CENTER FOR
LONG-TERM CARE
REFORM

Dedicated to ensuring quality long-term care for all Americans

# Briefing Paper #1:
# The History of Long-Term Care Financing, or How We Got Into This Mess

## The Status Quo

Long-term care (LTC) service delivery and financing in the United States are fraught with problems. Families provide most LTC for free, but suffer enormous financial and emotional strain. We have too many nursing homes and not enough home care. Medicaid and Medicare pay for most expensive LTC, but they are short of funds. LTC is a high probability and very expensive, yet too few people save or insure against the risk. Many end up as dual eligibles, the most costly of Medicaid's and Medicare's beneficiaries. Access to LTC and quality of care are always in doubt. Private capital is in short supply to build, operate and maintain LTC facilities or to support home care services. Bankruptcies and closures loom. Yet America's demographic age wave is only beginning to crest.

## What Should We Do?

This is the first question most people ask, but it is the wrong question. To address the dysfunctional status quo without first examining why it exists can lead to more of the same expensive interventions that have already failed. For example:

Free care stresses families? Then subsidize them. Too little home care? Rebalance Medicaid to buy more. Medicaid and Medicare lack funds? Add money. LTC insurance is unpopular? Offer tax deductions or credits (tax expenditures). Too many dual eligibles? Manage them better. Access and quality problems? Hire more surveyors and increase penalties. Too little private capital and investment? Provide tax incentives (more tax expenditures). Bankruptcies threatening? Increase reimbursements. Can't afford boomers' entitlements? Borrow more. Find yourself in a hole? Dig faster.

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## The Right Question

Lincoln said: "If we could first know where we are and whither we are tending, we could better judge what to do and how to do it." (House Divided Speech, 1858) Faced with any problem, the right question to ask first is: How did we get into this mess? Otherwise, we run the risk of doing more of what caused the problem in the first place. Before we propose LTC solutions, we should ask "How did long-term care come to be the way it is today?"

## History of LTC Financing

By 1965, most of the 20th century's life span extension had occurred. People lived longer and died slower often from the chronic illnesses of old age. Increasing numbers lived long enough to need LTC. Medicaid began to pay for nursing home care. Initially, the new program had no penalty for transferring assets to qualify and no requirement for recovery of benefits paid from recipients' estates. Virtually anyone could qualify easily for Medicaid-financed LTC.

Several things happened as a result. The public placed aging parents in nursing homes paid for by the government instead of paying for home care themselves. The nursing home industry expanded to take advantage of the new government funding source. Thus began the heavy use of nursing homes or "institutional bias," the lack of a privately financed home and community-based services market, and the absence of private LTC financing alternatives, such as home equity conversion or LTC insurance.

## The 1970s

Political satirist P.J. O'Rourke says "If you think health care is expensive now, just wait until it's free." With nursing home care virtually free, Medicaid LTC expenditures exploded, rising from $900 million in 1970 to $7.1 billion in 1980. In response, government capped the bed supply by requiring "certificates of need" before new nursing homes could be built. Medicaid could not be charged for beds that didn't exist went the reasoning.

But limiting their ability to expand gave existing nursing homes a government-enforced monopoly. To compensate for limits on growth, they began charging Medicaid higher rates. Government responded by capping

the rates nursing homes could charge. This was the origin of "cost shifting," which resulted from the differential between low Medicaid reimbursement rates (about 2/3 of private-pay rates) and much higher private-pay rates (about 1.5 times the Medicaid rate on average).

**The 1980s**

With nursing home supply and prices capped, and few controls on Medicaid LTC eligibility, demand soared. Costs continued to explode, rising from $7.1 billion in 1980 to $16.4 billion in 1990. Unable to build more beds or charge Medicaid more, nursing homes cut corners on quality to make ends meet.

By the mid-1980s, reports of dismal conditions in America's nursing homes led to Congressional action. The Omnibus Budget Reconciliation Act of 1987 required nursing homes to improve care or face legal and financial penalties. But OBRA '87 provided no extra Medicaid funds to finance the mandated improvements.

Caught now between the rock of inadequate reimbursement and the hard place of mandatory quality, nursing homes started suing state Medicaid programs for higher reimbursements. They won most of these lawsuits based on the 1981 "Boren Amendment" which required Medicaid to pay at least minimally adequate rates. But Congress repealed Boren in 1997 leaving no floor underneath Medicaid nursing home reimbursements.

**The 1990s**

Several cross currents developed in the 1990s, as Medicaid nursing home expenditures continued to rise from $16.4 billion in 1990 to $31.9 billion in 2000. Private payers declined as people, enticed by free or subsidized Medicaid benefits, found more and more creative ways to qualify for the program. Out-of-pocket expenditures fell from 49.5% of nursing home revenues in 1970 to 32.5% in 2000, while Medicaid's share of costs increased from 23.3% to 37.4% in the same period.

