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PUTTING BOOMERS TO PASTURE: DOES THE 2010 MIPPA LEGISLATION REINFORCE THE NURSING HOME BIAS?

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I. Introduction and Roadmap

Unfunded health related costs are the greatest financial uncertainty facing the baby boom generation as they enter retirement years. The vast majority of those costs will relate to home and institutional based health care services provided in the last months of their lives.¹ When presented with the choice of receiving such end-of-life care in a home based setting versus an institutionalized setting, almost every senior will opt for home based care.² Prior to 2010, the Medigap at-home recovery benefit covered expenditures incurred in connection with in-

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1. Samuel Marshall et al., *The Risk of Out-of-Pocket Health Care Expenditure at End of Life* 2 (Nat'l Bureau of Econ. Research, Working Paper No. 16170, 2010), available at http://www.nber.org/papers/w16170.pdf?new_window=1; see also Lisa R. Shugarman et al., *Differences in Medicare Expenditures During the Last 3 Years of Life*, 19(2) J. GEN. INTERNAL MED., 127, 127-35 (2004).

2. Amanda J. Lehning & Michael J. Austin, *Long-Term Care in the United States: Policy Themes and Promising Practices*, 53 J. GERONTOLOGICAL SOC. WORK 43, 50 (2009).

home skilled medical care covered by a Medicare policy,³ such as personal care services that many seniors require in order to avoid a nursing home stay. The at-home recovery benefit was eliminated by the Medicare Improvements for Patients and Providers Act (“MIPPA”) in 2010.⁴ The Supreme Court took a decidedly different approach regarding access to home based health care options for this Medicaid-eligible senior population in *Olmstead v. L.C. ex rel Zimring*.⁵ The *Olmstead* decision acknowledged the long standing bias toward providing end-of-life health care services in an institutionalized setting, typically a nursing home, and, in an effort to have more of these Medicaid services provided in-home, required that “public entit[ies] . . . administer . . . programs . . . in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”⁶ Through this “integrated care” mandate, the Supreme Court recognized that the unjustified segregation of poor seniors in institutions was discrimination and that home and community based services (“HCBS”) care options must be provided where appropriate and reasonable in light of the patient’s needs.⁷ However, it is the engrained nursing home bias that non-Medicaid-eligible middle class boomers are likely to fall victim to, despite their stated intentions to the contrary.

Because administering end-of-life care in a nursing home setting has become the default in the United States, today current retirees who fail to make affirmative decisions about how and where their end-of-life care will be administered will have little choice but to receive long-term care in an

3. While all seniors aged 65 and over are eligible for Medicare, only those with very limited financial resources qualify for Medicaid coverage. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP’T OF HEALTH & HUMAN SERVS., MEDICARE AND OTHER HEALTH BENEFITS: YOUR GUIDE TO WHO PAYS FIRST 8 (2011), available at <http://www.medicare.gov/publications/pubs/pdf/02179.pdf>. Though the asset threshold for Medicaid qualification varies across states, in most states, only those with assets valued at under \$2,000 will qualify. Mariacristina De Nardi et al., *Medicaid and the Elderly*, 36 ECON. PERSP., 17, 20 (2012).

4. Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, 122 Stat. 2494 (2008).

5. 527 U.S. 581 (1999).

6. *Id.* at 592 (quoting 28 C.F.R. § 35.130(d) (2012)).

7. *See id.* at 597.

institutional setting. Failure to affirmatively engage in planning for end-of-life care choices is often simply a byproduct of limited information and even less professional guidance available regarding such decisions. This article seeks to explore what lessons can be learned from how Medicaid end-of-life health care services are provided to the poor post-*Olmstead*, and how these lessons can be applied to middle class and upper middle class boomers. The article equally seeks to address how such lessons can be integrated into a meaningful dialogue with retiring boomers in a fashion that encourages discussion and decisions regarding end-of-life health care, as opposed to leaving such tough calls for surviving adult children.

To this end, Part II of this article begins by examining the hurdles seniors face in accessing HCBS after the defunding of the Medigap at-home recovery option in 2010, taking into account the difficulties involved in planning for long-term care that are caused by significant cost variances depending on the community in which the care is provided.⁸ This section further explores the impact of informal care provided by family members on the cost and effectiveness of long-term care performed in the home.

Part III provides a summary of the historical background of long-term care in the United States and explores the genesis and perpetuation of the bias toward providing end-of-life care in an institutional setting, despite the high costs of nursing home care, leading up to the integrated care mandate handed down by the Supreme Court in *Olmstead*.⁹ In Part IV, the varying degrees to which states have implemented the *Olmstead* mandate are examined to provide an empirical analysis of the cost-savings and reduction in nursing home admission rates that can be realized through effective and widespread implementation of HCBS programs.¹⁰ Spending on long-term care in states with underdeveloped HCBS programs is compared to expenditures in states offering comprehensive programs to determine the overall effect of increasing access to HCBS.

8. See discussion *infra* Part II.

9. See discussion *infra* Part III.

10. See discussion *infra* Part IV.

Part V identifies the planning gap that exists because of the reluctance of both advisors and clients to discuss end-of-life care.¹¹ This section recognizes the often-conflicting motivations of financial advisors and attorneys, as well as the disinclination of clients toward discussing the end of their lives, both of which can lead to a joint failure to develop effective strategies for funding end-of-life care.

Part VI aims to encourage advisors and clients to ignite the dialogue on end-of-life planning.¹² It discusses the possible imposition of filial responsibility upon adult children for the long-term care expenses of their elderly parents and suggests that selective enforcement of filial support statutes could promote financial preparedness among baby boomer retirees. This section also raises the notion that fiduciary liability may be a motivating force that could persuade advisors to initiate the planning dialogue. With both sides motivated to engage in fulsome planning for end-of-life choices, this article hypothesizes that this planning dialogue can be transformed from one that advisors avoid and clients recoil from into a conversation that imparts a message of empowerment and hope among seniors who can develop the tools necessary to control the course of their own end-of-life care.

II. Access to HCBS

The longstanding bias toward providing end-of-life health care in an institutional setting has been perpetuated by the government's elimination of the at-home recovery coverage relied upon by many seniors using HCBS for skilled medical care. Prior to the 2010 amendments to Medicare, retirees were provided with a wider range of coverage options and were thus able to exercise a greater degree of control over whether they received cost-effective HCBS recovery care versus substantially more expensive institutionalized rehabilitative care after a hospitalization.¹³ Medigap policies, which are federally

11. See discussion *infra* Part V.

12. See discussion *infra* Part VI.

13. *Health Reform Mandates Changes for Medigap Policies*, CENTER FOR MEDICARE ADVOC., INC., <http://www.medicareadvocacy.org/2011/01/07/health-reform-mandates-changes-for-medigap-policies/> (last visited Oct. 31, 2012);

standardized insurance policies purchased through private insurance companies to supplement traditional Medicare policies, provided an optional at-home recovery benefit prior to 2010.¹⁴ In 2010, the MIPPA revised the federal standards to eliminate the at-home recovery coverage provided by certain Medigap policies, dramatically limiting the availability of HCBS for many seniors.¹⁵ Because these Medigap policies are federally standardized, they provide only the medical coverage mandated by the federal rules even though the policies are purchased from private insurance companies.¹⁶ This means that non-indigent seniors bear the burden of payment for expenses not specifically mandated by these one-size-fits-all policies.

