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### Public-Private Partnerships and Insurance Regulation

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## NOTES

### PUBLIC-PRIVATE PARTNERSHIPS AND INSURANCE REGULATION

#### I. INTRODUCTION

Senator Hillary Clinton believes insurance companies should be regulated more heavily: “We’re going to tell the insurance companies that they’re going to have to change the way they do business . . . . You know, we regulate banks. We regulate utilities. Well, we’re going to regulate the insurance companies.”<sup>1</sup> While Clinton may simply have been throwing red meat to an audience on the campaign trail, her comments raise questions about proper and effective approaches to regulation of the insurance industry. She is certainly correct that other industries have long been regulated,<sup>2</sup> but her phrasing suggests an adversarial approach to regulation in which the government imposes requirements about how to behave on an unwilling private sector.<sup>3</sup> Recent scholarship suggests that regulatory processes are more collaborative in nature, with the government engaging in formal and informal contracts with regulated entities in the private sector to achieve regulatory goals.<sup>4</sup>

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<sup>1</sup> Abdon M. Pallasch, *Hillary Slams Health Insurers; Pledges To Regulate Insurance Companies*, CHICAGO SUN-TIMES, Dec. 19, 2007, at 30 (internal quotation marks omitted).

<sup>2</sup> See generally JAMES M. LANDIS, *THE ADMINISTRATIVE PROCESS* (1938) (the classic explication of the administrative state by one of its leading intellectual champions); THOMAS K. MCGRAW, *PROPHETS OF REGULATION* (1984) (documenting the history of various seminal figures of regulation).

<sup>3</sup> The traditional administrative law view of the relationship between regulators and regulated entities is one of hierarchy with adverse parties. See Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. REV. 543, 547–48 (2000) (“Most administrative law theory now adheres to a hierarchical, agency-centered conception of administrative power . . .”).

<sup>4</sup> See Jody Freeman, *Collaborative Governance in the Administrative State*, 45 UCLA L. REV. 1 (1997); see also Philip J. Harter & George C. Eads, *Policy Instruments, Institutions, and Objectives: An Analytical Framework for Assessing “Alternatives” to Regulation*, 37 ADMIN. L. REV. 221, 223–27 (1985); Michael P. Vandenbergh, *The Private Life of Public Law*, 105 COLUM. L. REV. 2029 (2005). This collaborative governance view may represent more accurately what is happening on the ground, where regulators and regulated entities are working interdependently, sharing information, and making various negotiated deals. See Jody Freeman, *The Contracting State*, 28 FLA. ST. U. L. REV. 155, 160–64 (2000) (connecting the contractual relationship between regulators and regulated entities to the trend of privatization); see also Orly Lobel, *The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought*, 89 MINN. L. REV. 343, 346–47 nn.1–23 (2004) (collecting citations to scholarship in this tradition and naming the tradition the “Renew Deal”). Some argue that even if the collaborative governance view is descriptively accurate, it is not normatively preferred. See, e.g., Sidney A. Shapiro, *Outsourcing Government Regulation*, 53 DUKE L.J. 389, 432–34 (2003) (using transaction cost analysis to identify shortcomings of outsourcing government regulation).

A public-private partnership (PPP) is an institutional arrangement that embodies this type of collaborative approach; it is a joint venture between the government and one or more private sector entities.<sup>5</sup> Although such partnerships come in many forms, this Note focuses on joint financing partnerships that link public financing and private insurance to pay for certain social goods. Where the financing for social goods is fragmented and overlapping, as it is for health and social care,<sup>6</sup> joint financing PPPs may help organize existing financing streams. This Note argues that partnerships of this type also present an opportunity for consumer-protective regulation of the insurance industry if certain conditions are met. Private insurers must perceive benefits to the partnership, government actors must be motivated to protect the government's financial stake, and government interests must align with those of consumers. This Note uses the Medicaid Partnership for Long-Term Care to illustrate the argument.

Part II identifies the objective of consumer-protective regulation, discusses the collaborative form of the public-private partnership, and specifies the conditions under which PPPs might create opportunities for consumer-protective regulation of the insurance industry. Part III describes the history and results of the Medicaid Partnership for Long-Term Care. Part IV analyzes the results of the Partnership in light of the conceptual framework set out in Part II. Part V concludes.

## II. OBJECTIVE AND METHOD

### *A. The Objective: Public-Interested Regulation, Consumer-Protective Regulation*

Regulation for regulation's sake is not a worthy goal. Lacking justification, intervention in the economy is bound to lead to undesirable inefficiencies and a reduction in liberty.<sup>7</sup> But regulation is desirable if it provides sufficiently large benefits to the general public. Thus, the objective might be identified as public-interested regulation, or "regu-

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<sup>5</sup> See Stephen H. Linder, *Coming to Terms with the Public-Private Partnership: A Grammar of Multiple Meanings*, in PUBLIC-PRIVATE POLICY PARTNERSHIPS 19, 19 (Pauline Vaillancourt Rosenau ed., 2000) (defining public-private partnerships as "cooperative ventures between the state and private business"); Lester M. Salamon, *The New Governance and the Tools of Public Action: An Introduction*, 28 FORDHAM URB. L.J. 1611, 1614-15 (2001) (noting the importance of for-profit and nonprofit entities in public-private arrangements).

<sup>6</sup> See Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL. L. REV. 777, 799 ("The current multifaceted system of Medicare Part A, Medicare Part B, Medigap insurance in its twelve variations, and long-term care insurance in its even more numerous mutations, plus Medicaid for people who have exhausted their financial resources, is simply too fragmented.").

<sup>7</sup> See Richard A. Epstein, *Exit Rights and Insurance Regulation: From Federalism to Takings*, 7 GEO. MASON L. REV. 293, 293-95 (1999) (discussing the perils of insurance regulation without justification).

lation that improves social welfare . . . [,] delivers no rents[,] or, if it does, [ensures that] the gains to those who benefit from the regulatory decision outweigh any losses to the rest of society.”<sup>8</sup> Public-interested regulation is contrasted with special interest regulation, which “delivers regulatory rents to the greater detriment of society.”<sup>9</sup>

This distinction could be cast in terms of the types of groups benefited or harmed by regulation — in other words, as a distinction between small groups with narrow interests and broad groups with diffuse interests.<sup>10</sup> Reduced to its essence, public-interested regulation benefits large groups over small groups, though it could also benefit both.<sup>11</sup> In the insurance context, insurance companies are the small group with narrow interests, and consumers are the broad group with diffuse interests.<sup>12</sup> Thus, under this framework, consumer-protective regulation of the insurance industry is a type of public-interested regulation that benefits consumers. Although there is room for debate over which types of regulations actually improve the welfare of consumers, such debates are best had on a case-by-case basis.<sup>13</sup> For the purposes of this Note, the broad definitions above are sufficient.<sup>14</sup>

<sup>8</sup> STEVEN P. CROLEY, REGULATION AND PUBLIC INTERESTS 10 (2008).

