995). There is a waiting period of up to three months after Medicare application. 42 C.F.R. § 406.13(e)(2) (1995).

Medicare coverage was extended to individuals with ESRD by Pub. L. No. 95-292, 92 Stat. 307 (codified in scattered sections of 42 U.S.C.) (approved June 13, 1978). This eligibility group is rather small, with 78,100 individuals enrolled based solely on end-stage renal disease. U.S. DEPT HEALTH & HUMAN SERVS., supra note 42, at 160, Table 8. The medical bills for persons with ESRD are not small. Including those who would qualify based on age or disability, Medicare made payments for about 205,600 beneficiaries with ESRD. Id. at 182, Table 16. Calendar year 1992 Medicare payments averaged $30,827 for these patients, as compared to $4,126 for Medicare enrollees without ESRD. Id. at 34.

83. In 1993, Medicare enrollment was at 35.583 million individuals, 13.8% of the total U.S. population. Id. at 172.

84. In 1993, Medicare enrollment was 36.339 million individuals, almost twice the 1966 enrollment of 19.109 million. Id. at 161.

85. The segment of the population age 65 and older is expected to grow to 20% of the total U.S. resident population by the year 2030. This percentage is expected to stabilize, but the total number of elderly will continue to increase to a projected 78.9 million in the year 2050. U.S. BUREAU OF THE CENSUS, CURRENT POPULATION REPORTS, SERIES P25-1130. POPULATION PROJECTIONS OF THE UNITED STATES BY AGE, SEX, RACE AND HISPANIC ORIGIN: 1995 TO 2050.

86. Medicare enrollment based on disability has been increasing at almost twice the rate of enrollment based on age, an annual average increase of 3.9% since 1973 for disability cases as compared to a 2.0% annual increase for aged cases. U.S. DEPT HEALTH & HUMAN SERVS., supra note 42, at 155.

87. In 1992, there were 3.579 million Medicare enrollees under the age of 65, representing 10.1% of the Medicare population. Id. at 155, Table 5.
Medicare is the primary medical insurance for enrollees except where Congress has legislated otherwise. Given that enrollees are by definition either aged or disabled, the program insures individuals who can be expected to need higher than average levels of medical care. Therefore, Medicare’s role in health care expenditures is larger than its enrollment numbers alone would suggest. Medicare pays almost 20% of the nation’s personal health care expenditures, despite the fact that it insures 14% of the U.S. population.

Like many private insurance policies in use when Congress enacted the program, Medicare benefits are separated into Hospital Insurance and Supplemental Medical Insurance. The Hospital Insurance benefit, commonly known as Part A, provides basic protection against the costs of a hospital stay, post-hospital care in a nursing home, home health services, and hospice care. Supplemental Medical Insurance, commonly known as Part B, covers as much as 80% of other medical services, including physician services, outpatient care, ambulance services, and durable medical equipment.

Medicare automatically enrolls aged individuals at the time of their entitlement to retirement benefits and disabled individuals after receipt of twenty-four months of disability benefits. Part B is nominally voluntary, but the individual must affirmatively decline the coverage.

All others seeking Medicare enrollment must file an application. The

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88. 42 U.S.C. § 1395y(b)(1)-(2) (1994). Medicare will act as the secondary insurer or make conditional payments that can later be recouped when the following sources of medical coverage are involved: federal or state workers’ compensation laws, automobile or liability insurance policies (including self-insured plans) and no-fault insurance, group health plans (plans for employers with more than 20 employees) for an insured or the insured’s spouse where the person qualifies for Medicare by reason of age, large group health plans (plans for employers with more than 100 employees) when an individual with current employment status is entitled to Medicare benefits based on disability, and group health plans for an insured where the person qualifies for Medicare by reason of end-stage renal disease, but only during the first 18 months of Medicare coverage. 42 U.S.C. § 1395y(b)(1)-(2) (1994).

89. Levit et al., supra note 2, at 285.
93. In 1992, 1.297 million Medicare Part A enrollees had declined coverage under Part B, and 438,000 individuals age 65 or older had chosen to enroll in Medicare Part B but not to apply for Part A. DEP’T HEALTH & HUMAN SERVS., supra note 42, at 155, Table 5.
94. 42 C.F.R. § 406.6 (1995). The application can be filed during the individual’s initial enrollment period, which extends from three months before to three months after both attaining age 65 and meeting the residency requirement. 42 C.F.R. §§ 406.20(b), 406.21(b) (1995). After that, general enrollment is open from January 1 to March 31 of each year. 42 C.F.R. § 406.21
benefits are available until death or for up to two years after the end of disability.\textsuperscript{95} Enrollment in Medicare Part A does not require a premium payment, unless the individual age sixty-five and older lacks the connection to the Social Security system needed for automatic enrollment.\textsuperscript{96} These individuals can buy Medicare coverage at the average cost of Part A services.\textsuperscript{97} For lower income individuals, the state Medicaid programs usually pay this Medicare Part A enrollment premium.\textsuperscript{98} Enrollment in Medicare Part B carries with it an agreement to pay a premium that collectively covers 25\% to 30\% of the program costs.\textsuperscript{99}

\begin{itemize}
\item \textsuperscript{95} Medicare coverage may continue for two years after disability benefits are stopped due to substantial gainful employment after a trial work period. 42 C.F.R. \S 406.12(e) (1995).
\item \textsuperscript{96} Part A is funded by a 2.9\% payroll tax, split between employer and employee. 26 U.S.C. \S\S 3101(b), 3111(b) (1994). Self-employed individuals pay the full 2.9\%. 26 U.S.C. \S 1401(b) (1994).
\item \textsuperscript{99} The 1996 premium is $42.50. Health Care Financing Administration Notice—Medicare
For 1996, Medicare coverage under Part A and Part B for individuals age sixty-five and older was worth an average of more than $5,500. The per capita payments for disabled participants are higher than those for individuals who are eligible based on age. Still, Medicare does not provide comprehensive coverage for its enrollees. Medicare households have seen their out-of-pocket expenditures increase from 10.6% of income in 1972 to 17.1% of income in 1991. Major categories of services left out of the Medicare program include most prescriptions, routine doctor visits, most foot care, dental care, eye examinations, hearing aids and examinations, cosmetic surgery, and some vaccines. Personal care services, such as assistance with activities of daily living, are also outside the scope of Medicare’s coverage unless professional medical services are also required.

Medicare limits the number of hospital and nursing home coverage days through a renewable benefit period termed a “spell of illness.”

Program: Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rate


103. Immunosuppressive drugs may be covered after an organ transplant, 42 U.S.C. § 1395x(s)(2)(J) (1994), and pain medication is covered as part of the hospice benefit. See THE NAT’L UNDERWRITER CO., supra note 27, at 170.


110. The terminology for long term care services is evolving. For this Article, “personal care services” means care that can be provided without the assistance or supervision of a medical professional. “Home health services” describes services provided in conjunction with the professional services of nursing or therapy, by aides who have undergone a standardized training.

111. 42 U.S.C. § 1395x(a) (1994). The initial Medicare coverage determinations are made by fiscal intermediaries (Part A) or carriers (Part B). These entities are large insurance companies that have contracted to administer the Medicare claims process for particular benefits on a regional basis. See Carol Small Jimenez, Medicare Overview, in PLANNING FOR AGING OR INCAPACITY
A spell of illness begins with the first day on which an individual is furnished inpatient hospital services or nursing home care. It ends with sixty consecutive days of not being an "inpatient." Physically residing outside the hospital and nursing home for sixty consecutive days meets this standard. Responding to a series of court decisions, Medicare added another possibility for ending a spell of illness. The Medicare regulations clarify that, for a nursing home resident, the spell of illness ends after sixty consecutive days of custodial care. There are no day limits on home care, hospice, or Medicare Part B coverage.

Deductibles and copayments apply to some covered services. Each Fall, the Secretary of Health and Human Services announces the Part A hospital deductible for a spell of illness beginning in the following calendar year. This deductible amount determines the daily coinsurance for nursing home covered days twenty-one to a hundred (one-eighth of the deductible). There are no deductibles for home health care services or hospice, and only very limited coinsurance for hospice services.

The statute restricts Medicare coverage to services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or...
to improve the functioning of a malformed body member.”120 This restriction prevents or limits coverage for experimental or otherwise unconventional medical treatments.121 It also focuses the Medicare coverage on acute medical care rather than on preventive health care, supportive social services, or enhancement of independence for enrollees. Medicare, for example, covers a small list of vaccines.122

The medical necessity criteria pushes care to a less expensive site. Institutional care that is skilled, but does not have to be provided on an inpatient basis, is not medically necessary. In such a situation Medicare can stop its coverage with proper notice, thus making a continued stay the full responsibility of the patient.123 If an individual can routinely leave the home, Medicare expects that individual to get needed professional care as an outpatient rather than having the care givers come to their house.124

By excluding custodial care, Medicare divides the universe of medical care into two subsets as follows: skilled care (coverable) and custodial care (not coverable). Identifying the boundary between the two in individual cases has been an ongoing struggle for the program. Medicare coverage determinations are made by fiscal intermediaries (Part A) or carriers (Part B) after the services have been provided.125 There is a strong dose of subjectivity in decisions regarding medical necessity and custodial care, especially in the context of long term care. In simple terms, custodial care is care that can be provided by a lay person without special skills and that does not require or entail the continued attention of trained or skilled personnel.126

In close cases providers may advise individuals that Medicare will deny coverage. Providers often use misleading “rules of thumb” or

121. National coverage decisions address specific treatments and procedures. See Medicare Coverage Issues Manual (HCFA-Pub. 6), 54 Fed. Reg. 34,555, 34,555 (1989), reprinted as updated in 5 Medicare & Medicaid Guide (CCH) ¶ 27,201 (Feb. 16, 1995). As an example, acupuncture is not covered “as an anesthetic or as an analgesic or for other therapeutic purposes.” Id. at 35-8.
123. See discussion infra Part II(B)(1); 42 C.F.R. 412.42c (1995).
124. HEALTH CARE FIN. ADMIN., MEDICARE HOME HEALTH AGENCY MANUAL, (HCFA-Pub. 11) § 204.1 [hereinafter MEDICARE HOME HEALTH AGENCY MANUAL].
125. These entities are insurance companies that have contracted to administer the Medicare claims process for particular benefits on a regional basis. 42 U.S.C. §§ 1395hh, 1395u(a) (1994).
otherwise misunderstand the coverage standards. The retrospective review of claims creates uncertainty that is exacerbated by the subjective standards of medical necessity and custodial care. Long term care providers simply may not want to do the additional paperwork for the uncertain prize of Medicare coverage. Where the Medicare coverage supplants private payment, a provider such as a nursing home may reduce its income by pursuing Medicare payment.