Several of these Medigap policies were required to provide at-home recovery coverage prior to 2010 as an optional method for funding the personal care services that are often required to assist seniors with activities of daily living (“ADLs”)¹⁷ while they receive in-home medical care funded by traditional Medicare policies.¹⁸ While Medigap and, in certain cases, traditional Medicare policies, continue to cover much of the in-home medical care required by seniors, assistance with performing ADLs is often essential to the ability of elderly

Genworth 2012 Cost of Care Survey, GENWORTH FIN., INC. (Mar. 13, 2012), http://www.genworth.com/content/non_navigable/corporate/about_genworth/industry_expertise/cost_of_care.html [hereinafter *Genworth 2012 Survey*]. The *Genworth 2012* survey provides an interactive tool that allows for effective comparison between the cost of HCBS care and institutionalized care in any given state. For example, in New York State the cost of a home health aide is approximately \$50,336 annually, while the annual cost for a private nursing home room is estimated to be \$123,005.

14. *Health Reform Mandates Changes for Medigap Policies*, CTR. FOR MEDICARE ADVOCACY, INC., <http://www.medicareadvocacy.org/2011/01/07/health-reform-mandates-changes-for-medigap-policies/> (last visited Oct. 31, 2012).

15. *Id.*

16. *See id.*

17. ADLs are those daily activities that are considered critical to independent living, and include activities such as “bathing, dressing, eating . . . and toileting.” Kenneth E. Covinsky et al., *Loss of Independence in Activities of Daily Living in Older Adults Hospitalized with Medical Illnesses: Increased Vulnerability with Age*, 51 J. AM. GERIATRIC SOC’Y 451, 451 (2003).

18. *See Health Reform Mandates Changes for Medigap Policies*, *supra* note 14.

patients to function independently in their homes.¹⁹

Seniors who are admitted into a nursing home, of course, receive assistance with ADLs because they are no longer living independently. Institutional care, by its nature, provides a level of supervision with ADLs that many seniors require. Since the MIPPA defunded coverage for personal care services for patients who are no longer able to perform ADLs independently, supervised nursing home living is often the only available option. Because the ability of seniors to perform ADLs is so critical,²⁰ the in-home skilled medical care covered by Medicare policies is often worth little for those who are unable to perform ADLs without assistance.

Therefore, access to HCBS is limited because of the gaps in coverage that exist for elderly patients relying on government health insurance programs to pay for care.²¹ While Medicare recipients are permitted to choose where their post-hospitalization *medical* care will take place, Medicare and Medigap policies no longer cover *non-medical* support from health aides that promote autonomy among seniors by

19. Covinsky et al., *supra* note 17, at 452.

20. *See* Covinsky et al., *supra* note 17.

21. Terence Ng et al., *Medicare and Medicaid in Long-Term Care*, 29 HEALTH AFF. 22, 23-24 (2010). Traditional Medicare policies provide limited coverage for skilled care or therapy services in the home following a hospitalization. While all seniors over age sixty-five qualify for Medicare coverage, long-term care benefits are limited because they are only available for a specified period of time (typically, full coverage lasts only twenty days, with partial coverage beginning on day twenty-one). Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK L. REV. 407, 420 (2007). Medicaid coverage of long-term care services, on the other hand, is limited to those "medically needy" patients who have spent-down their assets to state mandated levels (typically around \$2,000). *See* Sudipto Banerjee, *Effects of Nursing Home Stays on Household Portfolios*, EBRI ISSUE BRIEF, June 2012, at 1, *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_06-2012_No372_NrsHmStys.pdf. While states are permitted to provide more generous HCBS benefits, few states have implemented comprehensive and fully functional HCBS programs to supplement nursing home benefits. Once a patient qualifies for Medicaid coverage, however, there is no time limit to the length of time he or she can claim benefits. Medicaid pays for institutional services provided in a nursing home, in-home skilled medical care and the personal care services attendant to in-home medical coverage for those medically needy seniors who qualify for coverage.

providing the in-home personal assistance that is usually required during a post-hospitalization recovery period.²² Medicaid programs will pay for long-term care in an institution or in the home, and will also pay for the required personal care services for those seniors who require assistance with ADLs, but only for the medically needy who are able to qualify for coverage.²³ This MIPPA defunding has effectively forced many seniors to opt for recovery in nursing homes because they require non-medical assistance in order to safely live unsupervised while using HCBS options, and such assistance is no longer covered under any Medicare or Medigap policy.²⁴

Increased reliance on private funds for HCBS financing has generated a dilemma for those retirement-age seniors who attempt to plan for unfunded post-retirement medical expenses. Although financing the high cost of long-term care presents a challenge in any state, as expenditures for HCBS have grown by 235% in the last twenty years,²⁵ HCBS and nursing home cost variance among states is often significant. For example, when actuarial models developed by financial professionals are used to compare projected post-retirement medical expenses for a sixty-five-year-old couple living in New Jersey to the projected costs for a similarly-situated couple living in Hawaii, the variance is 33.7 percent.²⁶ Such large cost variances between states complicate effective planning for financing post-retirement medical expenses, especially considering the mobility of retirees today.

The complications inherent in projecting post-retirement medical expenses often result in seniors who are financially unprepared to fund professional HCBS. Approximately eighty

22. *Health Reform Mandates Changes for Medigap Policies*, *supra* note 14.

23. Ng et al., *supra* note 21, at 23-24.

24. *Health Reform Mandates Changes for Medigap Policies*, *supra* note 14.

25. THOMAS DAVIDOFF, LONG-TERM CARE HANDBOOK OF INSURANCE 2 (2012).

26. Dan McGrath, *States Ranking When It Comes to Healthcare Costs in Retirement*, HEALTHVIEW SERVICES (June 9, 2012), <http://www.hvsfinancial.com/2012/06/states-ranking-when-it-comes-to-healthcare-costs-in-retirement>.

percent of seniors receiving HCBS rely upon unpaid family members to provide some HCBS, whether on a full time or sporadic basis, in order to avoid institutionalization.²⁷ In fact, a 2009 study found that only one in four seniors who receive care at home rely upon any form of paid care.²⁸ Though adult children may be able to provide a portion of the care required by their elderly parents, the limitations inherent to provision of this informal care often mean that admission to a nursing home eventually becomes the norm.²⁹

Though informal care provided by adult children and other family members does not per se create a direct financial burden upon seniors or their families, the caregivers almost always experience lost opportunity costs, such as lost wages or time spent with children or spouses, when they must allocate a portion of their time to providing care.³⁰ Because forty-two percent of informal care is provided by adult children, rather than the senior's elderly spouse,³¹ the work, familial, and social commitments of these younger caregivers limit the level of care that can be provided. Unsurprisingly, studies have found that adult children who experience greater lost opportunity costs are much less likely to be able to provide sufficient levels of care to their elderly parents over the long term.³² From a policy perspective, the inherent limitations on adult children who provide informal long-term care services for their elderly parents make development of effective professional care

27. Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History*, 26 GA. ST. U. L. REV. 937, 962 (2010) (citing *Boon or Bane? Examining the Value of Long-Term Care Insurance: Hearing on Role of Private Insurance in Long-Term Care Before S. Spec. Comm. On Aging*, 111th Cong. 9 (2009) (testimony of Diane Rowland, Sc.D., Executive Vice President, Henry J. Kaiser Family Foundation), available at <http://aging.senate.gov/publications/632009.pdf>).

