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LONG TERM CARE IN THE POLITICAL BALANCE

Alison Barnes*

These comments serve to draw together some observations of the experts – policy analysts, practitioners, and scholars— who presented their research and analyses at Marquette University Law School's 2007 Health and Elder Law Symposium. They also seek to connect those points and others made in the excellent papers published in this dedicated issue of Elder's Advisor, with the larger social and political discussion of health and long term care costs.

The Deficit Reduction Act of 2005 continued the long history of squeezing off Medicaid eligibility for aged people with disabilities who are not destitute. Those most affected are elders who had steady modest incomes[1] and accumulated savings and housing with any excess. The Medicaid eligibility rules seek to utilize savings to pay for nursing facility care and recover expenditures from the value of assets generally exempt during the Medicaid recipient's lifetime, primarily the home. The rules cannot penalize the spender, only the thrifty.

Arguably, they do not reach more affluent elders. As one student (an affluent businessman, age 72) inquired (I paraphrase him): Do you mean that if I set aside assets to cover five years of nursing facility care (at $5,000 per month on average

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1. The amount of an individual's Social Security benefit is based on the thirty-five highest years of income, adjusted for inflation, an amount termed the PIA, or primary insurance amount. LAWRENCE A. FROLIK & ALISON MCCHRYSTAL BARNES, ELDER LAW CASES AND MATERIALS 171-172 (4th ed. 2007). References to ELDER LAW CASES AND MATERIALS will be limited to a few points, though much of my thinking on this topic is found there.

nationwide, or $300,000) then the government will pay for my nursing home care? That generally is correct, Medicaid eligibility should be assured since sixty months is the length of time states must examine the records of applicants to determine whether applicants either gifted away assets or were receiving income from undisclosed assets.

For the great majority, however, that set-aside is impossible. The question becomes: How much savings is "too much" to reserve from payment for nursing home care, and does society wish to scrutinize why the elderly owner seeks to set it aside from his or her support?[2] We report herein that the average transfer in one study, made by one in eight applicants in an affluent pool, was $46,000.[3]

We cannot lightly dismiss objections to Medicaid planning—the legal and lawyer-facilitated practice of arranging assets and income—in order to hasten partial state payments and reduced monthly cost for nursing facility care.[4] Objections are raised effectively by many who also advocate taxpayer rights, private sector reliance, and self-sufficiency as esteemed personal values. Such independence is fundamental to a belief structure of a group who might be apolitically termed "individualists."

On the other hand, we cannot ignore or disparage those whose values emphasize interdependence as essential to society. We don't individually maintain the infrastructure for health or other public goods. Neither can we concede, contrary to evidence, that Medicaid planning causes substantial economic

2. Ellen O'Brien's presentation reported the observations of Maryland Rep. Roscoe Bartlett's roundtable discussion (Republican, MD. 6th Cong. Dist.) that surely one's habit of tithing to one's church would not be counted against a Medicaid applicant. *See* Ellen O'Brien, *What is Wrong with the Long-term Care Reforms of the Deficit Reduction Act of 2005?*, 9 ELDER'S ADVISOR 103, 110 (2007). However, the rules do not assess the acceptability of gifting according to the worthiness of the gift recipient.

3. *See id.* at 116.

4. I distinguish here the practices permitted by statute, which might, in some circumstances, trigger a period of ineligibility for government payment and payment structure, as opposed to actions subject to civil or criminal action for fraud.

losses from government revenues. The Kaiser Family Foundation Commission on Medicaid and the Uninsured reports that if all assets transferred by aged Medicaid applicants were identified, they would total about 1% of state Medicaid long term care budgets.[5] But denying Medicaid eligibility to the elderly ill would have a substantial impact on expenditures.[6] A related, non-quantitative question is whether moral opprobrium is due for individuals who seek to arrange their assets or income to access a benefit according to government rules.

I have long asserted that much objection to the cluster of financial choices termed "Medicaid planning" arises from the fact that Medicaid originates as a program for the poor. Dealings with the poor are sometimes excessively and destructively paternalistic. That is, government says "tell me everything and fully comply these rules, and we will tell you what you get". This model of citizen/government interaction is a poor fit for the prudent middle class elder of modest means who seeks, above all, to maximize security for self and family. The Medicaid planning stakes are highest for this elder citizen.