<sup>9</sup> *Id.*

<sup>10</sup> See generally MANCUR OLSON, THE LOGIC OF COLLECTIVE ACTION (1971) (arguing that smaller groups are better able to organize than larger groups, because in smaller groups the costs of participation are more likely outweighed by the more concentrated benefits).

<sup>11</sup> See Steven P. Croley, *Public Interested Regulation*, 28 FLA. ST. U. L. REV. 7, 8 n.1 (2000) (“[P]ublic interested’ regulation is used in contradistinction to ‘special interest’ regulation, where the former refers to regulation that promotes diffuse interests while the latter describes the delivery of rents to narrow groups. . . . ‘Public interested’ regulation represents the category of ‘benign’ regulation that stands in opposition to the ‘bad’ regulation interest group theorists usually fear. Public interested regulation needs no further specification than to say that it aims at vindicating the preferences of diffuse interests, and it delivers no regulatory rents.”).

<sup>12</sup> In fact, Professor Mancur Olson identifies consumers as the quintessential broad group with diffuse interests that has difficulty organizing, especially as compared with organized economic interests. See OLSON, *supra* note 10, at 143 (“The multitude of workers, consumers, white-collar workers, farmers, and so on are organized only in special circumstances, but business interests are organized as a general rule.”); see also *id.* at 166 (“The consumers are at least as numerous as any other group in the society, but they have no organization to countervail the power of organized or monopolistic producers.”).

<sup>13</sup> The civic republican tradition suggests that through deliberation the public interest can be furthered in public law. See Cass R. Sunstein, *Interest Groups in American Public Law*, 38 STAN. L. REV. 29, 45–48 (1995) (deriving deliberative democracy from both the Federalist and Antifederalist strains in American political thought); see also Frank Michelman, *Law’s Republic*, 97 YALE L.J. 1493, 1510–13 (1988) (discussing the possibilities of persuasive processes). The administrative state, in turn, could be seen as the institution capable of realizing this deliberative goal. See, e.g., Robert B. Reich, *Public Administration and Public Deliberation: An Interpretive Essay*, 94 YALE L.J. 1617, 1631–41 (1985); Mark Seidenfeld, *A Civic Republican Justification for the Bureaucratic State*, 105 HARV. L. REV. 1512, 1541–62 (1992).

<sup>14</sup> This Note aims to identify a set of conditions that might generate such public-interested regulation, and it accepts the view that firms pursue their self-interest in dealing with the government and state regulators. However, the broader debate about whether public-interested regu-

*B. The Method: Collaborative Governance  
and Public-Private Partnerships*

With the objective of consumer-protective regulation identified, this section attempts to identify a method that might have promise for achieving that objective. The model of regulation implied by Senator Clinton is one of hierarchy, in which the state imposes regulations on private actors from above.<sup>15</sup> Some scholars, however, have challenged this model's descriptive accuracy as well as its normative appeal, proposing instead a model in which regulators and regulated entities cooperate to achieve common objectives, share information, and negotiate deals.<sup>16</sup> Public-private partnerships are emblematic of such an approach. They are less likely to involve hierarchical relationships because their existence requires the consent of both the government and the private actors. In fact, their success depends crucially upon the buy-in of both parties.

PPPs are usually geared toward the creation of a social good, such as education or health. All such goods have both a financing and a provision dimension, where financing concerns how to pay for the good and provision concerns how the good will be produced or the service delivered.<sup>17</sup> Responsibility for either dimension may be allocated partially or wholly to public or private actors.<sup>18</sup> Public financing

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lation is plausible and possible or naïve and improbable is bracketed here. The literature on public choice and capture theories espousing the latter view is vast, but for some key pieces, see JAMES M. BUCHANAN & GORDON TULLOCK, *THE CALCULUS OF CONSENT*, reprinted in 2 *THE SELECTED WORKS OF GORDON TULLOCK* 16–29 (Charles K. Rowley ed., 2004); THEODORE J. LOWI, *THE END OF LIBERALISM* 58 (2d ed. 1979); GEORGE J. STIGLER, *Supplementary Note on Economic Theories of Regulation*, in *THE CITIZEN AND THE STATE* 137, 137–41 (1975); Jeffrey M. Berry, *Subgovernments, Issue Networks, and Political Conflict*, in *REMAKING AMERICAN POLITICS* 239, 256 (Richard A. Harris & Sidney M. Milkis eds., 1989); and Richard A. Posner, *Theories of Economic Regulation*, 5 *BELL J. ECON. & MGMT. SCI.* 335, 341–44 (1974). For criticisms of this approach, see, for example, Geoffrey Brennan & James M. Buchanan, *Is Public Choice Immoral?: The Case for the “Nobel” Lie*, 74 *VA. L. REV.* 179 (1988) (discussing ethical critiques of public choice theory); Steven P. Croley, *Theories of Regulation: Incorporating the Administrative Process*, 98 *COLUM. L. REV.* 1, 41–56 (1998) (arguing that such an account fails to take notice of the benefits of administrative procedures); and Mark Kelman, *On Democracy-Bashing: A Skeptical Look at the Theoretical and “Empirical” Practice of the Public Choice Movement*, 74 *VA. L. REV.* 199 (1988) (applying critical legal studies analysis to public choice theory).

<sup>15</sup> This is the view associated with the New Deal and the birth of the administrative state. See Lobel, *supra* note 4, at 351–52. It is a development of a previous understanding in which the role of government was limited to facilitating “private orderings” through “freedom of contract and property security.” See *id.* at 362.

<sup>16</sup> See *supra* notes 3–4.

<sup>17</sup> See JOHN D. DONAHUE, *THE PRIVATIZATION DECISION* 7 (1989).

<sup>18</sup> For simplicity, this Note considers only two sectors, public and private, including nonprofit entities and families within the private sphere. Of course, nonprofits and families do not share the same incentives or goals as for-profit entities. For interesting discussions of the nature and composition of the nonprofit sector, see *THE STUDY OF THE NONPROFIT ENTERPRISE*

involves collective payment for goods, for instance, through taxation or social insurance; private financing involves individuals or other private sector entities using their own resources to pay for goods. Publicly provided goods come from a governmental source; privately provided goods come from nongovernmental sources, such as for-profit firms, nonprofit entities, or family members. Because the financing and provision dimensions are independent of each other, one can imagine four types of goods: publicly financed and provided (e.g., public schools), privately financed and provided (e.g., milk bought at a supermarket), publicly financed and privately provided (e.g., military equipment), and privately financed and publicly provided (e.g., the services of the U.S. Postal Service).<sup>19</sup>

Although public-private partnerships are far from new,<sup>20</sup> they have been the subject of renewed interest because of a recent trend toward privatization.<sup>21</sup> Privatization involves moving some of the responsibility for the financing or provision of a good from the public to the private sphere.<sup>22</sup> For goods that used to be entirely publicly financed and

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(Helmut Anheier & Avner Ben-Ner eds., 2003). For a history of the attack on the public/private distinction, see Morton J. Horwitz, *The History of the Public/Private Distinction*, 130 U. PA. L. REV. 1423, 1426 (1982). For an analysis of the difficulty in applying the public/private distinction to long-term care, see Mark Schlesinger, *Deceptive Dichotomies: Political Reasoning and Government Involvement in Long-Term Care*, in PUBLIC AND PRIVATE RESPONSIBILITIES IN LONG-TERM CARE 25, 32–35 (Leslie C. Walker, Elizabeth H. Bradley & Terrie Wetle eds., 1998).

