Long-Term Care: The Problem

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ABSTRACT

Providing and funding long-term care (LTC[1]) for the elderly is a large and growing challenge. Baby boomers start turning 85 — the age at which health and LTC costs spike — in 2031, as Social Security and Medicare face insolvency. The government, mostly through Medicare and Medicaid, finances almost three-fourths of LTC expenditures (72.3 percent in 2020).[2] Central planning, public funding, heavy regulation, and easy access to welfare benefits have caused most of LTC's problems, such as nursing home bias, poor access and quality, inadequate revenue for care providers, caregiver shortages, and the terrible emotional and financial distress for caregiving families. Medicaid especially is responsible because, despite the conventional wisdom that it requires impoverishment, the program's LTC benefits are routinely available not only to the poor but to the middle class and affluent as well.

The entrepreneurial private sector responded creatively to mitigate — though not completely resolve — the problems created by public financing and regulation. The dominance of Medicaid and Medicare financing for nursing homes and home care prevented alternative modes of LTC service delivery and financing from fully developing based on consumer preferences. Access to publicly financed LTC creates a moral hazard that discourages responsible LTC planning when people are still young, healthy, and affluent enough to save, invest, or insure for the risk. Policymakers should consider how public financing created and worsened LTC's problems before proposing more of the same to address those problems. This paper outlines the problems caused by well-intentioned but ultimately damaging government LTC policies. A forthcoming paper will describe the best policy options moving forward.

1 The term *long-term services and supports* (LTSS) has replaced long-term care (LTC) as the preferred term of art among policy analysts. The awkward neologism evolved to emphasize the need for home and community based services (HCBS) to replace nursing homes, the less desirable venue that had become synonymous with LTC. The irony is that Medicaid is responsible for the LTC system's nursing home bias. If Medicaid had not paid for nursing home care after the insurable event occurs for most Americans, including the middle class, since 1965, there would have been a healthier, private home-care-based service delivery system funded largely by personal savings, home equity conversion, and private LTC insurance. Ironically, the same people who caused the problem of institutional bias by demanding more and more government financing and interference in the LTC market are the ones now preferring the acronym LTSS and denigrating the traditional appellation LTC. This paper uses the term LTSS only when quoting other sources or when referring specifically to HCBS.

2 Kirsten Colello, "Who Pays for Long-Term Services and Supports?," *Congressional Research Service*, June 15, 2022, https://crsreports.congress.gov/product/pdf/IF/IF10343.

THE PROBLEM

America's LTC system is broken. It poorly serves, both financially and emotionally, the people who receive care as well as the workers and companies that provide care. Moreover, government funding and regulation are pervasive, whereas private financing and personal responsibility have declined substantially.

Leading LTC "reforms" to address this broken system have centered on expanding government programs. Examples include the Pepper Commission in 1990;[3] the Commission on Long-Term Care, 2013;[4] and the Biden administration's "Build Back Better" plan.[5] Based on analysis published in *Health Affairs*,[6] two February 2016 reports by Leading Age,[7] and the ad hoc LTC Financing Collaborative,[8] many leading policy experts who support increased government involvement have coalesced around a consistent plan: compulsory, payroll-tax-funded social insurance to finance LTC. Having failed to achieve such a system nationally,

3 "The commission voted overwhelmingly (11 to 4) in favor of a major government initiative in long-term care. First, this initiative would establish government or social insurance to keep resources intact for severely disabled people at home or with the potential to return home after a short nursing home stay, and second, it would establish a floor of protection against impoverishment for all nursing home users, no matter how long they stay. It is estimated that this long-term care program, although limited relative to the full social insurance some have proposed, would cost $43 billion if implemented in 1990 — almost two thirds of the $70 billion cost of the commission's full set of recommendations." John Rockefeller, "The Pepper Commission Report on Comprehensive Health Care," *New England Journal of Medicine*, vol. 323, no. 14 (1990), pp. 1005-1007, https://www.nejm.org/doi/full/10.1056/nejm199010043231429.

4 "The Commission did not agree on a financing approach, and, therefore, makes no recommendation." However, as the commission's co-chairs explained, "The Commission offered two different approaches for mechanisms to move toward this end — one relying largely on private options and the other largely on public social insurance.... The public social insurance approach described two possible models — create a comprehensive Medicare benefit for LTSS or create a basic LTSS benefit within Medicare or a new public program — both allowing for private sector involvement." Bruce Chernof and Mark J. Warshawsky, "Recommendations from the Federal Commission on Long-Term Care: Blueprint for a Bipartisan Path Forward," *Public Policy and Aging Report*, vol. 24, no. 2 (2014), pp. 37-39, https://doi.org/10.1093/ppar/pru008.

5 "That's the challenge President Biden has put forward with his bold proposal to spend $400 billion over eight years on home and community-based services — a major part of his $2 trillion infrastructure plan." Judith Graham, "What's in Biden's $400 Billion Plan to Support Families' Long-Term Health Needs," *NPR*, April 9, 2021, https://www.npr.org/sections/health-shots/2021/04/09/985567929/whats-in-bidens-400-billion-plan-to-support-families-long-term-health-needs.

6 "If the primary goal is to significantly increase insurance coverage, the mandatory options would be more successful than the voluntary versions. If the major aim is to reduce Medicaid costs, the comprehensive and back-end mandatory options would be most beneficial." Melissa Favreault, Howard Gleckman, and Richard Johnson, "Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans and Federal Spending," *Health Affairs*, vol. 34, no. 12 (2015), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1226.

7 "A universal insurance approach that covers catastrophic costs would have the greatest positive impact on both individuals and strained public programs, while creating a more rational system." *LeadingAge*, "Leading Age 2016 Pathways Report: Perspectives on the Challenges of Financing Long-Term Services and Supports," 2016, https://leadingage.org/leadingage-2016-pathways-report-perspectives-challenges-financing-long-term-services-and-supports.

8 "After careful consideration, we concluded that no voluntary insurance program is broadly affordable. Thus we recommend a universal catastrophic insurance program." Long-Term Care Financing Collaborative, "A Consensus Framework for Long-Term Care Financing Reform," *Convergence Center for Policy Resolution*, 2016, https://www.convergencepolicy.org/wp-content/uploads/2016/02/LTCFC-FINAL-REPORT-Feb-2016.pdf.

analysts and advocates have moved recently to propose the same approach in several states, including Washington, California, Pennsylvania, and New York.[9]

Before adopting a new government program, policymakers should confront several questions: How did LTC become so dysfunctional in the first place? Would adding more government funding and control improve a delivery and financing system already dominated by both? Are there ways to address these problems that reduce dependence on government and engage consumers' self-interest, personal responsibility, and individual effort more fully? What do policymakers need to know about the LTC market before they try to fix it with even more laws, regulations, and taxes? To answer those questions, understanding what services LTC includes, its history, and its financing is essential.

LTC BACKGROUND

LTC includes a wide range of medical and social services that people require when they are unable to take care of themselves. LTC need may arise at any age due to injury, illness, frailty, or cognitive impairment, but the focus here is illness or frailty due to old age.

The probability of needing LTC is high. Seventy percent of people who reach age 65 will eventually develop severe need, and 48 percent will receive paid care.[10]

The need for paid care spikes around age 85.[11] America's 85 and older population is growing rapidly, as the following figure shows. Americans over the age of 85 are projected to be 3.9 percent of the population in 2040, substantially more than the 1.5 percent of the population they made up in 2000 and the 2.2 percent of the population they make up today. Americans over the age of 85 will continue to increase thereafter. The percentage will nearly triple between 2015 and 2050.[12]

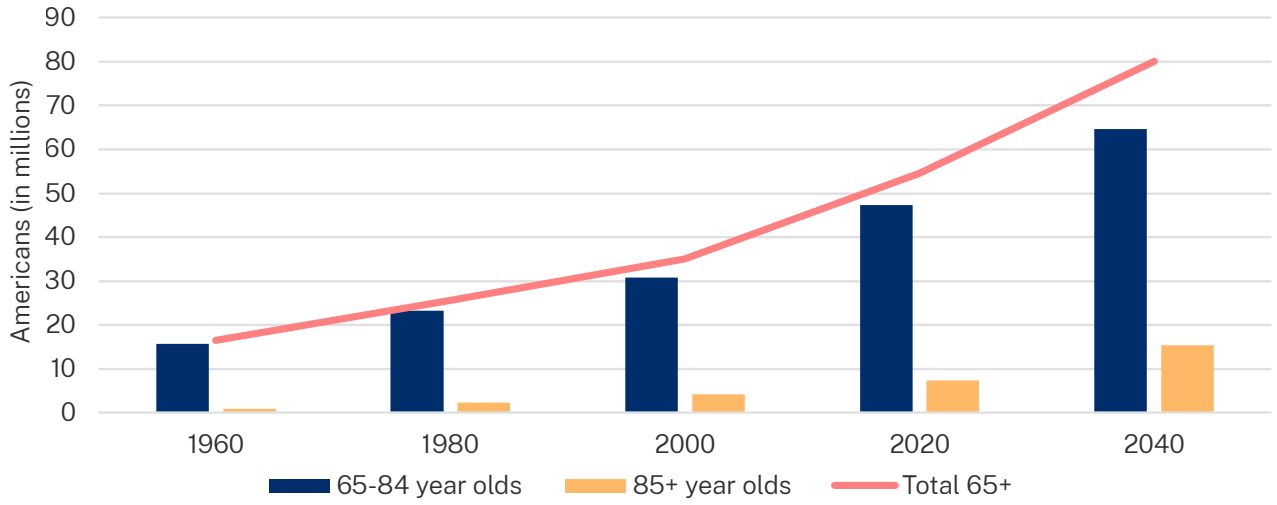
9 "Thirteen states, including California, New York, Pennsylvania, Illinois, Michigan, and Minnesota, are considering following Washington's lead in taxing those who do not own Long-Term Care Insurance." *LTC News*, "Multiple States Considering Implementing Long-Term Care Tax," October 30, 2021, https://www.ltcnews.com/articles/multiple-states-considering-implementing-long-term-care-tax.

10 Richard Johnson, "What Is the Lifetime Risk of Needing and Receiving Long-Term Services and Supports?," *Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services*, 2019, https://aspe.hhs.gov/reports/what-lifetime-risk-needing-receiving-long-term-services-supports-0.

11 "In 2014, 40 percent of adults ages 85 and older had severe LTSS needs, compared with 8 percent of those ages 65-74. Adults ages 85 and older were also much more likely than younger adults to receive all types of paid LTSS; 13 percent of the oldest-old received long-term nursing home care, compared with only 1 percent of those ages 65-74." Ibid.

12 Ari Houser, Wendy Fox-Grage, and Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports," *AARP Public Policy Institute*, 2019, https://blog.aarp.org/thinking-policy/across-the-states-profiles-of-long-term-services-and-supports.

Figure 1A: Substantial Growth in Older Americans Projected to Increase



Source: U.S. Census Bureau

Paid care is expensive, whether provided in a nursing home ($297 per day for a private room, $260 for a semi-private room) or assisted living facility ($4,500 per month) or at home by a home health aide ($27 per hour).[13]

LTC spending in the United States was $475.1 billion in 2020,[14] up 29.8 percent from $366.0 billion in 2016,[15] with 72.3 percent coming from public sources — including 42.1 percent from Medicaid and 18.2 percent from Medicare — and 27.7 percent from private sources, including out-of-pocket expenditures (13.5 percent) and private insurance (7.8 percent).[16] Besides this formal paid caregiving, families and friends provided unpaid care with an opportunity cost of $522 billion annually. To replace informal care with unskilled or skilled paid care would cost $221 billion and $642 billion, respectively.[17]

Medicaid's and Medicare's Role Financing LTC

Given the high and rising need and cost of LTC, figuring out how to pay for it is critical. Care providers receive over 70 percent of their revenue from government sources, primarily Medicaid and Medicare. Medicaid pays for most long-term custodial care. Medicare pays for

13 *Genworth*, "Genworth Cost of Care Survey: Summary of 2021 Survey Findings," 2022, https://pro.genworth.com/riiproweb/productinfo/pdf/131168.pdf.

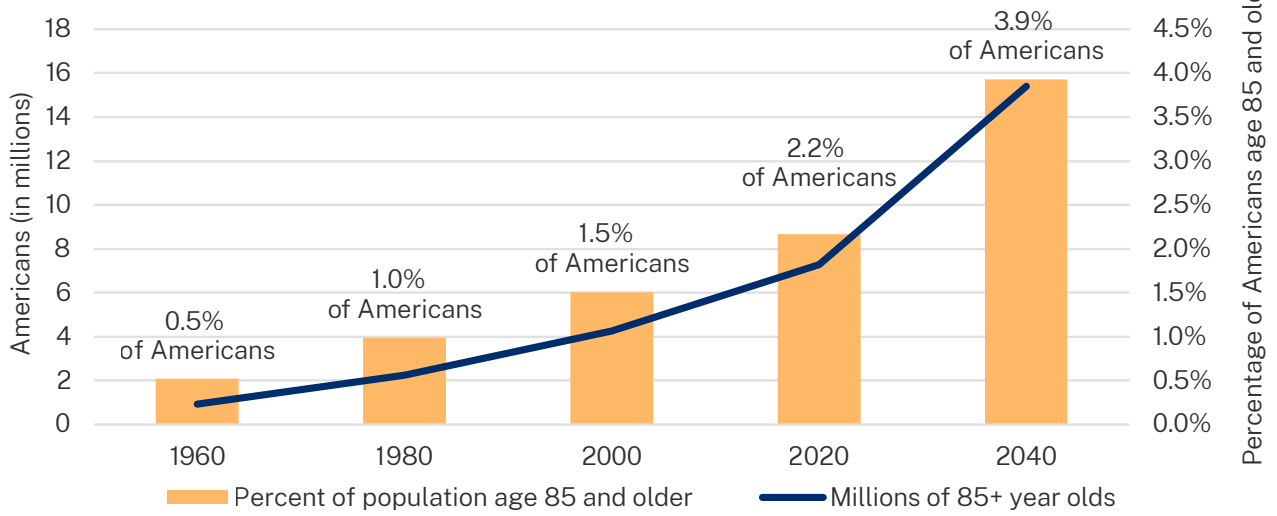
14 Colello, "Who Pays for Long-Term Services and Supports?"

15 Ibid.

16 Ibid.

17 Amalavoyal Chari et al., "The Opportunity Costs of Informal Elder-Care in the United States: New Estimates from the American Time Use Survey," *Health Services Research*, 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4450934/.

Figure 1B: Substantial Growth in Very Old Americans Projected to Increase Even More



Source: U.S Census Bureau

shorter-term sub-acute and rehabilitative care. Medicaid LTC reimbursement is notoriously meager, often less than the cost[18] of providing the care.[19] Medicaid funds 65.4 percent of nursing home patient days and contributes 49.6 percent of their revenue.[20] Medicare reimbursement is more generous and helps to make up for losses from Medicaid, but Medicare faces serious solvency problems. Medicare has large and growing unfunded liabilities — $34.6 trillion as of October 2, 2022[21] — and the Medicare Payment Advisory Commission (MedPAC) often recommends cutting reimbursement levels.[22] [23]

18 "In some states, AHCA [American Health Care Association] contends, the rate is actually less than the cost of care, leaving providers to leverage the other payor sources (Medicare, managed Medicare, and Private) to offset losses." Liz Liberman, "Medicaid Reimbursement Rates Draw Attention," *NIC/CARES blog*, 2018, https://www.nic.org/blog/medicaid-reimbursement-rates-draw-attention/.