28. Brenda Spillman, *Financial Preparedness for Long-Term Care Needs in Old Age*, in CONSUMER KNOWLEDGE AND FINANCIAL DECISIONS: LIFESPAN PERSPECTIVES 239, 241 (Douglas J. Lamdin ed., 2012).

29. See Jacey J. Vaughan & Nina M. Silverstein, *Leaving Home Care: Decision Making, Risk Scenarios & Services Gaps in the Home Care System*, GERONTOLOGY INST. PUBLICATIONS, Dec. 2011, at 1, 18.

30. David Byrne et al., *Formal Home Health Care, Informal Care, and Family Decision Making*, 50 INT'L ECON. REV. 1205, 1209 (2009).

31. *Id.* at 1218.

32. *Id.* at 1238-39.

services the only responsible method of providing safe and effective in-home care. Developing methods for funding this professional care is therefore necessary to allow seniors to access comprehensive in-home care services.

If funding methods are not developed so as to allow seniors access to professional in-home care, institutionalization will continue to be the only feasible option for many retirees. To illustrate further, eighty-one percent of respondents in a University of Massachusetts survey found that a lack of around-the-clock supervision was the largest gap in the HCBS system, while seventy percent found that a lack of informal support was one of the most common triggers to nursing home admission.³³ When informal familial caregivers become unable to provide the care necessary to maintain elderly family members in their own homes and professional in-home care cannot be financed, nursing home admission becomes the default solution.³⁴

Once a senior citizen is admitted into a nursing home, the likelihood that he or she will return home and receive home-based care becomes remote.³⁵ Nursing home care becomes the default modality for admitted seniors, largely because the dilemma of how to pay for institutionally-based care typically disappears very quickly.³⁶ Because the average annual cost for a nursing home in the United States is approximately \$75,555 per year,³⁷ most seniors admitted to nursing homes quickly spend-down their assets and qualify for Medicaid's need-based coverage.³⁸ In contrast, the challenge of how to pay for home-based care remains.

The defunding of HCBS has increased the likelihood that admission to a nursing home will become the solution for seniors who are unable to live independently because, as assets are quickly spent-down, the government steps in with Medicaid

33. Vaughan & Silverstein, *supra* note 29, at 6.

34. *See id.* at 18.

35. Alison Patrucco Barnes, *Beyond Guardianship Reform: A Reevaluation of Autonomy and Beneficence for a System of Principled Decision-Making in Long-Term Care*, 41 EMORY L.J. 633, 647 n.44 (1992).

36. *See* Banerjee, *supra* note 21, at 4.

37. *Id.*

38. *See id.* at 14.

coverage to fund this end-of-life care expense.³⁹ This engrained response to end-of-life health care perpetuates the bias toward administering care in an institutional setting instead of using HCBS where appropriate.

III. Historical Perspective

For most of the twentieth century, the social bias toward providing end-of-life care in institutional settings perpetuated the entrenchment of nursing homes in the United States. The bias toward nursing home care began in the nineteenth century, when almshouses were created to house poor patients who suffered from diseases for which there was no known cure.⁴⁰ Though patients were not always treated for their ailments, the almshouse served as a place to isolate them from the larger community.⁴¹

After the Great Depression, the government developed the federal Old-Age Assistance (OAA) program that discouraged the use of almshouses by providing federal funding for state programs focused on long-term care, but only if the recipient patients were not currently “inmates” in an almshouse.⁴² This incentivized states to develop “rest homes” and “convalescent homes” to replace the almshouses as the primary form of institutional care.⁴³

The OAA also created a disincentive to in-home care provided informally by a patient’s family members, because the provision of federal funding removed the stigma previously attached to institutional care in an almshouse. The negative connotations that accompanied the idea of an almshouse as a “poorhouse,” where the patients often suffered from diseases that were perceived to be incurable, such as alcoholism and mental infirmity, encouraged many families to avoid institutionalizing their elderly relatives to avoid being associated with these stigmatizations.⁴⁴ Nursing homes, however,

39. *Id.*

40. Watson, *supra* note 27, at 940-41.

41. *Id.*

42. *Id.* at 943.

43. *Id.* at 944.

44. *See generally id.* at 940 (affirming that the “home atmosphere was

were federally funded and able to offer real treatment, removing many of the negative associations that families of elderly patients had associated with institutional care prior to their development.⁴⁵

After Congress amended the Social Security Act in the 1950s, federal and state spending on nursing homes increased to nearly \$450 million annually.⁴⁶ The Kerr-Mills Act, which was the predecessor to Medicaid,⁴⁷ was enacted in the 1960s and, though it was technically permitted to fund both nursing home care and HCBS, it offered direct reimbursement to nursing homes instead of to individual recipients, which encouraged the widespread growth of private sector for-profit nursing homes that had the resources to aggressively seek out government reimbursement.⁴⁸

As the number of private sector nursing facilities expanded, institutional care became even more engrained in the medical industry by providing an easy solution for hospitals caring for seniors who required personal care services more than skilled medical assistance.⁴⁹ Because nursing homes had become so prevalent in the industry, medical professionals could release patients into nursing homes with the assurance that their care would continue to be funded by the government.⁵⁰

Under Medicaid, which succeeded Kerr-Mills as the primary conduit for funding medical care for the poor, all states developed long-term care programs to assist the “medically needy,” causing Medicaid spending on nursing home care to increase from approximately \$800 million to \$4.2 billion in the

viewed as the ideal place to be cared for . . . [and] [p]overty, disability, and illness were viewed as moral failings”).

45. *Id.* at 960.

46. *Id.* at 945 (citing ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 34 (Transaction Publishers 2d ed. 2003) (1974)).

47. Laura D. Hermer, *Federal/State Tensions in Fulfilling Medicaid's Purpose*, 21 ANNALS HEALTH L. 615, 618 (2012).

48. *Id.* at 951.

49. See DAVID BARTON SMITH, REINVENTING CARE: ASSISTED LIVING IN NEW YORK CITY 50-51 (2003).

50. See *id.* at 51.

1960s.⁵¹ Encouraged by Medicaid's requirement that aid recipients be "medically needy," the long-term care market became saturated with for-profit nursing homes that fueled the rapidly increasing cost of providing institutional care because once a patient's assets were spent down to the poverty level, Medicaid stepped in to fund nursing home payments indefinitely.⁵² Today, almost two-thirds of nursing homes are operated privately as for-profit entities⁵³—and these entities have an incentive to cause their patients to spend-down assets quickly because, once a patient has exhausted his or her personal resources, there is often little choice but to remain in the nursing home permanently.