<sup>19</sup> See DONAHUE, *supra* note 17, at 7–8 (discussing these four categories).

<sup>20</sup> See DONALD F. KETTL, SHARING POWER: PUBLIC GOVERNANCE AND PRIVATE MARKETS 4 (1993) (noting that “every major policy initiative launched by the federal government since World War II — including Medicare and Medicaid, environmental cleanup and restoration, antipoverty programs and job training, interstate highways and sewage treatment plants — has been managed through public-private partnerships” (emphasis removed)); Henry Hansmann, *The Changing Roles of Public, Private, and Nonprofit Enterprise in Education, Health Care, and Other Human Services*, in INDIVIDUAL AND SOCIAL RESPONSIBILITY 245 (Victor R. Fuchs ed., 1996) (detailing the history of intersectoral cooperation in social services).

<sup>21</sup> See Jody Freeman, *Extending Public Law Norms Through Privatization*, 116 HARV. L. REV. 1285, 1292–93 (2003).

<sup>22</sup> Privatization also implies a move from collective to individual decisionmaking. See Mark H. Moore, *Public Values in an Era of Privatization*, 116 HARV. L. REV. 1212, 1215 (2003); see also William L. Megginson & Jeffry M. Netter, *From State to Market: A Survey of Empirical Studies on Privatization*, 39 J. ECON. LITERATURE 321 (2001) (detailing various privatization schemes across the world). Privatization has foundations in certain conservative philosophies, particularly those that critique the collectivization of social goods under the banner of the state and that valorize the market as distributing social goods according to desert. See, e.g., F.A. HAYEK, *THE ROAD TO SERFDOM* (1976). Although economists are divided on privatization issues, many favor privatization on so-called efficiency grounds. See generally ANDREI SHLEIFER & ROBERT W. VISHNY, *THE GRABBING HAND: GOVERNMENT PATHOLOGIES AND THEIR CURES* (1998). Those interested in public administration focus on the perspective of policy planners, for whom privatization may be a way to deal with stress on public budgets as well as complaints about the quality of delivery of goods and social services. See Harvey B. Feigenbaum & Jeffrey R. Henig, *The Political Underpinnings of Privatization: A Typology*, 46 WORLD POL. 185, 187, 193–96 (1994).

provided, privatization often results in hybrid financing/provision arrangements that are characteristic of PPPs. The most common form of PPP in the United States is a “contracting out” arrangement — a pairing of public financing with private provision.<sup>23</sup> Examples of contracting-out PPPs include school voucher programs, privatized prisons, and publicly financed faith-based initiatives.<sup>24</sup>

A different sort of PPP involves both public and private financing. This arrangement might be termed a joint financing public-private partnership.<sup>25</sup> Private financing may come in the form of out-of-pocket spending by individuals, or it may be systematized into financial products such as insurance. This Note’s inquiry is limited to private financing involving an insurance mechanism of some sort; examples of such joint financing PPPs include the use of governmental tax credits to help people purchase insurance,<sup>26</sup> the government’s acting as a reinsurer for private insurance companies,<sup>27</sup> and the government’s making receipt of government money contingent upon the purchase of private insurance.<sup>28</sup> An obvious precondition for the existence of a joint financing PPP is the availability of public and private financing streams geared toward a given social good. If these financing streams already exist, the PPP performs a linking function between them. Otherwise, the PPP creates a source of financing, usually on the public side, to act in concert with a private financing stream that is already in place.

Unlike contracting-out PPPs, which often derive from a privatization impulse, joint financing PPPs derive from a desire to take advantage of multiple sources of financing for the same social good. The combination of private insurance and public money is an attractive ar-

<sup>23</sup> See Freeman, *supra* note 21, at 1289 (noting that “‘privatization,’ . . . in the American context[,] consists largely of contracting out”).

<sup>24</sup> See generally MARTHA MINOW, PARTNERS, NOT RIVALS: PRIVATIZATION AND THE PUBLIC GOOD (2002) (discussing the development of PPPs in many areas).

<sup>25</sup> Joint financing PPPs may involve either public or private provision of a good. For present purposes, it is not necessary to specify the provision aspect, so long as there is some supply of the good toward which the financing is aimed.

<sup>26</sup> See, e.g., Joshua M. Wiener, Jane Tilly & Susan M. Goldenson, *Federal and State Initiatives To Jump Start the Market for Private Long-Term Care Insurance*, 8 ELDER L.J. 57, 67–70 (2000) (discussing the tax credit approach for helping finance the purchase of long-term care insurance).

<sup>27</sup> See, e.g., Michael G. Faure, *Insurability of Damage Caused by Climate Change: A Commentary*, 155 U. PA. L. REV. 1875, 1885–89 (2007) (discussing the role of government in the insurance market for damage caused by climate change); Saul Levmore & Kyle D. Logue, *Insuring Against Terrorism — and Crime*, 102 MICH. L. REV. 268, 276–82 (2003) (describing the government as reinsurer for damages caused by terrorist attacks). See generally DAVID A. MOSS, WHEN ALL ELSE FAILS: GOVERNMENT AS ULTIMATE RISK MANAGER 292–325 (2002) (laying out the history and rationale for American risk management policy, implemented through various governmental interventions and programs).

<sup>28</sup> This is the approach of the Medicaid Partnership for Long-Term Care, which is discussed in Part III below.

rangement for dealing with the fragmentation of financing for important social goods. However, despite their separation from the trend of privatization, joint financing PPPs may be vulnerable to some of the criticisms that are leveled at contracting-out PPPs. For example, some public law scholars criticize the removal to private actors of either the financing or provision of social goods, arguing that it undermines democratic or constitutional values such as accountability, due process, and rationality.<sup>29</sup> This critique is in a sense historical, attacking the fact that responsibility for social goods has been transferred from the public to the private sphere over time. In another sense, however, the critique could be construed as attacking *any* private financing or provision of social goods.<sup>30</sup> Taken this way, the critique could apply equally well to joint financing PPPs and contracting-out arrangements.

Some have responded to these criticisms by arguing that public-private partnerships allow the government to extend public law norms to private actors through contract and regulation.<sup>31</sup> Taking this idea one step further, this Note argues that joint financing PPPs could help facilitate consumer-protective regulation of private insurance companies under certain conditions. Normally, consumer-protective regulation is justified and pursued by regulators under rationales such as paternalism or the need to remedy inadequate information or unequal bargaining power.<sup>32</sup> In the case of joint financing PPPs, however, the regulation may be pursued because of the dynamics described below.