The current status of government long term care benefits is hardly clear policy, but appears to be a reserved endorsement of assistance to the middle class Widespread lack of conviction about that help arises, I think, from the belief that most people can save and plan for their expenses in old age. This is mostly true, people can and do save if only in the form of restricted access retirement accounts including Social Security taxes. But it ignores the small minority of elders who have great, often medicalized needs, and few informal ways to meet them.

The need for long term care support arises because of a number of changes to life patterns and economics that took place

5. *See* Kaiser Family Foundation Daily Health Policy Report, Medicaid: States Becoming More Aggressive in Medicaid Estate Recovery Programs, Jan. 2, 2007 (citing AARP Public Policy Institute, which reported that only 8 states received more than 1% of their budgets in estate recovery revenues), http://www.kaisernet work.org/daily_reports/rep_index.cfm?hint=3&DR_ID=41870.

6. *See generally,* Kaiser Family Foundation, Medicaid's Long Term Care Beneficiaries: An Analysis of Spending Patterns (2006).

over recent decades, mostly without widespread recognition. First, longer lives and smaller families mean that some have fewer in the younger generation who are or would be burdened with extended periods of care. Confusingly, this is a generalization with contradictions, since lower infant and early adult mortality means that elders who had many children have a huge number of potential family caregivers. Second, the transfer of wealth from generation to generation has shifted with the move from family farming and businesses to a pattern of extended, parent-supported education as key to the success of the next generation. Wealth is no longer the family's land or work; rather it is financial and emotional support for post-secondary education. The third factor reflects the shift implied by factor two, from a small-production to a wage-based economy, with supply of many specific, current goods acquired only with cash rather than approximations of those goods generally acquired through barter and waiting. One aspect of the change is the number of family members who earn wages and whose earnings are considered necessary to maintain the family, leaving few available for home care of the old and the sick.

Another aspect of the shift in long term care from a home-like family matter to a concern of business and government is the growth of costs in health care and increasingly-medicalized long term care. Health care goods are increasingly expensive and, if needed in quantity, cost more than many individuals can or should reasonably save to finance.

One can envision that those who fail to plan to pay for long term nursing facility care although they can[7] may also reflect

7. Affordability and the ability to save for retirement expense is inherently difficult to assess because of many variables of income, costs of education for self and family, health-related expenses, geographic region, and personal expectations. However, doomsaying about the lack of adequate savings and urging each earner to save as much as possible has recently been criticized as erroneous and counterproductive. *See, e.g.*, Damon Darlin, *A Contrarian View: Save Less and Still Retire with Enough*, N. Y. TIMES, Jan. 27, 2007 at A1; Gayle B. Ronan, Is there really a retirement savings crisis? MSNBC.com, Oct. 30, 2007, http://www.msnbc.msn.com /id/20296654/.

some fundamental beliefs beyond that the nursing facility should be there to receive them regardless of their ability to pay. One such belief may be that the likelihood of a long-term, seriously debilitating condition is either remote or unimaginable. It is unclear why such a belief might be widespread, whether because disability that interferes with major life activities can be deferred through medical technology, or because disability income and widespread anti-begging ordinances make health-caused poverty invisible, or individual experience of an older person with chronic disabilities is otherwise very limited.

Another "belief" is that nursing facility care is an unwanted good that can be avoided, so the risk of need is not worthy of planning. Such a view of nursing facility care contrasts with the general view of health care, so planning may differ.[8] A suggested explanation is that we want to be assured (non-budget busting) health care when we are ill in order to get better and leave need behind. This pattern does not reflect the needs of chronically impaired elders, although they may improve and be free of the burdens of devoting most of their time to health. To some extent, it denies reality although the need for chronic care is reality for a small minority. That is, it denies reality for the significant few.

Another widespread belief is that nursing facility care must be avoided by all means. The stereotype was captured in the animated television show The Simpsons, in which the greedy and malicious casino owner Mr. Burns is shut down! His employees – card sharks, cheats and bottom-dealers – manage a nursing home![9] The nursing home industry continues to assert that its image problems are caused by a few bad apples, while statistics indicate that nursing aide staffing in most facilities is

8. Richard L. Kaplan, *Financing Long-Term Care in the United States: Who Should Pay for Mom and Dad?*, *in* AGING: CARING FOR OUR ELDERS 74-75 (David N. Weisstub et al., eds., 2001).