19 "The national increase in total cost PPD [per patient day] from 2019 to 2020 is $35.98. This $11.00 PPD difference represents the gap between the financial assistance the industry received and the additional cost that was incurred in 2020." *Marcum LLP*, "Benchmark Analysis: A Three-Year Nursing Home Statistical Review," 2022, https://info.marcumllp.com/2022-marcum-nursing-home-benchmark-study.

20 *National Investment Center for Seniors Housing and Care*, "Skilled Nursing Monthly Report: Data Through June 2022," 2022, https://info.nicmapvision.com/nic-map-vision-skilled-nursing-monthly-report-thank-you.html.

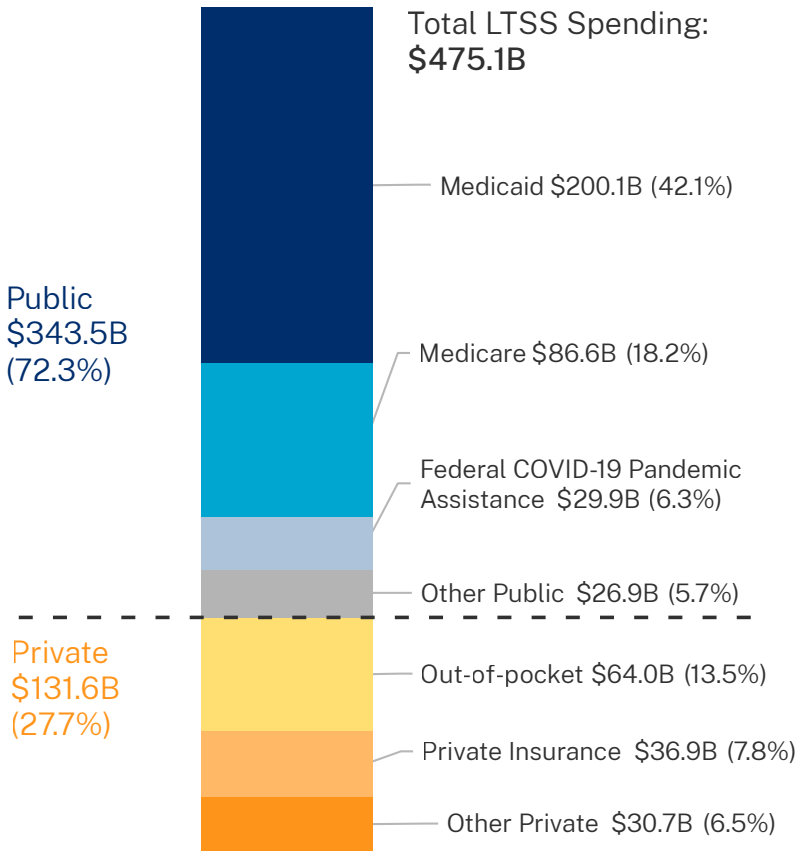
21 Usdebtclock.org, "US Debt Clock," https://www.usdebtclock.org/.

22 "Home health agencies could see a 5% Medicare decrease in reimbursement in fiscal year 2023, if Congress follows a draft recommendation from the Medicare Payment Advisory Commission (MedPAC)." Liza Berger, "MedPAC Recommends 5% Cut to Medicare Home Health in FY 2023," *McKnight's Home Care*, 2021, https://www.mcknightshomecare.com/medpac-recommends-5-cut-to-medicare-home-health-in-fy-2023.

23 "The MedPAC Commissioners convened December 10 to review the state of affairs for Medicare payments for Skilled Nursing Facilities and based upon this information, recommended to Congress that it reduce Medicare rates for SNF by 5%. Similar recommendations to reduce SNF Medicare rates have been made by MedPAC annually for many years to little or no avail." Nicole Fallon, "MedPAC Recommends Medicare Rate Cuts for SNF," *Regulation*, 2021, https://leadingage.org/regulation/medpac-recommends-medicare-rate-cuts-snf.

Figure 2: Government Programs Dominate Long-Term Care Financing

Long-Term Services and Supports (LTSS) Spending by Payer, 2020
Billions of Dollars



Source: Congressional Research Service

The amount of LTC funded by private pay, including out-of-pocket expenditures and private health insurance, has declined steadily since Medicaid began paying for nursing home care in 1965. In 1970, patients privately paid 49.2 percent of nursing home costs, but today they contribute only 23.0 percent.[24] Only 7.6 percent of nursing home revenues are from patients

24 *Centers for Medicare and Medicaid Services*, "Table 15: Nursing Care Facilities and Continuing Care Retirement Communities Expenditures; Levels, Percent Change, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2020," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.

paying privately.[25] Home care is similar. As of 2020 only 10.2 percent of home care costs were paid out of pocket.[26] The remainder came from public or private insurance.

Medicaid has a disproportionate impact on LTC. Although it paid only 42.1 percent of LTC dollars in 2020,[27] Medicaid's influence is much greater. The program covers 62 percent of all nursing home residents[28] and 16.5 percent of assisted living residents,[29] and it makes a rapidly growing contribution to home and community based services (HCBS).[30]

How can Medicaid pay only two-fifths of LTC costs but cover three-fifths of the most expensive patients (i.e., those in nursing homes)? Three factors principally account for this incongruity:

1. Costs are shifted from private patients. Medicaid provider reimbursements are roughly 70 percent of private-pay rates.[31]
2. Medicaid LTC recipients are required to contribute most of their income to offset the program's cost for their care.[32] This can and occasionally does result in a Medicaid recipient's income covering the entire cost of the care, leaving the nursing home in receipt of the low Medicaid rate even though Medicaid paid nothing.

25 *National Investment Center for Seniors Housing and Care*, "Skilled Nursing Monthly Report."

26 *Centers for Medicare and Medicaid Services*, "Table 14: Home Health Care Services Expenditures; Levels, Percent Change, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2020," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.

27 Colello, "Who Pays for Long-Term Services and Supports?"

28 "Medicaid is the primary payer source for most certified nursing facility residents, with more than six in ten (62%) residents — about 832,000 people — having Medicaid as their primary payer in 2016." Charlene Harrington et al., "Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016," *Kaiser Family Foundation*, 2018, https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/.

29 "Almost 1 in 6 residents relies on Medicaid to pay for daily services (16.5%)." *American Health Care Association/National Center for Assisted Living*, "Facts and Figures," https://www.ahcancal.org/Assisted-Living/Facts-and-Figures/Pages/default.aspx.

30 "HCBS account for 59% of LTSS spending in FY 2019, the highest share to date, though the national data mask notable state-level variation." Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Ammula, "Medicaid Home and Community-Based Services: People Served and Spending During COVID-19," *Kaiser Family Foundation*, 2022, https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-COVID-19-issue-brief/.

31 "The Medicaid reimbursement rate for nursing home care is approximately 70% of what a private payer pays." *American Council on the Aging*, "2021 Nursing Home Costs by State and Region," 2022, https://www.medicaidplanningassistance.org/nursing-home-costs/.

32 "Once eligible for Medicaid, individuals in institutions generally must contribute most of their monthly income to the cost of their care, with the exception of a small allowance used to pay for personal needs that are not covered by Medicaid, such as clothing." MaryBeth Musumeci, Priya Chidambaram, and Molly O'Malley Watts, "Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey," *Kaiser Family Foundation*, 2019, https://www.kff.org/medicaid/issue-brief/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-findings-from-a-50-state-survey/.

3. Medicare, which pays far more generously than Medicaid does for nursing home and home care,[33] enables LTC providers to survive financially while most of their patients' care is reimbursed at meager Medicaid rates.[34]

The impact of Medicaid LTC financing is substantially greater than the raw numbers suggest in ways almost never acknowledged in the literature. For example, most of the income Medicaid recipients contribute to offset Medicaid's cost for their care comes from Social Security. Although Social Security is not usually considered a financing source for LTC, the fact is that it contributes very significantly, albeit indirectly as "spend-through." Social Security spend-through refers to income most seniors collect in the form of Social Security benefits that they must contribute toward their cost of care when they receive LTC services paid for by Medicaid. There is very little in the literature about this source of LTC financing, although research from 20-30 years ago indicated it accounts for nearly half of reported out-of-pocket nursing home costs. Thus, Social Security spend-through amounts to nearly half of the $45.3 billion (23.0 percent) reported as "out-of-pocket" costs in 2020[35] as inferred based on Lazenby and Letsch (1989)[36] and McCall (2001).[37]

This added dependency of LTC providers on Social Security and Medicare contributes to the fragility of the LTC financing system. If the Social Security and Medicare Part A trust funds expire as expected in 2035[38] and 2028,[39] respectively, resulting in substantial cuts to those programs, LTC providers dependent upon those revenues will be in further financial peril.

33 "In 2016, the average Medicare margin for freestanding SNFs was 11.4 percent — the 17th year in a row that the average was above 10 percent.... The marginal profit, a measure of the relative attractiveness of treating Medicare beneficiaries, was at least 19.6 percent for freestanding facilities." *Medicare Payment Advisory Commission*, "Report to the Congress: Medicare Payment Policy," 2018, ch. 8, https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar18_medpac_entirereport_sec_rev_0518-pdf/.

34 MedPAC objects to Medicare's higher reimbursement margins for nursing homes and home care providers but fails to take into account the fact that higher Medicare margins make it possible for LTC providers to manage when most of their patients are on Medicaid with their care compensated often at less than cost. Ibid.

35 *Centers for Medicare and Medicaid Services*, "Table 15: Nursing Care Facilities and Continuing Care Retirement Communities Expenditures."

36 According to the Health Care Financing Administration (the predecessor of the Centers for Medicare and Medicaid Services): "An estimated 41 percent ... of out-of-pocket spending for nursing home care was received as income by patients or their representatives from monthly social security benefits." Helen Lazenby and Suzanne Letsch, "National Health Expenditures, 1989," *Health Care Financing Review*, vol. 12, no. 2 (1990).

37 Later research confirmed that Social Security spend-through is almost half of nursing home out-of-pocket costs. "As shown in this table, Social Security income is a substantial contributor to financing long-term care." The table referenced here shows that 15.3 percent of all nursing home expenditures for 1997 — more than half of the total 31 percent out-of-pocket expenditures for that year — came from Social Security income that Medicaid recipients were required to contribute to offset Medicaid's cost of their care. Nelda McCall, *Who Will Pay for Long Term Care? Insights from the Partnership Programs* (Chicago: Health Administration Press, 2001).

38 "Social Security's combined trust funds are projected to cover full payment of scheduled benefits on a timely basis until the trust fund reserves become depleted in 2035." Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, "The 2022 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds," 2022, https://www.ssa.gov/OACT/TR/2022/tr2022.pdf.

39 "The projected [Hospital Insurance] trust fund depletion date is 2028, 2 years later than estimated in last year's report." Boards of Trustees [Medicare], Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," 2022.

Likewise, LTC has a disproportionate impact on Medicaid. Despite a relatively small number of Medicaid enrollees using LTC services, the spending associated with these groups is outsized. As Figure 3 indicates, the aged and disabled who are most likely to use LTC were 21 percent of Medicaid enrollees[40] but accounted for 55 percent of Medicaid expenditures in 2019.[41] Furthermore, LTC users, who are 5.9 percent of enrollees, consumed 41.8 percent of total Medicaid benefit spending for both institutional and non-institutional LTC in 2013.[42]

The high cost of LTC, LTC providers' heavy dependence on public financing at low Medicaid reimbursement rates, and LTC's disappearing higher market-rate private revenue have serious consequences for care access and quality. People who need care often do not qualify immediately for the public programs that provide it. Yet they cannot afford to pay privately for care at market rates, at least not for very long. Underfunded nursing home and home health providers face labor shortages and wage pressures exacerbated by pandemic complications, including vaccine mandates and inflation. Direct caregivers are expected to do the hard work of attending patients for long hours at relatively low wages, so they are in short supply.[43] [44] Individuals, families, and friends fill the service gap by providing unpaid care. This often means foregone earnings, reduced leisure, and direct care expenses.

LTC History

The history of LTC involves a constant tension between public and private financing. Repeatedly, government interventions in the LTC financing system caused negative unintended consequences. In response, entrepreneurs attempted to ameliorate the problems but never solved them entirely.

For example, government involvement caused explosive costs and nursing home bias, impaired LTC financing, created caregiver shortages, hampered LTC access and quality, and obstructed promising private LTC insurance and home care services markets. In response,

40 *Kaiser Family Foundation*, "Medicaid Enrollees by Enrollment Group," 2019, https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/?dataView=1&currentTimeframe=0&sortModel=%7B"colId":"Location","sort":"asc"%7D.

41 *Kaiser Family Foundation*, "Medicaid Spending by Enrollment Group," 2019. https://www.kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/?dataView=1&currentTimeframe=0&sortModel=%7B"colId":"Location","sort":"asc"%7D.