Starting with the Tax Equity and Fiscal Responsibility Act of 1982 and continuing through the Deficit Reduction Act of 2005, the federal government tried to restrain the growth of Medicaid LTC expenditures by closing income and asset eligibility loopholes and by mandating recovery

from recipients' estates. Briefing Paper #3 in this series on "Medicaid Planning for Long-Term Care" covers those developments in detail and explains their failure to restrain costs significantly.

Simultaneously, throughout the 1990s and up to the current day, state and federal policy makers, encouraged by academic researchers, have argued that Medicaid can reduce costs by "rebalancing" from nursing home care to home and community-based services (HCBS). Briefing Paper #4 in this series on "Rebalancing Long-Term Care" explains that Medicaid's combined nursing home and HCBS expenditures have continued to increase in every state despite efforts to rebalance. This trend will continue absent restraints on Medicaid's generous eligibility criteria, which are described in Briefing Paper #2 titled "Medicaid Long-Term Care Eligibility."

**The 2000s**

A strong economy during the late 1990s, with lower welfare rolls and higher tax revenues, deflected political attention from Medicaid's growing role as the dominant LTC payer for most Americans. After 9/11, the internet bubble's collapse and the ensuing recession, state and federal officials began to worry about Medicaid LTC again and more than ever.

In the first decade of the new century, Medicaid nursing home expenditures moderated somewhat growing only 41.1% from $31.9 billion in 2000 to $45.0 billion in 2009. Total LTC costs did not decline, however, because Medicaid's home health care expenditures soared 113% from $11.5 billion in 2003 to $24.3 billion in 2009.

Meanwhile in the Deficit Reduction Act of 2005, the federal government tried to restrain Medicaid LTC growth by tightening eligibility criteria and encouraging the purchase of private long-term care insurance. In the same legislation, however, it made qualifying for Medicaid more attractive than ever by encouraging the program to offer more of the home care benefits people prefer and less of nursing home care they'd rather avoid.

**Today**

The preceding thumbnail history of long-term care services and financing answers the key question we posed at the beginning: How did we get into this mess? It suggests that our search for solutions should look in a different

direction than increasing government intervention and financing, which clearly has not worked.

**Do families provide most LTC for free, but suffer enormous financial and emotional strain?** Medicaid crowded out a market for affordable home and community-based services and discouraged private financial products to pay for them by subsidizing nursing home care.

**Do we have too many nursing homes and not enough home care?** Medicaid made nursing home care free in 1965, leaving lighter care the responsibility of families and making nursing homes the dominant venue for custodial care.

**Are Medicaid and Medicare short of funds for LTC?** By paying for most expensive LTC since 1965, these public programs exploded in cost while discouraging other venues for care and hampering potential private sources of payment.

**Do few people save or insure against the high risk and cost of LTC?** Easy access to Medicaid benefits after the insurable event occurred desensitized the American public to LTC liability resulting in their failure to plan early to save, invest or insure for LTC.

**Do too many people end up as dual eligibles, the most costly of Medicaid and Medicare beneficiaries?** Medicaid's home equity exemption, which was unlimited until 2006 and is still at least $500,000, prevented the use of home equity to fund LTC privately which could have delayed or prevented Medicaid dependency altogether for many duals.

**Are access to LTC and quality of care always in doubt?** By dominating long-term care financing and paying too little to ensure quality care, Medicaid created a serious drag on access and quality.

**Do we lack adequate private capital to build, operate and maintain LTC facilities or to support home care services?** Capital migrates to its highest and best use. Because of Medicaid's low reimbursement rates, profitability in the LTC sector is too low to attract enough investment capital.

**Do LTC bankruptcies and closures loom?** Medicaid's easy availability and low reimbursement rates caused cost shifting from public to private

patients who gradually converted to Medicaid in large numbers leaving LTC providers without adequate revenue.

**The Future**

Medicaid's heavy spending on LTC services created a perverse incentive that discourages responsible LTC planning and private financing. Government spending and interference in the LTC financing market caused the problems the system faces. More government spending and interference will exacerbate rather than ameliorate these problems.

Most measures currently under consideration to improve LTC services and financing, such as subsidizing family caregivers, rebalancing to more desirable home care services, and offering tax incentives for private insurance or investment, would increase public expenditures just when they need to be reduced.

America's demographic age wave is only beginning to crest. Soon it will crash as 76 million baby boomers retire, stop paying payroll taxes, and start drawing benefits from entitlement programs that are already facing unfunded liabilities in the trillions of dollars.

The question we should be asking now is "How can we preserve Medicaid as a quality safety net for people in need while reducing instead of increasing the program's LTC expenditures? The remainder of these Briefing Papers will explain how that can be done.