W(h)ither Medicaid?

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“The legitimate object of government is to do for the people what needs to be done, but which they can not, by individual effort, do at all, or do so well, for themselves. ... Making and maintaining roads, bridges, and the like; providing for the helpless young and afflicted; common schools ... are instances.”

— Abraham Lincoln

Introduction

Before Medicaid, life was bleak for those needing long-term care. Social Security payments were not enough to cover the major expense of long-term care, so those in

2 “Long-term care” is a general term describing a wide range of medical, nursing, supportive, and community services provided over an extended period of time for people who are chronically ill.
need depleted their savings and then turned to family, friends, or local institutions for help.\(^3\) Congress and federal agencies, beginning in the late 1950s, studied the difficulties faced by those needing long-term care, especially the elderly. The Senate Subcommittee on Problems of the Aged and Aging\(^4\) was established in 1959 to address these and other difficulties.\(^5\) Hearings and research led the Subcommittee to conclude that “The elderly, as a group, do not have sufficient income to support what may be considered an adequate standard of living.”\(^6\) The Social Security Administration’s (SSA) Survey of the Aged (1963) found that overall “the complex task of paying for necessary health services and providing adequate insurance for nonbudgetable expenses remains beyond the economic capabilities of most aged persons.”\(^7\) The 1959 Health, Education, and Welfare (HEW)\(^8\) report and the 1961 White House Conference on Aging reached similar conclusions about the inability of most seniors to pay for long-term care.\(^9\)

After initially missing the mark in its efforts to enact meaningful legislation to lessen the burden of even basic medical care,\(^10\) Congress, in 1965, created Medicaid,\(^11\) a joint federal-state program\(^12\) designed to provide, \textit{inter alia}, financial aid to those needing medical care who could not otherwise afford it.

As Medicaid now exists,\(^13\) a participant can get long-term care as well as basic medical care benefits provided that he or she is below certain income and asset levels. The eligible person needing long-term care pays almost all of his or her income toward the costs of care; Medicaid covers the rest.\(^14\) Medicaid thus serves as a safety net because it steps in

\(^6\) U.S. Sen., \textit{supra} n. 4, at 13.
\(^12\) The federal government provides financial support — matching 1:1 or better — for state health programs meeting federal standards.
\(^14\) Medicaid does not pay the balance of the private bill; rather, it pays the balance of the amount that the nursing home has agreed to accept as payment in full under the contract between the nursing home and Medicaid.
only after a participant has depleted his or her funds to ensure that he or she is not left out in the street. Because of Medicaid’s safety net character, we have progressed beyond the pre-Medicaid times when people, bankrupted by the cost of long-term care, burdened their families or hospitals or turned to charities for the care they were unable to afford themselves. Medicaid has dramatically improved the lot of those requiring long-term care.

Current policy discussions of Medicaid focus on the cost. Critics of Medicaid emphasize the high cost of the program and assert that it is “unsustainable,” predicting that it will collapse on itself.

Medicaid is no doubt expensive. The states and federal government spent over $400 billion on Medicaid in 2010, that annual amount growing at the rate of about 7 percent each year. John Hurson, president of the National Conference of State Legislators, expressed the views of many when he said, “Medicaid is bankrupting state and federal governments . . . the one thing everyone agrees on is that the program cannot be sustained as it is currently structured.”

The other side of the discussion is the benefits, and not just in keeping people off the streets. Although states have flexibility in running their own Medicaid programs, the federal government, which pays most of the costs of Medicaid, exercises a high degree of oversight, requiring states to comply with federal statutory and regulatory requirements. Federal requirements include, among many others, minimum federal quality standards for nursing facilities, prohibition of filial responsibility laws, and protections against spousal impoverishment. To the extent the cost-savings efforts fail to take into account what is