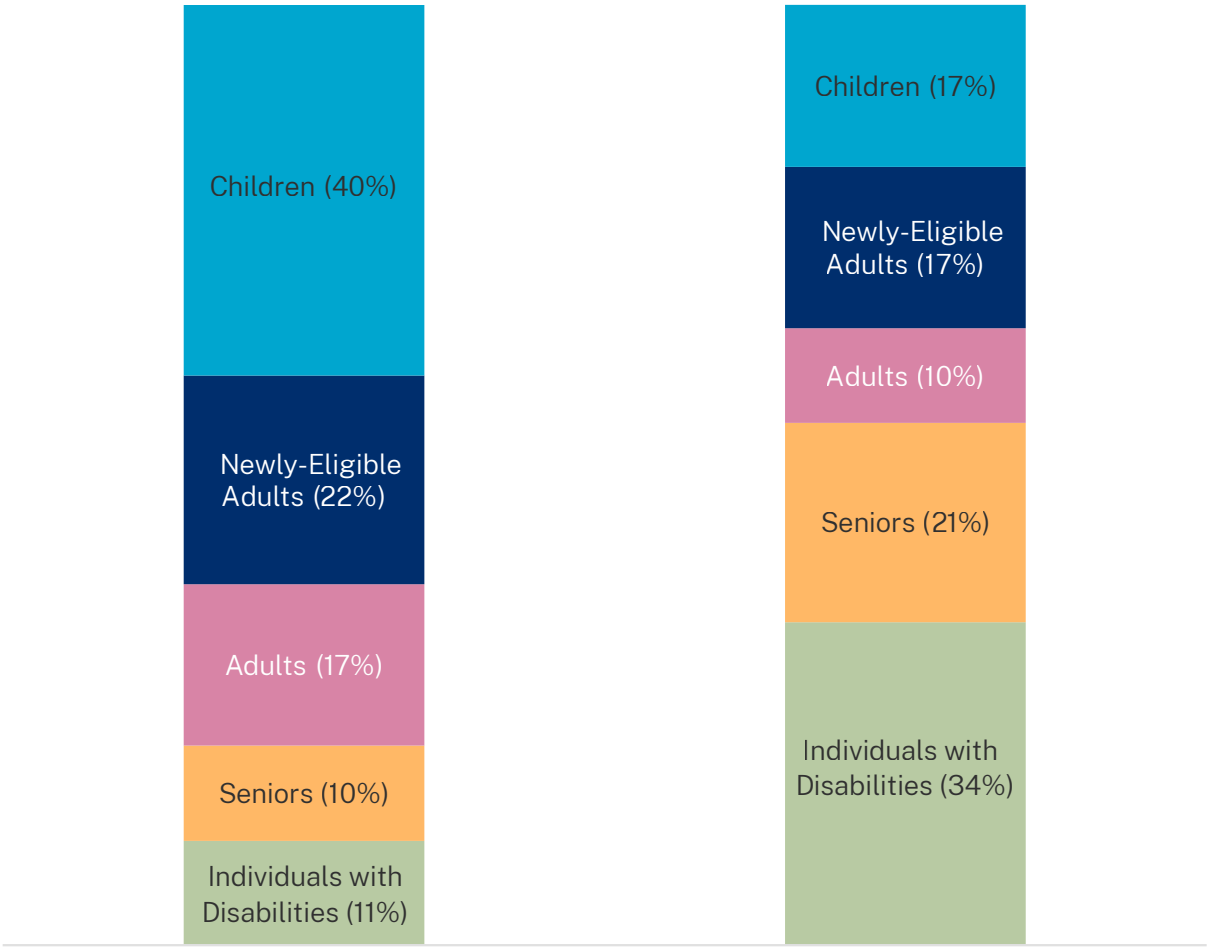
42 Nga Thach and Joshua Wiener, "An Overview of Long-Term Services and Supports and Medicaid Final Report," *Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services*, 2018, https://aspe.hhs.gov/system/files/pdf/259521/LTSSMedicaid.pdf.

43 "Low pay, a lack of opportunities for advancement and feeling disrespected at work were the top reasons Americans quit their jobs last year during what has been dubbed the Great Resignation, according to the results of a Pew Research Center survey." Kathleen Steele Galvin, "Low Pay, Lack of Advancement, Disrespect Cited by Most Workers as Reasons for Quitting Jobs: Pew," *McKnight's Senior Living*, 2022, https://www.mcknightsseniorliving.com/home/news/business-daily-news/low-pay-lack-of-advancement-and-disrespect-cited-by-most-workers-as-reasons-for-quitting-jobs-in-2021-pew-research-center/.

44 "Staff shortages were nearly as high for nursing staff as they were for aides, with 24% of facilities reporting nursing staff shortages. In the same time period, 14% reported other staff shortages. These patterns have held steady since nursing facilities began reporting this data in May 2020." Nancy Ochieng, Priya Chidambaram, and MaryBeth Musumeci, "Nursing Facility Staffing Shortages During the COVID-19 Pandemic," *Kaiser Family Foundation*, 2022, https://www.kff.org/coronavirus-COVID-19/issue-brief/nursing-facility-staffing-shortages-during-the-COVID-19-pandemic/.

Figure 3: Medicaid Spending is Disproportionately High for Seniors and Individuals with Disabilities

Medicaid Enrollment and Expenditures by Enrollment Group
As a Percentage of Total, 2019



Source: Kaiser Family Foundation

entrepreneurs developed more attractive alternatives such as assisted living and private-pay home care. But these alternatives struggled given the bias in policy toward nursing homes. Many wealthier consumers abandoned nursing homes for the alternative care settings even though they had to pay out of pocket. Most consumers remained in the dominant Medicaid-financed system. Because of competition with free or subsidized public LTC funding, private financing sources such as home equity conversion and private insurance were never able to take hold fully despite their obvious potential to mitigate the LTC funding shortfall.

PROBLEMS WITH THE CURRENT LTC SYSTEM

Explosive Costs

Social services and benefit programs in the United States evolved gradually in the country's first two centuries from a system based on British poor laws — "indoor relief" with many poor houses — toward a system based on cash relief payments.[45] Cash payments from programs such as Old Age Assistance and Social Security gave people funds to spend on residential LTC, enabling the nursing home industry to grow rapidly.[46] In 1960, the Medical Assistance for the Aged program made health care available to people 65 and older with low or moderate income and required state matching funds.[47] The same Kerr-Mills statute radically changed eligibility for nursing home care by adding people who "were not sufficiently needy to qualify for cash assistance to cover their ordinary expenses, but who were unable to pay their medical expenses."[48]

In 1965, the newly enacted Medicaid program dropped strict eligibility criteria, transfer-of-assets restrictions, and mandatory liens, which were commonplace in state programs previously.[49] These changes expanded eligibility for government-financed LTC services. For its first 15 years, Medicaid explicitly permitted asset transfers for the purpose of qualifying for LTC benefits.[50] Finally, Medicaid paid exclusively for nursing home care, incentivizing its use by covering "housing, food, housekeeping, and laundry services which were not covered for in-home services."[51]

45 *Senior* Living.org, "Senior Living History: 1776-1799," 2022, https://www.seniorliving.org/history/1776-1799/.

46 *Senior* Living.org, "Senior Living History: 1930-1939," 2022, https://www.seniorliving.org/history/1930-1939/.

47 *Senior* Living.org, "Senior Living History: 1960-1969," 2022, https://www.seniorliving.org/history/1960-1969.

48 Ibid.

49 "Typical relative responsibility requirements of public assistance programs are relaxed under the Medicaid program so that the only relatives with prior responsibility for payment of medical care costs are an individual's spouse and the parents of a child who is under 21, blind, or disabled. Liens may not be imposed against the property of any recipient while he is alive; recovery may be had only from the estates of recipients who were 65 [since lowered to 55] or over when they received medical assistance, and then only after the death of the spouse and if there is no surviving child aged under 21, or who is blind or disabled. The state agency is required to publicize the program so that potential applicants are aware of it and to keep persons eligible for the program informed about the changes in the program." Sydney Bernard and Eugene Feingold, "The Impact of Medicaid," *Wisconsin Law Review* (1970), p. 737, https://heinonline.org/HOL/LandingPage?handle=hein.journals/wlr1970&div=43&id=&page=.

50 "Prior to an amendment to the SSI program in 1980, applicants were expressly permitted to transfer resources that otherwise would have disqualified them from receiving any benefits. A number of decisions confirmed that states were not permitted to deny Medicaid eligibility to an applicant who had divested himself of resources for less than fair market value." Timothy Carlucci, "The Asset Transfer Dilemma: Disposal of Resources and Qualification for Medicaid Assistance," *Drake Law Review* (1986-1987), https://heinonline.org/HOL/LandingPage?handle=hein.journals/drklr36&div=26&id=&page=.

51 *Senior* Living.org, "Senior Living History: 1960-1969."

As a result of loose eligibility requirements and federal matching dollars for state spending, Medicaid LTC growth exploded,[52] a bias toward nursing home services solidified,[53] and private financing alternatives were crowded out.[54] Policymakers have been trying to reverse the damage ever since by discouraging the program's overuse through financial eligibility constraints and by diverting Medicaid financing toward HCBS.

Nursing Home Bias

Before the Great Society programs of the 1960s, small mom-and-pop facilities provided most formal LTC, and people generally paid out of pocket.[55] Medicaid began funding nursing home care — including room, board, laundry, and custodial and medical care — shortly after its founding in 1965. To qualify, people could give away assets and income rarely mattered, because Medicaid was designed to help not only the poor but also the "medically needy," meaning anyone with too little income to cover their LTC costs privately. Consumers responded predictably, taking advantage of the new subsidy. Why pay privately for LTC when the government provided generously? The nursing home business also responded, expanding and corporatizing rapidly.[56] By paying exclusively for nursing home care, Medicaid created the institutional bias that has plagued LTC ever since.

Rebalancing to Home Care

Analysts, advocates, and policymakers increasingly lamented Medicaid's institutional bias. They attempted to move Medicaid financing away from nursing homes toward more HCBS. Since 1981, waivers have allowed states to circumvent Medicaid rules that require nursing

52 "Spending under Medicaid, which has continued to rise since 1968, is clearly greatly in excess of the expectations of Congress and of the states. A major factor contributing to this unexpectedly high expenditure has been the unusually high increase in medical care prices since 1965, an increase to which Medicaid and Medicare contributed by suddenly adding large sums of money to the demand for medical care without substantially increasing or efficiently organizing the supply of medical services available." In Medicaid's first two years, "Ninety percent of expenditures went for hospital and nursing home care." Bernard and Feingold, "The Impact of Medicaid," p. 745.

53 "Within the Medicaid program, there has been a historical structural bias toward institutional care. States are required to cover nursing facility benefits, while coverage of most HCBS is optional." Erica L. Reaves and MaryBeth Musumeci, "Medicaid and Long-Term Services and Supports: A Primer," *Kaiser Family Foundation*, 2015, https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

54 "This paper provides empirical evidence of Medicaid crowd out of demand for private long-term care insurance.... We discuss reasons why, even with extremely stringent eligibility requirements, Medicaid may still exert a large crowd out effect on demand for private insurance." Jeffrey Brown, Norma Coe, and Amy Finkelstein, "Medicaid Crowd-Out of Private Long-Term Care Insurance Demand: Evidence from the Health and Retirement Survey," *University of Chicago Press Journals*, vol. 21 (2007), p. 1, https://www.journals.uchicago.edu/doi/abs/10.1086/tpe.21.20061913.

55 "OAA [Old Age Assistance] recipients were able to pay cash at a time when there was little real money in circulation, making them very attractive customers for proprietary operators, and old age homes were a perfect 'cottage' industry. They could be easily and often inexpensively launched by 'mom and pop' operators who boarded their elderly customers in unused rooms in private homes. Some were run by unemployed nurses who provided rudimentary care in addition to room and board, giving rise to the term 'nursing home.' In a time when many people were still out of work, the fledgling industry provided homeowners with an opportunity to use the only asset they owned to generate a welcome source of cash." *Senior* Living.org, "Senior Living History: 1930-1939."

56 "The nursing home industry is generally seen as an outgrowth of Medicare and Medicaid.... It has also produced a large new industry that grew and became profitable largely by providing services to the infirm and disabled poor." Catherine Hawes and Charles Phillips, "The Changing Structure of the Nursing Home Industry and the Impact of Ownership on Quality, Cost, and Access," *Institute of Medicine (US) Committee on Implications of For-Profit Enterprise in Health Care*, 1986, https://www.ncbi.nlm.nih.gov/books/NBK217907/.

home coverage but prevent home care options. All states have such waivers.[57] A new initiative called "Money Follows the Person," supported by several laws from 2005 through 2020, aimed to "increase the use of home and community-based services (HCBS) and reduce the use of institutionally-based services."[58] Over time, total Medicaid LTC spending has increased but has shifted proportionally from nursing homes to HCBS, as illustrated by Figure 4.

By 2016, 57 percent of overall spending was for HCBS, up from 18 percent in 1995.[59]

This shift to HCBS has favored the younger, developmentally disabled recipients over the elderly: 76 percent of Medicaid LTC spending for people with developmental disabilities was for HCBS, whereas only 44 percent of LTC spending for older people and younger persons with physical disabilities was for HCBS in FY2015.[60] Mathematica found that the elderly's share of HCBS spending for LTC slipped to 33.7 percent in FY2017 and 32.9 percent in FY2018, although several large states did not report data for those years, which probably reduced these amounts.[61]

Comparing 1995 with 2015 on Figure 4 reveals how much more the transition to HCBS has affected the developmentally disabled (from 20 percent institutional/8 percent HCBS in 1995 to 8 percent institutional/24 percent HCBS in 2015) compared to older adults (60 percent institutional/12 percent HCBS in 1995 to 38 percent institutional/30 percent HCBS in 2015).[62]

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57 "All states operate one or more Medicaid waivers, which are generally referred to by the section of Social Security Act granting the waiver authority and are categorized either as program waivers or research and demonstration projects." *Medicaid and CHIP Payment and Access Commission*, "Medicaid 101/Waivers," https://www.macpac.gov/medicaid-101/waivers/.

58 Medicaid.gov, "Money Follows the Person," https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html.

59 Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Ammula, "Medicaid Home and Community-Based Services Enrollment and Spending," *Kaiser Family Foundation*, 2020, https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/.

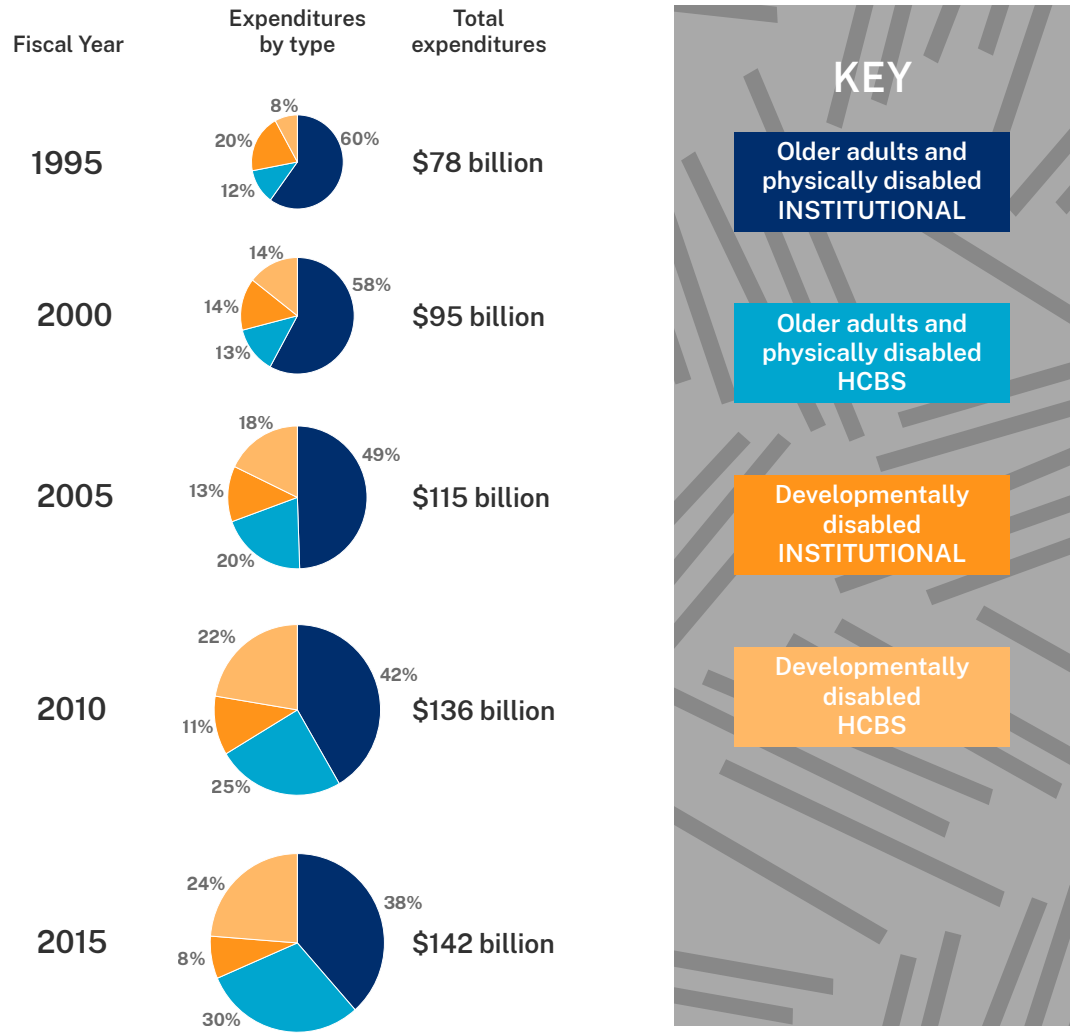
60 "Although the broad trend is clearly toward Medicaid spending for HCBS rather than institutional care, wide variations exist across population groups. In 2015, 44% of Medicaid LTSS spending on older people and younger persons with physical disabilities was for HCBS.... In contrast, nationally, 76% of Medicaid spending on LTSS for people with developmental disabilities was for HCBS." Joshua Wiener, Michael Lepore, and Jessica Jones, "What Policymakers Need to Know About Long-Term Services and Supports," *Public Policy and Aging Report*, vol. 28, no. 1 (2018), https://academic.oup.com/ppar/article-abstract/28/1/29/4958395.