### C. *Linking Method to Objective*

When private insurance and public financing are linked, the government and the private sector jointly take on risk for the financing of

<sup>29</sup> See, e.g., Martha Minow, *Public and Private Partnerships: Accounting for the New Religion*, 116 HARV. L. REV. 1229, 1246–55 (2003) (laying out the “reasons for concern” about the trend toward public-private partnerships); see also PAUL R. VERKUIL, *OUTSOURCING SOVEREIGNTY: WHY PRIVATIZATION OF GOVERNMENT FUNCTIONS THREATENS DEMOCRACY AND WHAT WE CAN DO ABOUT IT* (2007) (focusing criticism on contracting-out PPPs).

<sup>30</sup> In other words, public control of financing or provision could be seen as a superior way of organizing affairs, as it allows public values to be expressed. See, e.g., Mark R. Meiners, *Public-Private Partnerships in Long-Term Care*, in PUBLIC AND PRIVATE RESPONSIBILITIES IN LONG-TERM CARE, *supra* note 18, at 115, 121 (“[A]rguments against the [Medicaid Long-Term Care Insurance] Partnership were raised primarily by social insurance advocates, who viewed the program as an incremental step that would erode support for more ambitious reform.”).

<sup>31</sup> See Freeman, *supra* note 21, at 1285. Thus, parallel processes of privatization and publicization — the process “through which private actors increasingly commit themselves to traditionally public goals” — could proceed in tandem. *Id.* In the context of local government law, Professor Gerald Frug has defined publicization as the process of “bringing government closer to its constituents.” See Gerald E. Frug, *Is Secession from the City of Los Angeles a Good Idea?*, 49 UCLA L. REV. 1783, 1784 (2002).

<sup>32</sup> See STEPHEN BREYER, *REGULATION AND ITS REFORM* 26–28, 32–34 (1982) (discussing these rationales).



social goods.<sup>33</sup> They are then operating in a paradigmatically collaborative way, and it is in the negotiations over the parameters of the joint financing PPP that opportunities for the promulgation of consumer-protective regulation may appear, provided certain conditions are met. First, the insurance industry must see the PPP as beneficial. Second, government actors must be able to seize upon the opportunity to protect governmental interests. Third, the interests of the government and consumers must be aligned.

1. *Private Sector Benefits.* — For-profit private sector entities seek profit, and they pursue opportunities for profit when they are aware of them. Insurance companies would thus welcome a joint financing partnership to the extent that it would expand the market and net profits. The companies would weigh the costs of increased regulation associated with the partnership against the economic benefits of the partnership as a whole, and they would accept a partnership arrangement in which benefits exceeded costs. To be sure, not all joint financing PPPs would provide the private sector with benefits. Insurance companies would presumably resist any arrangement in which the government merely shifted financial risk to them.<sup>34</sup> But certain factors increase the likelihood that insurance companies would benefit from partnership with the government. If the government provided funding directly to individuals for the purchase of insurance, insurance companies would benefit from the increased demand for their policies. Moreover, companies that insure against particularly unpredictable events would welcome government assistance to help insulate them from risk. Finally, insurers in markets in which consumer distrust runs high would benefit from a positive association with the government, which could be used in marketing to allay consumer fears about market instability or poor company reputation. This type of benefit is analogous to the benefits of perceived stability and viability that flow to securities or banking firms when the government intervenes to structure those markets.<sup>35</sup>

2. *Regulator Motivation.* — In order for public-interested aims to be realized, government actors must be motivated to achieve them.<sup>36</sup>

<sup>33</sup> See Linder, *supra* note 5, at 29–30 (conceptualizing the risk-shifting function of public-private partnerships).

<sup>34</sup> This may explain why, as discussed in Part III below, standard long-term care insurance policies have been regulated far less heavily than policies associated with the Medicaid Partnership for Long-Term Care.

<sup>35</sup> See JOHN FRANCIS, *THE POLITICS OF REGULATION* 20 (1993) (“In the areas of finance, banking, and insurance, questions of equilibrium often appear along with risk as compelling arguments for regulation.”).

<sup>36</sup> See Croley, *supra* note 11, at 29–31 (discussing the importance of administrator motivation to public-interested regulation); Freeman, *supra* note 21, at 1329–35 (noting that administrators

In the case of a joint financing PPP, the government's interest in regulation might be to safeguard consumers of insurance products or to protect the public fisc. But even if the insurance industry is receptive to regulation because of the other benefits of the PPP, insurance regulators will not necessarily act to protect the government's interest.<sup>37</sup> Regulators may be captured by the entities they regulate, or they may be pressured by the legislative or executive branch to pursue regulation that does not benefit the general public.<sup>38</sup>

Capture, however, is not inevitable. Regulators may be ideologically motivated to pursue their own conception of the public interest.<sup>39</sup> In addition, administrative procedures may insulate regulators from corrupting legislative influence,<sup>40</sup> the judiciary may provide a check on decisions that would favor special interests in an arbitrary way,<sup>41</sup> or the executive branch may direct more public-interested action.<sup>42</sup> If one or several of these motivations or pressures lead administrators to regulate in the public interest, then these regulators can be said to have successfully policed the parameters or assumptions of the PPP, ensuring that enough risk has been allocated to the private sector to make the PPP worthwhile for the government.

3. *Alignment of Interests.* — In addition to private sector benefits and regulator motivation, consumer-protective regulation requires an alignment between consumer and government interests. Given that the government's motivation may be based on a desire to promote some conception of the public interest or to protect the public fisc, or both, there is ample opportunity for a misalignment to occur. First, regulators might misinterpret the interests of the general public or misunderstand the market that they are regulating, in which case they might pursue regulation that is actually harmful to consumers. This mistake is likely if the government adopts a top-down approach to regulation and refuses to accept input from regulated entities. Second, in an effort to protect public money, regulators might shift too much risk to the private sector, overregulating the insurance industry, for instance, by requiring that policies cover a variety of costly situations for

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must be motivated to extend public law norms to private actors for the process of publicization to function).

<sup>37</sup> See Daryl J. Levinson, *Making Government Pay*, 67 U. CHI. L. REV. 345, 345 (2000) (arguing that governmental officials are not necessarily responsive to the government's financial interests).

<sup>38</sup> See, e.g., GEORGE J. STIGLER, *The Theory of Economic Regulation*, in THE CITIZEN AND THE STATE, *supra* note 14, at 114, 114–28.

<sup>39</sup> See Croley, *supra* note 11, at 29–31.

<sup>40</sup> See *id.* at 31–49.

<sup>41</sup> See *id.* at 49–53.

<sup>42</sup> See, e.g., Elena Kagan, *Presidential Administration*, 114 HARV. L. REV. 2245, 2335–38, 2372–83 (2001).

extended periods of time. Such action would drive up the cost of insurance, pricing lower-income consumers out of the market and thereby depriving them of the benefits of the partnership. Government must balance what is feasible for the insurance industry with what is necessary to achieve adequate financing of a given social good, all the while taking account of the importance of consumer choice.

These three conditions — private sector benefits, regulator motivation, and alignment of government and consumer interests — are all necessary to open up the opportunities for consumer-protective regulation of the insurance industry. The first condition guarantees that the private sector will have an incentive to enter into a partnership with the government. Buy-in is a necessary component of such arrangements. The second condition ensures that the government will see the partnership as an opportunity to regulate. The third condition ensures that the promulgated regulation will actually benefit consumers by taking stock of the insurance market and properly weighing price, consumer choice, and other factors.