15 See e.g. Nina Bernstein, With Medicaid, Long-Term Care of Elderly Looms as a Rising Cost, N.Y. Times (Sept. 6, 2012), http://www.nytimes.com/2012/09/07/health/policy/long-term-care-looms-as-rising-medicaid-cost.html?pagewanted=all&_r=0, referring to Medicaid as “the only safety net for millions of middle-class people whose needs for long-term care, at home or in a nursing home, outlast their resources.”
16 As Stevens and Stevens note in supra n. 13, at 139, among the purposes of the New Deal precursors to Medicaid was “to stamp out the poor-farm and the workhouse,” which still existed in the U.S. in 1935.
17 Richard Kronick & David Rousseau, Is Medicaid Sustainable? Spending Projections for the Program’s Second Forty Years, 26(2) Health Affairs w271, w271 (2007), http://content.healthaffairs.org/content/26/2/w271.full.pdf+html (indicating that “a search of the Nexis database for the words ‘Medicaid’ and ‘unsustainable’ found 785 instances in which they were used within twenty words of each other between January 2005 and December 2006.”).
22 See infra pt. IIA for discussions about federal nursing home standards of care, the ban on filial responsibility, and the protection against spousal impoverishment.
lost, it is impossible to know whether they are wise and, indeed, what the real world long-
term costs are.

Part I of this article looks at what the world would actually look like for those need-
ing long-term care if there were no Medicaid. While some think Medicaid’s demise is
inevitable, others say it can be preserved by significantly cutting spending.23 Three major
proposals have been implemented or are pending: the use of “block grants,” the use of
“managed care,” and the extension of the “look-back period” for asset transfers. These are
discussed in Part II. These ideas save money for the federal or state government not by
increasing efficiency but by significantly decreasing the scope of Medicaid coverage and
care for those needing long-term care, leading to a host of other problems. Finally, less
drastic methods of solving the long-term care financing problem, discussed in Part III,
have been implemented or proposed, including federalizing Medicaid and implementing
various long-term care insurance programs.

I. A WORLD WITHOUT MEDICAID

A world without Medicaid would bring us back to pre-Medicaid conditions, when
families took on the financial and emotional responsibilities of long-term care and some-
times went bankrupt in the process. Moreover, federal standards of care and other protec-
tions associated with federal oversight of Medicaid would be gone, exposing individuals
and their families to financial and medical uncertainty. But life would be more than “un-
certain.” The history of Medicaid cuts and recent research show that taking away Medicaid
would mean certain death for many no longer eligible for Medicaid long-term care benefits.
When Medicaid benefits are denied people who cannot provide for themselves, they die.

In 2005, Congress in the Deficit Reduction Act of 2005 (DRA ’05)24 determined
to change Medicaid by eliminating benefits for illegal immigrants and legal immigrants
in the U.S. for less than five years.25 No longer covered by Medicaid and left to fend for
themselves, many immigrants needing long-term care ended up in hospitals since the
hospitals could not deny care to those needing it and Medicaid would pay for short-term
emergency care.26 Hospitals responded. No longer being paid for the care they provided
illegal aliens, and unable to discharge them to nursing homes, which would also be un-
paid, many U.S. hospitals began engaging in the practice of “private repatriation” — ar-
ranging and paying for the immigrant patient to be flown back to his home country.27 A
New York Times article reporting on this practice painted an unpretty picture of the results.
It quoted Dr. Steve Larson, an emergency room doctor and expert on migrant health, who
said, “[Private] repatriation is pretty much a death sentence.” It gave as a case study, Luis

23 House Budget Committee Chairman Paul Ryan (R-Wis.), for example, has proposed a Medicaid reform
that would cut federal spending on Medicaid by about $800 billion over 10 years. Known as the “block
grant” proposal, Ryan’s plan is discussed infra pt. IIA.
25 Id.
26 See Deborah Sontag, Immigrants Facing Deportation by U.S. Hospitals, N.Y. Times (Aug. 3, 2008),
http://www.nytimes.com/2008/08/03/us/03deport.html?pagewanted=all. Medicaid emergency provi-
sions provide short-term emergency care to those otherwise ineligible for Medicaid (such as illegal im-
migrants). Thus, hospitals will not turn away illegal immigrants who are in need of emergency care.
27 Id.
Jimenez, whose health was rapidly deteriorating after an automobile accident. He was sent back to his home country of Guatemala via private jet (paid for by the hospital) and left to rely on his 72-year-old mother, who did the best she could to provide for his care in their village hut. But without proper care or medication, Mr. Jimenez’s health was deteriorating, and the article suggested that it was only a matter of time before he would die.