Compounding the above problem is provider concern over potential financial penalties for failing to warn of possible noncoverage. Medicare does not have an approval process for determining coverage prior to service delivery. Providers must screen each case for Medicare eligibility and exclusions, the most important of which are custodial care and lack of medical necessity. The provider does not know whether the fiscal intermediary will agree with the determination until after the fact. As partial protection for the provider, Medicare will sometimes pay for services that are not medically reasonable and necessary or that constitute custodial care. The key question is whether the patient or provider knew, or could have been expected to know, of the noncoverage. The Medicare beneficiary is entitled to presume that Medicare will cover inpatient hospital and long term care as well as physician’s services, unless the provider puts them on notice of possible noncoverage. If the patient was not put on notice, there can be no patient liability for that care.

Medicare law contains other consumer protections. Beyond deductibles and copayments, a hospital or nursing home may charge Medicare beneficiaries only for noncovered items such as TV rentals, barber or beautician services, and private rooms that are not medically necessary. In addition, the amount a physician can bill a Medicare enrollee

129. Until January 1, 1996, Medicare gave the nonhospital provider the benefit of the doubt, presuming that it did not know unless it had a history of inappropriate coverage decisions. This favorable presumption waived the provider’s liability for uncovered care.

Medicare proposes to eliminate the use of the favorable presumption in determining whether a hospital, skilled nursing facility, or home health agency should be held liable for furnishing a noncovered service. All such decisions would be made on a case-by-case basis. 51 Fed. Reg. 6222, 6222 (1986). Congress has postponed the effective date of the elimination for nonhospital providers several times, most recently to December 31, 1995. With the failure to enact a budget bill affecting Medicare, the congressional extension has expired. See Omnibus Reconciliation Act of 1990, Pub. L. No. 101-508, § 4207(b)(3), 104 Stat. 1388 (1990) (codified in scattered sections of 42 U.S.C.).
130. 42 C.F.R. §§ 489.30, 489.32 (1995). To participate in the Medicare program, a nursing home, home care agency, or other provider must agree “not to charge, except . . . [for patient responsibility for the Medicare Part A coinsurance amounts], any individual or any other person
is limited in most instances to the Medicare Fee Schedule, with payment split between Medicare (80%) and the enrollee (20%). The few physicians who choose to "balance bill" (i.e., charge more than the Medicare Fee Schedule), have their maximum billing capped at 9.25% over the Fee Schedule, except where state law sets a lower amount.

131. Medicare participating physicians accept the Physician's Medicare Fee Schedule amount as full payment for a service. Physicians who accept assignment will not balance bill for a particular service. Ninety-three percent of charges submitted by physicians were limited to the Medicare fee as of 1994. PHYSICIAN PAYMENT REVIEW COMM'N. ANNUAL REPORT TO CONGRESS 25, 26 (1995). For 1995, almost 75% of M.D.s and D.O.s were participating providers. For limited license providers, such as optometrists, podiatrists, chiropractors, or oral surgeons, the participation rate was less than 50%. A new requirement as of January 1, 1995 mandated that many nonphysician providers must participate, including certified registered nurse anesthetists, physician assistants, nurse practitioners, nurse midwives, clinical nurse specialists, clinical psychologists, and clinical social workers. The rule does not apply to audiologists, physical therapists, psychologists, and occupational therapists. HEALTH CARE FIN. ADMIN. PRESS OFFICE. PRACTITIONER ENROLLMENT IN MEDICARE PROGRAM INCREASES FOR 1995 (1995).

132. Sections 1395w-4(g)(2)(C) and (D) of Title 42 cap billing by nonparticipating physicians at 115% of the recognized payment, set at 95% of the Medicare Fee Schedule. Medicare prohibits having a patient agree not to have a claim submitted to Medicare or to be financially responsible for full charges. HEALTH CARE FIN. ADMIN., MEDICARE CARRIERS MANUAL § 7330 (1995).


A skilled nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and covered services for all individuals no matter the source of payment.\textsuperscript{133} A skilled nursing facility may not require individuals to waive their benefits under Medicare or Medicaid, seek oral or written assurance that individuals are not eligible for, or will not apply for, those benefits, or require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility.\textsuperscript{134}

Concurrent amendments to the Medicare and Medicaid statutes have stopped nursing homes from using chemical or physical restraints on residents "for purposes of discipline or convenience."\textsuperscript{135} The only restraints allowed are those ordered by a physician for physical safety.\textsuperscript{136} Federal law has also sought to promote patient self-determination. The Patient’s Self Determination Act,\textsuperscript{137} effective December 1, 1991, requires the hospital, nursing home, hospice program, or home care agency to provide notice to the patient of her state law rights to decide the course of medical care and of the availability of advance directives.\textsuperscript{138} On July 1, 1995, new nursing home quality standards were implemented.\textsuperscript{139}

\textsuperscript{133} 42 U.S.C. § 1395i-3(c)(4) (1994).
\textsuperscript{134} 42 U.S.C. § 1395i-3(c)(5) (1994).
\textsuperscript{136} The need to comply with the law led to a practice guideline developed by the nursing home industry. \textit{American Health Care Ass’n, Clinical Practice Guidelines for the Use of Physical Restraints} (1992).
\textsuperscript{138} \textit{Id.}
\textsuperscript{139} The rule “implemented provisions of the Omnibus Budget Reconciliation Act of 1987, and will significantly increase federal nursing quality standards affecting the nation’s 17,000 nursing homes certified to care for Medicare and Medicaid patients.” \textit{HCFA Implements Tough New Nursing Home Rule}, 6 Medicare Rep. (BNA), at 775 (July 7, 1995). The American Health Care Association, a nursing home trade group, sought to further delay the implementation, claiming that “about 82% of homes will be out of compliance with the regulation.” \textit{Id.} at 776. The rule lists increasingly severe remedies federal and state governments may take to bring nursing homes into compliance with federal guidelines. \textit{Id.} They include a requirement by HCFA of a direct plan of action, denial of payments for new admissions, temporary management appointed by a state or HCFA, or the closing down of a home by a state. \textit{Id.} Efforts are underway to repeal the Congressional authority for these rules. \textit{Id.}
B. The Medicare Promise for Long Term Care Coverage

Long term care coverage under Medicare has been substantially, but quietly, improved in the last eight years. The changes are reflected in the higher rates of use of long term care services. For example, the percentage of Medicare enrollees receiving Medicare covered home care services more than doubled from 1980 to 1992, as did the average number of visits per person served. Medicare covered 1.5% of the national aggregate of nursing home costs in 1987. In 1993, Medicare covered 8.8%. This increase suggests that Medicare has been underutilized as a source of nursing home coverage. There is no reason to believe that all the barriers have been removed or that maximum coverage has been achieved.

1. Hospital Services

The Medicare limits on patient liability for hospital stays are relevant to long term care patients since they are likely to spend time in the hospital. The renewable Medicare benefit period for inpatient hospital care is ninety days per spell of illness. The patient can use a one time benefit of sixty Life Time Reserve days after exhausting the renewable benefits. This benefit effectively provides coverage for more than 150 days. Having even one benefit day left as of the date of admission to a hospital makes the entire medically necessary stay Medicare-covered.
A hospital may not charge a beneficiary for custodial care or care that is medically unnecessary until the hospital or its utilization review committee properly determines that the beneficiary no longer requires inpatient hospital care and puts the beneficiary on notice of the determination. No liability can accrue until the second day following the date the patient is provided with proper notice of the determination and her right to an appeal. "Inpatient hospital care" includes periods when a beneficiary needs a skilled level of nursing home care rather than hospital care, but no available nursing home bed has been offered to the patient. The primary responsibility for developing an adequate discharge plan belongs with the hospital and its social work or discharge planning department. Until the hospital develops the plan and offers a nursing home bed, the patient who needs skilled nursing care is to be treated as a hospital inpatient for purposes of Medicare benefits.

2. Skilled Nursing Facility Services

Medicare's nursing home coverage is restricted in several ways. There must be a prior three day hospital stay. The maximum benefit is 100 days of coverage per spell of illness. The resident owes substantial copayments for covered days 21 to 100. To secure

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a single hospital stay exceeds 150 days of acute care, or the stay falls into the outlier category, or both. The regulations suggest that the deductible and copayment should cap the personal liability in such a case. See 42 C.F.R. § 412.42(a) (1995) ("A hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital's costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment systems."). See also 42 C.F.R. §§ 489.30, 489.32 (1995).

146. 42 C.F.R. § 412.42(c) (1995).
147. Id.
148. Id.


151. 42 U.S.C. § 1395d(a)(2) (1994). The Medicare nursing home limit of 100 days per spell of illness is especially harsh for nursing home residents needing long term care. The benefit may be sufficient for short term rehabilitation stays, but not for residents with chronic degenerative conditions. For this group, a nursing home stay can last for years. It is a reflection of our ignorance on the topic that we do not have good data on lengths-of-stay in nursing homes.