61 "Although it is difficult to definitively attribute LTSS expenditures to different LTSS subgroups without detailed information about beneficiary-level service use, the findings suggest that HCBS accounts for a majority of LTSS spending for people with ASD, ID, or DD. *However, it accounts for a much smaller share of LTSS spending for older adults* and people with PD or OD and for people with behavioral health conditions (Figure VIII.1 and Appendix Tables C.36 to C.39). *In particular, LTSS spending for older adults and people with PD or OD lags far behind the other population subgroups in terms of the balance of HCBS and institutional expenditures.* Even though many states have made substantial progress in rebalancing their LTSS systems overall, with more than half of states exceeding 50 percent of expenditures on HCBS, *the progress is not equally distributed across different population subgroups*.... In FY 2017, states spent $56.1 billion for LTSS for this population group, with *33.7 percent of total Medicaid LTSS expenditures devoted to HCBS. In FY 2018, states spent $50.8 billion, with 32.9 percent of total LTSS for HCBS*" (emphasis added). Caitlin Murray et al., "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018," *Mathematica*, 2021, https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf.

62 In 1995, the ratio of institutional care spending to HCBS spending for the developmentally disabled was $16 billion to $6 billion (in 2015 inflation-adjusted dollars). By 2015, that ratio shifted to just $11 billion of institutional care spending to $34 billion for HCBS. While there has been a shift to HCBS among the aged and people with physical disabilities — the institutional care/HCBS spending ratio went from $47 billion/$9 billion in 1995 (in 2015 inflation-adjusted dollars) to $55 billion/$43 billion in 2015 — it was much more gradual, as institutional care spending still exceeds HCBS spending for them.

Figure 4: Rebalancing Long-Term Care Services Driven by Shift to Home-Based Services for the Developmentally Disabled

Expenditures for Institutional Care and HCBS, 2015 Dollars



Source: Truven Health Analytics

Due to a change of methodology in the latest report, this important distinction between Medicaid HCBS for the elderly versus younger, disabled recipients will no longer be tracked.[63]

63 "The most notable change to the methodology is the lack of FY 2019 LTSS spending breakouts and rebalancing ratios — the share of total LTSS spending devoted to HCBS — for four major LTSS population subgroups: older adults and people with physical disabilities; people with intellectual or developmental disabilities; people with serious mental illness; and other individuals who need LTSS." Caitlin Murray et al., "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019," *Mathematica*, 2021, https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf.

Importantly, despite the shift from institutional services to HCBS, total public spending on LTC continues its substantial increase.

Thanks both to the popularity of HCBS and the government's cost-neutrality requirement (i.e., waivered HCBS may not exceed what would have otherwise been spent on institutional services), access to Medicaid home care remains plagued by several problems, including:

- long waiting lists, which totaled 665,000 people in 2020[64] (see Figure 5[65]);
- low wages for workers;[66]
- worker shortages;[67]
- poor quality of care;[68] and
- significant risk of waste, fraud, and abuse.[69]

Despite long-standing claims that home care saves money compared to institutional care, this is not the case. Studies and practical experience showed that while home care was less expensive for some patients, it delayed but did not replace institutional care for many people.[70] [71] Consequently, despite a higher percentage of spending on home care, total Medicaid LTC expenditures for home care and nursing home care increase steadily year after

64 "Most states (39) have a waiting list for at least one HCBS waiver, with over 665,000 people on HCBS waiver waiting lists nationally at any point in FY 2020." Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Ammula, "State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic," *Kaiser Family Foundation*, 2022, https://www.kff.org/medicaid/issue-brief/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic/.

65 The smaller waiting list for 2020 is likely a result of challenges related to demand or reporting during the pandemic.

66 "It is perhaps not surprising, but participants in the paid direct care worker groups universally agreed that their wages are low and do not reflect the demands of their jobs." MaryBeth Musumeci, Meghana Ammula, and Robin Rudowitz, "Voices of Paid and Family Caregivers for Medicaid Enrollees Receiving HCBS," *Kaiser Family Foundation*, 2021, https://www.kff.org/medicaid/issue-brief/voices-of-paid-and-family-caregivers-for-medicaid-enrollees-receiving-hcbs/.

67 "Experts predict the low pay will result in significant workforce shortages and worsen access to care for individuals needing LTSS." *Bipartisan Policy Center*, "Bipartisan Solutions to Improve the Availability of Long-Term Care," 2021, https://bipartisanpolicy.org/report/improving-ltc/.

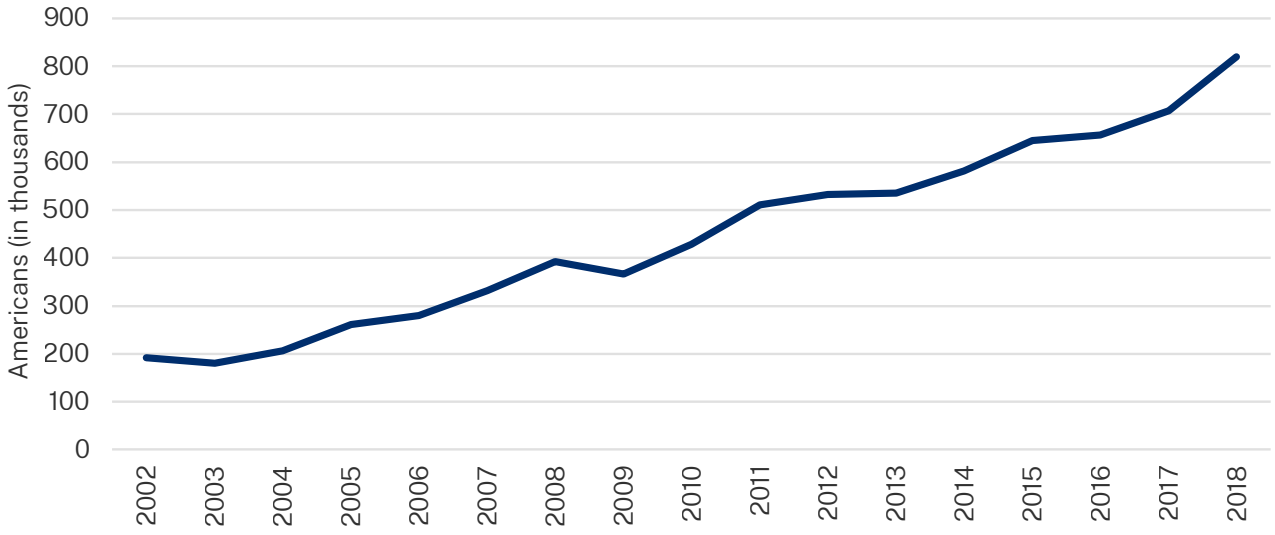
68 "Most current measures used to assess the quality of HCBS focus on compliance with waiver reporting requirements such as confirming that provider qualifications or personal goals were included in service plans. There are relatively few measures for service delivery and effectiveness, community inclusion, and caregiver support." *Medicaid and CHIP Payment and Access Commission*, "Quality of Home-and Community-Based Services," https://www.macpac.gov/subtopic/quality-of-home-and-community-based-services/.

69 *U.S. Department of Health and Human Services, Office of Inspector General*, "Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases," 2016, https://oig.hhs.gov/oei/reports/oei-05-16-00031.asp.

70 "This is one of only a few scientifically rigorous research studies to have found a statistically significant association between use of paid HCBS (and, specifically, Medicaid-financed HCBS) and reduced use of long-stay nursing home care. However, the amount of nursing home use reduced was not enough to produce savings sufficient to HCBS costs." Brenda Spillman, "Does Home Care Prevent or Defer Nursing Home Use?," *Urban Institute*, 2016, https://aspe.hhs.gov/reports/does-home-care-prevent-or-defer-nursing-home-use-0.

71 "In almost every state, home and community-based services are 'sold' primarily on their ability to achieve cost savings. Most research, however, suggests that total long-term care costs are likely to rise as large increases in the use of home care more than offset small reductions in nursing home use." Joshua Wiener and David Stevenson, "Repeal of the 'Boren Amendment': Implications for Quality of Care in Nursing Homes," *Urban Institute*, series A, no. A-30 (1998), https://www.urban.org/sites/default/files/publication/70621/308020-Repeal-of-the-Boren-Amendment.PDF.

Figure 5: Wait List for Medicaid HCBS Waivers Steadily Growing



Source: Kaiser Family Foundation

year, as Figure 4 shows,[72] further impinging on state and federal budgets, as Figure 6 shows. The bottom line is that what has happened is not so much rebalancing from nursing home care to HCBS as rapid expansion of HCBS while nursing home expenditures remained relatively flat during FY2012-FY2015.[73] So transitioning from nursing home care to HCBS has not proved to be the panacea it was long hoped and expected to be for reducing Medicaid budgetary pressure.

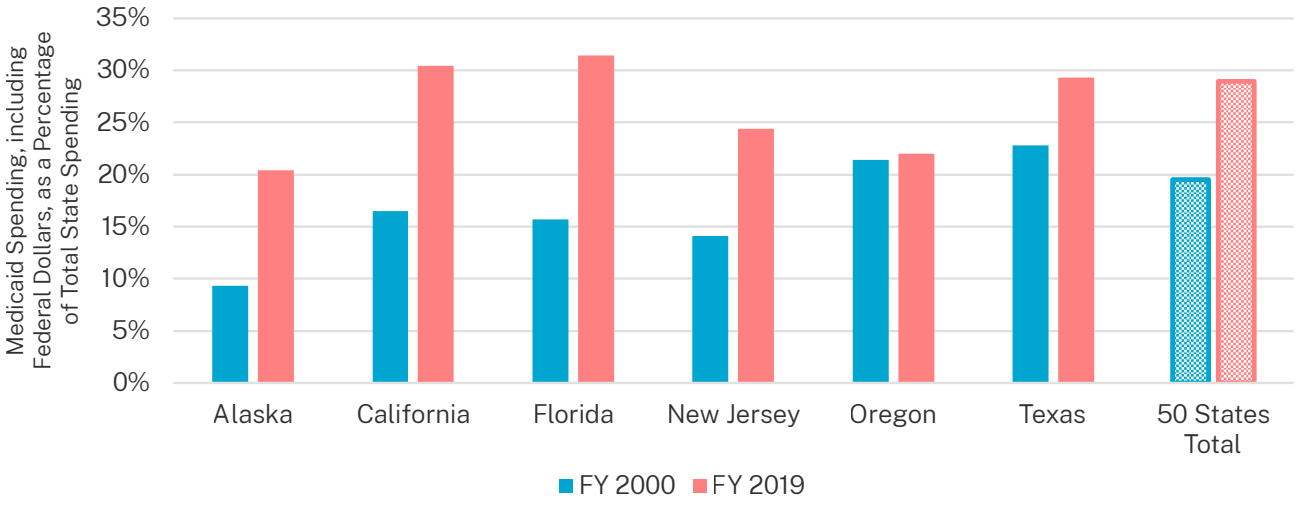
Inadequate LTC Financing

Rapidly increasing Medicaid LTC expenditures, especially in the early years, motivated government to contain them in various ways. Figuring "they can't charge us for a bed that doesn't exist," certificate of need (CON) laws were passed that restricted the construction of new nursing homes and effectively capped the number of nursing home beds in many

72 "Out of the $162.1 billion in total LTSS expenditures in FY 2019, $95.0 billion (58.6 percent) were for HCBS and $67.1 billion (41.4 percent) were for institutional services (Figure II.1 and Appendix Table C.1). Total Medicaid LTSS growth over the last decade is attributable largely to an increase in HCBS expenditures, which rose from 43 percent of total LTSS expenditures in FY 2008 to 58.6 percent in FY 2019.... Both HCBS and institutional expenditures increased substantially between FY 2018 and 2019 because of more complete data for several states in FY 2019, but the increase in HCBS expenditures outweighed the increase in institutional expenditures." Murray et al., "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019."

73 "HCBS have accounted for all Medicaid LTSS growth in recent years while institutional service expenditures have been flat. HCBS spending increased seven percent in FY 2015, with three-year average annual growth of eight percent. Institutional service spending decreased less than 0.1 percent in FY 2015, with an average annual decline of 0.2 percent over three years." Steve Eiken et al., "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015," *Truven Health Analytics* (2017), p. 3, https://www.appliedselfdirection.com/sites/default/files/LTSS%20Expenditures%20FFY%202015.pdf.

Figure 6: Medicaid Has Grown Substantially Over the Past Two Decades as a Share of State Spending



Source: National Association of State Budget Officers

states.[74] The nursing home lobby did not object. CON laws created an artificial barrier to market entry, thus securing a government-enforced monopoly for nursing homes already in place.[75]

But with their market expansion restricted, nursing homes sought to grow their profits by raising the rates they charged state Medicaid programs. The federal government and states responded by capping Medicaid rates. These capped rates created the large differential between market-based private-pay nursing home payments (national average: $297 private room; $260 shared room) and Medicaid rates ($208; $182, respectively), which are often less than the cost to provide the care and *average* about 70 percent of private rates today.[76]

These higher private pay rates created an additional incentive for people to find ways to qualify for Medicaid. Magazine articles, popular books, and formal legal literature proliferated explaining how families can organize their income and assets to qualify for Medicaid LTC

74 "Certificate of Need (CON) laws are state regulatory mechanisms for approving major capital expenditures and projects for certain health care facilities.... Currently, 35 states and Washington, D.C., operate a CON program with wide variation state to state." *National Conference of State Legislatures*, "Certificate of Need (CON) State Laws," 2021, https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx.