Even here in the United States, Medicaid cuts have ultimately resulted in death for those taken off Medicaid’s rolls. In the same year that the DRA ’05 was enacted, the Tennessee Medicaid program disenrolled 170,000 Medicaid beneficiaries as part of the TennCare cuts of 2005. Family members blamed Medicaid for some of the resulting deaths. Jerry Inman said of his wife “she wouldn’t have died…if the state hadn’t taken away TennCare.” Her aneurysm had been held in check for 12 years due to long-term care and compensation for medications provided by Medicaid; 13 days after she was dropped from Medicaid, she died in pain because she was no longer able to afford her prohibitively expensive medications. Similarly, the parents of a schizophrenic man who had been treated through Medicaid before the TennCare cuts, and who killed himself after losing access to needed mental treatment, blamed the cuts for his death.

Such anecdotes accurately portray life without Medicaid. Hard statistics confirm that loss of Medicaid means loss of life. A University of Tennessee study about the TennCare cuts, for example, found that “cuts of that magnitude would result in an additional preventable death every 36 hours among the group that lost their coverage.” Echoing this report, a Harvard study from July 2012 found that in states undertaking Medicaid expansions (as opposed to cuts like the TennCare cuts) there were fewer deaths per year. “We estimated that Medicaid expansions were associated with a reduction in mortality.”

Equating a total loss of Medicaid to certain death may be dramatic, even overly dramatic, but eliminating Medicaid altogether would certainly usher in a return to the conditions that left individuals needing long-term care before Medicaid’s passage with no choice but to become impoverished before turning to friends, family, and local institutions for help. With no way to pay for the cost of long-term care, people without

28 Id.
29 Id.
30 Id.
33 Id.
34 ABC 24, Parents: TennCare Cuts Led to Son’s Suicide (Apr. 12, 2011), http://www.abc24.com/most popular/story/Parents-TennCare-Cuts-Led-To-Sons-Suicide/ngkt0ZlwS2EW88sFZI5jn7iow.cspx.
35 The study found that these cuts would result in an additional 221 deaths per year (on average) over the next 15 years — a total of 3,311 additional deaths that would not have happened but for the cuts. See Ctr. for Health Servs. Research, The Impact of Reducing TennCare Enrollment on Mortality Rates (2010), http://www.tnjustice.org/wp-content/uploads/2010/12/UT-Ctr-for-Hlth-Svc.Res._-Bulletin-3-02.pdf.
37 See supra Introduction.
Medicaid today would be left to fend for themselves. Bankrupted by the high cost of care, those surviving long enough would have to turn to family to shoulder the burden for their care, and they would no longer enjoy protections such as Medicaid’s ban on filial responsibility and benefits to avoid spousal impoverishment. Finally, federal nursing home standards of care would be lost; it is hard to see what would prevent a return to the inadequate standards of care that motivated the Nursing Home Reform Act in 1987.

In considering the consequences of a world without Medicaid, we should heed the words of George Santayana, who famously wrote, “Those who do not remember the past are condemned to repeat it.” We have come far since 1965 in providing long-term care and related protections, and it would be a shame to return to the conditions that plagued the elderly and others needing long-term care before Medicaid’s passage. Most people on both sides of the political aisle appear to agree that staving off the death of Medicaid is desirable, and several Medicaid reform proposals have been promoted primarily to reduce costs. Reform proposals to reduce Medicaid outlays include the block grant, the managed-care model for providing long-term care, and the extension of the look-back period. All of these are aimed at saving the states and the federal government money. A closer look shows that they do so by significantly and detrimentally reducing Medicaid’s scope of coverage, especially for those needing long-term care.