152. 42 U.S.C. § 1395d(a)(2) (1994). The Medicare nursing home limit of 100 days per spell of illness is especially harsh for nursing home residents needing long term care. The benefit may be sufficient for short term rehabilitation stays, but not for residents with chronic degenerative conditions. For this group, a nursing home stay can last for years. It is a reflection of our
Medicare coverage for a nursing home stay, the facility must be certified to participate in the Medicare program.\textsuperscript{153}

Despite the reluctance of nursing homes to rely on Medicare as they did prior to Intermediary Letter 371,\textsuperscript{154} several changes are again making Medicare a significant player in the nursing home industry. States have been shifting nursing home coverage to Medicare, both directly and indirectly. Medicare maximization efforts by the state Medicaid programs direct or encourage nursing homes to submit more claims to Medicare.\textsuperscript{155} Moreover, state limits on the rate of increase for Medicaid nursing home reimbursement make Medicare a relatively more attractive alternative. Medicare payment principles set the upper limit on Medicaid reimbursement.\textsuperscript{156} Also significant is the expanded interpretation of Medicare’s skilled care coverage standards, which began in 1987. The Office of Hearings and Appeals staff was advised of “a significant problem in the defensibility” of Medicare nursing home decisions denying coverage on the basis that the services constituted custodial care.\textsuperscript{157}

The courts have consistently held that . . . in determining whether or not an individual requires and receives skilled nursing care, the correct legal standard which must be applied is to consider the patient’s condition as a whole, not merely whether individual services rendered in the [skilled nursing facility] were skilled. The courts have, in fact, been reversing those cases where the decision fails to consider and adequately evaluate the patient’s total condition.\textsuperscript{158}
In April 1988, HCFA totally rewrote sections of the Medicare Intermediary Manual (MIM),\(^\text{159}\) and the Medicare Skilled Nursing Facility Manual to include new, more inclusive standards.\(^\text{160}\) The Peer Review Organization then serving New York summarized the changes as follows: “The new guidelines are more liberal in interpretation of Medicare coverage. The range of services which are considered ‘skilled’ has been expanded and there is a broader acceptance of coverage based on the need for the skilled supervision or management of an aggregate of unskilled services.”\(^\text{161}\)

The specific issue regarding nursing home coverage is whether the patient required or received skilled nursing care on a daily basis or skilled rehabilitation services that, as a practical matter, could only have been provided in a skilled nursing facility on an inpatient basis.\(^\text{162}\) Skilled care is “so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.”\(^\text{163}\)

The key criterion is the need for professional involvement. Some services, such as intramuscular injections or feeding tubes, are obvious indicators of skilled services. Other services are harder to identify, but represent the bulk of skilled services provided. The development, management, and evaluation of a patient care plan constitutes a skilled service when the patient’s physical or mental condition makes involvement of technical or professional personnel necessary to meet the patient’s needs, promote recovery, and ensure medical safety.\(^\text{164}\) Observation and assessment of a patient’s changing condition is a skilled service when a professional person is required to identify and evaluate the patient’s need for modification of treatment until his or her

\(^{159}\) The HCFA manuals, such as the Medicare Skilled Nursing Facility Manual, HCFA-Pub. 12 and the Intermediary Manual, HCFA-Pub. 13, provide the various Medicaid and Medicare providers and the entities administering the programs with more specific, if less authoritative, instructions for implementing the programs than is found in the regulations. See Medicare Home Health Agency Manual, supra note 124, § 100(A), (C).


\(^{161}\) Empire State Medical, Scientific & Educational Foundation, Expanded Skilled Nursing Facility Level of Care Guidelines (on file with author).


condition is stabilized. Further, as stated in section 409.32(b) of the Code of Federal Regulations, "A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in [section] 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel." Improvement in the patient's condition is not a prerequisite of Medicare coverage. The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. "[A] patient may need skilled services to prevent further deterioration or preserve current capabilities." Medicare provides coverage based on a thorough analysis of the patient's total condition and individual need for care.

Very few nursing home residents receive only "custodial care" as defined by Medicare. Most nursing home residents need a medical professional to observe and assess their conditions or manage and evaluate their care plans. They would not be in the nursing home but for a complex, but not acute, set of conditions. Patients who require daily skilled nursing care or therapy five times a week, which as a practical matter can be provided only in a nursing facility, should receive Medicare coverage for up to 100 days in a spell of illness.

The seemingly simple step of submitting a Medicare claim shows the conflicts inherent between nursing homes and their residents. The submission of nursing home claims to Medicare is not automatic. In Sarrassat v. Sullivan a group of nursing home residents challenged...
the Medicare reimbursement system as a violation of their due process rights. Their allegations described the problem as follows:

[N]ursing homes are unwilling to submit claims to Medicare in unclear or close cases because of the system used by [the federal defendant] to make determinations on [nursing home] level[s] of care claims. This system includes various financial incentives for [nursing homes] not to submit such claims, particularly the waiver of liability presumptions and length of stay norms.\textsuperscript{174}

The parties settled when federal officials agreed to issue rules requiring that nursing homes provide uniform notices of noncoverage for their patients at the time of admission or at the time of a change in level of care.\textsuperscript{175} According to the rules, the notices should state the specific bases for the expected denial and notify beneficiaries that they may submit a demand bill to Medicare.\textsuperscript{176} If a submission is requested, billing the patient is prohibited until Medicare reviews the claim.\textsuperscript{177} If the nursing home fails to tell a patient that Medicare might not cover the care, and Medicare later determines that the care was only "custodial" or not medically necessary, the nursing home cannot charge the resident for the care.\textsuperscript{178} The process still screens out too many claims. The notice of noncoverage convinces many individuals that Medicare has denied coverage and they do not ask that the claim be submitted.

3. Home Health Care

Medicare-covered home health care is care that is provided to a person who is "homebound" and that consists of physician-ordered nursing or therapy services with home health aide services added on.\textsuperscript{179} Medicare fully covers services provided through a certified home health agency (CHHA) to the extent that the services fit within the guidelines. Medicare Manual guidelines issued in April 1989 rejected "rules of thumb," such as the notion that Medicare would cover no more than

\begin{itemize}
\item \textsuperscript{174} Id. at 22.842.
\item \textsuperscript{175} See \textit{Sarrassat} v. \textit{Sullivan}, No. 89-16326, 1992 WL 86580, at *2 (9th Cir. Apr. 28, 1992).
\item \textsuperscript{177} Id. at 22.842.
\item \textsuperscript{178} Id. at 22.843.
\item \textsuperscript{179} See 42 U.S.C. § 1395x(m) (1994).
\end{itemize}
nine hours of nursing and aide care per week, for no more than six weeks.\footnote{180}

Individuals who meet the qualifying criteria are entitled to the following coverage for an indefinite period: all medically necessary physical therapy, speech therapy, occupational therapy (for continuing care cases), and a combination of skilled nursing and home health aide services for up to thirty-five hours per week (more in exceptional cases).\footnote{181} Medicare covers even more hours for finite, predictable periods.\footnote{182} Coverage is long term if continued skilled services are needed to treat or maintain the patient’s condition.\footnote{183} If an individual needs more care, he may be able to pay out of pocket or utilize private insurance or Medicaid to add on to the Medicare covered services.

To qualify for Medicare covered home health care, the individual must have a physician’s plan of care for home care and be “homebound.”\footnote{184} The term “homebound” is defined as needing assistance to leave the home.\footnote{185} The test, ultimately, is whether the patient has the capacity to obtain the needed health care outside the home.\footnote{186} The individual must need therapy or a moderate amount of skilled care.\footnote{187} A skilled nursing service in the home care context is defined by the same standards that apply to covered care in a nursing home.\footnote{188} Examples of skilled nursing services include wound care, education of a patient or his family about how to manage the treatment regimen, management and evaluation of a care plan, and skilled observation and assessment of a patient’s status.\footnote{189} The skilled nursing care which qualifies a patient for Medicare coverage must be recurring, such as a home visit at least once every sixty or ninety days.\footnote{190} Full time nursing over an extended period usually does not qualify for Medicare


182. \textit{Id.} § 206.7(B).


185. \textit{Id.} § 204.4(A).

186. \textit{Id.}

187. \textit{Id.} § 204.4.


190. \textit{Id.} § 205.1(C).}
The need for up to four days a week of skilled care can go on indefinitely. A Medicare certified Home Health Care agency must provide the services, and such an agency should be contacted to arrange for providing the prescribed care. The application process consists of calling a certified agency and requesting an assessment. The agency, with assistance from the individual, his family, and the treating physician, will perform a medical and social assessment to determine whether home care is appropriate and whether Medicare coverage may be available. Advocacy plays a role in this determination. The agencies have generally been cautious when taking on cases that go beyond the now discredited "rules of thumb." Working with the agency to review the new manual provisions may be productive. In other cases, getting an opinion from another certified agency will accomplish the goal of obtaining the needed care.

4. Hospice

Hospice is a specialized program for patients who are "terminally ill." A patient is considered "terminally ill" if a physician has certified that the patient has a life expectancy of no more than six months. Hospice coverage includes counseling for the individual and his family, respite care, and active use of pain medication. While receiving hospice coverage, Medicare beneficiaries are not eligible for Medicare coverage of curative treatments. There is no restriction, however, on beneficiaries choosing to revert to full Medicare coverage. As with home care, Medicare coverage is limited to certified agencies. Hospice programs are being developed in many previously unserved areas, but access to a Medicare-approved hospice program is by no means universal. Some programs offer primarily home care,
while others regularly use hospital or nursing home beds. As noted above, the only out of pocket cost for this coverage is a copayment of $5 or 5%, whichever is less, for prescriptions, and a 5% copayment for the cost of institutional respite care. 203

C. Medicare Appeals

There is a good deal of discretion involved in making Medicare coverage determinations. To correct errors and to provide some measure of consistency and fairness, an appeal process exists for each Medicare Part. The appeal process for Part A, the part associated with long term care coverage, is intricate but amazingly productive. The process consists of three levels of administrative review: reconsideration, 204 a hearing by an Administrative Law Judge (ALJ) (requiring a $100 minimum in controversy), and review by the Appeals Council. 205 The final administrative decision can be appealed to a federal district court (requiring a $1,000 minimum in controversy). 206 Forty to seventy-five percent of the determinations at each level, excluding dismissals and withdrawals, result in a full or partial determination favorable to the claimant. 207

Many Medicare participants are not knowledgeable about the appeal process. A recent survey by the Office of Inspector General found that more than 30% of the respondents did not know they could appeal or request review of a Medicare denial. 208 Only 5% had ever appealed a Medicare decision. 209 Of those who did appeal, about 25% did not understand the resulting decision, and less than two-thirds felt that Medicare handled the appeal fairly. 210

An enrollee should not take an initial Medicare denial too seriously. The procedure for appealing the initial denial, called reconsideration under Part A, consists of obtaining a second opinion on the submission. A reconsideration reviewer takes a closer look at the claim using the

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203 See supra note 119.
204 For Part B, a carrier review and a separate carrier hearing replace the reconsideration step. 42 C.F.R. § 405.801-877 (1995).
206 42 U.S.C. §§ 405(g), 1395f (1994).
207 Interview with Gene Kelley, Statistics Dep’t of Health Care Fin. Admin.
209 Id.
210 Id.
same file and information. The work involved in winning this additional coverage consists of writing a one line letter and sending it to the fiscal intermediary or the local Social Security Office within the sixty day deadline.

The ALJ hearing is a full review of the case with an opportunity to develop the record. The single most important addition to the file, where the level of care is at issue, is a letter from the patient’s treating physician providing reasons for concluding that the care was medically “reasonable and necessary,” required the direct involvement of medical professionals to ensure the patient’s safety, and was provided at the most appropriate level of service, for example, at the hospital, skilled nursing facility, or home. Several federal courts of appeals have come very close to holding that the “treating physician rule” used in disability cases also applies to Medicare appeals. The rule provides that the medical opinion of the patient’s treating physician is: “(i) binding on the fact-finder unless contradicted by substantial evidence; and (ii) entitled to some extra weight because the treating physician is usually more familiar with a claimant’s medical condition.