In support of this argument, the next Part describes a case in which all three conditions were met and consumer-protective regulation appears to have resulted.

### III. THE MEDICAID PARTNERSHIP FOR LONG-TERM CARE

This Part describes the Medicaid Partnership for Long-Term Care, a joint financing PPP directed toward the social good of long-term care.<sup>43</sup> The Partnership links two independent financing streams — the long-term care financing provided by Medicaid, and private long-term care insurance (LTCI) — through the creation of a new long-term care insurance product. This Partnership product exists alongside the standard LTCI product, and both are subject to state insurance regulation. The differences between the two regulatory regimes are suggestive of how the joint financing PPP institutional arrangement can influence regulatory outcomes.<sup>44</sup>

#### A. *The Social Good: Long-Term Care*

Long-term care is “broadly defined as an array of health care, personal care, and social services generally provided over a sustained period of time to persons with chronic conditions and with functional

<sup>43</sup> Technically, since Medicaid finances long-term care that is provided on a private basis, a PPP of the contracting-out variety exists independently of any joint financing arrangement. However, this Note focuses on the joint financing PPPs, and the fact that long-term care may be provided on a private basis is not relevant to the analysis.

<sup>44</sup> Moreover, because the federal government recently loosened restrictions on states’ participation in the Partnership program, *see infra* p. 1380, an analysis of these differences is useful to understanding how future states may choose to regulate LTCI policies.

limitations.”<sup>45</sup> Depending on the nature of the condition or limitation, an individual requiring long-term care may have difficulty performing certain activities of daily living, such as communicating, dressing, going to the bathroom, or eating. In addition, such an individual may have trouble with instrumental activities such as financial management or shopping.

Although many caregivers are employed through formal market mechanisms, relatives and family members provide the bulk of long-term-care services, and this informal care is generally unpaid.<sup>46</sup> The caregiving workforce is predominantly female,<sup>47</sup> and the need for separate financing mechanisms arises perhaps because various social trends contribute to the inadequacy or unavailability of this traditional, unpaid female workforce. For example, population aging has increased the number of individuals needing care, and women have moved into the workforce in large numbers.<sup>48</sup> Since individuals can no longer rely primarily on family support, the commodification of the provision of long-term care has been necessary to increase supply.<sup>49</sup> Two sources of support — Medicaid on the public side and long-term care insurance on the private side — have evolved to deal with the need for further financing.<sup>50</sup>

### B. Financing Mechanisms

1. *The Public Financing Mechanism: Medicaid.* — Medicaid<sup>51</sup> is a means-tested program that is jointly funded by the federal and state governments and administered by the states. It is the somewhat accidental public payment program for long-term care, as it was originally

<sup>45</sup> INSTITUTE OF MEDICINE, IMPROVING THE QUALITY OF LONG-TERM CARE 27 (Gooloo S. Wunderlich & Peter O. Kohler eds., 2001).

<sup>46</sup> See James J. Callahan, Jr., *Care in the Home and Other Community Settings: Present and Future*, in THE FUTURE OF LONG-TERM CARE 169, 171 (Robert H. Binstock, Leighton E. Cluff & Otto von Mering eds., 1996).

<sup>47</sup> See ELAINE M. BRODY, WOMEN IN THE MIDDLE: THEIR PARENT CARE YEARS 5 (2d ed. 2004).

<sup>48</sup> See *id.* at 7–22 (describing the demographic changes).

<sup>49</sup> For an argument that such commodification is desirable, see Katharine Silbaugh, *Commodification and Women's Household Labor*, 9 YALE J.L. & FEMINISM 81 (1997).

<sup>50</sup> It is unlikely that such financing will cause family caregiving to disappear or even decrease substantially, as studies both nationally and internationally have shown that formal care services do not substitute for informal care services; they are merely supplementary. For the national context, see Sharon L. Tennstedt, Sybil L. Crawford & John B. McKinlay, *Is Family Care on the Decline?: A Longitudinal Investigation of the Substitution of Formal Long-Term Care Services for Informal Care*, 71 MILBANK Q. 601 (1993). For international studies, see FAMILY SUPPORT FOR THE ELDERLY: THE INTERNATIONAL EXPERIENCE (Hal L. Kendig, Akiko Hashimoto & Larry C. Coppard eds., 1992).

<sup>51</sup> See 42 U.S.C.A. §§ 1369–1396v (West 2003 & Supp. 2007).

intended to provide health care for the poor.<sup>52</sup> However, in 2005, approximately one-third of the Medicaid budget, or close to \$95 billion, was devoted to long-term care expenses, primarily in nursing homes.<sup>53</sup> In fact, nearly forty percent of all expenditures on nursing home facilities are Medicaid dollars.<sup>54</sup>

Federal guidelines prescribe general rules that states must follow to receive matching funds for their activities, but states have some leeway in constructing eligibility guidelines. As a result, eligibility for Medicaid varies by state.<sup>55</sup> The federal government also provides waivers from its normal rules, and the long-term care context has been rich in waiver activity. For example, Medicaid money for long-term care has traditionally been directed toward nursing care, but under a popular Medicaid waiver program, several states have experimented with financing home and community-based long-term care services.<sup>56</sup> Many of these waiver programs become semi-permanent, though they can be changed by Congress, as the history of the Medicaid Partnership for Long-Term Care shows.<sup>57</sup>

2. *The Private Financing Mechanism: Long-Term Care Insurance.*

— Long-term care insurance is meant to insure against the nonmedical costs of disability, as opposed to the acute medical costs associated with illness, which are covered by traditional health insurance. LTCI policies provide indemnity coverage; after meeting a requisite level of disability defined by set benefit triggers, the policy makes fixed dollar payments for each unit of service received (such as a day of nursing home care or a day of home care), regardless of the actual cost of the service.<sup>58</sup> For a given premium, the per-unit allowance varies depending on the type of care. For example, a policy that pays \$100 per day of nursing home care might pay only \$50 per day of home care. LTCI generally pays benefits only for a fixed period, such as two years of nursing home care, with longer coverage costing more.<sup>59</sup>

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<sup>52</sup> See LAWRENCE A. FROLIK, *THE LAW OF LATER-LIFE HEALTH CARE AND DECISION MAKING* 128 (2006) ("Although originally enacted to pay for the acute care costs of low-income individuals, over the years the [Medicaid] program's support for nursing home care for 'needy' elderly has become a costly aspect of the program.").

<sup>53</sup> See LAURA SUMMER, GEORGETOWN UNIV. LONG-TERM CARE FINANCING PROJECT, *MEDICAID AND LONG-TERM CARE* (Jan. 2007), available at <http://ltc.georgetown.edu/pdfs/medicaid2006.pdf>.

<sup>54</sup> See CONG. BUDGET OFFICE, *FINANCING LONG-TERM CARE FOR THE ELDERLY* 8 (2004), available at <http://www.cbo.gov/ftpdocs/cfm?index=5400&type=1>.