The Supreme Court recognized this decades old funding and societal bias toward nursing home care in its *Olmstead* decision.⁵⁴ In *Olmstead*, the plaintiffs were two mentally disabled women who had been receiving care in an institutional setting.⁵⁵ Their physicians had found that they could receive appropriate care in a home-based setting, but the women remained institutionalized despite their requests to be transferred into HCBS programs.⁵⁶ They filed suit alleging that the state's failure to transfer them into the community-based program, despite the physician's finding that such care was appropriate, was discrimination under the Americans with Disabilities Act.⁵⁷

The Court agreed that de facto institutionalization can constitute discrimination, holding that:

[S]tates are required to provide community-based treatment for persons with mental

51. *Id.* at 49.

52. Nathalie D. Martin & Elizabeth Rourke, *Les Jeux Ne Sont Pas Faits: The Right to Dignified Long-Term Care in the Face of Industry-Wide Financial Failure*, 10 CORNELL J.L. & PUB. POL'Y 129, 149 (2000).

53. David G. Stevenson & David C. Grabowski, *Private Equity Investment and Nursing Home Care: Is it a Big Deal?*, 27 HEALTH AFF. 1399, 1399 (2008), available at <http://content.healthaffairs.org/content/27/5/1399.full.html>.

54. See *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

55. *Id.* at 593.

56. *Id.*

57. *Id.*

disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.⁵⁸

In reaching its conclusion, the Court noted the importance of avoiding the negative effects that come from isolating an individual from the community and diminishing his or her contact with family and friends.⁵⁹

Through this decision, the Supreme Court sought to encourage investment in HCBS by recognizing that professionally administered HCBS can provide a level of care comparable to that found in nursing homes without the negative side effects faced by the institutionalized elderly. Through increased use of HCBS, end-of-life care can be provided while maintaining the economic and social independence of the patient and without isolating the elderly from their families and communities.⁶⁰

Because many elderly nursing home residents primarily require personal care services, as opposed to more expensive skilled medical care, HCBS can help reduce the rate at which assets are spent-down and, therefore, avoid trapping seniors in nursing homes. The integrated care mandate handed down through the *Olmstead* decision represented the first step away from the nursing home bias perpetuated throughout the twentieth century. *Olmstead* recognized that simply because nursing homes are an *easy* option does not mean that they represent the most effective or cost-efficient route to providing end-of-life care.⁶¹

58. *Id.* at 607.

59. *Id.* at 601.

60. *Id.* at 600-01.

61. *See id.*

IV. Empirical Analysis of Impact of Greater Access to HCBS

In the thirteen years since the Supreme Court decided *Olmstead*, states have had ample opportunity to implement appropriate HCBS programs to comply with the Court's integrated care mandate. However, states have implemented HCBS programs to increase integration of patients within their communities at varying paces.⁶² This tiered approach to implementing HCBS programs provides a unique opportunity to evaluate and compare the effectiveness of HCBS programs in their varying stages of development. By comparing empirical data from states with newly-formed or nonexistent HCBS programs with data from states maintaining fully functional HCBS programs, it is possible to evaluate the effectiveness of HCBS in reducing admission rates to institutions, as well as determining dollars spent on this institutionalized care.

Empirical studies have shown that spending on long-term care initially increases when states aggressively seek to fulfill the *Olmstead* integrated care mandate, which can be expected because these states are establishing new programs and adding services that were previously unavailable.⁶³ In states where HCBS programs were in the development phases, overall state spending on long-term care increased by approximately 24.2%.⁶⁴

This spending increase is logical because, as HCBS become more widely accessible, seniors who had previously relied upon the unpaid services of their adult children will begin to supplant these services with professional home-based care providers as they become available. Further, the increase in spending is only temporary, as studies have shown that where states have spent diligently to implement the *Olmstead* integrated care mandate, the cost of long-term care actually declines by about 7.9% once HCBS programs are fully

62. See, e.g., Elizabeth P. Allen, *The ACA's Medicaid HCBS Long-Term Care-Reforms: Potential Positive Impact on the Fiscal Health of the States*, 243 ELDER L. ADVISORY 1 (2011).

63. Stephen H. Kaye et al., *Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?*, 28 HEALTH AFF. 262, 265 (2009).

64. *Id.*

established.⁶⁵

Widespread availability of HCBS programs also decreases overall spending on nursing homes specifically, suggesting that seniors who are presented with the choice between institutional care and HCBS are more likely to choose HCBS and remain in their homes.⁶⁶ In recent years, nursing home spending grew by about 3.4% in states with poorly developed HCBS programs, while spending on nursing homes declined by 15.3% in states that offered widespread access to HCBS.⁶⁷

While studies have found that nursing home spending remained stable for the years immediately following implementation of comprehensive HCBS programs, it began to decline in the fourth year following expansion and continued to decline in every subsequent year.⁶⁸ This suggests that as HCBS programs become established and recognized within the community, seniors begin to take advantage of cost-effective in-home care in order to avoid costly institutionalization in a nursing home. It is, therefore, not surprising that states with well-established HCBS programs are able to reduce their overall spending on long-term care, given the extremely high cost of nursing home care.

The three-year delay in recognizing cost savings on long-term care spending is to be expected, because while widely accessible HCBS will delay or reduce admission into nursing homes, it will not increase the rate at which seniors are released from nursing homes.⁶⁹ Because of this, states experience the additional expenses associated with developing and maintaining new HCBS programs and must still spend on nursing home care for those seniors who reside in an institutional setting when the HCBS programs become available.⁷⁰ While additional seniors may begin to take advantage of HCBS services to decrease their reliance upon unpaid, informal care provided by family members, seniors who have already spent down their assets to qualify for Medicaid-

65. *Id.*

66. *See id.*

67. *Id.* at 265.

68. *Id.* at 269.

69. *Id.* at 270-71.

70. *See id.*

funded institutional care will remain in these nursing homes, often for the remainder of their life expectancies. States will, therefore, experience a lag in recognizing significant cost savings until this overlap is diminished.⁷¹

By implementing the *Olmstead* integrated care mandate and providing the Medicaid-eligible population with the choice of in-home care, states eventually become able to reduce spending on long-term care by decreasing the rate of admission to nursing homes.⁷² The balance of this article assumes that if the non-indigent Medicare-eligible population had funding options similar to Medicaid-eligible seniors, they would, analogously, choose to take greater advantages of HCBS programs.

By using HCBS, these seniors would be admitted to institutional care facilities less frequently, increasing the period during which they are able to live free of Medicaid support.⁷³ Perhaps even more importantly, greater access to HCBS will provide an incentive for seniors to engage their financial advisors and plan for funding their own end-of-life care in an effort to avoid institutionalization and remain in their homes.

In light of the 2010 MIPPA defunding of the Medigap at-home recovery option, encouraging seniors to plan and prepare for financing their own in-home care is now more important than ever. The advice of financial advisors and attorneys can be invaluable to middle class retirees who may be planning to rely on government funding for their end-of-life care. If avoiding institutionalization is the goal for these retirees, planning to privately fund HCBS must become a priority. Unfortunately, many who are approaching retirement age lack the professional guidance necessary to recognize this need and, as such, remain financially unprepared to take advantage of the HCBS options that would allow them to continue living independently in their own homes while receiving long-term care.