The ALJ hearing may be a full-blown, de novo, in-person hearing, but sometimes that is not required. The level of care determination will rest on the medical records, supplemented by the physician’s statement and, on occasion, by testimony from the patient or other witnesses. The claimant does not have to be represented by an attorney. In fact, many ALJ hearings are done pro se. A trained advocate, such as a paralegal, is helpful, however, when making the presentation. An advocate should summarize the medical evidence and relate it to the proper decisional standards. This process may be done through a written submission rather than a personal appearance. The ALJ may agree to review the case on the papers prior to the hearing, in which case a hearing will be

211. MEDICARE INTERMEDIARY MANUAL, supra note 165, § 3784. The reviewer can accept additional medical evidence and can solicit additional information from the attending physician. Id. § 3784.1.
212. MEDICARE INTERMEDIARY MANUAL, supra note 163, § 3782.1.

The treating physician rule for disability cases has now been incorporated, with some modification, into the Secretary’s regulations, thus giving it nationwide impact. 20 C.F.R. §§ 404.1527, 416.927 (1995). See Schisler v. Sullivan, 3 F.3d 563 (2d Cir. 1993) (regarding the legality of the new regulations).

held only if she is unable to render a favorable decision based on that record. Fees for representation at the administrative level are generally limited to 25% of the Medicare benefits recovered.\textsuperscript{216}

The Social Security Administration’s Appeals Council is the last step in the Medicare administrative appeals process.\textsuperscript{217} A claimant dissatisfied with the ALJ’s decision can request review by the Appeals Council.\textsuperscript{218} If the Appeals Council grants the request for review, they may issue a new decision or remand the matter to the ALJ.\textsuperscript{219} The Appeals Council also reviews cases on its own motion.\textsuperscript{220}

Review serves as a form of quality control with regard to the ALJs.\textsuperscript{221} The Appeals Council will grant review when there appears to be an abuse of discretion, error of law, or lack of substantial evidence in the decision.\textsuperscript{222} The Appeals Council will also review if new and material evidence is submitted or the case involves “a broad policy or procedural issue that may affect the general public.”\textsuperscript{223} The policymaking role of the Appeals Council has declined as the twenty member body struggles to keep up with a burgeoning caseload.\textsuperscript{224}

A federal court may review both the legal conclusions and factual conclusions of the Secretary, although each is reviewed under different standards. With respect to the Secretary’s legal conclusions, or more generally his application of legal principles, judicial review is de novo.\textsuperscript{225} If the Secretary does not evaluate evidence properly because of a misapplication or erroneous view of the law, the decision cannot be upheld.\textsuperscript{226} The application of the “treating physician rule” comes into play in this evaluation.\textsuperscript{227}

The court restricts the review of factual findings to the “substantial evidence” test. In determining what is substantial evidence, the

\begin{itemize}
\item \textsuperscript{217} 20 C.F.R. § 404.967 (1995); 42 C.F.R. § 405.724 (1995).
\item \textsuperscript{218} 20 C.F.R. § 404.967 (1995).
\item \textsuperscript{219} Id.
\item \textsuperscript{220} Id. § 404.969 (1995).
\item \textsuperscript{221} Scholars have questioned the extent to which the Appeals Council can effectively perform its job. Charles H. Koch & David A. Koplow, The Fourth Bite at the Apple: A Study of the Operation and Utility of the Social Security Administration’s Appeals Council, 17 FLA. ST. U. L. REV. 199 (1990), [hereinafter Fourth Bite].
\item \textsuperscript{222} 20 C.F.R. § 404.970 (1995).
\item \textsuperscript{223} 20 C.F.R. § 404.970(a)(4) (1995).
\item \textsuperscript{224} Fourth Bite, supra note 221, at 266-268.
\item \textsuperscript{225} Townley v. Heckler, 748 F.2d 109, 112 (2d Cir. 1984); Marcus v. Califano, 615 F.2d 23, 27 (2d Cir. 1979); Spena v. Heckler, 587 F. Supp. 1279, 1282 (S.D.N.Y. 1984).
\item \textsuperscript{227} Klementowski v. Secretary, Dep’t of Health & Human Servs., 801 F. Supp. 1022, 1025 (W.D.N.Y. 1992).
\end{itemize}
reviewing court must look to the record as a whole, not merely to the
evidence which supports the Secretary’s decision. As stated by the
Second Circuit in New York ex rel. Bodnar v. Secretary of Health and
Human Services, “in assessing whether the evidence supporting the
Secretary’s position is substantial, [the court] will not look at that
evidence in isolation but rather will view it in light of other evidence
that detracts from it.”

In cases that win after an appeal to federal court, if the government’s
position is not substantially justified, the court may order the govern-
ment to pay the claimant’s attorney’s fees under the Equal Access to
Justice Act (EAJA). The fee awards, based on prevailing rates, may
include the time spent on the federal court case and any subsequent
administrative hearings held on remand.

III. VETERANS’ BENEFITS

A. Introduction to Veterans’ Benefits

The United States has perhaps the most comprehensive system of
veterans’ assistance programs in the world. The Department of Veterans
Affairs (VA) is responsible for providing an array of services and
benefits to civilians who have served in the United States military.

228. Hurley v. Bowen, 857 F.2d 907, 912 (2d Cir. 1988); see also Universal Camera Corp.
229. 903 F.2d 122, 126 (2d Cir. 1990).
230. Id.
233. The Bureau of War Risk Insurance was created within the Department of the Treasury
398 (1917). The Veterans’ Bureau, an independent administrative agency within the Executive
In 1930, Congress authorized the President to consolidate veterans’ programs being run by the
Bureau of Pensions in the Interior Department, the National Home for Disabled Volunteer Soldiers,
the United States Public Health Service, and the Veterans’ Bureau into a new agency called the
Veterans’ Administration. Veterans’ Administration Act, ch. 863, 46 Stat. 1016 (1930). The
President promptly did so. Exec. Order No. 5398 (July 21, 1930). The agency was elevated to
Cabinet status and renamed the Department of Veterans Affairs, effective March 15, 1989.
Department of Veterans Affairs Act, Pub. L. No. 100-527, 102 Stat. 2635 (codified as amended
at 38 U.S.C. § 301(a) (1994)).
234. A veteran must have served in active duty, broadly defined to include the Armed Forces
reserve units, commissioned officers of the Public Health Service, the National Oceanic and
Atmospheric Administration, and United States Army, Air Force, Navy or Coast Guard Academy
disabilities or death while on active or inactive duty training qualify. 38 U.S.C. § 101(24) (1994); see also id. § 106. Certain discharged members of the armed forces of World War I and World
War II allies also qualify for health care benefits through the VA. Id. § 109.
For example, a veteran, whether he has served in wartime or in peace, has a claim to VA medical care for both service-connected and non-service-connected conditions. To serve this population, the federal government owns and operates a huge socialized medical system, including hospitals, nursing homes, and domiciliaries. The VA cash benefits, loans, and loan guarantees are administered separately through regional and local VA offices. Because of the huge mobilizations for the World Wars, the Korean Conflict, and the Vietnam War, the commitment to assist all U.S. veterans has produced over twenty-six million veterans potentially eligible for VA services and benefits. The veteran population is relatively old, with a median age of 56.7 years as of July 1, 1994. The median age for World War II veterans was 72.1. This cohort is reaching the age where they need the most medical and long term care. By the turn of the century, more than 60% of all U.S. males over age sixty-five will be veterans. These demographics show a considerable gender bias. More than 95% of all veterans are male.

VA medical centers are the primary entry points for medical care provided directly by the VA and for arranging payment to non-VA providers. This structure evolved from the federal commitment to

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The VA direct delivery system includes 171 hospitals with over 53,000 beds, 240 outpatient clinics, 126 nursing homes with almost 15,000 beds, and 35 domiciliaries with over 7,400 beds to serve the nation's approximately 27 million veterans. The VA employs over 7,500 full-time and 3,200 part-time physicians, 1,650 residents, 37,300 registered nurses, and 24,500 other nursing staff. U.S. GOV'T ACCOUNTING OFFICE, VETERANS' HEALTH CARE, IMPLICATIONS OF OTHER COUNTRIES' REFORMS FOR THE UNITED STATES, I n.I (1994): DEP'T OF VETERANS AFFAIRS, SUMMARY OF MEDICAL PROGRAMS, 1, 119 (1994) [hereinafter DVA SUMMARY].

As of July 1, 1994, there were an estimated 1.2 million female veterans out of the total veteran population of 26.5 million. Id. at Table 1. Until 1975, the VA laws addressed all veterans as males and provided spousal benefits only to wives. The wording was corrected by The Veterans and Survivors Pension Interim Adjustment Act of 1975, Pub. L. No. 94-169, § 101(1), 89 Stat. 1013, 1013.