II. A WORLD WITHOUT MUCH MEDICAID

Critics of Medicaid complain about its uncontrollable cost, over $400 billion per year, one-third of that for long-term care, and growing 7 percent annually over the next


40 Medicaid’s ban on filial responsibility and protections against spousal impoverishment are discussed infra pt. IIA.

41 The Nursing Home Reform Act is discussed infra pt. IIA.

42 George Santayana, The Life of Reason vol. 1, 284 (C. Scribner’s Sons 1905).

43 See infra pt. II.

44 Discussed infra pt. II.

45 See supra text accompanying nn. 17, 20.

46 See supra text accompanying n. 18.

decade. These costs prompt many to predict its total collapse. To avert the dire consequences of a total collapse of Medicaid, one school of thought focuses on cutting expenditures at the state and/or federal level. The three most prominent ideas are to replace Medicaid with block grants to the states, shift to managed care, and extend the look-back period for asset transfers. All three strategies would ostensibly cut spending on Medicaid at the state and/or federal level but at the cost of seriously harming those needing long-term care. Under any of these reforms, Medicaid ultimately becomes a shell of its former self, unable to adequately provide the level of services for which it was initially implemented.

A. The Block Grant Proposal

Under the current system of Medicaid, jointly financed by the federal government and the states, the federal government more than matches states’ spending on Medicaid on an open-ended basis. The federal matching rate varies from state to state based on the state’s per capita income but is never less than one-to-one (where the federal government pays one half of the costs). Critics contend that the open-ended feature of federal funding results in excessive expenditures.

With the purported goal of cutting Medicaid spending (federal and state) and giving states more flexibility, House Budget Committee Chairman Paul Ryan (R-Wis.) in 2011 breathed new life into the proposal to convert the federal share of Medicaid into a block grant. Under this plan, the federal government would give each state a lump sum of money every year to support its medical care programs instead of the present open-ended funding. As proposed by Ryan, the amount given as block grants would be significantly less than is paid today in Medicaid federal matching funds, and the federal share of spending on state medical care programs would decline by about $800 billion over 10 years.

See supra text accompanying n. 19.

See supra pt. 1.


Id. Poorer states receive higher matching amounts. On average, the federal government pays 57 percent of Medicaid costs. Id.


In the name of state flexibility and economic autonomy, the states would be subject to less federal oversight and would get to choose how they spend federal money earmarked for medical care generally and who would be covered. However, the significant cuts in federal government spending that the plan calls for would result in a loss of care and a host of other problems.

The block grant proposal calls for significantly less federal money to be spent on Medicaid over the next several years. It neither assumes nor suggests that states will make up the loss of federal dollars, so the anticipated result would be reduced care and coverage, especially for those needing long-term care. More than one-third of all Medicaid spending is on long-term care, even though those needing long-term care make up only a small fraction of Medicaid recipients overall. Because long-term care makes up such a large portion of Medicaid spending, state governments would likely look to make cuts there first. The diminished availability of long-term care, though not as dire as a total loss of Medicaid, would still present grave consequences for the indigent elderly and their families.

The future of Medicaid under a block grant scheme goes well beyond the common-sense conclusion that less funding means less care. With the federal government providing so much money to states (on average, 57 percent of Medicaid costs), the states have little choice but to accept the money and the federal Medicaid rules and regulations that go with it — everything from nursing home standards of care, to the protection against


Id. See also Adam Sonfield, Political Tug-of-War over Medicaid Could Have Major Implications for Reproductive Health Care, 14(3) Guttmacher Policy Rev. 11 (2011), which states “The Center on Budget and Policy Priorities contends that a rollback in funding of this magnitude, combined with increased state flexibility, would inevitably lead to substantial restrictions in enrollment, services and access to providers, along with increases in patient cost-sharing.”

Id.

Id.

Id. See also Nat’l Senior Citizens L. Ctr., supra n. 47.

According to recent data from the Kaiser Family Foundation, only 6 percent of the Medicaid population receives long-term care services and supports. Kaiser Commn. on Medicaid & the Uninsured, Medicaid Facts, Medicaid and Long-Term Care Services and Supports (June 2012), http://www.kff.org/medicaid/upload/2186-09.pdf.

See supra text accompanying n. 52.

“States must comply with certain requirements imposed by the [Medicaid] Act and regulations promulgated by the Secretary of Health and Human Services (Secretary). To qualify for federal assistance, a State must submit to the Secretary and have approved a ‘plan for medical assistance,’ § 1396a(a), that contains a comprehensive statement describing the nature and scope of the State’s Medicaid program. 42 C.F.R. § 430.10 (1989).” Wilder v. Va. Hosp. Ass’n, 496 U.S. 498 (1990).
spousal impoverishment, to the ban on filial responsibility. Medicaid reduced to block grants would leave states free to administer their programs without being constrained by federal standards that now protect Medicaid beneficiaries.