71. *Id.* at 271.

72. *Id.*

73. See Naoko Muramatsu et al., *Risk of Nursing Home Admission Among Older Americans: Does States' Spending on Home- and Community-Based Services Matter?*, 62 J. GERONTOL SOC. SCI. S169, S171 (2007).

V. Absence of Guidance

Many financial advisors and attorneys today have a difficult time approaching their clients to discuss planning strategies for funding end-of-life care, whether in an institution or in the client's own home. Planning for end-of-life care has negative connotations for clients, who naturally recoil from discussing the end of their lives. Because financial planners and attorneys frequently fail to initiate the dialogue necessary to develop a plan for financing end-of-life care, a substantial gap in retirement planning has developed, leaving many retirees unprepared to fund their own post-retirement medical expenses. Frequently, the cadre of advisors employed by today's retirees simply has conflicting focuses that tend to negate the importance of planning for end-of-life care.⁷⁴ The professional training and engrained focus of the respective advisor groups leads to an embedded bias toward failing to adequately consider the cost of this care.

Financial planners commonly focus on allocating a client's assets so as to provide sufficient retirement income to fund post-retirement living expenses. Projecting end-of-life unfunded health care expenses is more difficult, often because the mobility of seniors today makes it challenging for an advisor to determine the proper funding levels, as costs for medical and long-term care vary widely from state to state. For example, unfunded post-retirement health care costs anticipated by a New Jersey resident are more than one-third as high as those projected for a similarly situated senior citizen living in Hawaii.⁷⁵ The difficulty inherent in making an

74. See Joseph F. Coughlin & Lisa A. D'Ambrosio, *Seven Myths of Financial Planning and Baby Boomer Retirement*, 14 J. FIN. SERVICES MARKETING 83 (2009), (describing questions related to healthcare and long-term care as a new variety of questions facing financial professionals today); Betty Meredith & John R. Salter, *How Prepared Is the Retirement Industry for Meeting the Needs of Retiring American Workers?*, 17 FIN. SERVICES REV. 87 (2008) (identifying the traditional focus of retirement planning as wealth accumulation and the need for financial advisors to focus more heavily on post-retirement planning).

75. McGrath, *supra* note 26. HVS has developed a tool that allows financial planners to input client data such as age, general level of health and location in order to determine their estimated costs for end of life care. This model projects that a seventy year old New Jersey resident will require

accurate estimation of these post-retirement medical expenses often results in financial planners altogether ignoring or underestimating these expenses.⁷⁶

Similarly, too often attorneys' professional focus as they advise new retirees is not primarily aimed at helping seniors plan for financing end-of-life medical expenses. Trust and estate attorneys primarily focus on the disposition of a client's assets post-mortem or on the tax issues surrounding a client's estate plan. If an attorney specializing in trusts and estates does provide guidance on planning for post-retirement medical care, the discussion is commonly limited to advice regarding the execution of a durable health care power of attorney.⁷⁷ A durable health care power of attorney, while useful in some circumstances, provides little opportunity for seniors to direct the course of their own end-of-life care, as it instead serves to delegate control over medical decisions to another in the event that the senior becomes incapable of making his or her own choices.⁷⁸

Elder care attorneys are typically the only group of attorney-advisors who commonly discuss end-of-life care choices with their clients. Despite these conversations, it is sometimes the case that when elder care attorneys advise their clients, they may tend to tilt the discussion toward Medicaid planning as a solution to the problem of financing end-of-life care.⁷⁹ Though this is not the only approach used to account for end-of-life choices, it is one that is commonly employed. As a policy matter, this approach is suspect because Medicaid planning focuses on creating artificial indigence in order to

approximately \$465,000 in today's dollars to fund medical and long-term care expenses of just over \$1 million over his anticipated remaining lifespan. In Florida, a similarly situated senior would require only \$372,000 in today's dollars to fund roughly \$785,000 in medical and long-term care expenses. These variances can make it difficult for a financial planner to assist his or her clients in planning for end of life care if they do not have access to a comparable planning tool.

76. *Id.*

77. *See, e.g.,* Maralee Buttery Vezie, *Some Estate Planning Fundamentals (With Forms)*, 42 PRAC. LAW. 67, 76 (1996).

78. *See id.* at 76-77.

79. *See, e.g.,* Joel C. Dobris, *Medicaid Asset Planning by the Elderly: A Policy View of Expectations, Entitlement and Inheritance*, 4 REAL PROP. PROB. & TR. J. 1, 19 (1989).

shift responsibility for financing end-of-life care to the government.

At its core, Medicaid planning involves shifting a client's assets into trusts and other vehicles to create artificial indigence so that the client will qualify for Medicaid benefits.⁸⁰ Once a senior is indigent and qualifies for Medicaid benefits, he or she becomes eligible for Medicaid-financed nursing home care, which often eliminates access to many in-home care options because in-home care, by definition, requires the senior to fund an independent lifestyle. While Medicaid will cover the personal care services that a senior may need, it will not fund general living expenses that the senior will require to maintain his or her home.

It is questionable whether this approach to end-of-life care planning is the most effective or appropriate, in that it encourages seniors to relinquish the responsibility for financing their own post-retirement medical expenses. These seniors, who in many circumstances are otherwise fully capable of planning and paying for their own end-of-life care with the proper guidance, are instead encouraged to rely on government aid.

Though shifting these health care expenses to the state obviously provides a quantifiable benefit to the client, who becomes assured that the government will step in to fund his or her end-of-life care, it is doubtful whether this provides the most effective planning solution. By rendering themselves artificially indigent in order to qualify for Medicaid, these seniors relinquish control over their ability to access HCBS because the course of their care defaults to the state guidelines for Medicaid coverage. These state guidelines, as discussed above, are biased toward the provision of long-term care in an institutional setting, which is exactly what most seniors would rather avoid.

Essentially, the mission of most advisors conflicts with the need to assist clients in forming strategies to finance end-of-life medical expenses. Allocating scarce assets to fund end-of-life care arguably diverges from the primary mission of a financial planner, which is to maximize retirement living expenses.

80. *See generally id.*

Though many financial planners do attempt to account for these unfunded medical expenses, the inherent difficulty in accurately predicting the costs creates a bias toward underestimating them in favor of allocating that post-retirement cash flow to income. This tendency is also in accord with the reality that many recent retirees will avoid confronting the choice of whether to allocate funds to retirement travel and entertainment versus using their hard earned dollars to pay for home health aides.

Though retirees perhaps most commonly choose to consult a trust and estate attorney at some point in their later years, such attorneys' focus is similarly diverted and centers upon post-mortem disposition of their client's debts and assets. Any allocation of funds to end-of-life care expenses would deplete the finite resources available for their clients to distribute after death. Even if retirees do receive advice on paying for these unfunded health costs, it is likely provided by an elder law attorney advising them to shift the expenses to the state. In adopting this approach, elder law attorneys are also unwittingly shifting control over how this care will be provided from the client to the Medicaid funding guidelines adopted by their particular state.