The VA spends $500 million annually to reimburse non-VA facilities for services to
provide medical care to veterans serving in World War I.\textsuperscript{243} Following the mold of the then-popular concept of workers' compensation, Congress authorized compensation payments to any member of the military or naval forces disabled in the line of duty.\textsuperscript{244} Congress also promised that "medical, surgical, and hospital services" would be "furnished by the United States" to such injured persons.\textsuperscript{245} In 1924, the need for hospital space expanded when Congress authorized medical care for any disabilities, not just service-connected disabilities, suffered by war time veterans.\textsuperscript{246} Nearly fifty years later, Congress further expanded the VA's role to provide care to peacetime veterans with non-service-connected disabilities.\textsuperscript{247}

The VA regional and field offices handle applications for a wide range of benefits. Especially important for long term care needs are the cash benefits paid to veterans and their family members based on service-connected disabilities, also known as compensation, and those paid to non-service-connected disabilities, also known as pensions.\textsuperscript{248} The former is akin to Social Security benefits in that payment is independent of the recipient's financial situation. Congress designed the latter to be better than public assistance. The primary purpose behind the VA Improved Pension (VAIP) is to "assure a level of income above

\begin{itemize}
\item veterans. This is done where the VA cannot feasibly provide a specific service or cannot provide treatment economically due to geographic inaccessibility. 38 U.S.C. § 1703 (1994).
\item War Risk Insurance Bureau Act, ch. 105, 40 Stat. 398 (1917). The Act promised veterans injured in the line of duty "such reasonable governmental medical, surgical, and hospital services" as were determined "to be useful and reasonably necessary." Id. § 302(3).
\item War Risk Insurance Bureau Act, ch. 105, § 302(3), 40 Stat. 398 (1917). The Bureau of War Risk Insurance, and later the Veterans' Bureau, were responsible for both benefit administration and arranging or buying necessary medical care. The need for medical care by veterans overwhelmed the United States Public Health Service, the government's first choice for providing the care. See, e.g., Act of July 19, 1919, ch. 24, 41 Stat. 172 (authorizing an appropriation to the Public Health Service for servicing "war-risk insurance patients"). In 1921, Congress appropriated money for construction of the first veterans' hospital. Act of March 4, 1921, ch. 156, 41 Stat. 1314. Subsequent acts appropriated much larger sums for construction and acquisition of facilities, and also transferred government owned hospitals from other agencies. By 1930, the veterans' system had 54 hospitals. \textsc{Dept of Veterans Affairs, A Brief History}, available on the Internet at: http://www.va.gov/vatlis.htm.
\item World War Veterans' Act, ch. 320, § 202(10), 43 Stat. 607 (1924).
\end{itemize}
minimum subsistence level allowing veterans and their survivors to live out their lives in dignity.\textsuperscript{249}

During most of its existence, the VA had very limited outside review on its medical care decisions and its benefits decisions. States could not monitor or regulate the federal system of medical care, even though no system for overseeing medical care existed at the federal level outside the VA. The VA statute precluded court review of benefit decisions. Until 1989, some variation of the following statutory language applied:

\begin{quote}
The Administrator shall decide all questions of law and fact necessary to a decision by the Administrator under a law that affects the provision of benefits by the Administrator to veterans or the dependents or survivors of veterans. The decision of the Administrator as to any such question shall be final and may not be reviewed by any other official or any court.\textsuperscript{250}
\end{quote}

These conditions allowed VA medical services and benefit programs to develop under a non-due process administrative model.\textsuperscript{251} The VA had a great deal of discretion in benefit decisions, and the written guidelines were quite vague.\textsuperscript{252} Denials were appealed to a very decentralized Board of Veterans' Appeals.\textsuperscript{253}

Recent legislative changes have sought an end to this splendid isolation and to direct the VA systems into the United States mainstream. The Veterans’ Judicial Review Act created the United States Court of Veterans Appeals (CVA), an Article I court.\textsuperscript{254} The CVA provides limited review of the Board of Veterans’ Appeals findings. VA benefit claimants now have greater access to lawyers' services as well, with the lifting of the $10 cap on attorneys’ fees that had been in place since shortly after the Civil War.\textsuperscript{255} Additionally, Congress made the notice and comment rule making provisions of the Administrative Procedure Act applicable to the program.\textsuperscript{256}

\begin{itemize}
\item \textsuperscript{251} \textit{See generally} Lawrence B. Hagel & Micheal P. Horan, \textit{Five Years Under the Veterans’ Judicial Review Act}, 46 ME. L. REV. 43 (1994).
\item \textsuperscript{252} Id.
\item \textsuperscript{253} Id.
\item \textsuperscript{255} 38 U.S.C. § 3404(c) (1994).
\item \textsuperscript{256} Id. §§ 501-502.
\end{itemize}
The VA retains some unusual statutory and regulatory provisions that
provide favorable treatment to applicants. For instance, the VA has an
affirmative duty to conduct outreach and to notify eligible veterans of
the benefits to which they are entitled.\footnote{Id. §§ 7721-7726.} Favorable treatment exists in
the area of pensions as well. The threshold question for pension claims
is whether the person is disabled.\footnote{Until recently, any veteran age 65 or older was to be classiﬁed as permanently and totally
disabled for purposes of VA pension eligibility. See id. § 502, amended by Omnibus Budget
The VA disability standard is less
demanding than that used in determining eligibility for Social Security
As part of its duty to help claimants, the
VA must search for records, produce records, and conduct medical
exams. Much like the Social Security Administrative Law Judge’s role,
the hearing personnel must assist the claimant to develop a complete
record.\footnote{It is the responsibility of the VA personnel “conducting the hearings to explain fully the
issues and suggest the submission of evidence which the claimant may have overlooked and
which would be of advantage to the claimant’s position.” 38 C.F.R. § 3.103(c)(2) (1995).}
Furthermore, the doctrine of reasonable doubt gives the
claimant the beneﬁt of the doubt in resolving any factual issue.\footnote{The doctrine is explained in the VA regulations as follows:
It is the deﬁned and consistently applied policy of the Department of Veterans Affairs
to administer the law under a broad interpretation, consistent, however, with the facts
shown in every case. When, after careful consideration of all procurable and assembled
data, a reasonable doubt arises regarding service origin, the degree of disability, or any
other point, such doubt will be resolved in favor of the claimant.
Id. § 3.102.}
The importance, and uniqueness, of this provision has been emphasized by
the CVA:

In other words . . . the preponderance of the evidence must be against the
claim for beneﬁts to be denied. In a very real sense, the Secretary faces an
easier task than other administrative or judicial fact ﬁnders who must render
a decision even in the closest of cases: when a veteran seeks beneﬁts and the
evidence is in relative equipoise, the law dictates that veteran prevails. This
unique standard of proof is in keeping with the high esteem in which our
nation holds those who have served in the Armed Services. It is in recogni-
tion of our debt to our veterans that society has through legislation taken upon
itself the risk of error when, in determining whether a veteran is entitled to
beneﬁts, there is an “approximate balance of positive and negative evidence.”
By tradition and by statute, the beneﬁt of the doubt belongs to the veteran.\footnote{Gilbert v. Derwinski, 1 Vet. App. 49, 54 (1991).}
wartime veterans.\textsuperscript{263} A veteran, however, needs only to have served one day during a period of war and a total of ninety days.\textsuperscript{264} The broadly defined periods of war as set by the VA reflect the generous spirit behind the program.\textsuperscript{265}

B. The VA Promise of Long Term Care

Veterans with service-connected disabilities and several groups of veterans with non-service-connected disabilities are entitled to free hospital care from the VA without having to satisfy an income eligibility test.\textsuperscript{266} Lower income veterans with non-service-connected disabilities are also entitled to free care.\textsuperscript{267} If space and the VA budget allow, the VA may provide hospital care to other veterans, subject to a minor copayment.\textsuperscript{268} Space availability varies regionally, but the national occupancy rate for VA hospitals is about 75%.\textsuperscript{269} It is a reflection of both the VA philosophy and the mix of patients using VA

\textsuperscript{263} Veterans may no longer apply for the “old pension” or the Section 309 pension. If payment under these programs exceeds the VAIP benefits, however, veterans will continue to receive the higher benefits. VA FEDERAL BENEFITS, \textit{supra}, note 25, at 8.

\textsuperscript{264} Id. Veterans who enlisted on or after Sept. 8, 1980 generally must serve 24 months to be eligible for benefits.


\textsuperscript{266} Id. § 1710; 38 C.F.R. § 17.47(a) (1995). The other groups include veterans who were exposed to herbicides while serving in Vietnam, veterans who were exposed to ionizing radiation during atmospheric testing or who participated in the occupation of Hiroshima and Nagasaki, veterans who suffer from a condition related to service in the Persian Gulf, former prisoners of war, veterans on VA pension, veterans of the Mexican Border period, veterans of World War I, and veterans eligible for Medicaid. VA FEDERAL BENEFITS, \textit{supra} note 25, at 39.

The health care benefits are not limited to veterans. The spouses and children of veterans who either died of a service-connected disability or who currently have a service-connected disability are entitled to VA care. \textit{Id.} at 56. They may also get some relief from medical costs by means of the compensation and pension programs that provide limited benefits for family members of veterans. \textit{See generally id.}

\textsuperscript{267} 38 U.S.C. § 1710(a)(1)(l) (1994). The veteran is considered to be of low income if he is eligible for Medicaid, is in receipt of a VA Improved Pension, or has annual income of $21,001 or less if he has no dependents or $25,204 or less if he is either married or is single with one dependent. The income maximum is raised $1,404 for each additional dependent (1996 figures). VA FEDERAL BENEFITS, \textit{supra} note 25, at 39. Excessive net worth, defined as having over $50,000, excluding one’s home and personal property, may result in a copayment requirement. See VA DIRECTIVE 10-95-004, available on the Internet at:


\textsuperscript{269} \textit{See DVA SUMMARY, supra} note 236, at Table 8A. VA surgical beds had an occupancy rate just over 60%, while the VA psychiatric units had an occupancy rate of over 80%.
facilities that 97% of the medical services provided are cost-free. The "application process" consists of the veteran presenting himself at the VA hospital. This also represents the choice of the VA system as primary payer, as opposed to Medicare or private insurance.

One indication of the unique VA approach to medical care is the longer lengths-of-stay for VA hospital patients. The average length-of-stay for a Medicare beneficiary in an acute care hospital is 8.6 days, and for the entire population, it is 6.4 days. These figures are not strictly comparable, however, because the VA medical centers may provide acute surgical and medical care, psychiatric care, and "intermediate care" in a single center. Thus, the average overall length-of-stay figures include all these types of care. As another example of unorthodox health care benefits, the VA statute continues a tradition of furnishing hospitalized veterans with tobacco products.