The Nursing Home Patients Bill of Rights, enacted as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA ’87), established federal standards of care in response to widespread problems plaguing the nursing home care industry. It required nursing homes receiving federal Medicare or Medicaid funding in whole or part to “attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” Even if more honored in the breach, it still set a high standard by which to judge and assess nursing homes. It is difficult to see how these standards would be maintained or enforced if Medicaid were converted to a block grant.

Federal oversight and requirements also protects spouses and children of those needing long-term care, and that too might be lost in block granting. In the Medicare Catastrophic Coverage Act of 1988 (MCCA ’88), Congress provided spouses of nursing home residents with basic financial autonomy, preventing rather than requiring their impoverishment as a condition of benefits for the nursing home spouse. It allows the “community spouse” to retain his or her home and additional, albeit modest assets. It allows low-income community spouses to retain some or all of their nursing home spouses’ income to meet their basic maintenance needs. Under a block grant system, the states would be free to alter eligibility rules and impose stricter asset and income requirements, as was the case prior to the passage of MCCA ’88, when people would sometimes resort to sham divorces to spare one spouse from being forced into complete impoverishment so that the other could qualify for Medicaid long-term care.

64 The federal standards of care can be found in scattered sections of 42 U.S.C., two of the most important being § 1396r and § 1395i-3.
65 42 U.S.C. § 1395i-3. The protections include the requirement that facilities’ multi-disciplinary teams comprehensively assess each resident and develop an individualized plan of care to meet each resident’s medical, nursing, therapy, activity, and social services needs; the requirement that facilities provide each resident with care and services to maintain each resident’s “highest practicable physical, mental, and psychosocial well-being”; the requirement that facilities respect residents’ rights, including the right to privacy, access and visitation rights, protection from discrimination, protection of funds, and transfer and discharge rights; and the requirement that nurse aides be trained and demonstrate competency before providing care to residents. The nursing home reform law also requires annual surveys and investigations of complaints and sets out a system of remedies that may be imposed against facilities that fail to provide residents with the quality of care and quality of life they need.
67 The person married to an institutionalized person and who lives in the community is referred to as the “community spouse.”
68 Medicaid allows the community spouse to retain a “community spouse resource allowance.” The relevant section of the U.S. Code outlining which resources the community spouse gets to keep can be found at 42 U.S.C. § 1382b(a).
69 42 U.S.C. § 1396r-5(d).
70 “Not infrequently, couples married for decades pursued divorce as a means of protecting modest savings for the community spouse while attaining Medicaid eligibility for the spouse in need of nursing home care.” Medicaid’s Spousal Impoverishment Protections, Georgetown U. Long-Term Care Financing Project, Fact Sheet (Feb. 2007), http://ltc.georgetown.edu/pdfs/spousal0207.pdf.
Adult children of those needing long-term care are also protected by federal Medicaid rules that might fall by the wayside under a block grant system. Twenty-nine states have “filial responsibility laws” under which an adult child can be held responsible for payment of his or her parents care. Federal law, however, explicitly prohibits a nursing home facility from seeking or accepting reimbursement from third parties for the cost of the residents’ long-term care above and beyond its Medicaid contract, so that filial responsibility laws are unenforceable in that setting. Nursing homes are thus banned from asking family members for any reimbursement. The facility is required by law to accept Medicaid as payment in full, thereby leaving recipients’ families out of the daunting financial equation of long-term care.

Again, the proposed block grant system does not carry these protections forward. Nursing homes (and even the states themselves) might start asking the adult children of residents to pay for the cost of care if Medicaid is not available. Where federal funding has been block granted, filial responsibility is already in play. Maryland, for example, gets a block grant from the federal government to cover the care of patients housed in state psychiatric facilities. Under this block grant program, Maryland has imposed spouse and filial responsibility. Spouses and children of an institutionalized person, as well as parents of a minor child, can be held liable by the state or by the psychiatric facility for the cost of the care for the committed individual. To be sure, Maryland does not take every dollar of the responsible relative’s earnings. The amount they have to pay is their total “adjusted gross monthly income” less a “base monthly deduction.” The “base monthly deduction” — the amount of his or her income that the responsible relative is allowed to keep to live on — is “the average monthly consumption for a family of four of moderate means in an urban area.” Where Medicaid is not involved — as may be the case with block granting — filial responsibility laws allow service providers to impose costs on unwitting adult children. In a recent Pennsylvania case, the adult son of a woman needing