This absence of guidance from financial advisors and attorneys usually leaves seniors unprepared to direct or fund their own end-of-life care. Clients nearing retirement age may be wholly unaware that Medicare coverage of long-term care expenses is extremely limited and that funding restrictions often entirely eliminate home-based care as an option.⁸¹ Seniors lack guidance as to the complications and undesirable financial aspects of Medicaid qualification, but this is often the only option that remains for retirees who are financially unprepared for long-term care expenses. Further, the void created by this lack of guidance often leaves seniors uninformed as to their choices for where their end-of-life care will take place and unaware of options that do not involve institutionalization.

81. Vincent Mor et al., *The Revolving Door of Rehospitalization from Skilled Nursing Facilities*, 29 HEALTH AFF. 57 (2010).

With proper planning and guidance, many seniors will be able to take advantage of a wide range of intermediate care options to avoid nursing home care, including adult daycare programs and personal care services that can be provided in the home. Seniors who have actively engaged in planning for end-of-life expenses will find that institutionalization in a nursing home is not the only avenue open to them. Remaining in the home, which is a primary goal for most retirees,⁸² is possible for seniors who are informed and prepared to control their own end-of-life care.

VI. Initiating the Dialogue on End-of-Life Choices

The absence of guidance by financial advisors and attorneys is a contributing factor to the lack of preparedness among many seniors when it comes to funding post-retirement medical expenses, but the unfortunate reality is that seniors themselves help perpetuate this planning gap by largely avoiding the conversation. There is a cognitive dissonance among the aging baby boomer population, in that they wish to retain control and independence,⁸³ yet they often remain in denial of the need to take the required steps to create the plans necessary to remain in command of their end-of-life medical care.⁸⁴

This dichotomy is natural because, while baby boomers crave financial independence and control, and want to ensure that their children are provided for, they shy away from discussions that focus upon the inevitable physical and mental deterioration that could prevent them from achieving these ideals. The remainder of this article will advance the theory that the two halves of this dichotomy can work in conjunction

82. Barbara J. Edlund et al., *Long-Term Care Planning for Baby Boomers: Addressing an Uncertain Future*, ONLINE J. ISSUES NURSING (May 31, 2003), <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume82003/No2May2003/CarePlanningforBabyBoomers.html>.

83. *Id.*

84. Lois A. Vitt, *Consumers' Financial Decisions and the Psychology of Values*, J. FIN. SERVS. PROFESSIONALS, Nov. 2004, at 68, 69.

in order to encourage seniors to engage in meaningful dialogue with advisors to plan for financing end-of-life care. By appealing to the sense of accountability and individualism that is the hallmark of this generation,⁸⁵ society can motivate the baby boomer population to regain control over the fiscal choices that will define their end-of-life medical care.

A. Imposing Filial Support Liability to Motivate Planning Among Retiree-Clients

Today, twenty-nine states have filial support statutes on their books under which financially capable adult children can be held responsible for the unpaid medical bills of their indigent parents, including nursing home bills.⁸⁶ The statutes are enforceable even against the children of elderly individuals who have not planned for end-of-life care and become eligible to rely upon Medicaid to fund long-term care expenses.⁸⁷ Although these statutes are rarely enforced and Medicaid continues to fund most extended nursing home stays in the United States, modern budgetary constraints caused by the rising costs of nursing home care coupled with the economic recession that began in 2008 have compelled nursing homes to examine alternate funding methods.⁸⁸ Rather than seek Medicaid reimbursement, some nursing homes have sought enforcement of these filial support statutes to collect payment for nursing home care from the adult children of elderly nursing home residents.⁸⁹ As the baby boomer generation ages and imposes a greater strain upon the Medicaid system, it is likely that more nursing homes will begin to regularly seek enforcement of

85. See generally LEONARD STEINHORN, *THE GREATER GENERATION: IN DEFENSE OF THE BABY BOOM LEGACY* (2006).

86. Katherine C. Pearson, *Filial Support Laws in the Modern Era: Domestic and International Comparison of Enforcement Practices for Laws Requiring Adult Children to Support Indigent Parents*, 20 ELDER L.J. (forthcoming Fall 2012) (manuscript at 8) (on file with Penn. State eLibrary).

87. 23 PA. CONS. STAT. ANN. § 4603(a)(1) (2005) (permitting enforcement of the filial support law even if the indigent adult is a “public charge”); see, e.g., *Health Care & Ret. Corp. of Am. v. Pittas*, 2012 PA Super 96, 46 A.3d 719 (2012).

88. See Pearson, *supra* note 86.

89. *Id.*

these statutes.

To illustrate, in May 2012, a Pennsylvania court required that the adult child of an indigent nursing home resident pay an unpaid nursing home bill of approximately \$93,000.⁹⁰ The defendant's mother had no choice but to leave nursing home bills unpaid while her application for Medicaid, which was still pending at trial, was being considered.⁹¹ The Pennsylvania appellate court agreed with the trial court that the elderly woman's son was liable under the filial support statute regardless of whether the Medicaid application was eventually approved.⁹² This is because, under the Pennsylvania law, the spouse, children, and parents of an indigent person have the responsibility to "care for and maintain or financially assist [that] indigent person, *regardless of whether the indigent person is a public charge.*"⁹³

Although the Pennsylvania statute provides an exception for individuals who are financially unable to provide the legally mandated assistance,⁹⁴ this provision did not exempt the adult child in *Pittas* who, while solvent, had an annual income of approximately \$85,000 and claimed his personal expenses rendered him unable to satisfy the \$93,000 debt.⁹⁵

Filial responsibility was imposed in the *Pittas* case despite the absence of fault on the part of the defendant⁹⁶—but this has not always been the norm. Though enforcement of the statute has been rare, as mentioned above, in *Presbyterian Medical Center v. Budd*,⁹⁷ the Pennsylvania courts imposed filial responsibility upon the adult daughter of an indigent woman when the court found that the daughter had engaged in a type of Medicaid planning that directly caused her mother's indigence.⁹⁸ In this case, the daughter used her power of attorney to transfer over \$100,000 of her elderly mother's

90. *Pittas*, 2012 PA Super 96, 46 A.3d at 724.

91. *Id.* at 723.

92. *See id.* at 722.

93. 23 PA. CONN. STAT. ANN. § 4603(a)(1) (emphasis added).

94. 23 PA. CONN. STAT. ANN. § 4603(a)(2)(i).

95. *Pittas*, 2012 PA Super 96, 46 A.3d at 722-23.

96. *Id.*

97. 2003 PA Super 323, 832 A.2d 1066.