The VA statute allows but does not mandate that the VA provide nursing home coverage. VA nursing home care includes an extended stay in a hospital section of the VA medical center, as well as care in a designated nursing home floor or ward at a VA medical center or at a VA-owned and -operated nursing home. There are also State Homes, subsidized by the VA but run by the state, that provide nursing home care for veterans. Finally, the VA may pay for up to six months of care in a community nursing home. Even with this array

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270. Out of 2,932,968 applications for VA medical care made between October 1, 1993 and September 30, 1994, 2,845,557 fell into the mandatory category, with no charge to the veteran. Id. at Table 2.
273. DVA SUMMARY, supra note 236, at 1.
274. The average length-of-stay for VA psychiatric patients is 29.6 days. The intermediate care population includes many individuals who otherwise would be nursing home residents. The average length-of-stay for this population is 116.2 days. Id.
277. VA FEDERAL BENEFITS, supra note 25, at 48-49.
279. 38 C.F.R. § 17.51(b)(4) (1995). The VA has been expanding the number of beds in its own facilities, while reducing usage of community nursing homes. In 1985, the average daily census in VA nursing home facilities was 9,556 and in community nursing homes, it was
of sites, the number of beds in VA nursing homes and the VA budget are limited. The VA rations the limited nursing home resources according to a list of priorities which is headed by veterans with service-connected disabilities.\(^{280}\) Higher income veterans with non-service-connected disabilities are at the bottom of the list. These veterans have access to services “[t]o the extent resources and facilities are otherwise available . . . .”\(^{281}\) The occupancy rate for VA nursing home facilities is more than 90%, so access can be difficult.\(^{282}\)

The VA may provide nursing home care for life, at no cost, to the same classes of veterans entitled to free hospital care.\(^{283}\) Other veterans are subject to the same means test used for hospital care.\(^{284}\) The VA charges higher income veterans with non-service-connected disabilities a copayment which is equal to one-half of the Medicare inpatient deductible for every ninety days of nursing home care in a VA facility.\(^{285}\) Otherwise, the veteran is entitled to between four and six months of full nursing home coverage when placed in a community nursing home following hospitalization in a VA hospital.\(^{286}\)

The State Homes and domiciliaries, begun after the Civil War, represent the oldest of the veterans’ benefits. State Homes have evolved to handle the increasing care needs of veterans by shifting toward nursing home care.\(^{287}\) Domiciliary care is an unusual benefit available to veterans. Domiciliaries extend the continuum of institutional care.\(^{288}\) As described by the VA, “[d]omiciliary care provides rehabilitative and long-term, health-maintenance care for veterans who require minimal

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11,444. By 1994 the VA facilities had expanded, and the daily census had increased to 13,550. This increase was offset by a decrease in the use of community nursing home beds to a daily census of 9,028. Compare DVA SUMMARY, supra note 236, at 1 with S. Doc. No. 242, supra note 240, at 361.

282. See DVA SUMMARY, supra note 236, at 1, Table 11.
284. VA FEDERAL BENEFITS, supra note 25, at 41.
287. State Homes are established by a state, the District of Columbia or the Commonwealth of Puerto Rico, to provide care for veterans “disabled by age, disease, or otherwise who by reason of such disability are incapable of earning a living.” 38 U.S.C. § 101(19) (1994). The term includes domiciliaries and nursing homes. The average 1994 daily census in State Homes was approximately 11,000 nursing home residents and 3,300 domiciliary residents. DVA SUMMARY, supra note 236, at 1. The VA finances the major part of the construction or expansion of State Homes and also provides a per diem covering a portion of the services provided.
medical care but who do not need the skilled nursing services provided in nursing homes. Coverage of this level of care is not available under the other insurers examined in this Article. For example, Medicare will not cover any institutional care below the level of a nursing facility.

The only VA home care benefits are a hospital-based home care program that does not provide home health or personal care aides and a demonstration project allowing the VA to contract with certified home health agencies to provide services to veterans with service-connected disabilities. For veterans without family members or other care givers, the VA can arrange placement in private homes through the community residence care program. Limited personal care and supervision is provided at the home. The veteran pays for the residential care.

Other long term care-related benefits include home improvements and structural alterations. Given the population that it serves, the VA system has a great deal of experience with prosthetics and other methods of accommodating the loss of body functions. For example, the VA will provide automobile adaptive equipment to veterans with service-connected loss of use of hands or feet. The VA also provides a range of outpatient services, including rehabilitation services, physician care, prescription drugs, dental treatment, certain adaptive

289. VA FEDERAL BENEFITS, supra note 25, at 41.
290. See THE NAT'L UNDERWRITER CO., supra note 27, at 172-73.
equipment, and mental health services. The VA does not have a separate hospice facility or benefit.

VA compensation is paid to veterans with service-connected disabilities. The payment depends on the degree of the disability, ranging from $91 monthly for a 10% disability to $1,870 monthly for a 100% disability. Wartime veterans with non-service-connected disabilities may avail themselves of the VA Improved Pension benefits if they have family income that is less than the maximum amount allowed in their particular category after deducting unreimbursed medical expenses. As noted above, the maximum income levels are set significantly above welfare levels. The VAIP provides higher maximum benefits as the veteran's need for care increases and may reimburse the veteran for some out-of-pocket medical expenses that he or his dependents incur. A married veteran who is in need of "aid and attendance" may receive up to $15,744 per year in VAIP benefits. The VA will reduce VAIP payments to $90 per month for a nursing home resident who has no dependents.

C. The Problems with VA Long Term Care Coverage

Despite the universal availability to veterans, the VA provides medical care services to about only 8% of veterans in any given year. One factor that contributes to the low rate of utilization is that the VA

298. 38 U.S.C. §§ 1701(6), (8) (1994). For outpatient services, veterans who must pay a co-payment are charged the average cost of a VA outpatient visit for that year. Id. § 1712(l). The amount was $14 in 1987 and increased to $39 in 1995. Sec. e.g., 38 C.F.R. § 17.51(a)(4) (1995).

299. VA FEDERAL BENEFITS, supra note 25, at 4.

300. Id. (1996 figures).


302. VA FEDERAL BENEFITS, supra note 25, at 8-9.

303. Id. Veterans are considered to be in need of "aid and attendance" if they are either in a nursing home or are "helpless or blind, or so nearly helpless or blind as to need or require the regular aid and attendance of another person." 38 U.S.C. § 1502(h) (1994). Higher maximum rates apply if both members of a couple are veterans. A veteran of the Mexican Border Period or of World War I will have his annual maximum rate increased by $1,867.


medical centers are not conveniently accessible to all veterans. The VA has retained an institutional model of providing long term care. As an example, the home care benefit is hospital-based, meaning that medical professionals go out from the hospital to the veteran’s home for visits. The VA provides no home health aides or personal care aides to help with the activities of daily living. Thus, only veterans with a strong community support system and a home within a reasonable driving distance of a VA hospital can take advantage of the home care benefit.

The nursing home coverage is also subject to geographic limitations. Proximity to family and friends is an important consideration when choosing a nursing home placement. Many states have only one or two VA nursing homes and not every state has a State Home. This means that the VA facility will be an acceptable choice for only some veterans. Additionally, veterans with non-service-connected disabilities cannot receive nursing home coverage in a community facility without a prior stay in a VA hospital. There are more VA hospitals than nursing homes, but the hospitals are not available in every community.

Persistent concerns are expressed regarding the quality of care provided in VA facilities. In the same vein, the VA has a reputation for slow service in benefit administration. The VA frequently loses supporting documents for claim applications. In addition, applicants must resubmit some documents because two separate offices work on the claim, but only one has a full file. In 1993, the average processing time for an initial disability compensation claim was twenty-seven weeks. The VA then announced a major initiative to reduce that average to fifteen weeks. Veterans’ advocates have found that the trend went in the opposite direction:

It was to be expected that the U.S. Department of Veterans Affairs (VA) would have some difficulty accommodating itself to judicial review under the Veterans’ Judicial Review Act of 1988. It takes time to reform any bureaucracy, especially one that had been exempt from judicial supervision for more than five decades. However, it is now clear that VA’s claims adjudica-

306. See S. Doc. No. 242, supra note 240.
307. DVA SUMMARY, supra note 236, Tables 11, 13.
309. DVA SUMMARY, supra note 236, Table 7.
310. The VA has announced a restructuring plan designed to increase the quality and public image of its health services. Plan for Restructuring VA Health System Puts Focus on Patients, THE NATION’S HEALTH, Sept. 1995, at 4.
312. Id. at 4, 5.
tion system—highly decentralized, staffed at the origination level by nonattorneys, and handling hundreds of thousands of claims a year—was fundamentally unprepared for change. VA’s current problems are worse than difficult. The agency’s claims system is in crisis, with a backlog of 39,000 cases at the Board of Veterans’ Appeals (BVA) and long delays in claim adjudications at the regional offices (which serve as the agencies of original jurisdiction, or AOJ, for veterans’ benefits claims). In February 1993, it took 185 days to adjudicate an original compensation claim; in February 1994, it took 216 days.313

The problems for veterans are compounded because information regarding VA benefits is disseminated by state veterans’ offices, county veterans’ offices, and veterans’ service organizations, thus increasing the likelihood of inconsistent and inaccurate information.314

With the creation of the Court of Veterans Appeals, the possibility exists for a more uniform decision making process on benefit claims. In one of the CVA’s first decisions, Gilbert v. Derwinski,315 the court reviewed well-established administrative law principles that were new to the VA. Critical to the new appeals process was the requirement that the VA state the reasons and factual basis supporting a benefit denial.316 Nevertheless, the institutional culture is not responding quickly to the new approach.317 The fact remains that non-due process approaches, such as a complaint to the appropriate elected federal representative, may bring a faster, more helpful response than does the formal appeal process.

IV. PRIVATE INSURANCE

A. Introduction to Private Insurance

Group hospital insurance began in late 1929 when 1,500 school teachers paid Baylor University Hospital $6 each to provide coverage for up to twenty-one days of hospital care for a group member.318 The fund protected individuals against the escalating costs of hospitalization, while providing a reliable funding source for the hospital.319 Three years later several community hospitals in Sacramento joined in offering a hospital service contract to employed persons. This contract

318. STARR, supra note 51, at 295.
319. See PROSPECTIVE PAYMENT ASSESSMENT COMM’N, supra note 272, at 22-23.
developed into the model for Blue Cross plans.\textsuperscript{320} Private insurance enrollment grew slowly until 1940. During World War II wages were frozen due to the shortage of labor. Employers used fringe benefits, such as providing medical insurance, to compete for workers. After the war, employer-provided insurance for workers and their families became a major bargaining goal for unions.\textsuperscript{321} Dependent coverage became widely available. The percentage of the U.S. population covered by private health insurance increased from less than 10\% to almost 66\% between 1940 and 1960.\textsuperscript{322} As of 1993, private insurance still covered about two-thirds of the U.S. population.\textsuperscript{323}

Seventy-five percent of individuals age sixty-five and older have health insurance coverage from non-governmental sources in addition to Medicare.\textsuperscript{324} In most circumstances the private insurance is a secondary payer to Medicare.\textsuperscript{325} This allows the premiums to be affordable by limiting and defining the risks. Retirement benefits often include the continuation of group coverage for retirees and many policies are available on a group or individual basis.\textsuperscript{326}

"Medicare Supplements" are federally defined medical insurance policies.\textsuperscript{327} Congress simplified the choice of policies sold under the title of "Medicare Supplement" by limiting the choices to one of ten standard plans.\textsuperscript{328} The premiums for these policies are modest,\textsuperscript{329} as are the benefits.\textsuperscript{330} The policies do not cover long term care, with the