9. Eric M. Carlson, *Seige Mentality: How the Defensive Attitude of the Long-Term Care Industry is Perpetuating Poor Care and an Even Poorer Image*, 31 MCGEORGE L. REV. 749, n. 9 (1999) (episode viva Ned Flanders).

inadequate for all the basic hands-on care required by the number of facility residents. In a dismaying recent report, the staffing at investor-owned nursing facilities is shown to drop sharply and the well being of residents to suffer with suffering and early deaths.[10] Profit taking and the intensive work of human care apparently are incompatible.

Fears about a bad and costly end of life play out in politics and business on Medicaid eligibility for the middle class, in part for historical reasons. Medicaid is an errant growth from the social conscience that raised all boats in the 1950s and the Great Society of the 1960s. As early as 1950, Congress allocated grants to the states to pay for health care for states' poor citizens. Other government involvement in health care was resisted by organized medicine which feared unnecessary interference and the health insurance industry which found a lively business in employer-based health insurance for returning veterans of World War II.

A most intense debate was about responding to the needs of the one-third of elders living in poverty in an era predating the annual cost of living adjustment to Social Security income payments. In May 1965, with a shift of representation in Congress and other political regrouping, the opportunity for nationwide health care programs appeared. Almost all debate centered on the coverage that would become Medicare, yet in July 1965, with little discussion, Congress also institutionalized the payment formula and benefits that would become Medicaid.

States could, by submitting plans that met federal rules, such as statewide availability of services, patient choice of providers and continuity over a period of years, receive federal funds of 50% to 80% to match their own spending for health care for the poor. Mirroring Medicare, the services states must provide included only skilled nursing facility care as a long-term care service. Less intensive nursing home care was deemed optional, at the discretion of each state. However, states that

9. Charles Duhigg, *At Many Homes, More Profit, Less Nursing*, N.Y. TIMES, Sept. 23, 2007, at 1A.

chose initially to provide only skilled care found that they paid higher "skilled" rates for elders who could not stay home because of a lack of family support or poor housing that caused serious health problems for impaired elders.

The four-decade Medicaid long term care evolution that followed included waivers of the fundamental federal rules to allow, on a state or locality basis, home care for those who would be eligible for nursing facility placement, demonstrations packaging intensive community-based health and long term care services, and Medicaid payment for "assisted living" so fewer elders need nursing facility care. All seek the most cost-effective way to meet the needs of disabled elders.[11]

In the meantime, the cost of health care and more intensive medicalized long-term care services has risen dramatically. An individual who has the misfortune to need substantial care finds her savings rapidly consumed.

Yet insurance coverage, particularly for long term care, is in its prolonged, troubled immaturity. Insurance generally suffers from the widespread troubles of greed by both seller and buyer. Moral hazard, adverse selection, underwriting and various forms of reunderwriting, and overly aggressive marketing have created small risk pools protected only by stop-loss insurance (i.e., insurance to prevent disastrous loss on the major policy risk). All these factors intervene in the original concept, according to which all with risk of loss pooled a reasonable sum to be paid to the unlikely sufferer of major loss. Long term care insurance seeks to play all the actuarial games, and has indeed early distinguished its ability to fend off claims.[12] Meanwhile, long term care insurers are likely to collect premiums for decades before a policyholder makes a claim. The most likely

11. Nursing facility care of skilled and other levels is now a required Medicaid service, however, states have set various rates of payment that encourage or discourage care for patients of varying intensity of need. Further freedom of choice to deny nursing facility eligibility is provided by the DRA. *See generally* Gene Coffey, *Narrowing Medicaid's LTC Coverage? The Implications of the DRA's Home and Community-Based Care Benefit*, 9 ELDER'S ADVISOR 131 (2007).

12. Charles Duhigg, *Aging, Frail and Fighting Insurers to Pay Up*, N.Y. TIMES, Mar. 26, 2007 at A1 (part of the series *Golden Opportunities, Long-Term Trouble*).

end of the individual policy is lapse without payout.

Some individualists look to adult children to pay for their parents' care. Thirty-three states have filial responsibility laws that allow an indigent parent to sue an adult child for support. Admittedly, few cases illustrate the appropriate applications of such laws. Many find the idea anywhere on a continuum from impractical to repugnant. Compelling behavior within the family has been associated with the risk of abuse.