72 42 U.S.C. § 1396a(a)(17)(d); 42 C.F.R. § 435.602(a)(1). See also 42 U.S.C. §§ 1395i-3, 1396r(c) (prohibiting Medicare/Medicaid–certified nursing homes from requiring third-party guarantees of payment as a condition of admission).
73 “Under the block grant vision of Medicaid, that federal role in oversight would end.” Bernstein, supra n. 15. See also Nat’l Senior Citizens L. Ctr., supra n. 47.
74 The Maryland Mental Health Block Grant is administered by the Maryland Department of Health and Mental Hygiene (DHMH). For a copy of DHMH’s most recent application for the block grant from the federal government (2012–2013), see http://dhmh.maryland.gov/mha/Documents/MHBG%202012-2013FINAL.pdf.
75 Such individuals are billed as “responsible relatives” pursuant to Md. Health-Gen. Code § 16-101(f); see id. at § 16-102. Md. Health-Gen. Code § 16-203 provides for a defense in cases in which the parents abused or abandoned their children.
76 Code Md. Regs. § 10.04.02.04C(9)(a).
77 Code Md. Regs. § 10.04.02.04C(8)(a).
care was held liable for more than $92,000 in nursing home charges for her.\textsuperscript{79}

In sum, under the block grant proposal, there will likely be less care resulting from less funding and the narrowing or elimination of Medicaid’s protective provisions for spouses and adult children. States, given the opportunity to forego the economically burdensome limitations of federal regulation, will likely act in their own self-interest. Paul Nathanson, executive director of the National Senior Citizens Law Center (NSCLC), said, “our experience has shown that states, if given free rein, intend to serve fewer people by restricting access and benefits.... There is clear evidence that, given the opportunity, states will not provide an adequate safety net.”\textsuperscript{80} Over the past 40 years, thousands of lawsuits have been filed seeking to bring state Medicaid programs up to federal standards; it is probably fair to say that this has been the most common single form of challenge to the inadequacy of state programs.

Three cases from different states and different time periods illustrate this. In \textit{Kerr v. Holsinger},\textsuperscript{81} the State of Kentucky tried to take away Medicaid coverage from 3,500 people residing in nursing homes by changing the “medical need” standard. The reason for this change in Medicaid eligibility was to save the state money in the face of a “budget crunch.”\textsuperscript{82} Because under the current rules a state cannot “alter eligibility for a mandatory Medicaid service simply because the state does not wish to pay the price required to provide the service to all eligible recipients,” the District Court denied the state’s motion to dismiss and granted an injunction.\textsuperscript{83} Similarly, in \textit{Valdivia v. CA Dept. of Health Services},\textsuperscript{84} the State of California attempted to ignore the new nursing home reform laws passed under OBRA ’87. The District Court issued an injunction to prevent the state from foregoing its federal responsibilities.\textsuperscript{85} Finally, in \textit{Koehler v. Colorado Department of Health Care Policy and Financing},\textsuperscript{86} Colorado attempted to ignore Medicaid’s protections against spousal impoverishment found in MCCA ’88. The Colorado Court of Appeals ordered the state to restore benefits that it had unjustly withheld from the community spouse.\textsuperscript{87} Cases like these abound.

Block granting will reduce that litigation, not by meeting the needs of poor sick people, but by eliminating the federal legal rights on which they would normally depend to get the care they need.