75 "Lane (1984) suggested that the CON laws have given a monopoly to existing providers and have increased the threshold costs for entry into the market for providers constructing new facilities. This franchising system may have done less to control growth than to fuel financial speculation in the market, as buyers pay higher market rates for facilities because of the difficulty in constructing new facilities." Charlene Harrington, James H. Swan, and Leslie A. Grant, "Nursing Home Bed Capacity in the States, 1978-86," *Health Care Financing Review*, vol. 9, no. 4 (Summer 1988), pp. 81-97, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4192881/.

76 "In some states, AHCA [American Health Care Association] contends, the rate is actually less than the cost of care, leaving providers to leverage the other payor sources (Medicare, managed Medicare, and Private) to offset losses." Liberman, "Medicaid Reimbursement Rates Draw Attention."

benefits without impoverishment. Nursing homes became increasingly dependent on Medicaid, lost most of their higher private payers, and relied more and more on Medicare's higher reimbursements for shorter-term sub-acute and rehabilitative care.

Poor Access and Quality

Demand for Medicaid nursing home care grew rapidly. By the early 1980s, nursing homes were 95 percent occupied[77] at a time when hospitals were only 78 percent full.[78] If a nursing home was willing to accept Medicaid's low reimbursement rates, it could fill all its beds, almost regardless of the quality of care it offered. Consequently, care quality collapsed in principally Medicaid-financed nursing homes.[79] Surveys showed and continue to show[80] that many people would rather die than reside in a Medicaid nursing home. Congress responded in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), also known as the Nursing Home Reform Act, by mandating more caregiving staff, better training, and higher pay. But OBRA '87 provided no extra funds to support these new requirements, and quality remained dubious decades later.[81] In 2017, on the 30th anniversary of OBRA '87, the Kaiser Family Foundation published a review of HCBS and nursing home quality highlighting ongoing deficiencies and inadequate tracking.[82]

77 "Lane (1984) estimated that the average occupancy rates had risen to 95 percent nationwide by 1982. In their eight-State study, Feder and Scanlon (1980) found reports of waiting lists for nursing home admissions and high occupancy rates, concluding that there was excess demand for nursing home services." Harrington, Swan, and Grant, "Nursing Home Bed Capacity in the States."

78 *Statista*, "Curative Care Hospital Bed Occupancy Rate in the U.S. from 1960 to 2019," https://www.statista.com/statistics/185904/hospital-occupancy-rate-in-the-us-since-2001/.

79 "In the past 15 years many studies of nursing home care have identified both grossly inadequate care and abuse of residents. Most of the studies revealing substantial evidence of appallingly bad care in most parts of the country have dealt with conditions during the 1970s. However, testimony in public meetings conducted by the committee in September 1984, news reports published during the past 2 years, recent state studies of nursing homes, and committee-conducted case studies of selected state programs have established that the problems identified earlier continue to exist in some facilities: neglect and abuse leading to premature death, permanent injury, increased disability, and unnecessary fear and suffering on the part of residents. Although the incidence of neglect and abuse is difficult to quantify, the collective judgment of informed observers, including members of the committee and of resident advocacy organizations, is that these disturbing practices now occur less frequently." Institute of Medicine (US) Committee on Nursing Home Regulation, *Improving the Quality of Care in Nursing Homes* (Washington, D.C.: National Academies Press, 1986), https://www.ncbi.nlm.nih.gov/books/NBK217556/.

80 "In a blow to the skilled nursing industry, 61% of Americans now report that they would rather die than live in a nursing home. That's according to a Nationwide Retirement Institute survey of almost 1,300 U.S. adults aged 24 or more years conducted by the Harris Poll." Amy Novotney, "More Than 6 in 10 Americans Now Say They Would Rather Die Than Live in Nursing Home," *McKnight's Long-Term Care News*, 2020, https://www.mcknightsseniorliving.com/home/news/business-daily-news/more-than-6-in-10-americans-now-say-they-would-rather-die-than-live-in-nursing-home-survey/.

81 "More than 90 percent of all certified facilities were cited for one or more deficiencies in 2006, and nearly one-fifth of all certified facilities were cited for deficiencies that caused harm or immediate jeopardy to residents. Although there was an initial upgrading of the quality of care as a result of OBRA 87, improvements appear to have reached a plateau. Substantial proportions of nursing homes are still cited for inadequate care. Staffing levels have been relatively stable for many years, despite the increased acuity and disability of residents. The best available studies suggest that the vast majority of nursing homes are significantly understaffed." Joshua Wiener, Marc Freiman, and David Brown, "Nursing Home Quality Twenty Years After the Omnibus Budget Reconciliation Act of 1987," *Kaiser Family Foundation*, 2007, https://www.kff.org/wp-content/uploads/2013/01/7717.pdf.

82 Charlene Harrington et al., "Key Issues in Long-Term Services and Supports Quality," *Kaiser Family Foundation*, 2017, https://www.kff.org/medicaid/issue-brief/key-issues-in-long-term-services-and-supports-quality/.

Caught between inadequate reimbursement and quality mandates, nursing homes and their trade associations began suing for higher Medicaid reimbursement.[83] They won most of those lawsuits by appealing for relief under the Boren Amendment of 1980, which ensured "reasonable and adequate" Medicaid reimbursement rates to provide care "in conformity with applicable state and federal laws, regulations, and quality and safety standards."[84] In the end, Congress repealed that part of the Boren Amendment, leaving no floor under Medicaid nursing home reimbursement rates. Thus, the quality problems and resulting caregiver shortages have persisted to the present.[85] The Biden administration appears to be making the same mistake now by demanding minimum staffing requirements, stronger regulatory oversight, and better public information about nursing home quality[86] without providing sufficient additional funding to support the new requirements.[87]

Today, in the ongoing COVID disruption, access to and quality of Medicaid LTC are increasingly problematic. Besides long wait lists for home care, Medicaid nursing home beds are scarce due to staff shortages, causing facilities to limit admissions.[88] Discrimination against patients who rely on Medicaid payments is also a serious and growing problem.[89]

Disappearing Private Revenue

Private-pay rates are often one and a half times as much as what Medicaid pays. Given the ease with which people could qualify for Medicaid — especially in the early years — fewer and

83 "Medicaid expenditures for nursing home and hospital services are stampeding out of control, spurred on by a decade of increasing federal mandates and decreasing federal financial support. States' attempts to rein in Medicaid expenditures are regularly thwarted by court decisions that find states in violation of the Boren Amendment." John Burman, "Judicial Review of Medicaid Hospital and Nursing Home Reimbursement Methodologies Under the Boren Amendment," *Annals of Health Law*, vol. 55, no. 6 (1994), https://lawecommons.luc.edu/cgi/viewcontent.cgi?article=1341&context=annals.

84 Wiener and Stevenson, "Repeal of the 'Boren Amendment.'"

85 "Over the years, numerous state and federal policy initiatives have targeted the improvement of nurse staffing levels, and countless quality improvement projects initiated by the government, by researchers, or by nursing homes themselves have targeted key aspects of clinical quality. However, although many high-quality nursing homes exist and meaningful gains have been made, low quality and understaffing remain endemic." R. T. Konetzka, "The Challenges of Improving Nursing Home Quality," *JAMA Network Open*, 2020, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2759755.

86 *The White House*, "FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes," 2022, https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/.

87 "Biden's reform plan was unveiled earlier this month. It includes more than 20 initiatives to improve quality of care, with minimum staffing requirements a top priority. The effort, however, could 'decimate' the nursing home industry if it fails to address underlying funding and workforce challenges, warned Seema Verma, CMS administrator during the Trump administration." Danielle Brown, "Former CMS Leader Rips Biden's Nursing Home Reform Plans," *McKnight's Long-Term Care News*, 2022, https://www.mcknights.com/news/former-cms-leader-rips-bidens-nursing-home-reform-plans/.

88 "There's a shortage of nursing home beds for the elderly in America due to a severe staffing crisis that has caused long-term care facilities to cut back on new admissions, new research shows.... Three out of five nursing homes (61%) have limited new admissions due to staffing shortages, according to a survey conducted by the American Health Care Association/National Center for Assisted Living (AHCA/NCAL) of 759 nursing home providers. And nearly three out of four (73%) are concerned that they'll have to close their facilities over staffing problems, the survey found." Dennis Thompson, "Staffing Shortages Have U.S. Nursing Homes in Crisis," *HealthDay*, 2022, https://consumer.healthday.com/6-29-staffing-shortages-have-u-s-nursing-homes-in-crisis-2657543731.html.

89 "[P]roviders already know they and their peers are making tough decisions about who to admit, often based on who's paying for their care. Those 'gray-area' decisions were the topic of critical research earlier this year that highlighted 'widespread discrimination' against Medicaid-covered patients.... Likely, for skilled nursing patients, that discrimination is worst in states with low daily Medicaid reimbursement rates." Kimberly Marselas, "Medicaid Access: Worth a Closer Look," *McKnight's Long-Term Care News*, 2022, https://www.mcknights.com/daily-editors-notes/medicaid-access-worth-a-closer-look/.

fewer patients and their families were willing to pay out of pocket for services they could get from Medicaid for free or with a large subsidy. Out-of-pocket expenditures for nursing home care plummeted from 49.2 percent in 1970 to 23.0 percent in 2020.[90] Notably, about half of those out-of-pocket costs for nursing home care come from Social Security and other income that Medicaid recipients are required to contribute toward their cost of care — that is, not from spend down of personal savings.[91] In 2011, CMS changed the National Health Expenditure Account categories to add Continuing Care Retirement Communities (CCRCs) to Nursing Care Facilities. This change had the effect of reducing Medicaid's reported contribution to the cost of nursing home care from over 40 percent in 2008 to under one-third (32.8 percent) in 2009. Because CCRCs are almost entirely private pay and they cover independent and assisted living as well as nursing home care, this definitional change made Medicaid's contribution smaller for this category and out-of-pocket expenditures greater. Thus, for nursing homes only, excluding CCRCs, Medicaid is a bigger contributor and out-of-pocket spending a smaller contributor than the data for the combined category suggest.

Out-of-pocket expenditures for home-based LTC services are also low: about 10 percent of total spending in 1970 and today.[92] Even less are out-of-pocket expenditures for HCBS, residential, and personal care at only 3.2 percent.[93]

In all three categories, Medicaid and Medicare expenditures increased significantly from 1970 to 2020: from 26.8 percent to 47.1 percent for nursing homes and CCRCs; from 33.4 percent to 66.1 percent for home health care services; and from 11.8 percent to 60.5 percent for other health, residential, and personal care services.

Clearly, the increasing availability of Medicaid and Medicare to fund LTC and related health care expenses created a strong disincentive for consumers to plan for the risk and cost of someday needing extended care.

90 *Centers for Medicare and Medicaid Services*, "Table 15: Nursing Care Facilities and Continuing Care Retirement Communities Expenditures."

91 Lazenby and Letsch, "National Health Expenditures, 1989;" McCall, *Who Will Pay for Long Term Care?*

92 *Centers for Medicare and Medicaid Services*, "Table 14: Home Health Care Services Expenditures; Levels, Percent Change, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2020."

93 *Centers for Medicare and Medicaid Services*, "Table 13: Other Health, Residential, and Personal Care Services Expenditures; Levels, Percent Change and Percent Distribution by Source of Funds: Selected Calendar Years 1970-2020," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.

Paid Caregiver Shortages and Overwhelmed Family Caregivers

Both nursing home and home care workers generally receive lower wages than do their peers with similar credentials.[94] An LTC system dominated by public financing at less than the cost of providing the care simply cannot attract enough caregivers.[95] By paying LTC providers so poorly, Medicaid created the caregiver shortages and quality deficiencies that have characterized America's LTC system ever since. Long-term caregiving — which involves monitoring, turning, lifting, transferring, and bathing often helpless patients — is challenging and often dangerous work.[96] Finding people to do that work for low wages proved daunting. In the throes of the COVID pandemic, employing and retaining enough paid caregivers became almost impossible.

Too Many Dual Eligibles

Easy access to Medicaid nursing home care once care is needed reduces the necessity to plan ahead to pay privately if the need arises and causes several other distortions in the LTC market. The dual eligible population — people eligible for Medicare and Medicaid simultaneously — grew to alarming levels. Dual eligibles are the most expensive beneficiaries of both programs. Twenty percent of Medicare beneficiaries and 15 percent of Medicaid recipients are duals, but they consume 34 percent of Medicare and 33 percent of Medicaid expenditures, respectively.[97] Nevertheless, their care outcomes are poorer.[98]

> Duals are 5.0 times more likely to have a disability and 2.6 times more likely to be of minority race or ethnicity than their non-dual counterparts. They have markedly worse health outcomes, being two times more likely to be hospitalized or die after adjusting for comorbidities, than nondual beneficiaries.[99]

94 "Registered nurses who work for nursing homes tend to earn less than those working for other major employers. The average hourly rate for registered nurses was $29.66 in 2020, according to Payscale.com. However, the average long term care nurse salary was lower. In 2020, the hourly average for registered nurses working in nursing homes was $28, with an average of $15.62 per hour for all types of nurses working in nursing homes (RNs, LPNs, CNAs)." *Chron*, "Disadvantages for an RN Who Is Working at a Nursing Home," 2020, https://work.chron.com/disadvantages-rn-working-nursing-home-23640.html.

95 Liberman, "Medicaid Reimbursement Rates Draw Attention."

96 "When you think of the most dangerous jobs in the U.S., you might imagine something like logging, fishing or truck driving. But in 2020 one of the deadliest professions of all did not involve operating heavy machinery, braving the elements or driving big rigs — but rather caring for the elderly." Tanya Lewis, "Nursing Home Workers Had One of the Deadliest Jobs of 2020," *Scientific American*, 2021, https://www.scientificamerican.com/article/nursing-home-workers-had-one-of-the-deadliest-jobs-of-2020/.

97 *Centers for Medicare and Medicaid Services*, "People Dually Eligible for Medicare and Medicaid," 2020, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

98 "The findings of this study indicate that, even among the highest-quality hospitals, dually eligible patients may have poorer outcomes and higher spending." Kathryn Taylor, Adrian Diaz, and Usha Nuliyalu, "Association of Dual Medicare and Medicaid Eligibility with Outcomes and Spending for Cancer Surgery in High-Quality Hospitals," *JAMA Surgery* (2022), https://jamanetwork.com/journals/jamasurgery/article-abstract/2789378.

99 Karen Joynt Maddox and Kenton Johnston, "Advancing Equity for the Dually Eligible Population in Alternative Payment Models," *Health Affairs*, 2022, https://www.healthaffairs.org/do/10.1377/forefront.20220506.72938.

People age into Medicare at 65, but they often become dual eligibles because Medicaid is relatively easy to qualify for financially when care is needed many years later. Diverting people earlier in their lives from later dependency on Medicaid could substantially reduce the number and cost of dual eligibles in later years. Such diversion would require getting consumers concerned and acting about LTC risk and cost much earlier in their lives. Part 2 of this series will propose a plan to achieve that objective.

The next paper (Long-Term Care: The Solution) will explain the necessary steps to end the government's distortions of the LTC market and to incentivize people to prepare financially for the future.