That last objection may not currently apply, however, opening the possibility for intergenerational support on a family, rather than societal, basis.[13] Formerly, the opportunity for mistreatment arose when the unwilling family took in an elder. Until the economic changes around World War II, the location of care typically would be the family farm or town homestead, where goods might be scarce but need for household work was never in short supply. Now, we are in a money economy with over 25% of households of just one person, many of whom are older. The message of the statutes now, therefore, is "just send money," without significant opportunity for undetected abusive treatment. The model for enforcement, should society choose to adopt it, is a registry with interstate tracking similar to the system for child support.

The newest filial responsibility law therefore is worth a look. Pennsylvania, which had repealed its old law, enacted a new one in 2006.[14] The Pennsylvania statute conditions the child's obligation on a finding by the court of excess income, and requires that a percentage of that excess be paid for a needy parent's basic care, including medical expenses. This could include housing, food, and medical expenses. It is well thought out, regardless of whether one agrees with the underlying

13. *See generally* Seymour Moskowitz, *Adult Children and Indigent Parents: Intergenerational Responsibilities in International Perspective*, 86 MARQ. L. REV. 401, 402 (2002) (regarding filial responsibility statutes in the states).

14. 23 PA. CONS. STAT. ANN. § 4603 (West 2006). Subsection (b)(2) provides that the amount "for medical assistance ... other than public nursing home care ... The amount of assistance is to be the lesser of ... six times the excess of the liable individual's average monthly income over the amount required for the reasonable support of the liable individual ... (or) the cost of medical assistance."

premise.

Notably, however, the statute does not require the adult child to contribute for nursing facility expenses if the parent is eligible for such Medicaid placement. That is, the state will pay for nursing home care according to complex rules of income and asset eligibility similar to those in other states. The cost of the care is implicitly acknowledged, even by determined individualist-minded legislators, to be different in type and magnitude. The adult child who otherwise must provide support for the poor parent can leave that bill to the state and its taxpayers.

The time when Medicaid long term care was a program for the poor has passed. Our speakers talk about health and long term care as parts of a whole, regardless of the mechanisms triggering government benefits.[15] Some strategies for achieving Medicaid eligibility have been created by Congress, such as the Miller (or Medicaid Qualified Income) Trust[16]. Some are acknowledged by the states, such as special needs trusts[17] and use of annuities to convert assets into an income stream and thereby achieve eligibility and slow the rate of spending on long term care by triggering the Medicaid rate of payment to the nursing facility.[18]

All such strategies are allowed in order to address the conceptual and practical problems of Medicaid long term care

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15. Medicare, the national health care program for the elderly and disabled, has always been "community rated", charging each beneficiary the same premium if fully insured for Part A – Hospital Insurance or eligible for Part B – Supplemental Medical Insurance. The Medicare Modernization Act of 2003 created means-tested premiums for Medicare Part B, and recent Senate initiatives propose means-tested premiums for Medicare D – Prescription Drug Plans. *See, e.g.*, Jonathan Weisman, *Higher Medicare premiums considered* (reprinted from the WASHINGTON POST) MILWAUKEE JOURNAL SENTINEL, Oct. 5, 2007, at A6 (Senator John Ensign (R-NV) proposes to attach provisions to means-test drug plan premiums to any available legislation, noting that "working couples with incomes over $160,000 should not be subsidized by retired firefighters or schoolteachers").

16. 42 U.S.C. § 1396p(d)(4)(B) (Westlaw current through November 20, 2007).

17. § 1396p(d)(4)(C). A special needs trust for a beneficiary over age 65 when the trust is created must be administered by the state or a private non-profit designated by the state as acceptable to the Medicaid program.

18. 42 U.S.C. § 1396c (Westlaw current through November 20, 2007).

eligibility as extended to the non-destitute. They acknowledge that it is incoherent to cause an elderly person to literally spend everything[19] they have worked for in order to trigger Medicaid nursing home benefits, while they live, know of their inevitably tenuous financial and personal circumstances, and have only a tiny monthly allowance from their income for all non-Medicaid expenses.[20] It is incoherent because prudent people of modest means and savings are most greatly burdened. Those who earn much but spend most profligately are destitute at the time of application, and therefore accepted as eligible.