\textbf{B. Managed Care for Long-Term Care}

The second cost-cutting solution is the use of a “managed care” model for providing long-term care.\textsuperscript{88} Under this model, states pay private insurance companies a fixed

\begin{itemize}
  \item \textsuperscript{79} \textit{Id}. at 720. Here, the nursing home was not banned from seeking reimbursement from the adult son because the resident had not applied for Medicaid.
  \item \textsuperscript{80} Nat’l Senior Citizens L. Ctr., News Release, \textit{Medicaid Block Grants Mean Low-Income Older Adults Could Lose Benefits} (Apr. 25, 2011).
  \item \textsuperscript{81} \textit{Kerr v. Holsinger}, 2004 WL 882203 (E.D. Ky. 2004).
  \item \textsuperscript{82} \textit{Id}. at 1.
  \item \textsuperscript{83} \textit{Id}. at 8.
  \item \textsuperscript{84} \textit{Valdivia v. Cal. Dept. of Health Servs.}, 1991 WL 22812 (E.D. Cal. 1991).
  \item \textsuperscript{85} \textit{Id}.
  \item \textsuperscript{86} \textit{Koehler v. Col. Dept. of Health Care Policy and Financing}, 252 P.3d 1174 (Colo. App. 2010).
  \item \textsuperscript{87} \textit{Id}.
  \item \textsuperscript{88} Kaiser Commn. on Medicaid & the Uninsured, Issue Paper, \textit{Examining Medicaid Managed Long-Term
amount of money monthly per Medicaid long-term care recipient, and the insurance companies decide what long-term care to provide. This system is in contrast to the more traditional “fee-for-service” model typically employed by the states. Ultimately, states save money under this model because they are paying significantly less money for long-term care — a fixed, monthly amount, as opposed to paying for the costs of care incurred.

Managed care is the system that failed in the 1990s when it was sold under the title “health maintenance organizations,” which “failed to improve the delivery of health care or to control health care costs in the U.S.” As with the block grant, less money spent on Medicaid long-term care means less care. This is only exacerbated by the fact that the responsibility for providing the care shifts under the managed care model from the state to the insurance company, usually a for-profit corporation. In a normal commercial marketplace, a company’s incentive to keep costs down is constrained by its need to offer goods or services that keep customers coming back. Even in the face of that constraint, HMOs failed. There is no such constraint with Medicaid. The company’s incentive to limit benefits to save costs in pursuit of profitability is not constrained by the risk that unhappy consumers will go elsewhere if they are unhappy enough. Medicaid beneficiaries are only in the program because Medicaid is the insurer of last resort; there is nowhere else to go. Beneficiary dissatisfaction might get expressed in other ways, such as complaints to representatives, but not in any way consistent with the familiar model for profit-seeking companies. Insurance companies will therefore often only provide a fraction of the care necessary to support those needing long-term care.

A common practice managed-care companies may employ to try to save money is to move a person from an expensive nursing home back to the community, providing home care services such as “personal care” services (i.e., home nursing care). Supporters of this approach claim that doing so “liberates” the elderly from the nursing home. No

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90 See supra text accompanying n. 89.


92 This bottom-line-motivated decrease in services is what concerns opponents of the managed care model, such as AARP and other advocates for the elderly. See Galewitz, supra n. 89, which states, “AARP and some other advocates [for the elderly] worry that, because of the incentives to restrain costs, managed care plans might make it harder for patients to get the services they need.” See also Bernstein, supra n. 15, quoting Toby Edelman, Senior Policy Attorney at the Washington office of the Center for Medicare Advocacy, who said that with this approach, “It’s just more money going off the top. … The managed care company has to take its cut.”

93 These managed care programs “reduce the use of institutional services and increase access to home and community-based services.” Kaiser Commn. on Medicaid & the Uninsured, Issue Paper, Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider (Oct. 2011).

doubt, for those who want to return home with services that may well be true. But with no customer-dissatisfaction measure of clients walking away, it is at least as likely that necessary care is mostly provided by family members, adult children, and spouses. In a sense, then, the managed care model is a back door to family responsibility, a condition that may be ill suited to the demands of modern life.

Many states have adopted the managed care model for providing long-term care in order to cut costs. In New York, for example, which has the largest Medicaid budget of all the states, with over 40 percent of it going to long-term care alone, enrollment in managed care is mandatory for those receiving long-term care. In Florida, which has a large elderly population, a recent legislative push to implement a similar program has been held up by vehement opposition based on the established problems associated with the managed care model.

Ironically, shifting to managed care does not necessarily save costs. Managed care’s inability to deliver its promised cost reduction is precisely why some states, such as Maryland, have elected not to adopt such an approach after running pilot programs.