Many Problems Driven by Medicaid's Financial Structure

Medicaid's financing system, in which the federal government matches state expenditures at a minimum of 50 percent, creates an incentive for states to maximize Medicaid without being cost conscious. States with lower per capita income receive a more generous federal match. For every dollar states spend on Medicaid, they draw at least one additional dollar from the federal government, and on average states draw two federal dollars for each dollar of state spending with state resources.[100]

To generate extra federal contributions, states often charge their LTC providers special taxes, spend that money through Medicaid, obtain matching funds from the federal government for that expenditure, and often reimburse the providers in whole or in part for the tax. This "provider tax" system has the effect of increasing the cost of Medicaid to federal taxpayers and generating a windfall of extra federal revenue for states.[101] Famously, the state of New York turned Medicaid into a verb by "Medicaiding" all sorts of state activities to pull in extra federal funds.[102]

100 "FY 2020, FY 2021, and FY 2022 FMAPs reflect higher federal matching funding made available through the Families First Coronavirus Response Act (amended by the Coronavirus Aid, Relief, and Economic Security Act). The additional funds are available to states from January 1, 2020 until the end of the public health emergency period for the COVID-19 pandemic. This act provided a 6.2 percentage-point increase to all FMAP rates for all states (including DC)." *Kaiser Family Foundation*, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/.

101 "Provider taxes are imposed by states on health care services where the burden of the tax falls mostly on providers, such as a tax on inpatient hospital services or nursing facility beds. Provider taxes have become an integral source of financing for Medicaid. For FY 2016, all but one state (Alaska) reported having at least one Medicaid provider tax and two-thirds of states reported three or more provider taxes." *Kaiser Family Foundation*, "States and Medicaid Provider Taxes or Fees," 2017, https://www.kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/.

102 "'Medicaid became a verb — to Medicaid,' said James R. Tallon Jr., president of the United Hospital Fund, a health care policy and research organization. 'We Medicaid things.' It wasn't long before New York was using Medicaid to pay for new and expanded services." Joyce Purnick, "Metro Matters; 'Medicaid' As a Verb, Then a Crutch," *New York Times*, February 24, 2003, https://www.nytimes.com/2003/02/24/nyregion/metro-matters-medicaid-as-a-verb-then-a-crutch.html.

HOW THE PRIVATE SECTOR AMELIORATES PROBLEMS THE GOVERNMENT CAUSES

Private consumers and companies responded creatively to the nursing home bias, exploding costs, poor quality, caregiver shortages, and excessive strain on family caregivers that Medicaid created. They partially repaired the damage from government policies and regulations that created the problems.

Assisted Living

In the 1980s, a new venue of care evolved called assisted living.[103] Characterized by attractive facilities offering private rooms and lighter, non-medical, custodial caregiving, the assisted living model quickly gained popularity. While assisted living gave consumers a choice, its growth was hamstrung by the availability of free or highly subsidized nursing home care provided by Medicaid. Over time, struggling to fill the industry's rapidly increasing capacity, assisted living providers began accepting residents whose bills were paid by Medicaid. They reckoned that it was better to accept Medicaid's impecunious payment rates than to have an empty unit. Today, 16.5 percent of assisted living residents rely on Medicaid.[104] The assisted living business is gradually following nursing homes down a primrose path of dependency on public assistance.

Private Home Care

Another way consumers and entrepreneurs have responded to ease LTC problems caused by Medicaid is through the creation of a market for privately financed home care. As an example, Amada Senior Care, recognizing that their service, however critical, is also hard for families to afford, pursues creative ways to help people find the funds to pay their fees. The company seeks potential customers who already own private LTC insurance that covers home care, as most such policies do. Amada works closely with LTC insurance carriers and distributors to ensure that its insured customers receive all the benefits they are entitled to under their policies. As many older people are house rich but cash poor, Amada helps prospects and customers who own homes utilize reverse mortgages to generate the cash flow to cover their home care costs. Likewise, older people often own life insurance policies with considerable cash value. Amada assists them to find life settlement opportunities, freeing up funds to pay for its home care services. In a free market, companies have strong incentives to help their

103 "Although it may seem like the term 'assisted living' has been around forever, it's actually a relatively new concept. And today's senior living facilities are a far cry from the institutionalized setting that comes to mind when we think of the phrase 'nursing home.' … Park Place in Portland, Oregon opened in 1981 and is considered the first modern assisted living facility as we know them today. It offered residents private rooms with doors that locked, 24-hour staffing for medical emergencies, as well as community areas for social interaction." *American Senior Communities*, "The Evolution of Assisted Living," 2014, https://www.asccare.com/evolution-assisted-living/.

104 *American Health Care Association/National Center for Assisted Living*, "Facts and Figures," 2022, https://www.ahcancal.org/Assisted-Living/Facts-and-Figures/Pages/default.aspx.

customers afford their products and services. In markets dominated by public financing, all financial incentives lean toward adapting to rules and regulations imposed by the controlling government agency whether they redound to consumers' benefit or not.[105]

Other Market-Based Approaches

The private sector is developing other ways to ameliorate the damage Medicaid has done. For example, many businesses are trying to improve HCBS:

> Walmart is among a growing legion of retailers including Amazon, CVS, Walgreens and Dollar General that are moving aggressively into healthcare, with most offering services aimed directly at the home. Walmart's online Wellness Hub sells products and services, including diagnostic testing.[106]

Villages are "membership organizations created by and for older adults whose purpose is to help people live independently while staying in their own homes. Typically, villages help arrange services for members: a handyman to fix a broken faucet, a drive to and from a doctor's appointment, someone to clean up the yard or shovel the snow. Volunteers do most of the work."[107]

Imagine the possibilities that entrepreneurs and investors could create to provide the kinds of LTC products and services consumers prefer if public policy did not channel them into providing only those products and services for which government pays.

Private Insurance Stifled by Medicaid

LTC insurance carriers, distributors, and producers struggled to market the product despite obstacles put in their way by crippling public policies. Medicaid gave away the LTC protection that the industry was trying to sell. Medicaid benefits became available long after the insurable event occurred, thus desensitizing future potential buyers of the product about the risk. Brown and Finkelstein "estimate that Medicaid could explain the lack of private long-term care insurance for about two-thirds of the wealth distribution, even if no other factors limited the market's size."[108] The Federal Reserve has forced interest rates down since the 1980s and

105 Full disclosure: I delivered the keynote address at Amada's 2021 national convention, which is where I learned how the company assists customers to find the funds to pay its fees.

106 "Home health technology, in particular, is a booming industry. Market analytics company MarketsandMarkets estimates the industry will grow 50% over the next four years from just under $200 billion this year to nearly $300 billion by 2026." Diane Eastabrook, "Walmart Partnership Provides Lifeline to Family Caregivers," *McKnight's Long-Term Care News*, 2022, https://www.mcknightshomecare.com/walmart-partnership-provides-lifeline-to-family-caregivers/.

107 Judith Graham, "Despite Seniors' Strong Desire to Age in Place, the Village Model Remains a Boutique Option," *Kaiser Health News*, 2022, https://khn.org/news/article/seniors-aging-in-place-village-movement-boutique-option/.

108 Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," *American Economic Review*, vol. 98, no. 3 (2008), pp. 1083-1102, https://www.aeaweb.org/articles?id=10.1257/aer.98.3.1083.

to near zero in the past decade,[109] making it impossible for insurers to receive the returns on their reserves that they would need to pay benefits when they come due. With very little long-term morbidity experience to base premiums on, carriers underpriced early products, which were nevertheless still crowded out by the available public financing from Medicaid.

The insurance industry adapted creatively, designing new kinds of LTC coverage that would pay whether the insured incurred an LTC cost or not, such as hybrid policies combining annuities or life insurance with LTC protection. The federal government has made half-hearted efforts to encourage private LTC insurance — such as tax deductibility of premiums that proved unavailable to most seniors and the unsuccessful "LTC Partnership" program to forgive Medicaid estate recoveries, which were easily avoided and only sporadically enforced anyway. Despite those efforts, easy access to Medicaid ruined the possibility that private insurance could play a major role in funding LTC. The number of carriers offering the product plummeted from over 100 to under a dozen.

Confronted with too few reserves to meet contractual obligations to beneficiaries, private LTC insurers raised their premiums to make up the difference. That cost them the good will of prospects and the enmity of insureds who endured substantial premium increases. But unlike the government programs that pile up debt with politicians seeming incapable of shoring up their reserves, private insurers did the right thing. Importantly, private insurance will pay when claims occur. The ability of Medicare and Social Security to pay full benefits in the future is dubious.

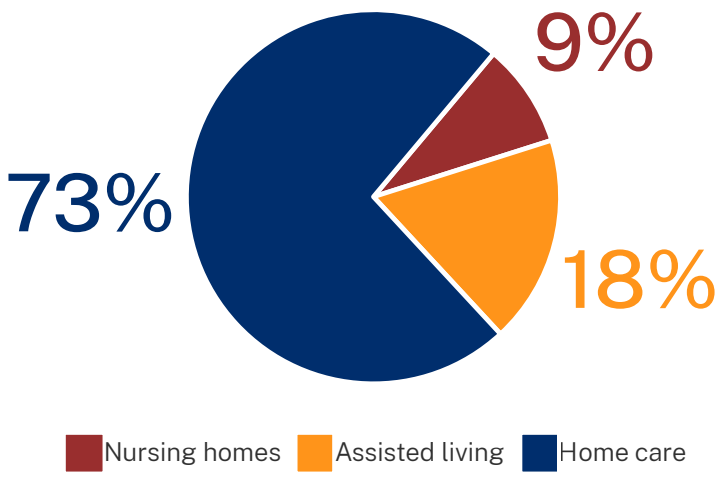
Because of the problems Medicaid created in LTC, being able to pay privately in order to access quality care in the most appropriate venue has become critically important. Nursing homes eagerly welcome patients who can pay privately because they pay higher rates than Medicaid recipients do. Assisted living remains mostly private pay. To get into the nicest skilled nursing and assisted living facilities, people must be able to pay privately, at least temporarily. To avoid the kind of small congregate home care settings of dubious quality or low-quality nursing homes for which Medicaid primarily pays, consumers need to be able to pay privately for a topline home care provider.

The latest Genworth Cost of Care Survey shows substantial increases in the cost of all three levels of care.[110] Nursing home care is $94,900 annually for a semi-private room; assisted living is $54,000 per year; homemaker and home health care services are $26 per hour and

109 Sarah Foster, "Fed's Interest Rate History: A Look at the Fed Funds Rate from the 1980s to the Present," *Federal Reserve*, 2022, https://www.bankrate.com/banking/federal-reserve/history-of-federal-funds-rate/.

110 *Genworth*, "Genworth Cost of Care Survey: Summary of 2021 Survey Findings," 2022, https://pro.genworth.com/riiproweb/productinfo/pdf/131168.pdf.

Figure 7: Where Do Traditional Long-Term Care Insurance Claims Begin?



Source: American Association for Long-Term Care Insurance

$27 per hour, respectively.[111] Between wage pressures to attract scarce caregivers and economy-wide inflation, these costs will likely increase significantly. The 5 percent cost-of-living increases built into many early LTC insurance policies, which seemed excessive during recent low inflation, may prove inadequate going forward due to rapidly increasing inflation.

Increased use of private LTC insurance could have prevented much of the damage Medicaid caused, freeing millions of Americans to choose the care venues they prefer. Data indicate that the vast majority (73 percent) of new LTC private insurance claims occur while the patient is still at home. Medicaid, on the other hand, mostly pays for claims occurring in nursing homes and usually pays for home care only after the recipient has waited for a long time.

Growth of Managed Long-Term Services and Supports

Another aspect of Medicaid LTC that the private sector has impacted, though with only questionable benefit, is the burgeoning expansion of Managed Medicaid LTSS, or MLTSS.[112] MLTSS refers to the delivery of LTC through capitated Medicaid managed

111 Ibid.

112 "There has been increasing interest among states in transitioning from the traditional fee-for-service financial model to managed care to deliver and coordinate services for Medicaid long-term services and supports beneficiaries." Reaves and Musumeci, "Medicaid and Long-Term Services and Supports: A Primer."

care programs.[113] It is based on the idea that private companies can provide better care for less cost by receiving a per-person rate across a coverage group. As of 2021, 24 states operated such programs, compared to eight in 2004.[114] The hope is that managed LTC can promote wellness and save money by reducing institutionalization through increased home-and community-based care. The model is not yet proven. MLTSS places an extra level of administration and compensation between LTC patients and providers, often reducing providers' reimbursement.[115] The Government Accountability Office found "significant problems with the quality of care provided through these contracts" in the six states it reviewed.[116]

The Fallacy of Impoverishment

The biggest public misperception, shared by average citizens as well as many experts, is that Medicaid LTC eligibility requires impoverishment. It does not. There is no evidence that it does. Researchers — who routinely claim that wide swaths of the American public spend down catastrophically for LTC before becoming Medicaid eligible — never cite empirical evidence. If Medicaid eligibility did require impoverishment, the public would seek to avoid catastrophic LTC spend down by saving or insuring against the risk. But because it does not, most people ignore LTC risk until they need expensive care. At that point, the only way to avoid paying for care privately is to qualify for Medicaid. Both patients and their adult child heirs have a strong incentive to follow this path and frequently do.

Why does the myth that Medicaid requires impoverishment persist despite the lack of evidence for it? Medicaid law and regulations appear to require financial destitution in order to qualify. The law limits income to $841 per month — the Supplemental Security Income (SSI) monthly payment for a single person — and caps assets at $2,000. Only the truly poor could qualify if these were really the rules that applied.

113 "Increasing numbers of states are using MLTSS as a strategy for expanding home-and community-based services, promoting community inclusion, ensuring quality, and increasing efficiency." Medicaid.gov, "Managed Long Term Services and Supports," https://www.medicaid.gov/medicaid/managed-care/managed-long-term-services-and-supports/index.html.

114 *Medicaid and CHIP Payment and Access Commission*, "Managed Long-Term Services and Supports," https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/.

115 "Capitated rates can have a major impact on the adequacy of provider networks. If the capitated rates paid to the MCO are insufficient to cover the enrollees' true cost of care, the MCO will likely have to reduce its provider payment rates, making recruitment of providers more difficult." *American Health Care Association*, "Medicaid Long Term Services and Supports: A Review of Available Evidence," https://www.ahcancal.org/Reimbursement/Medicaid/Documents/MLTSS%20Analysis.pdf.

116 *Government Accountability Office*, "Medicaid Long-Term Services and Supports: Access and Quality Problems in Managed Care Demand Improved Oversight," 2020, https://www.gao.gov/products/gao-21-49.