Another response calls for encouraging widespread use of long term care insurance. It is an apparently prudent idea because long term care is an "insurable event" of potentially very high costs that will be incurred by very few. Such an insurance pool could work. However, the hype for the product is generated in significant part by the insurance industry itself, denying the high cost and problems with coverage that make long term care policies unsuited to many people. First, the costs are high because the pool is small and may be tainted by moral hazard, i.e., older people who anticipate long term care needs choose coverage. On the other hand, those who buy coverage while they are young and premiums are relatively low are likely to allow a policy to lapse and receive nothing for their premiums. Second, private long term care insurance is a product that unfortunately incorporates many of the most dysfunctional aspects of insurance, including the splintering of risk pools, cherry-picking of healthier applicants and rejection of others, aggressive marketing at low prices to achieve market share with unwarranted post-claims denials, and some

19. Medicaid eligibility is determined by the states within federal guidelines. However, the rule of thumb for assets that can be retained by a single Medicaid applicant is $2,000. Certain other assets, notably the homestead if the individual has an expectation of returning, are exempt from the eligibility calculation, though subject to recovery from the individual's estate.

20. The monthly personal needs allowance from individual income is $35 - $45 in most states, though the minimum allowed under federal law is $30. High cost states such as Alaska and Hawaii allow as much as $85 for all expenses outside of the housing, food and shelter covered by Medicaid.

providers who simply scam their purchasers. It is difficult to determine whether addressing all such problems through regulation would cause insurers to withdraw their products as unprofitable.

A worrisome aspect of Deficit Reduction Act changes is the option for the states, as related by Gene Coffey in this issue,[21] to opt for home care for elders sufficiently impaired as to need nursing facility care. That is to say, the state might make the choice against nursing home care. An elder in such condition will not be going home to live alone, but must have caregiver(s), family or others.

That is a recipe for neglect and abuse if the caregivers are unwilling. We know what home care for seriously disabled people looks like when caregivers are willing, as recorded in such classics as The 36-Hour Day,[22] as the relentless requirements of a home resident might not remember meals or other interactions immediately past, or might cry out constantly around the clock. The emphasis of the U.K. on home care, significantly budget-driven, provides reports of the results of such home care placements: Families severely disrupted, unable to care effectively for themselves, much less for a person with serious disability and need.

In sum, the response to the state option is that institutions are, in some instances, the good option. Nursing facilities are good when they are needed. They need to be well-run by caring and conscientious people, and inhabitated only by those who need them.

Health care and long term care are for many purposes now one, unitary. The health care component dwarfs the room-and-board component when significant care is needed, but the growing use of variations on assisted living – traditionally nonmedical residential care – can offer living standards above

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20. *See generally* Coffey, *supra* note 11.

21. NANCY L. MACE, THE 36-HOUR DAY: A FAMILY GUIDE TO CARING FOR PEOPLE WITH ALZHEIMER'S DISEASE, OTHER DEMENTIAS, AND MEMORY LOSS IN LATER LIFE (4th ed. 2006).

the minimum, even for those who qualify under a Medicaid assisted living waiver.[23] We know that we need to correct health insurance, and that long term care coverage should be included in any solution. Because many believe that they will never need long term care, it is particularly important that coverage be universal, that all should have it. This is a better answer than the DRA, which simply squeezes off benefits for prudent people of modest income and with perhaps difficult circumstances late in life.

This choice would end a culture of fear of need with little chance of good care and appropriate choices of services, such as a well-run facility near former residence or family. It would cut resources needed for marketing and administering competing insurance plans and much of the waste of the resources benignly called "coordination of benefits" of various possible payers.

Eligibility would not become simple, the great advantage of the Social Security program and its derivative Medicare coverage. Rather, arguments about eligibility would shift from income and assets to health/disability status, i.e., the need for the care sought. Some would, out of need or frugality, seek any type of care with minimal out of pocket costs in terms of deductibles and copayments. Much state choice might be provided, preserving the Medicaid legacy, creating different treatment of elders according to their home locations. Such incremental change does not create a perfect match of need and care.

Advocacy of elder lawyers for clients shows that the status quo causes deprivation and distress. Change is possible. The reconception of more intensive, medicalized forms of long term care as health care is key.

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23. *See, e.g.*, Mulder v. S. Dakota Dep't. of Social Services, 675 N.W. 2d 212 (S.D. 2003) (see especially the dissent: state allowance for assisted living, for which Mulder qualified, is $993 per month, which is paid for eligible persons who choose an assisted living facility that charges more. The balance must come from other funds, such as those of adult children).