\textsuperscript{320} STARR, supra note 51, at 296.
\textsuperscript{321} As a tax-exempt benefit, health insurance could provide more value to workers than a salary increase. Additionally, the group rates were substantially below the rates for individual subscribers.
\textsuperscript{322} STARR, supra note 51, at 310-13.
\textsuperscript{323} PROSPECTIVE PAYMENT ASSESSMENT COMM'N, supra note 272, at 80.
\textsuperscript{324} 57 Fed. Reg. 37,980, 37,981 (1992).
\textsuperscript{325} 42 U.S.C. §§ 1395d. 1395k (1994). For the portion of the elderly population still working who have an employer-provided group health plan, the private insurance will be the primary payer. Id. §§ 1395y(b)-(c).
\textsuperscript{326} PROSPECTIVE PAYMENT ASSESSMENT COMM'N, MEDICARE AND THE AMERICAN HEALTH CARE SYSTEM: A REPORT TO CONGRESS 115 (1993).
\textsuperscript{328} The plans are designated as Plans A through J. 42 U.S.C. § 1395ss (1994). The requirements are based on the revised model regulations for Medicare supplemental policies, as adopted July 30, 1991. See 57 Fed. Reg. 37,980 (1992). The new rules apply to policies sold after the states adopted implementing legislation, which is generally no later than July 30, 1992. These rules do not apply to policies provided by an employer or labor organization. 42 U.S.C. § 1395ss(g)(1) (1994).
\textsuperscript{329} There is open enrollment at community rated premiums for the first six months of an individual's Medicare Part B enrollment. 42 U.S.C. § 1395ss(s)(2) (1994). The annual premium in 1992 for the minimum package was in the range between $340 and $595. PROSPECTIVE PAYMENT ASSESSMENT COMM'N, supra note 326, at 116.
\textsuperscript{330} Plan A contains only the Basic Benefits, defined to leave hospital and Part B deductibles
exception that most plans cover the nursing home copayment for days 21 to 100 and some plans cover up to $1,600 per year for assistance with daily activities.\textsuperscript{331} Except for this limited benefit, these contracts adopt the custodial care and level of care exclusions of Medicare. The only catastrophic coverage available is an additional year of hospital care, provided that the insured meet the coverage standards.\textsuperscript{332} The plans must also adhere to a laundry list of consumer protection provisions.\textsuperscript{333} Individuals younger than sixty-five years of age rely on private insurance for primary health care coverage, unless they are poor enough and categorically eligible for Medicaid,\textsuperscript{334} they qualify for Medicare based on their disability or end-stage renal disease,\textsuperscript{335} or they are veterans who choose to receive their care from the VA.\textsuperscript{336} Despite recent cutbacks, 87% of the individuals under the age of sixty-five with private insurance have employer-provided coverage. The remaining

and the nursing home co-payment for covered days 21 to 100 unpaid. The hospital copayment for days 61 to 150 are covered, plus up to 365 additional hospital days lifetime, the 20% Part B copayment, and the blood deductible. Plan B adds the hospital deductible, while Plan C adds the Part B deductible and the nursing home copayment. Plans D through J offer benefits in addition to those in Plan C, such as basic or extended drug coverage, limited unskilled home care services to supplement the Medicare-covered home care benefits, and preventive care. Each of these categories has an annual dollar limit that is quite low. 57 Fed. Reg. 37,980 (1992) sets out the requirements for each plan, and also provides the full text of the standards defining the plans, the National Association of Insurance Commissioners Medicare Supplement Insurance Minimum Standards Model Act.

\begin{itemize}
\item All plans except A and B cover the nursing home copayment for covered days 21 to 100.
\item Pre-existing condition exclusions are limited. 42 U.S.C. § 1395ss(s) (1994). The condition must have been diagnosed or treated in the six months prior to policy purchase and the restriction on payments cannot exceed the first six months that the policy is in effect. \textit{Id.} § 1395ss(s)(2)(B). The policy is guaranteed renewable. \textit{Id.} § 1395ss(q)(1). Subsequent Medicaid eligibility will allow the individual to suspend payment of premiums for as long as 24 months. \textit{Id.} § 1395ss(q)(5)(A). The Medicaid program may well decide to pay the premiums or allow an income deduction for the premium amount as "cost-effective" insurance. \textit{Id.} § 1395ss(q)(5)(B). State Medicaid programs must identify available cost-effective insurance and pay the premiums on behalf of eligible individuals. \textit{Id.} §§ 1396e(a), (c).
\end{itemize}

These policies must disclose the anticipated loss ratio, which is the percentage of premiums taken in that the insurer expects to pay out on claims. The minimum loss ratios are 75% for group plans and 65% for individual contracts. \textit{Id.} § 1395ss(t)(1)(A). The new rules also provide strict penalties for companies and agents that sell duplicate coverage or fail to advise the insured that Medicaid eligibility may eliminate the need for the Medicare Supplement. \textit{Id.} § 1395ss(d)(3).

\begin{itemize}
\item See supra note 65 and accompanying text.
\item 42 U.S.C. § 1395(c) (1994).
\item See discussion of VA benefits, supra Part III.
\end{itemize}
13% are covered under individual insurance policies. Recent statistics, however, indicate the weakness in relying on employer-provided coverage. Most of the growing number of uninsured are employed. Only one state, Hawaii, has an effective employer mandate requiring that employees be insured.

Apart from Medicare supplements, there is a wide array of private insurance products with a wide array of contract provisions. Traditional service-benefit group insurance contracts are quickly disappearing. Once the staple of employer-provided coverage, they are giving way to a variety of new formats that restrict the choice of providers. Most are a form of capitated payment for primary care provided through a closed panel of physicians. These physicians serve as gatekeepers for all additional care, with the costs coming from the capitated amounts. The contract may require policy holders to obtain preauthorization by insurance administrators before using any out-of-plan providers. This practice is especially common for long term care services. Gaining an exception to these requirements through the appeals process is time consuming and risky.

Individuals are often unaware of the specific coverage available under their private insurance contracts. Even after understanding the coverage provided, an individual will not know whether the coverage is as valuable as other possible contracts, or worth the cost of premiums. A very helpful concept for comparing the value of various contracts is that of the “benefit ratio.” This figure is an estimate of the benefits expected to be paid out as a percentage of the premiums paid in by the group of people covered by the particular contract. State law may regulate the benefit ratio or require its disclosure with a health insurance policy. A very good basic hospital policy will have a benefit ratio of 90% to 95%, under which enrollees can expect to have all but 5% to 10% of their premium amounts paid out on claims. The

337. PROSPECTIVE PAYMENT ASSESSMENT COMM’N, supra note 4, at 75.
339. PROSPECTIVE PAYMENT ASSESSMENT COMM’N, supra note 4, at 80-81.
340. Id. at 81.
342. See, e.g., 42 C.F.R. § 403.250-258 (detailing loss ratio computation for Medicare Supplements).
343. See, e.g., 11 N.Y. COMP. CODES R. & REGS. tit. 11, § 52.54 (1995). The worst medical insurance policies sold in New York cannot have a loss ratio below 50%. Id. § 52.45. The benefit ratio must appear on the contract or its separate disclosure page. See N.Y. INSURANCE LAW § 3218(b)(5) (McKinney 1985).
benefit ratio is no predictor of the payments actually made for any one person, but it is a helpful measure of value when comparing policies.

Congress has taken very tentative steps toward stemming some of the problems inherent in a system so heavily dependent on employer provided insurance. For example, the Emergency Medical Treatment and Active Labor Act requires a hospital emergency department to provide stabilizing care to individuals in need of emergency medical assistance and women in active labor, regardless of their insurance status.\(^\text{344}\) In addition, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides a virtually irresistible incentive for employers who offer group health coverage to offer continuation of coverage to persons who are at risk of losing coverage.\(^\text{345}\)

COBRA continuation beneficiaries include employees who are laid off, terminated (except for gross misconduct) or who have their hours reduced, the dependents of such employees, widowed spouses and dependent children of such employees, and divorced or separated spouses and dependent children of such employees.\(^\text{346}\) The continuation of identical coverage for these groups is at the expense of the individuals, but the cost may not exceed 102% of the group rate.\(^\text{347}\) The employer is responsible for notifying the individuals of this option at the time they first become entitled to coverage under a group plan subject to COBRA and again at the time of the qualifying event, for example, termination, death, or divorce.\(^\text{348}\) This continuation is temporary—up to eighteen months if the qualifying event is termination or reduction of hours and up to thirty-six months for other qualifying events.\(^\text{349}\) The goal of these provisions is to prevent gaps in coverage, so the right to continued coverage ends when the beneficiary obtains equivalent coverage under any other group plan or Medicare.\(^\text{350}\)

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B. ERISA and Private Insurance

The Employee Retirement Income Security Act\(^{351}\) (ERISA) has brought great insecurity to employer-provided health insurance coverage. ERISA established improved employee pension vesting rules and increased pension fund protections against fraud and mismanagement. In return, employers were freed of concerns over possibly conflicting state laws regarding employee benefits.\(^{352}\) ERISA preempts state regulation that "relates to" employee benefit plans, except state laws regulating insurance.\(^{353}\) Employer-provided health insurance is an employee benefit plan within the meaning of ERISA.\(^{354}\) As explained by a health law scholar:

This preemption provision has potentially powerful impact because, outside of pension plans, ERISA does little to replace state law with supervening federal regulation; therefore, in the context of health insurance, it has the potential for leaving insurers free of all regulation, state or federal, to the extent of their employee group plan business.\(^{355}\)

ERISA preemption has had a major impact at three different levels within the medical care system. First, ERISA has impeded state efforts to reform the medical care system.\(^{356}\) It has freed employers of state law constraints against reducing or eliminating medical coverage benefits. For example, the Fifth Circuit held that an employer did not violate the anti-discrimination provisions of ERISA by lowering the $1,000,000 cap on medical coverage to $5,000 for AIDS patients in response to learning that an employee had AIDS.\(^{357}\) Nevertheless, ERISA preempted all state law claims.\(^{358}\) Second, ERISA preemption has special force for employers who self-insure against health care costs as opposed to buying medical care insurance. Self-insured programs are completely exempt from state regulation because they are not

\(^{352}\) See generally Nina Martin, ERISA—the Law that Ate Health Care Reform, CALIFORNIA LAWYER, May 1993, at 40.
\(^{358}\) Id. at 407-08. Insurance coverage does not vest as do pension benefits, and it never becomes a protected right under ERISA. Id. Whether such actions violate the Americans with Disabilities Act is an important issue now working its way through the appeals process.
deemed insurance for state law purposes.\textsuperscript{359} It is estimated that over 60% of employer-provided insurance is now provided through self-insured plans.\textsuperscript{360} Third, as discussed below, ERISA may change the standard of review applied to appeals of individual coverage denials.\textsuperscript{361}