But the practical reality is very different.[117] Most states allow Medicaid applicants to deduct their health and LTC expenses from their income before applying the income eligibility criterion. As most older people in need of LTC have very high health and LTC expenses, this policy allows people with incomes well above the median to qualify. Other "income cap" states apply an income limit of 300 percent of the SSI monthly payment, or $2,523 per month. Income above that amount may be diverted into a Miller income diversion trust, which then pays the Medicaid provider's fee with any excess devolving from the trust at death to the state.[118] A common rule of thumb is that anyone with income below the cost of a nursing home is eligible based on income. With nursing home fees averaging nearly $8,000 per month — nearly quadruple the median income of an elderly person ($2,283 per month[119]) — almost all older Americans are eligible for Medicaid based on the income rules.[120]

The situation with asset eligibility is similar. Analysts often ignore or discount the difference between "countable assets," which are limited to $2,000, and exempt assets, which have no set limit. The reason most elderly Americans qualify for Medicaid LTC without having to spend down their wealth, despite the common assumption that they do and must, is that the vast majority of that wealth is held in assets that are exempt from the Medicaid asset test. Exempt resources include home equity — up to $636,000 in most states and $955,000 in the rest except California, which applies no limit at all in open defiance of federal law.[121] Many other assets are exempt[122] without any dollar limit, including one vehicle, home furnishings and personal belongings (including family "heirlooms," regardless of when they were purchased), prepaid burial plans, term life insurance, one business (including the capital and cash flow), and individual retirement accounts if they are in payout status (all accounts are in payout

117 "Exceeding the income limits does not mean an individual cannot qualify for Medicaid. Most states have multiple pathways to Medicaid eligibility. Furthermore, many states allow the use of Miller Trusts or Qualified Income Trusts to help person who cannot afford their care costs to become Medicaid eligible. There are also Medicaid planning professionals that employ other complicated techniques to help person become eligible. Finally, candidates can take advantage of spousal protection law that allow income (or assets) to be allocated to a non-applicant spouse." *American Council on the Aging*, "Medicaid Eligibility: 2022 Income, Asset and Care Requirements for Nursing Homes and Long-Term Care," 2021, https://www.medicaidplanningassistance.org/medicaid-eligibility/.

118 "A Miller Trust is a type of trust that holds excess income so you can qualify for Medicaid long-term care benefits. Your state may have an alternative name for this type of trust. For example, in Arizona, it's called an Income-Only Trust. In Oregon, it's called an Income Cap Trust. In New Mexico, it's called an Income Diversion Trust." Lisa Eramo, "What Is a Miller Trust?," *Help Adviser*, 2021.

119 "The median income of older persons in 2019 was $27,398." Or $2,283 per month. *Administration for Community Living*, "2020 Profile of Older Americans," 2021, https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2020ProfileOlderAmericans.Final_.pdf.

120 A peculiar phenomenon can occur because of these Medicaid income eligibility determination methods. People with relatively high incomes but even higher deductible health and LTC out-of-pocket costs may become eligible for Medicaid LTC benefits but have enough income left over to pay their entire nursing home bills. In other words, the nursing home receives the low Medicaid reimbursement rate, but the program pays nothing toward the recipient's care. This is one of several reasons why Medicaid LTC expenditures are relatively low compared to the damaging impact the program has on the LTC financing system.

121 "California is the only state that does not have a home equity limit." *American Council on the Aging*, "Medicaid Eligibility."

122 "The following is a list of exempted resources in assessing a Medicaid applicant's eligibility for Medicaid nursing home services: 1. Homestead residence.... 2. Real estate for sale.... 3. Automobile.... 4. Household goods and personal effects.... 5. Burial spaces.... 6. Term life insurance.... 7. Any Other life insurance in certain situations.... 8. Fixed funeral plan.... 9. Livestock.... 10. Retirement benefits.... 11. Rental or Income producing property.... 12. Business property essential to self-support." *Plan Right Law*, "What Assets Are Exempt from Medicaid?," 2019, https://planrightlaw.com/what-assets-are-exempt-from-medicaid/.

status for people 72 years and older due to the required minimum distribution rules).[123] It is very easy — and universally recommended by books and legal experts — to convert countable assets into exempt assets. In fact, state Medicaid eligibility workers routinely advise applicants to reduce their countable resources by purchasing exempt assets, especially prepaid burial plans for the applicant and immediate family members, and other items such as televisions or furnishings for their new Medicaid-financed assisted living or nursing home rooms.

Why People with Sizeable Estates End Up on Medicaid

Medicaid is a welfare program, meaning that it is means-tested public assistance.[124] How do people who possess substantial incomes and assets qualify? Consider a hypothetical example of an elderly couple with median income and assets.

John and Mary Smith were born in 1937, when life expectancy was 58 years for men and 62 years for women.[125] They married in 1959, started a family, and began payments on a home. Theirs was the American dream — happiness and prosperity — until the 2010s. At age 80, with a life expectancy of an additional eight years,[126] John was stricken by Alzheimer's Disease.[127] After a gradual onset, he began to require almost full-time care. Even with daily help from a home health aide ($27/hour)[128] and the couple's adult children — in their late 50s themselves — the responsibility finally overwhelmed Mary. By 2020, the family concluded that institutional care could no longer be postponed.[129]

Bob, the couple's first child and a successful businessman, did some research. He located several excellent LTC facilities but was alarmed to learn that nursing homes charge over $100,000 per year for a private room.[130] Even the more attractive assisted living facilities offering less skilled care would cost half that or more. Bob knew his

123 "Your required minimum distribution is the minimum amount you must withdraw from your account each year. You generally have to start taking withdrawals from your IRA, SEP IRA, SIMPLE IRA, or retirement plan account when you reach age 72 (70 ½ if you reach 70 ½ before January 1, 2020). Roth IRAs do not require withdrawals until after the death of the owner." *Internal Revenue Service*, "Retirement Plan and IRA Required Minimum Distributions FAQs," 2022, https://www.irs.gov/retirement-plans/retirement-plans-faqs-regarding-required-minimum-distributions.

124 The purpose of Medicaid as defined in the Social Security Act is "to furnish medical assistance on behalf of aged, blind, or permanently and totally disabled individuals and families with dependent children, whose income and resources are insufficient to meet the costs of necessary medical services, and rehabilitation and other services to help such individuals and families attain or retain capability for independence or self-care." *Social Security Administration*, "Social Security Amendments of 1965," 1965, https://www.ssa.gov/history/pdf/Downey%20PDFs/Social%20Security%20Amendments%20of%201965%20Vol%201.pdf.

125 *University of California, Berkeley*, "Life Expectancy in the USA, 1900-1998," https://u.demog.berkeley.edu/~andrew/1918/figure2.html.

126 *Social Security Administration, Office of the Chief Actuary*, "Period Life Table, 2019, as Used in the 2022 Trustees Report," 2022, https://www.ssa.gov/oact/STATS/table4c6.html.

127 "The percentage of people with Alzheimer's dementia increases with age: 5.0% of people age 65 to 74, 13.1% of people age 75 to 84, and 33.2% of people age 85 and older have Alzheimer's dementia." *Alzheimer's Association*, "2022 Alzheimer's Disease Facts and Figures," 2022, https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf.

128 *Genworth*, "Genworth Cost of Care Survey: Summary of 2021 Survey Findings."

129 "A relatively small number of people (1.2 million) age 65 and older lived in nursing homes in 2019. However, the percentage increases with age, ranging from 1% for persons ages 65-74 to 2% for persons ages 75-84 and 8% for persons over age 85." *Administration for Community Living*, "2020 Profile of Older Americans."

130 *Genworth*, "Genworth Cost of Care Survey: Summary of 2021 Survey Findings."

father could easily live several more years.[131] With his mother getting frailer every day, their combined care costs would consume his parents' annual income of $34,925[132] (mostly Social Security and an annuity) and in time their entire financial assets. Their main assets totaled $235,000, which included a home with no mortgage worth $148,000[133] and roughly $87,000[134] in retirement savings — comprised of $25,000 in stocks, bonds, and certificates of deposit, plus their individual retirement accounts (IRAs) — totaling $62,000.[135]

Bob thought that Medicare, which his father had already had for 15 years, would cover these expenses and ease the burden. When Bob visited the local Social Security office, however, he learned that Medicare does not cover custodial LTC.[136] He checked his parents' Medicare supplemental insurance policies and found that they were no help either.[137] Furthermore, the couple had not purchased a private insurance policy that would have covered custodial LTC. They did not know they were unprotected,[138] and no one ever tried to market such a policy to them.[139]

As his worry increased, Bob got some advice from a colleague who had been through the same wringer. "Talk to the people at the Department of Public Assistance about Medicaid," she said. She explained that Medicaid has its shortcomings but might be a big help. Somewhat abashed, Bob arranged an appointment with a Medicaid eligibility worker. He received some good news and some better news. First, income would be no problem. Medicaid doesn't count Mary's annual $5,000 Social Security income because she receives it in her sole name, and John's remaining income of $29,925 (or $2,500 per month) would not disqualify him because his private health and LTC costs would be deducted before comparing the remainder ($0) to the state's $841 monthly income standard. He'd also be allowed to keep a $30 per month personal needs

131 Average duration of Alzheimer's Disease from diagnosis to death is 10 years. *Dementia Care Central*, "Stages of Alzheimer's and Dementia: Durations and Scales Used to Measure Progression (GDS, (FAST), and CDR)," 2020, https://www.dementiacarecentral.com/aboutdementia/facts/stages/#duration.

132 Personal Capital, "What Is the Average Retirement Income in 2021 and How Do You Compare?," *Daily Capital*, 2021, https://www.personalcapital.com/blog/retirement-planning/average-retirement-income/.

133 These numbers roughly represent the median home equity and net worth for people 75 years and older. PK, "Average Net Worth by Age plus Median, Top 1%, and All Percentiles," *Don't Quit Your Day Job*, https://dqydj.com/average-median-top-net-worth-percentiles-by-age/.

134 Alana Benson, "What Is the Average Retirement Savings by Age?," *NerdWallet*, 2022, https://www.nerdwallet.com/article/investing/the-average-retirement-savings-by-age-and-why-you-need-more.

135 These numbers reflect the median amounts for people in their 70s with a little adjustment among various sources to make them balance.

136 "Medicare doesn't cover long-term care (also called custodial care) if that's the only care you need. Most nursing home care is custodial care, which is care that helps you with daily living activities (like bathing, dressing, and using the bathroom)." *Centers for Medicare and Medicaid Services*, "Long-Term Care," https://www.medicare.gov/coverage/long-term-care.

137 "Even the most comprehensive Medigap plans do not cover long term care for the elderly." *Paying for Senior Care*, "Medicare Supplemental Insurance (Medigap) Benefits for Long Term Care," 2022, https://www.payingforseniorcare.com/medicare/medigap.

138 "The results indicate that relatively few older people have private long-term care insurance coverage, even among wealthy older adults who could gain the most from coverage." Howard Gleckman, "Who Owns Long-Term Care Insurance?," *Forbes*, 2016, https://www.forbes.com/sites/howardgleckman/2016/08/18/who-owns-long-term-care-insurance.

139 "Despite the growing need, the number of insurers offering LTCI coverage has decreased from slightly more than 100 in 2004 to about a dozen in 2020." *National Association of Insurance Commissioners*, "Long-Term Care Insurance," 2022, https://content.naic.org/cipr-topics/long-term-care-insurance.

allowance while in the nursing home. Bemused, Bob realized that if his father's income had been much higher — say, $8,000 per month — he still would have been eligible for Medicaid after the state deducted his monthly out-of-pocket nursing home bill of $8,500.

The better news Bob received was that his father would immediately pass the asset test for Medicaid eligibility. None of his resources was disqualifying. The eligibility worker explained that the couple's home was exempt. In fact, John and Mary could have had over four times their actual home equity, up to $636,000, and John would still have qualified. On top of that, Mary's IRA funds held in her own name and John's IRA funds — currently in "payout status" because of his required minimum distribution — were exempt.[140]

To prevent "spousal impoverishment," Medicaid allows the community spouse (Mary) to keep half the couple's joint assets but at least $27,480.[141] So their combined assets of $25,000 would all go to Mary, leaving John nothing and therefore eligible for benefits. The eligibility worker did explain that any resources left over after John's passing would be vulnerable to recovery from his estate to cover the cost of his care. But that would happen only if Mary predeceased him. Otherwise, her own estate could be liable later, but few states pursue "spousal recovery," so they and their heirs would likely never be affected by Medicaid estate recovery.

Relieved, but with his interest piqued, Bob did some more research. What he found surprised him. His parents possessed almost exactly the median wealth of people their age. But if they had much greater net worth of $790,000,[142] they could still have qualified for Medicaid LTC benefits almost as easily. Deducting home equity of up to $636,000 leaves $154,000. Assuming none of that remainder is held in exempt IRAs or other noncountable resources,[143] it is all countable. Mary's Community Spouse Resource Allowance[144] — the amount of their combined assets she can keep — is one-half of $154,000 or $77,000, which leaves John the same amount, $77,000. That is $75,000 over Medicaid's $2,000 countable asset limit. The eligibility worker would set up a "spend down" plan for John based on the average cost of a nursing home in the state. If that cost were $7,700 per month, John would become eligible for Medicaid in 10 months ($77,000/$7,700). Not bad, but this is where Bob discovered that there are many legal methods to avoid Medicaid asset spend down altogether.

140 Tax-deferred retirement accounts — including IRAs, Keoghs, and 401(k)s — are exempt if the holder is receiving a regular payout. Such payouts are required by the time an individual reaches 72 years old, although they may begin as early as 59.5 years old without a withdrawal penalty. *Elder Law Answers*, "Can an IRA Affect Medicaid Eligibility?," 2021, https://www.elderlawanswers.com/can-an-ira-affect-medicaid-eligibility-14544.

141 This is the minimum Community Spouse Resource Allowance as of 2022. It increases with inflation every year.

142 This number is approximately the 80th percentile of net worth for 80-year-olds. PK, "Net Worth by Age Calculator for the United States," *Don't Quit Your Day Job*, https://dqydj.com/net-worth-by-age-calculator-united-states/.

143 Medicaid limits "countable" assets to $2,000 in most cases. Countable assets are things such as cash, stocks, bonds — anything easily convertible to cash. Assets that are not countable are exempt from consideration in the calculation of financial eligibility.

144 The Community Spouse Resource Allowance for 2022 is a minimum of $27,480 up to a maximum of $137,400.

On a tip from a colleague, he did an internet search for "Medicaid planning" and discovered dozens of law firms that specialize in helping affluent clients self-impoverish artificially. He also found a vast formal legal literature as well as numerous popular books and articles on the topic. It turned out that using that last $77,000 in the example without having to spend it on LTC as intended by the state and federal Medicaid program was very easy. The couple could buy a new car, since one car is exempt regardless of value. If they had a mortgage and their home equity was below the $636,000 limit, they could pay it down. They could buy unlimited personal belongings or home furnishings, all of which are exempt in unlimited amounts. The most common way to reduce countable assets, a method even recommended routinely by Medicaid eligibility workers themselves, is to prepay burial expenses. Medicaid planning attorneys give their clients long checklists of exempt assets and encourage them to use as much of their countable assets as possible to purchase things that will not interfere with their eligibility.