98. *See id.* ¶ 28, 832 A.2d at 1077.

assets into her own accounts in order to cause her mother to qualify for Medicaid coverage.⁹⁹ When the elderly woman's Medicaid application was denied, the nursing home attempted to collect the unpaid bills under theories of breach of contract and fraudulent transfer.¹⁰⁰ Both arguments were rejected by the court in its decision to rely solely upon the filial support statute.¹⁰¹

While fault is not an element of Pennsylvania's filial support law, the court discussed the defendant's improper appropriation of her mother's assets in analyzing the elements of the statute.¹⁰² The court found that the defendant's transfer of over \$100,000 to her personal accounts rendered her mother indigent and the defendant financially capable in the same transaction, thus allowing the court to impose liability.¹⁰³

Pennsylvania is only one of twenty-nine states to maintain a filial support statute, but the state's rare enforcement of the law is still much more frequent than in the twenty-eight other states where enforcement is possible.¹⁰⁴ This article does not intend to suggest that imposition of filial liability is an appropriate means to finance the end-of-life medical expenses of seniors, though enforcement of the law in limited circumstances would serve to raise awareness among the aging baby boomer population. Widespread national media coverage of the *Pittas* case has alerted many to the possibility that these laws could be enforced,¹⁰⁵ but enforcement is still viewed as a fluke occurrence that is not likely to be repeated. Eliminating the perception that these statutes are antiquated and unlikely to be enforced through regular enforcement where, as in *Budd*, some degree of fault can be demonstrated, could provide baby boomers with the necessary deterrent to spur planning for end-of-life care.

99. *Id.* ¶ 3, 832 A.2d at 1069.

100. *Id.* ¶¶ 3-4, 832 A.2d at 1069.

101. *Id.* ¶ 29, 832 A.2d at 1077.

102. *Id.* ¶ 18, 832 A.2d at 1076.

103. *Id.*

104. *See* Pearson, *supra* note 86, at 17.

105. *Id.* at 21-22.

By causing baby boomers to become alert to the possibility that filial support obligations could be imposed upon their children, society can appeal to the individualism and sense of accountability that is characteristically found among members of this generation.¹⁰⁶ The idea of leaving large debts to their children likely will have more immediacy and be more disturbing to a boomer, in contrast to the more nebulous idea that their generation may leave this burden to the entirety of the next generation. To avoid the real possibility of imposing liability upon their children, baby boomers may be more willing to engage their advisors in a discussion about managing their eventual physical and mental deterioration and the allocation of resources necessary to effectively control the course of their own end-of-life care.

Not only will selective enforcement of filial support statutes encourage baby boomers to engage in meaningful planning dialogue with their financial advisors, it could serve as the germ of an empowering message of hope and control that financial advisors and attorneys alike can share with their aging clients. These clients' general aversion to discussing end-of-life decisions contributes enormously to the difficulty experienced by advisors who wish to generate awareness of the need to financially prepare for funding end-of-life care. By focusing on the need for seniors to take responsibility for their own future liabilities, financial advisors can impart a message of hope and possibility to their clients, rather than discouraging and alienating these clients through forced discussion of their future infirmities.

B. *Changing the Content of the Planning Dialogue*

Because seniors value the ability to maintain autonomy and control in the final years of their lives so greatly, the abhorrent prospect of institutionalization tends to mask the vision of hope and possibility that can be found in the long-term care planning landscape. Instead of focusing on the negative aspects of long-term care late in life, advisors can pitch proper planning to their clients as an opportunity to

106. See generally STEINHORN, *supra* note 85.

ensure that they maintain the greatest possible degree of control over their care.

While it is impossible to plan for or predict every scenario, fulsome end-of-life planning can ensure that the course of a senior's care most closely resembles that which he or she chooses to design. Seniors who are reluctant to leave the financial liability for long-term care expenses to their children will be equally unwilling to allow these children to become solely responsible for the burden of making the decisions regarding the course of their care.

As discussed above, the adult children of seniors are very likely to end up providing some level of informal in-home care for their parents.¹⁰⁷ These adult children may have motives that conflict with the end-of-life choices preferred by their parents, in that they might not have the time or resources to provide the in-home care needed by their elderly parents.¹⁰⁸ The lost opportunity costs and lack of training in effective care giving, outlined in Part II,¹⁰⁹ means that these adult children will eventually become unable to continue providing informal care and, in many cases, will be forced to resort to institutionalizing their elderly parents in nursing homes.

Seniors can avoid this result with proper financial planning for professional in-home care. When seniors have the funds necessary to finance their own care, there is often no need for adult children to forego wages or their own familial responsibilities to provide their parents with informal care. This allows seniors to retain the control and autonomy they desire instead of relinquishing independence by transferring responsibility to adult children with potentially conflicting motivations.

Translating awareness of the need to plan for end-of-life care into an empowering and hopeful message for seniors will change the way retirees look at end-of-life planning. By structuring the dialogue as a way to plan for retaining autonomy and control late in life, advisors can help seniors recognize end-of-life planning as a path toward avoiding the

107. See Byrne et al., *supra* note 30, at 1205.

108. *Id.* at 1232.

109. See *supra* Part II.

institutionalization that they dread. Allocating sufficient resources toward end-of-life expenses can allow these seniors to take advantage of the home and community based health and personal care services available outside of the Medicaid-financed path. Though HCBS allows seniors to maintain ties with their families and social networks, with proper planning these families and social networks will not be obligated to become the HCBS program.

C. The Professional Duty to Begin the Dialogue on End-of-Life Choices

Advisors also have a professional responsibility, and perhaps even a legal duty, to engage their clients in these planning discussions.¹¹⁰ Lawsuits against advisors who have improperly omitted end-of-life planning strategies from a client's overall financial plan are uncommon today. However, the increasing costs of health care coupled with the possibility of more stringently enforced filial support laws indicate that this liability may become much more common in the future.

Attorneys, who undeniably act as fiduciaries, have a professional responsibility to advise their clients of the need for long-term care planning as a corollary to estate or Medicaid planning.¹¹¹ Financial planners may similarly be held liable for failing to properly advise their clients with regard to long-term care planning as the scope of fiduciary liability continues to expand.¹¹² While most cases imposing liability upon financial advisors under fiduciary liability theories involve improper investment advice surrounding annuity sales or investment strategy,¹¹³ the classification of a financial advisor as a fiduciary in any context is significant because of its

110. Robert D. Hayes et al., *What Attorneys Should Know About Long-Term Care Insurance*, 7 ELDER L.J. 1, 3 (1999).

111. *See id.*

112. *See* W. Reserve Life Assurance Co. v. Graben, 233 S.W.3d 360, 373-74 (2007) (finding a relationship of trust and confidence existed to support a fiduciary relationship between the financial advisor and client).

113. *See* Sally Balch Hurme, *Who's in the Batter's Box?: Regulating and Litigating Unsuitable Sales of Variable Annuities*, 1 PHOENIX. L. REV. 365, 423 (2008).

precedential value.

Broker-dealers and investment advisors have been categorized as fiduciaries in certain circumstances, depending upon the degree of trust and confidence that the client places in her advisor.¹¹⁴ Where a fiduciary duty is found to exist, the advisor has a “heightened duty” to act on the client’s behalf.¹¹⁵ The client in the fiduciary relationship can, in some instances, bring an individual cause of action against a fiduciary who breaches this duty by failing to give proper advice.¹¹⁶ When financial advisors and attorneys acting in a fiduciary capacity ignore the need to plan for clients’ unfunded end-of-life care expenses, they invite potential lawsuits from these clients alleging that failure to provide such planning advice constitutes a breach of their fiduciary obligations. This is because the analogy between imposing fiduciary liability for improper investment advice, and imposing this liability for failing to advise on a planning issue as critical as planning for long-term care, could easily be accepted in court.