<sup>55</sup> See FROLIK, *supra* note 52, at 128–29.

<sup>56</sup> See *id.* at 129.

<sup>57</sup> See *infra* p. 1380.

<sup>58</sup> See STEPHANIE LEWIS ET AL., *THE HENRY J. KAISER FAMILY FOUND., REGULATION OF PRIVATE LONG-TERM CARE INSURANCE* 2 (2003), available at <http://www.kff.org/insurance/6073-index.cfm>.

<sup>59</sup> See *id.*

Long-term care insurance is a relatively new form of insurance, having been offered for the first time in the mid-1970s and marketed heavily only since the 1980s. Its early history was tarnished with reports of marketing abuses.<sup>60</sup> Consumers report similar problems today with denials of coverage,<sup>61</sup> which have led to demands for inquiries into the conduct of long-term care insurance companies.<sup>62</sup> Insurance regulation is primarily a state matter.<sup>63</sup> The National Association of Insurance Commissioners (NAIC), an organization of state insurance regulators, has developed uniform standards for long-term care insurance regulation.<sup>64</sup> Although many states have adopted these recommendations in whole or in part, the degree of consumer protection in state regulations varies.<sup>65</sup>

*C. The Linkage: The Medicaid Partnership for Long-Term Care*

The Medicaid Partnership for Long-Term Care works by encouraging consumers to purchase private long-term care insurance in exchange for asset protection under Medicaid rules. In other words, the Partnership permits an individual who has purchased long-term care insurance to transition to Medicaid after the insurance policy runs out, even if she would otherwise have too many resources to qualify for Medicaid.<sup>66</sup> The Partnership links two financing streams for long-term care that had previously operated independently: the LTCI market handles the front end, and the state picks up at least some of the back end. This arrangement makes LTCI policies less expensive, provided there is no accompanying cost-increasing regulation, because the government has taken on some of the responsibility for insuring poli-

<sup>60</sup> See *id.* at 5.

<sup>61</sup> See Charles Duhigg, *Aged, Frail, and Denied Care by Their Insurers*, N.Y. TIMES, Mar. 26, 2007, at A1.

<sup>62</sup> See Elder Law Prof Blog, [http://lawprofessors.typepad.com/elder\\_law/2007/03/nyt\\_article\\_on\\_.html](http://lawprofessors.typepad.com/elder_law/2007/03/nyt_article_on_.html) (March 28, 2007) (collecting reactions to news of long-term care insurance company abuses).

<sup>63</sup> However, the federal government reserves the right to step in. See McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15 (2000) (delegating to the states the authority to regulate insurance); *United States v. Se. Underwriters Ass'n*, 322 U.S. 533 (1944) (holding that insurance transactions constituted interstate commerce and thus were potentially regulable by Congress under the Commerce Clause).

<sup>64</sup> See NAT'L ASS'N OF INS. COMM'RS, LONG-TERM CARE INSURANCE MODEL REGULATION, in 4 MODEL LAWS, REGULATIONS, AND GUIDELINES 641-1 (2007).

<sup>65</sup> See LEWIS ET AL., *supra* note 58, at x-xii.

<sup>66</sup> California, Connecticut, and Indiana offer "dollar for dollar" asset protection up to the amount of insurance purchased. New York uses a "total assets" model, in which all assets are protected so long as the insurance policy pays out benefits for a certain amount of time. See Janice Cooper Pasaba & Alison Barnes, *Public-Private Partnerships and Long-Term Care: Time for a Re-Examination?*, 26 STETSON L. REV. 529, 545-47 & n.93 (1996).

cyholders.<sup>67</sup> The program is supposed to encourage middle-class individuals to purchase long-term care insurance instead of engaging in complex estate planning or spending down their resources in order to qualify for Medicaid.<sup>68</sup> Avoiding these situations would theoretically have the effect of more efficiently allocating societal resources and saving the government money.<sup>69</sup>

Starting with seed money from the Robert Wood Johnson Foundation, four states — California, Connecticut, Indiana, and New York — piloted Partnership programs under Medicaid waivers.<sup>70</sup> However, Congress restricted this activity with the Omnibus Budget Reconciliation Act of 1993,<sup>71</sup> preventing additional states from pursuing Partnership Medicaid waivers. Legislators passed these restrictions out of a concern that the Partnership programs were not lessening pressure on public budgets and were allowing higher-income individuals who would have purchased LTCI anyway to access Medicaid resources for which they would not otherwise have been eligible.<sup>72</sup>

More recently, the Deficit Reduction Act of 2005<sup>73</sup> (DRA) loosened the restrictions on states' engagement in the Partnership program. Since then, at least twenty-one more states have moved to take advantage of the opportunity to create and implement a Partnership program.<sup>74</sup> The provisions of the DRA set a regulatory floor that incorporates many sections of the NAIC's model regulation;<sup>75</sup> however, states are free to enact more consumer-protective regulations.

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<sup>67</sup> See Wiener, Tilly & Goldenson, *supra* note 26, at 84 ("The key observation supporting the public-private approaches is that long-term care insurance products that cover shorter periods of nursing home and home care are less expensive and more affordable than policies that cover longer periods of care.").

<sup>68</sup> See FROLIK, *supra* note 52, at 133–34.

<sup>69</sup> Whether the Partnership actually saves money is open to debate. See U.S. GOV'T ACCOUNTABILITY OFFICE, LONG-TERM CARE INSURANCE: PARTNERSHIP PROGRAMS INCLUDE BENEFITS THAT PROTECT POLICYHOLDERS AND ARE UNLIKELY TO RESULT IN MEDICAID SAVINGS 9–10 (2007), available at <http://www.gao.gov/new.items/do7231.pdf>.

<sup>70</sup> See JULIE STONE-AXELRAD, CONG. RESEARCH SERV., MEDICAID'S LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM 1–2 (2005), available at <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3261001212005.pdf>. Connecticut was the first to request a waiver. *Id.*

<sup>71</sup> See Pub. L. No. 103-66, § 13611, 107 Stat. 312, 571 (codified as amended at 42 U.S.C.A. § 1396p (West 2003 & Supp. 2007)).

<sup>72</sup> See STONE-AXELRAD, *supra* note 70, at 2.

<sup>73</sup> Pub. L. No. 109-171, § 6021, 120 Stat. 4, 68–72 (2006) (codified at 42 U.S.C.A. § 1396p(b)).

<sup>74</sup> These are Arkansas, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, Virginia, and Washington. See ENID KASSNER, AARP PUB. POLICY INST., LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAMS 1 tbl.2 (2006), available at <http://www.allhealth.org/BriefingMaterials/AARPFactSheet-450.pdf>.

<sup>75</sup> For example, the DRA requires that insurance companies develop and maintain their own suitability standards for determining whether consumer purchase is appropriate, see 42 U.S.C.A.