The one fly in the ointment Bob found was that Medicaid has a bad reputation for providing poor quality care. "Who would want to go to a welfare-financed nursing home or wait in a long line[145] for rare Medicaid home care slots?" he thought. Then Bob spoke with an elder law attorney who has specialized expertise on this subject. He said, "We advise all our clients to hold back enough cash to pay privately for a few months. We call it key money. The best facilities roll out the red carpet for private payers, because they can charge them half as much as Medicaid pays. When we flip the switch and start Medicaid, there is nothing the providers can do. State and federal laws prohibit expelling residents because their source of payment changes."

"Heck of a way to run a railroad," Bob thought. "It's welfare for the well-to-do, and it's set up so only they get the best care, and the poor, who lack 'key money,' are shunted into the welfare homes."

Beyond these already generous financial eligibility limits, the Medicaid law and regulations contain many "loopholes" that allow even very affluent people to qualify for the program while preserving all or most of their wealth. Special legal experts known as elder law attorneys or Medicaid planners employ "Medicaid friendly" annuities, Medicaid asset protection trusts,

145 "Most states (39) have a waiting list for at least one HCBS waiver, with over 665,000 people on HCBS waiver waiting lists nationally at any point in FY 2020." Watts, Musumeci, and Ammula, "Medicaid Home and Community-Based Services Enrollment and Spending."

modern and reverse half-a-loaf strategies,[146] and other sophisticated techniques to pry open restrictions intended to target Medicaid to the needy so that their well-to-do clients can qualify. Medicaid planners also counsel clients on how to avoid Medicaid's estate recovery mandate, which is relatively easy to do and facilitated by the requirement's generally weak enforcement by state Medicaid programs. Prosperous people who work routinely with financial planners, accountants, and lawyers on their estate planning learn about the importance of LTC early enough to transfer their assets to the next generation five years before requiring LTC. Assets transferred outside that five-year window, no matter how large, are not counted for purposes of determining Medicaid eligibility.

Some of the strategies used to qualify people for Medicaid LTC benefits without their having to spend down resources for care are listed in Table 1.[147]

Medicaid LTC eligibility workers and supervisors often complain that the income and asset restrictions they are required to enforce treat truly needy people more harshly than they do other more prosperous applicants. For example, a New York Medicaid assistant administrator from Long Island testified before Congress in 2011 that about 60 percent of applicants do some form of Medicaid planning:

> It is not at all unusual to encounter individuals and couples with resources exceeding a half million dollars, some with over one million. There is no attempt to hide that this money exists; there is no need. There are various legal means to prevent those funds from being used to pay for the applicant's nursing home care. Wealthy applicants for Medicaid's nursing home coverage consider that benefit to be their right, regardless of their ability to pay themselves.[148]

146 Half-a-loaf (as in "better than none") was a strategy to give away half one's assets and spend down the rest during the resulting period of ineligibility. The Deficit Reduction Act of 2005 prohibited this practice, so Medicaid planners replaced it with the "modern" and "reverse half-a-loaf" strategies. "The Modern Half a Loaf Medicaid planning strategy works as follows. The Medicaid applicant gifts approximately 50% of their assets over Medicaid's asset limit to a family member(s) and then purchases a short-term annuity with the remaining assets. Annuities take countable assets and turn them into a stream of income, which means they no longer count as assets. Between the gifting and the purchase of the annuity, there are no longer any 'excess' assets. This allows persons to apply for Medicaid since they no longer are asset ineligible. While Medicaid compliant annuities do not violate Medicaid's look-back rule, gifting assets does violate this rule. This means an applicant will be penalized with a period of ineligibility for doing so. The income from the annuity, combined with other income sources (if applicable) pays for an applicant's long-term care during the penalization period (for gifting assets to family).... With the Reverse Half a Loaf planning technique, Medicaid applicants give 100% of their excess assets to their family. Since this is a violation of Medicaid's look back rule, a penalty period of Medicaid ineligibility will result. The family then returns approximately half of the gifted assets to the Medicaid applicant, the penalty period is recalculated and shortened, and the care recipient uses the returned assets to pay for care during the penalization period. This strategy is not permitted in all states, as some states will not recalculate one's penalty period unless 100% of the assets are returned." *American Council on Aging*, "How the Modern Half a Loaf Strategy Helps Families Become Medicaid Eligible and Preserves Assets," 2022, https://www.medicaidplanningassistance.org/modern-half-a-loaf/.

147 *American Council on the Aging*, "Medicaid Planning Strategies: Approaches to Qualify for Medicaid Long Term Care," 2022, https://www.medicaidplanningassistance.org/medicaid-planning-techniques/. The source has detailed descriptions and explanations of each of the strategies listed in the table and more.

148 *U.S. House of Representatives, Committee on Oversight and Government Reform*, "Examining Abuses of Medicaid Eligibility Rules," 2011, https://archive.org/details/gov.house.ogr.dc.20110921. The witness's testimony begins at 29:36 minutes.

Analysts who downplay the role of Medicaid planning in expanding eligibility and costs rarely acknowledge the vast formal legal literature describing and advocating methods to artificially impoverish clients to qualify them for assistance. They dismiss Medicaid planning as something the affluent would not do because of the program's poor reputation,[149] but they ignore the ways Medicaid planners get special treatment for their clients by withholding "key money" to buy their way into the best LTC facilities. Medicaid planning clients crowd out the poor from the best facilities because they can afford to pay privately at market rates for a time, making them prime candidates for admission at revenue-starved nursing homes and assisted living facilities. After a short period as private payers, the advisers convert their clients to Medicaid. The public is aware of the key money trick, as several answers to an "AgingCare GoFundMe" query indicate.[150]

Easy access to Medicaid LTC benefits once care is needed has had the effect of desensitizing the public to LTC risk and cost. Most people ignore LTC until they need it. At that point, Medicaid's many deficiencies seem less onerous than the prospect of paying catastrophic LTC costs out of pocket. Unfortunately, the way the system works is that people with little wealth, low incomes, and scant exposure to legal and financial advice are quickly wiped out by Medicaid's austere financial eligibility rules. But those with more wealth and higher incomes who are accustomed to working with legal and financial professionals learn how to preserve their wealth, qualify for Medicaid, and use key money to access the best services and facilities. Medicaid's more favorable treatment of affluent people in terms of eligibility and access has led recently to charges of structural racism.

> Structural racism in coverage and financing has created a two-tier system of racially segregated care in which minority people receive poorer-quality care.... Inequities in nursing home care provide a particularly vivid example.... Stark racial segregation in nursing homes persists today.[151]

Because of the fallacy of impoverishment's predominance among scholars — and the convenience of using it to condemn the current system while promoting a new universal compulsory LTC program — we have little hard evidence about Medicaid LTC overuse. Studies that could produce the evidence are rare. In 2012, however, four members of

149 "Nursing homes that rely the most on Medicaid tend to provide the worst care for their residents — not just the people covered by the program but also those who pay privately or have Medicare coverage." Jordan Rau, "Why Glaring Quality Gaps Among Nursing Homes Are Likely to Grow If Medicaid Is Cut," *Kaiser Health News*, 2017, https://khn.org/news/why-glaring-quality-gaps-among-nursing-homes-are-likely-to-grow-if-medicaid-is-cut/.

150 *AgingCare*, "Has Anyone Used GoFundMe to Help Pay Assisted Living Costs?," 2022, https://www.agingcare.com/questions/has-anyone-used-gofundme-to-help-pay-assisted-living-costs-473710.htm.

151 Ruqaiijah Yearby, Brietta Clark, and José Figueroa, "Structural Racism in Historical and Modern US Health Care Policy," *Health Affairs*, vol. 41, no. 2 (2022), https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2021.01466.

Table 1: Medicaid Planning Techniques

Annuities	Medicaid Divorces
Child Caregiver Exception	Qualified Income Trusts / Miller Trusts
“Half a Loaf” Strategies	Sibling Exception
Income Spend Down	Spend Down Excess Assets
Irrevocable Funeral Trusts	Spousal Asset Transfers
Lady Bird Deeds	Spousal Income Transfers
Medicaid Asset Protection Trusts	Spousal Refusal

Source: American Council on Aging

Congress queried all state governors about Medicaid planning. Here are some examples of the replies they received:

- **North Dakota:** A couple with $700,000 in liquid assets qualified for Medicaid LTC benefits by purchasing a more expensive house, a car, and an additional annuity while receiving $8,000 per month from pensions, Social Security, annuity payments, and oil lease money. Another couple had more than $528,000 in assets but qualified when the community spouse bought a new home, a new car, and two annuities worth $240,000 and then applied for Medicaid to pay the institutionalized spouse’s nursing home costs.
- **Wisconsin:** An ill spouse transferred $600,000 to the community spouse, who refused to sign the Medicaid application, making the ill spouse eligible for Medicaid because “interspousal transfers are not considered divestment.”
- **New York:** Using promissory notes, immediate annuities, and spousal refusal, affluent LTC Medicaid applicants qualify while retaining unlimited assets. This occurs even when the state has legal recourse, because “Medicaid does not have sufficient resources to pursue all these cases in court.”
- **Rhode Island:** A couple with $400,000 in a bond account became eligible in one month by purchasing “a large single premium immediate annuity.” A single man transferred $100,000 to his son but dodged half of the penalty for transferring assets by using a promissory note to carry out a reverse half-a-loaf strategy.

- **Virginia:** A man bought a $900,000 annuity in his wife's name, which paid her $89,000 per month, but "the Virginia Medicaid program could not count this income for purposes of determining the husband's Medicaid LTC eligibility."

"Spending down" assets to qualify for Medicaid without expending those funds for LTC or any other health-related expense is far easier and more commonplace than most economists and LTC policy analysts willingly acknowledge.

GOVERNMENT VS. MARKET PRINCIPLES

How Government Impacts Markets in General

This paper first explained how government financing and regulation of LTC, primarily by Medicaid and Medicare, caused the sector's biggest problems, including institutional bias, inadequate financing, access and quality problems, caregiver shortages, and excessive dependency on unpaid family caregivers. Next the paper described how private sector initiatives mitigated some of the damage done by government, giving examples such as the development of mostly private-pay assisted living, home care, and private insurance. Then it explained how Medicaid dominates LTC, desensitizes the public to this major risk and cost, crowds out potential private financing sources such as insurance or home equity conversion, and so discourages instead of encourages private market solutions that could alleviate LTC's problems.

What is it about government funding and regulation that causes such problems? Likewise, what is it about private markets that enable them to solve or at least relieve those problems?

Markets with heavy government involvement, such as the LTC market, operate on different principles than freer markets do. Consider the concepts associated with government compared to parallel notions more commonly related to markets:

- Government evokes politics, politicians, and voters. Markets suggest economics, entrepreneurs, and consumers.
- Government involves interest groups, cronyism, and compulsion. Markets rely on individuals, competition, and persuasion.
- Those who are governed must accept the policies they get from the officials they choose in periodic elections. Market participants continually choose what they want by spending their money in voluntary, mutually beneficial exchanges.

- Governments rely on central planning by powerful elites, often resulting in misallocation of resources, inflation, and shortages of the goods and services people prefer. Markets generate spontaneous order from countless voluntary exchanges, producing price data that tell investors where and how to invest their capital to satisfy people's needs and wants.
- Government bends toward coercion and socialism. Markets lean toward freedom and capitalism. Their extremes are totalitarianism and anarchy, respectively, so both government and markets must be tempered with good sense, moderation, and, when necessary, litigation.

Furthermore, government and market principles actualize differently. They tend in opposite directions. Government is public, collectivist, and socialistic. Markets are private, individualistic, and capitalistic. Government decisions are made through voting where voters often get only two choices of politicians or ballot measures with no gradations for preference, amount, or quality. In the market, free-acting consumers vote with their cash for (that is, they choose) whatever they want in the quantity and quality they desire. In government, politicians compete by satisfying interest groups with benefits paid for by others, with quality and efficiency notoriously absent. In markets, entrepreneurs compete by creating or identifying and meeting consumers' needs based on quality and efficiency. In government, the Federal Reserve sets interest rates based on balancing political powers and influence, resulting in asset bubbles, malinvestment, and economic inequality. In markets, millions of transactions among willing buyers and sellers create spontaneous economic order, set interest rates (the price of money) through supply and demand, and generate price data that tell investors and businesses how much of which products and services to produce. Government subjugates; markets liberate.

Is it any wonder, then, that government funding and regulation tend to create economic problems, while markets are inclined to find and implement ways to fix or improve them?

How Economic Principles Express in the LTC Market

Because of the LTC market's heavy reliance on central planning and government financing, it does not produce the price data investors would need to allocate resources in the most productive and beneficial ways. Medicaid's dominance of LTC financing compels consumers to adapt to its eligibility and coverage restrictions. It influences providers to supply only such services as Medicaid offers in the quantity and quality it is willing and able to fund. Consequently, U.S. LTC endures access and quality problems; provides too much institutional care and too few HCBS; and suffers caregiver shortages, inadequate public financing,

Table 2: General Principles

Markets	Government
Private/Individual	Public/Collective
Economics	Politics
Gradations	Only "yes" or "no"
Trade-offs	Promises
Capitalism	Socialism
Competition	Cronyism
Entrepreneurs	Politicians
Consumers	Voters
Free actors	Subjects
Choose	Accept
Persuasion	Compulsion
Please consumers	Buy votes with promises
Money	Benefits
Goods and services compete	Ideologies compete
Quality/efficiency	Quality/efficiency unusual
Meet consumers' needs	Satisfy interest groups
Spontaneous order	Design and control
Price data	Power and influence
Market sets interest rates	Fed sets interest rates

Source: Author's research inspired by the work of economist Thomas Sowell

declining private funding, and consumer indifference to planning ahead for future LTC risk and costs. These problems are worse where government prevails in the LTC system and less damaging where markets predominate.

For example, some components of the senior living and LTC markets rely more on public financing and some less. Nursing homes depend most heavily on government financing, especially Medicaid and Medicare. They are the least profitable and the most financially vulnerable sector. Assisted living evolved as a fully private-pay alternative to Medicaid nursing home care, but now one in six assisted living residents receives Medicaid. Specialized memory care in assisted living facilities gets little public funding, but less desirable dementia care in nursing homes receives substantial revenue from Medicare and Medicaid. Home care is

heavily financed by government and has more access and quality problems in publicly financed congregate care settings. Independent living is exclusively private pay. By most measures, the more market-based independent and assisted living sectors fare better economically over time than do the more government-dependent nursing home and home health sectors. Profitability — and hence access and quality in the senior housing and care business — is inversely proportional to the level of government funding and regulation.

CONCLUSION

It behooves analysts and policymakers to consider how public financing created and worsened LTC's problems before proposing more of the same to fix those problems. The lessons of LTC history are clear: public programs have paid for most expensive LTC since 1965. They diverted the public from responsible LTC planning and left too many people dependent on welfare-financed nursing home care. Easy access to Medicaid LTC financing after expensive care is needed created a moral hazard that discouraged early planning for the risk and cost. The private sector interceded repeatedly with preferred options such as assisted living, private home care, and insurance. But the dominance of Medicaid and Medicare financing for nursing homes prevented alternative modes of LTC service delivery and financing from fully developing based on consumer preferences.

This question remains: Knowing what we know now about the damage government financing has wrought, what are the best policy options going forward? That is the question addressed in Part 2, "Long-Term Care: The Solution."