114. See ANGELA A. HUNG ET AL., INVESTOR AND INDUSTRY PERSPECTIVES ON INVESTMENT ADVISERS AND BROKER-DEALERS 11 (2008), available at http://www.rand.org/pubs/technical_reports/TR556.html.

115. See generally Arthur B. Laby, *Fiduciary Obligations of Broker-Dealers and Investment Advisers*, 55 VILL. L. REV. 701, 719-29 (2010). While investment advisors are classified as fiduciaries under the Investment Advisers Act of 1940, SEC v. Capital Gains Research Bureau, Inc., 375 U.S. 180, 191 (1963), broker-dealers are only considered to act in a fiduciary capacity in limited circumstances. See Laby, *supra* note 115, at 719-29. Broker-dealers are often able to take advantage of an exception in the Investment Advisers Act because they commonly provide investment advice only as an incidental aspect of their duties. George Steven Swan, *The Law and Economics of Interprofessional Frontier Skirmishing: Financial Planning Association v. Securities and Exchange Commission*, 16 U. MIAMI BUS. L. REV. 75, 106 (2007). However, broker-dealers who have investment discretion over client accounts, or who provide more than incidental investment advice, will often be held to a fiduciary standard. Laby, *supra* note 115, at 704-05, 715. Broker-dealers act in several capacities, one of which is the “broker” capacity in which part of their role involves buying and selling on behalf of their clients, rather than simply trading securities with their own customers. See *id.* at 2-3. Broker-dealers who act in a “broker” capacity act as agents for their clients and are, therefore, more likely to be held to the higher fiduciary standard. See generally Thomas Lee Hazen, *Are Existing Stock Broker Standards Sufficient? Principles, Rules and Fiduciary Duties*, 2010 COLUM. BUS. L. REV. 710 (2010).

116. See Hurme, *supra* note 113.

In *Western Reserve Life Assurance*, for example, a Texas court found that an advisor had a fiduciary duty to provide appropriate investment advice to his clients and that he breached this duty.¹¹⁷ The plaintiffs in *Western Reserve* were relatively unsophisticated investors who testified that they relied heavily upon the advice of the defendant in their financial planning.¹¹⁸ While the plaintiffs had broadly described their financial goals, they placed substantial trust in the appropriateness of the defendant's investment advice.¹¹⁹

The court rejected the defendant's argument that no fiduciary relationship could be found because the activities between the parties constituted arm's-length business transactions.¹²⁰ In its holding, the court stressed the importance of the advisor's role in finding that he "acted as a financial advisor whom the [c]lients trusted to monitor the performance of their investments *and recommend appropriate financial plans to them.*"¹²¹ According to the court, when the defendant assumed the role of investment advisor, managing and monitoring his client's investments, he himself caused the relationship to elevate to a fiduciary level.¹²²

Though the financial plans in *Western Reserve* were not related specifically to funding post-retirement medical expenses, the reasoning could easily be expanded to apply to advisors neglecting to plan for end-of-life care. Therefore, by failing to recommend that clients plan for financing end-of-life care, advisors expose themselves to the potential expansion of this line of reasoning to include failure to provide advice with regard to unfunded post-retirement health care expenses. This possibility of exposure to professional and legal liability for failing to properly advise clients in planning to fund end-of-life care provides a compelling argument that will motivate advisors to engage in comprehensive planning discussions with their clients. If the deterrent effect of selectively enforcing filial support statutes becomes effective, seniors themselves will be

117. *W. Reserve Life Assurance Co.*, 233 S.W.3d at 374.

118. *Id.* at 370.

119. *Id.* at 367.

120. *Id.* at 374.

121. *Id.* (emphasis added).

122. *See id.*

equally motivated by the fear that they will burden their children by failing to properly account for the cost of their end-of-life care.

D. Dual Motivation for Crafting a Comprehensive End-of-Life Care Plan

These dual deterrent motivators, working in conjunction, will serve to force the dialogue between advisors and seniors, even if the discussion begins by focusing only on a “necessary evil” that must be addressed. Discussion of the “evils” inherent in failing to plan for end-of-life care can provide enough of a spark to ignite the fuller planning dialogue.

Convincing aging clients that planning for end-of-life care is “the right thing to do” is only a starting point for providing seniors with the tools necessary to direct the course of their future long-term care. Advisors who are motivated by fear of professional liability can initiate an empowering discussion that emphasizes the paradigms of familial and fiscal responsibility among their baby boomer clients, and, in the process, may remove some of the stigma attached to end-of-life planning. Through more in-depth discussion of long-term care planning, advisors can help seniors avoid not only the financial burden they could leave to their children, but also the emotional burden imposed when children are forced to determine the course of their parents’ end-of-life care, after the seniors themselves can no longer make the relevant decisions.

Raising the long-term care issue itself is necessary, but it is not a sufficient solution to the problem, which can only be solved through a dialogue in which both advisor and client are invested in creating a comprehensive plan. A fulsome discussion of end-of-life planning opens the door for advisors to move beyond solutions involving insurance and financing, to the use of detailed living wills and advanced directives to help seniors control the course of their own care late in life. Opening the door to the consideration of financial burdens will not only allow seniors to avoid indigence late in life, but can lead to development of this all-encompassing, comprehensive end-of-life plan that will leave seniors feeling prepared and in control of their future care.

VII. Conclusion

Since Medigap's at-home recovery option was defunded, Medicare-eligible seniors have been largely unable to access HCBS programs, leaving them with little choice but to receive long-term care in nursing homes. The post-*Olmstead* Medicaid experience has illustrated the ability of states to reduce institutional expenses by developing and implementing comprehensive HCBS programs. In a post-MIPPA world, the next logical step is increasing access to HCBS among the non-indigent senior population by helping them create financial plans that would allow these seniors to access HCBS without government assistance.

Despite advancing HCBS programs, attorneys and financial planners currently have little incentive to initiate a conversation with clients about planning for end-of-life care and making use of HCBS. This lack of motivation, coupled with client's reluctance to discuss end-of-life care, has led to a planning gap among retirees that leaves many unprepared to fund their own end-of-life care. Selective enforcement of filial support statutes in cases where some degree of fault can be demonstrated can motivate baby boomer clients to engage their advisors in a planning dialogue to avoid leaving the debt for end-of-life care to their children.

Further, increasing the awareness of advisors' professional duty to engage in this planning dialogue, as well as the possibility of fiduciary liability for failing to do so, can provide motivation for these advisors to initiate the conversation. These dual motivators can work together to create an environment in which end-of-life planning discussions can be empowering and positive as advisors and clients work together to develop comprehensive plans for end-of-life care. Forcing this dialogue to the surface can provide baby boomer retirees the independence and control they crave and allow them to make responsible choices about their end-of-life care plans.