Employer-provided retiree coverage is susceptible to reduction or elimination in the collective bargaining process. Unions may rank the interests of retirees lower than those of active employees. Employers were prompted to review their liabilities for retirees when the Financial Accounting Standards Board revised its standards to require that companies treat health care coverage promises as a current expense.\textsuperscript{362} Efforts to prevent the elimination of retiree health benefits have been successful, despite the ERISA limits, where there has been a contractual agreement not to alter future benefits.\textsuperscript{363}

Apart from the three federal statutes noted above, the regulation of insurance policies is almost exclusively a matter of state law.\textsuperscript{364} For instance, state law may control the form and content of insurance contracts.\textsuperscript{365} Also, the practices of health insurance companies may be subject to civil remedies.\textsuperscript{366} Sales practices of agents and insurers, and unfair claim settlement practices, have been areas of abuse. Common problems include the sale of more insurance policies than are needed and extended delays and confusion in responding to claims.\textsuperscript{367}

When the focus shifts to interpreting the coverage promised in a private insurance contract, the fundamental rule of construction is that any ambiguity must be resolved in favor of the claimant.\textsuperscript{368} As a result,

\begin{itemize}
  \item \textsuperscript{359} 29 U.S.C. § 1144(b)(2)(B) (1994).
  \item \textsuperscript{360} Dan Wise, \textit{What Happens to ERISA under Health Care Reform}, BUS. & HEALTH, Oct. 1993, at 53.
  \item \textsuperscript{361} See infra note 370 and accompanying text.
  \item \textsuperscript{362} Employer's Accounting for Post-Retirement Benefits Other Than Pension, F.A.S. No. 106.
  \item \textsuperscript{365} See, e.g., N.Y. INSURANCE LAW § 3201(b) (McKinney Supp. 1996).
  \item \textsuperscript{366} See, e.g., N.Y. INSURANCE LAW §§ 109, 2601 (McKinney 1985).
  \item \textsuperscript{367} The federal regulation of Medicare Supplements, 42 U.S.C. § 1395ss, was a reaction to such abuses with respect to elderly policy buyers and holders. 3 Medicare & Medicaid Guide (CCH) ¶ 13,893 (Feb. 15, 1996). There has been some limited success in utilizing the civil Racketeer Influenced Corrupt Organizations Act on these claims. The act allows for treble damages and attorney's fees. 18 U.S.C. § 1964 (1994).
  \item \textsuperscript{368} See KEETON & WIDISS, supra note 28, at 628.
\end{itemize}
the insurer must clearly state exclusions. These favorable standards of review may not apply to employee benefit plans under ERISA. Courts will review benefit determinations de novo unless the benefit plan gives the plan administrator or fiduciary discretion regarding benefit eligibility or plan construction. In these cases, the standard of review is "arbitrary and capricious," the same standard used under the Federal Employee Health Benefit Act and the CHAMPUS program.

C. The Promise of Long Term Care Coverage by Private Insurance

Private insurance contracts often cover long term care, although no one knows the full extent of what has been promised. Blue Cross and Blue Shield reports that almost all of their plans provide coverage for home care and almost half of the commercial contracts do likewise. Federally qualified Health Maintenance Organizations (HMOs) must include home care as one of the basic covered health services. Nursing home coverage is more often in a special rider to the basic contract, such as a Major Medical rider.

The language describing the benefit and the exclusions is typically quite sparse. When long term care is in the contract, many plans adopt the Medicare language that provides coverage for medically necessary skilled care and excludes custodial care. Failure to define custodial care within the terms of an ERISA plan may constitute a violation of ERISA disclosure requirements.


373. The Omnibus Reconciliation Act of 1993 mandated the creation of a Medicare and Medicaid Data Bank that would collect health coverage information from employers' group health plans. 42 U.S.C. § 1320b-14 (1994). Congress has failed to fund the Data Bank and no information has yet been collected.


Long term care contracts are relatively new insurance products that offer coverage for home care and nursing home services, but not hospital or physician services. They are mostly indemnity contracts that promise a daily cash payment to the individual upon the occurrence of an event, such as nursing home placement. The payment may be well below the private pay rate for long term care. The policies currently being sold are better than earlier generations that excluded coverage through restrictive levels of care, prior hospitalization, and other means. The most comprehensive policies cover all levels of nursing home care and a wide range of home care services.  

The Robert Wood Johnson Foundation has supported four state demonstration projects that correlate Medicaid benefits with long term care insurance. State Medicaid agencies hope to encourage use of the approved private insurance contracts by making an additional Medicaid benefit available to those who use such policies. A New York State resident who has exhausted his minimum of three years of benefits may then apply for Medicaid with none of his remaining resources considered available for purposes of eligibility. The other states will disregard resources in determining Medicaid eligibility in an amount equal to the benefits paid out under the private policy. The key attraction to these demonstration projects is the security of limited exposure available to those who can afford to prepay a substantial portion of the potential cost of long term care.

Life care communities promise to take care of the needs of an individual, no matter the level of care, short of hospitalization. They typically charge the residents a one-time, sizable entry fee in addition to monthly fees. These arrangements are truly a form of insurance, with the premium paid up front. Given the serious consequences if the community fails, individuals must exercise great care in choosing to use such a product.

D. The Practice of Long Term Care Coverage by Private Insurance

Despite widespread enrollment, private insurers were responsible for only 21% of 1960 personal health care expenditures and no long term care costs. From their origin as hospital insurance, the policies

378. See e.g., N.Y. COMP. CODES R. & REGS. tit. 11, §§ 52.12, 52.13 (1995) (setting minimum standards for policies sold in New York under the title of Long Term Care Insurance).
381. Private insurance paid none of the nursing home costs. Levit et al., supra note 2. at 285.
expanded to include physicians’ services and major medical benefits.\textsuperscript{382} The coverage for the selected private insurance enrollees expanded until the mid-1980s. For example, dental care and prescription drugs were almost exclusively out-of-pocket payments in 1960. By 1993, private insurance covered almost 45% of total dental costs and 25% of prescription costs.\textsuperscript{383} Overall, payment under these contracts increased to about one-third of the personal health expenditures in the United States. Despite this fact, private insurance policies covered only 2% of nursing home costs and 12% of home health care payments.\textsuperscript{384}

Individuals often overlook private insurance policies as a source of long term care coverage. There are several impediments to improving coverage of long term care costs by private insurance. First, commercial insurers are generally free to choose who to cover and the premiums to charge. Selective sales practices seek to avoid the higher risk applicants. Medical underwriting allows the insurer to charge higher premiums for individuals that appear to pose higher risks of using the coverage. Insurers rely upon pre-existing condition exclusions to limit their risks. These practices provide a competitive advantage over the traditional Blue Cross practice of open enrollment and community rating.\textsuperscript{385}

Even where they include coverage in a contract, insurers can promote the failure to have claims submitted.\textsuperscript{386} Discouraging providers from submitting claims works well. As noted in the introduction, there is a great deal of subjectivity in determining long term care needs.\textsuperscript{387} In insurance plans funded on a per capita basis, the financial pressures are strong to assess needs very conservatively. Preliminary studies indicate that these pressures correlate to poorer patient outcomes.\textsuperscript{388} Conservative assessments of need and the corresponding low level of expectations they engender are very effective rationing tools. Moreover, denying claims initially and dragging out the review process will eliminate all but the most persistent claimants.

\textsuperscript{382} The commercial home health care sector was virtually nonexistent at that time.

\textsuperscript{383} Major medical coverage is defined on a state by state basis. Generally, major medical refers to insurance designed to cover particularly large medical expenses due to severe or prolonged illness. RANDOM HOUSE UNABRIDGED DICTIONARY 1161 (2d ed. 1993).

\textsuperscript{384} \textit{Id.}

\textsuperscript{385} Some states have sought to “level the playing field” as between these competing approaches. See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671 (1995).

\textsuperscript{386} Medicare requires that Part A providers prepare and submit claims. 42 U.S.C. § 1396g (1994). There is no such mandate regarding private insurers.

\textsuperscript{387} See supra text accompanying notes 6-16.

\textsuperscript{388} See Shaughnessy et al., supra note 5, at 187.
The most important roles for the patient advocate dealing with private insurance will be ensuring that claims are submitted and navigating the internal appeals process of the insurer. Few reported court decisions address medical claim denials. This lack of precedent may be attributable to the standards of review that favor patients. Insurers could logically choose to resolve those claims rather than litigate them. Where the less favorable standards for patients apply, such as under ERISA or FEHBA, there are a number of reported cases. In these cases, courts tend to be sympathetic to the patients. For example, courts challenge trustees’ decisions to deny coverage under employee benefit plans governed by ERISA. Moreover, courts may apply a “treating physician rule,” much like that used in Social Security Disability cases, when reviewing whether the decision is proper.

V. CONCLUSION

The pluralistic system of covering long term care in the United States has brought a good deal of confusion and insecurity into the lives of those who need long term care. Each individual must analyze the various programs to determine which they qualify for and what each insurer offers. The variety of programs, and the range of services under each one, makes this a daunting task. As we move toward a more cost conscious system, the quiet voices, and those most in need, are at risk of losing the most. Long term care providers play a significant role in screening individuals. This process can have as much to do with the financial incentives of the provider as it does with the assessment and provision of the best medical care for the individual. Each insurer is under pressure to engage in cost avoidance. This pressure can take the form of cost-shifting to other insurers, or avoiding the filing of claims. Each program has taken advantage of its unique structure to develop unique methods for discouraging use of its benefits. Under managed care structures, individuals in need of long term care will lose the physician or other provider as an advocate. There will be increasing conflict among patient, provider, insurer, and claims reviewer.


Given these developments, advocacy is increasingly important for each individual in need of long term care. Based on the needs of the individual, a hand-crafted package of services needs to be designed. Then the task becomes determining the categories of coverage for which the individual is eligible and how those programs can help. Advocates who approach this challenge from the client’s perspective will cross over the artificial boundaries set by and between programs. They will need to recognize the situations where the interests of the client conflict with those of the insurer, the service provider, or both. The insurers will need to be pushed to meet the promises they have made. The providers will need to be reminded that their mission is one of service, not self-interest. This continuing dialogue will shape the future of U.S. health care.