#### D. Regulatory Outcomes

When California, Connecticut, Indiana, and New York implemented their Partnership programs, they had a choice about whether to regulate Partnership LTCI policies in the same manner as they regulated standard LTCI products.<sup>76</sup> In each state, the regulation of the Partnership product was more extensive and arguably more consumer-protective than that of standard LTCI products.<sup>77</sup> Among other things, the Partnership regulations required greater standardization of benefit triggers,<sup>78</sup> more extensive coverage of home care services,<sup>79</sup> more notification provisions to prevent unintentional policy lapse,<sup>80</sup> and greater data reporting requirements<sup>81</sup> than the standard LTCI regulations required.

The most interesting contrast between Partnership and standard LTCI regulation, however, concerns the provisions for inflation protection. Because LTCI benefits are disbursed in terms of a fixed dollar amount per day, inflation has the potential to eat away at benefits over time.<sup>82</sup> The earlier one buys a policy — and buying early is generally recommended — the more likely it is that benefits will disappear before the onset of functional limitations. Inflation protection provisions increase benefits each year to take account of inflation. Without infla-

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§ 1396p(b)(5)(A)(i)(XV), a requirement that was previously proposed by the NAIC's model regulation, see NAT'L ASS'N OF INS. COMM'RS, *supra* note 64, § 24, at 641-38 to -39.

<sup>76</sup> This is not the case for states that adopt Partnership programs under the DRA, which prohibits differential regulation of Partnership and non-Partnership LTCI. See 42 U.S.C.A. § 1396p(b)(1)(C)(iii)(VII) (prohibiting states from "impos[ing] any requirement affecting the terms or benefits of [a long-term care insurance] policy unless the State imposes such requirement . . . without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership").

<sup>77</sup> For a summary of the different regulations, see Nelda McCall, *Insurance Regulation and the Partnership for Long-Term Care*, 16 J. INS. REG. 73 (1997).

<sup>78</sup> See *id.* at 78-80.

<sup>79</sup> See *id.* at 82-83, 85.

<sup>80</sup> See *id.* at 95-97.

<sup>81</sup> See *id.* at 97-98. The data reporting requirements may be an attempt to extend public law accountability mechanisms to private actors. See Freeman, *supra* note 21. For standard policies, states require only "aggregate reporting of rescissions" and, in some cases, "aggregate reporting of . . . lapses, replacements, policies sold, [or] policies in force." McCall, *supra* note 77, at 97. Although these requirements allow some minimal degree of oversight, regulators cannot make more specific inquiries because the data is aggregated. In contrast, for Partnership policies, insurance companies must report information on "policyholders and the characteristics of policies purchased (including information on changes in coverage and dropped policies); assessments for benefit eligibility; claims paid as part of the policy benefit; and individuals who were denied policy coverage." *Id.* The greater amount of information allows more effective monitoring of the functioning of the insurance product; the requirements may also act as a check on bad behavior even if states do not actively bring enforcement actions or support litigation by individual claimants.

<sup>82</sup> For examples of how inflation protection can drastically change the benefits available, see Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK L. REV. 407, 432-33 (2007).



tion protection, buyers can self-insure by calculating the effect of inflation on their benefits and saving up money to make up the gap. However, it is not clear that consumers can or want to plan for long-term care needs so far in advance and in so much detail;<sup>83</sup> moreover, many consumers cannot save enough on their own to fully cover long-term care expenses.

Mandated inflation protection provisions could be categorized as a form of consumer-protective regulation on the theory that policies that do not have such a provision are defective and should not be sold on the open market, at least not to those for whom an insurable event is likely years away.<sup>84</sup> Such regulation increases the price of policies, putting them outside of the price range of some consumers. Most likely on these grounds, insurance companies generally oppose a requirement of mandatory compound inflation protection.<sup>85</sup> Thus, many states, including the Partnership states<sup>86</sup> and states that have adopted the NAIC's model regulation,<sup>87</sup> require that standard LTCI products provide merely an *offer* of inflation protection. However, when it came to regulating Partnership policies, the Partnership states all promulgated regulations requiring compound inflation protection.<sup>88</sup>

<sup>83</sup> See Diane Lourdes Dick, *Tax and Economic Responses to the Medicaid Long-Term Care Financing Crisis: A Behavioral Economics Approach*, 5 CARDOZO PUB. L. POL'Y & ETHICS J. 379, 390–99 (2007) (detailing how consumers experience utility losses just through the contemplation of their future disabled selves).

<sup>84</sup> Cf. Daniel Schwarcz, *A Products Liability Theory for Judicial Regulation of Insurance Policies*, 48 WM. & MARY L. REV. 1389, 1398 (2007) (arguing that judicial regulation of insurance policies is justified to ensure that insurers that issue “defective” policies provide coverage to insureds, just as firms that make defective products must pay for the injuries their products cause). Consistent with this theory, some states that mandate inflation protection for their Partnership policies lift the requirement for purchasers who are above a certain age. See, e.g., CONN. AGENCIES REGS. § 38a-475-4(c)(3)(B) (1999) (lifting the requirement with respect to purchasers over age 65). An arguably less paternalistic method for protecting consumers would be to require an opt-out provision, with inflation protection being the default rule. See Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. CHI. L. REV. 1159, 1174–77 (2003) (discussing the importance of default rules in structuring decisions while preserving freedom of choice); see also Colin Camerer et al., *Regulation for Conservatives: Behavioral Economics and the Case for “Asymmetric Paternalism,”* 151 U. PA. L. REV. 1211, 1224–25 (2003) (discussing the relationship between defaults and status quo bias). For a contrary view, see Gregory Mitchell, *Libertarian Paternalism Is an Oxymoron*, 99 NW. U. L. REV. 1245, 1260–69 (2005) (arguing that default rules should be set so as to maximize liberty, not welfare).

<sup>85</sup> See McCall, *supra* note 77, at 100–01 (“[Insurance companies] argue against requiring specific policy features, especially ones which are cost-increasing, such as inflation protection and nonforfeiture, and they oppose the standardization of products as an affront to consumer choice and a barrier to innovation.”).

<sup>86</sup> See CAL. INS. CODE § 10237.1 (West 2005); CONN. AGENCIES REGS. § 38a-501-20 (1998); 760 IND. ADMIN. CODE 2-7-1 (2001); N.Y. COMP. CODES R. & REGS. tit. 11, § 52.25(c)(3) (1995).

<sup>87</sup> See NAT'L ASS'N OF INS. COMM'RS, *supra* note 64, § 13, at 641-18 to -20.

<sup>88</sup> See CAL. WELF. & INST. CODE § 22005.1(b)(3) (2001); CONN. AGENCIES REGS. § 38a-475-4(c)(3); 760 IND. ADMIN. CODE 2-20-38.1(a)(2) (2001 & Supp. 2007); N.Y. COMP. CODES R. & REGS. tit. 11, § 39.6(b)(11) (2005). How the new Partnership states will develop their inflation

## IV. ANALYSIS

Along several dimensions, the regulations governing Partnership LTCI were more stringent and arguably more consumer-protective than the regulations governing standard LTCI. These regulations were not imposed from above, but instead were the result of negotiations between regulators and insurance companies.<sup>89</sup> If the regulators had been dissatisfied with the types of policies that the insurance companies were prepared to sell, they could have refused to endorse those policies. Similarly, if the proposed regulations had been too harsh, the insurance companies could have walked away from the table. The framework established in Part II helps explain why the parties were able to reach an agreement.

A. *Private Sector Benefits*

The Partnership has arguably benefited insurance companies. To be sure, mandatory inflation protection provisions and other regulations increase the cost to insurance companies of providing insurance. This presumably causes the price of policies to rise, and thus the market shrinks as some consumers are priced out. However, three factors would seem to counter this effect. First, the costs of long-term care are notoriously difficult to insure against,<sup>90</sup> and insurance companies may welcome financial assistance from the government in the task. Second, insurance companies can expand their customer base by marketing the Partnership policy, which may be more attractive to consumers because it provides extended coverage.<sup>91</sup> Potential purchasers on the margin may be attracted by the higher quality product. In addition, because long-term care insurance companies suffered from reputational problems following the abuses that existed at the time of the

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protection regulations is an interesting question. The DRA requires compound inflation protection for purchasers under age 61, “some level of inflation protection” for those between 61 and 76, and for those over 76, the policy “may (but is not required to) provide some level of inflation protection.” 42 U.S.C.A. § 1396p(b)(1)(C)(iii)(IV) (West 2003 & Supp. 2007). Although it appears that there is no wiggle room with respect to purchasers under 61, states will have discretion to define what “some level of inflation protection” means for the older groups.

<sup>89</sup> See McCall, *supra* note 77, at 75 (“[E]ach state, in collaboration with the insurers, developed specific regulations with which Partnership policies had to comply . . . . These regulations were developed by the states in open forums with participation by the insurers and, in some states, by consumer representatives.”).

<sup>90</sup> See, e.g., NICHOLAS BARR, *THE WELFARE STATE AS PIGGY BANK* 81–83 (2001) (detailing the information problems faced by insurance companies). This forms part of the argument for a social insurance approach to long-term care financing. See *id.* at 83–85.

<sup>91</sup> Ironically, insurance companies may have marketed against the Medicaid benefits provided by Partnership policies. See Wiener, Tilly & Goldenson, *supra* note 26, at 89–91 (noting that consumers were often attracted to LTCI as a way to avoid Medicaid and highlighting the fact that insurers often marketed their policies as such).

Partnership's inception,<sup>92</sup> the governmental stamp of approval implicit in the Partnership may have convinced some individuals to buy the insurance who otherwise would not have done so. Third, because the four states that implemented Partnership programs allowed insurance companies to maintain their standard policies under the older regulatory regime, consumers who were more sensitive to price than to policy quality were not lost to the insurance companies. Thus, insurance companies likely achieved a net gain in profits as a result of the Partnership, even if their customer base for Partnership policies was smaller than that for standard LTCI policies due to regulation.

### *B. Regulator Motivation*

The fact that the regulatory regimes for standard and Partnership policies differed seems to suggest that state regulators were not entirely captured by the insurance industry, even though state insurance regulators are often thought of as more likely than other types of regulators to be captured.<sup>93</sup> Consumer protection, however, was likely not the primary motive for regulators to pursue more stringent Partnership regulations; otherwise, they would have regulated standard LTCI products in a similarly consumer-protective way. In the case of Partnership policies, the government had an additional financial interest in making sure that insurance companies were providing an insurance product that adequately financed the front end of long-term care expenses. The presence of this rationale may have moved regulators to act in a more aggressive way based on some preexisting ideology, or there might have been pressure from the legislative or executive branches of the state to regulate in a way that saved the state money. The important fact is that there was a persuasive rationale available for those regulators who wished to respond to it.

### *C. Alignment of Interests*

In the case of the Partnership, the governmental interest in ensuring that private insurance was adequate to cover the costs of long-term care during the period in which the private sector was responsible for it may have aligned with a consumer interest in having high quality policies singled out for endorsement, both symbolically and financially, by the government. Whether such regulations are optimal for consumer welfare or whether a less paternalistic approach would be more appropriate is open to debate,<sup>94</sup> but given the continued existence of

<sup>92</sup> See *supra* p. 1379.

<sup>93</sup> See Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. ST. U. L. REV. 625, 639-41 (1999) (discussing the particular problems of capture in the insurance context).

<sup>94</sup> See *supra* note 84.

standard LTCI policies with less stringent requirements, it is likely that consumer freedom of choice was not harmed in a significant way.

*D. The Future of the Partnership*

Many of the aspects of the Partnership that contributed to the promulgation of consumer-protective regulation may be absent going forward. First, insurance companies may be less willing to enter the Partnership, seeing fewer benefits than before. The DRA requires that states creating a Partnership apply the same regulations to Partnership policies as they apply to standard policies.<sup>95</sup> If insurance companies were forced to make all of their products comply with the stringent regulations currently applicable to Partnership policies, the Partnership would presumably be less profitable for them. In addition, insurance companies have been disappointed with the sales of Partnership policies thus far, even though there is evidence that sales of LTCI policies in the four pilot Partnership states were somewhat better than sales in non-Partnership states.<sup>96</sup> Consequently, insurance companies may perceive the costs of complying with stringent regulations that differ from state to state as exceeding the benefits of entering into the Partnership.

Second, it is not clear that the Partnership actually saves the government money,<sup>97</sup> and so one of the government's rationales for entering into the Partnership may no longer apply. Without such a rationale, public-interested regulators may be less motivated to pursue regulation that could be consumer-protective, or they may overregulate in hopes of shifting enough risk to the private sector to make the Partnership cost-saving for the government. The latter of these two possibilities could actually harm consumers or lead insurance companies to withdraw from the Partnership or the LTCI market altogether.

Finally, given the DRA's requirement that regulations apply equally across standard and Partnership policies, it is unclear whether new Partnership states will pursue regulations similar to those pursued by the original Partnership states. Determining the proper amount of regulation involves a careful balancing of priorities, often requiring the government to take into account input from the insurance industry about the nature of the market and consumer demand. If consumer-protective regulations akin to the ones promulgated in California, Connecticut, Indiana, and New York would increase costs beyond the reach of a large number of middle-class consumers, significantly harm-

<sup>95</sup> 42 U.S.C.A. § 1396p(b)(1)(C)(iii)(VII) (West 2003 & Supp. 2007).

<sup>96</sup> See Kaplan, *supra* note 82, at 447–48.

<sup>97</sup> See *supra* note 69.

ing insurance companies in the process, then regulators may hesitate before promulgating them.

## V. CONCLUSION

This Note presents an argument that joint financing public-private partnerships may create situations hospitable to the promulgation of consumer-protective regulation in the insurance context if certain conditions are met. The opportunities for such PPPs are greatest in areas in which there exist fragmented financing mechanisms for the same social good, as is common in the areas of health and social care. The Medicaid Partnership for Long-Term Care is suggestive of the processes detailed in this Note, although there are questions about whether future states implementing Partnership programs will follow a similar route. Regardless, Senator Clinton and other policymakers at the state and federal levels should be alert to the possibilities for positive developments in insurance regulation and collaborative governance presented by joint financing public-private partnerships.