Ultimately then, as under the block grant proposal, significant cuts in funding reduce care and increase hardships on family and friends. Where enrollment in managed care is mandatory, long-term care beneficiaries have no choice but to take what care the insurance companies provide, “sacrific[ing] beneficiary freedom of choice in the quest for cost savings.”

C. Lengthened Look-Back Period

Rather than curb Medicaid spending directly, as with block grants and managed care, a third proposal would cut Medicaid spending indirectly by limiting the number of people eligible for long-term care benefits. It would achieve this reduction by extending the “look-back period” for asset transfers beyond its present five years.

The principle behind penalizing transfers is that Medicaid is for poor people and that those who are not really poor should not be able to qualify and obtain benefits from it by...
artificially impoverishing themselves by simply giving away their accumulated wealth.\textsuperscript{103} The penalty was intended to neatly fit the wrong: ineligibility for long-term care benefits for the period of time the assets disposed of could have paid for the applicant’s care. The length of the penalty is the total amount given away divided by the average cost of nursing home care. No penalty applies where the applicant intended to get fair market value or where the transfer was made “exclusively for a purpose other than to qualify for” Medicaid.\textsuperscript{104}

Operationally, when a person applies for Medicaid long-term care, he or she is required to report any uncompensated transfers of assets within the previous five years. In addition to requiring a disavowal of such gifts, a state Medicaid agency also requires the applicant to provide records of all of his or her financial affairs for the five years preceding the month of application — monthly bank and brokerage statements, HUD-1s, tax returns, life insurance policies, virtually anything that would reflect worldly wealth. The state Medicaid agency staff reviews these financial records from the “look-back” period to uncover transfers the applicant did not voluntarily report.\textsuperscript{105} For transfers made during that period for less than fair market value, the state will penalize the applicant by deeming him or her ineligible for Medicaid long-term care benefits for the penalty period.\textsuperscript{106}

The current length of the look-back—five years—is a fairly recent development. Congress first introduced the anti-transfer rule, look-back period, and penalty period in 1982 in the Tax Equity and Financial Responsibility Act,\textsuperscript{107} which allowed states to impose an asset transfer penalty for transfers made within two years prior to the date of the individual’s Medicaid application.\textsuperscript{108} In 1988, with the passage of MCCA ’88,\textsuperscript{109} Congress made the look-back and penalty mandatory and extended the look-back to two-and-a-half years, but in other ways it lightened the penalty: the length was based on the average private pay cost of care, and the penalty period was capped at the length of the look-back.\textsuperscript{110} The Omnibus Budget Reconciliation Act of 1993 (OBRA ’93)\textsuperscript{111} extended the look-back

\textsuperscript{103} Benefits should be limited to those who are already impoverished or who \textit{involuntarily} impoverish themselves by paying for care until their money runs out. For a concise description of the policy behind the look-back rule, see Coulson Elder Law, \textit{Understanding the Medicaid “Look-Back” and “Transfer Penalty” Rules}, http://coulsonelderlaw.com/understanding-medicaid-lookback-transfer-penalty-rules (accessed Oct. 26, 2012).


\textsuperscript{105} SSA § 1917(c)(1)(b), codified at 42 U.S.C. § 1396p(c)(1)(b).


\textsuperscript{108} The penalty began with the month of transfer; its length was based on the average of what Medicaid paid for care, not the private cost, thus imposing a penalty period longer than the period in which the transferred assets could have paid for care.


\textsuperscript{110} Capping the penalty at the length of the look-back period appears to be a fairness issue. Without a cap, the penalty is a trap for the ill-advised or unadvised who apply “too soon” and therefore must disclose a transfer that results in a penalty period longer than the self-imposed period of waiting until the transfer is no longer in the look-back period.

period from two-and-a-half to three years, introduced a separate and longer five-year look-back for transfers to trusts, and eliminated the cap on the penalty period.\textsuperscript{112} Finally, the DRA of 2005\textsuperscript{113} (DRA ’05) extended the look-back period for all transfers to five years and, even more significantly, pushed back the date when the penalty period would start. Under prior law, the penalty began at the time of transfer; under DRA ’05, it does not start until the applicant is in a nursing home, medically eligible for long-term care benefits, and “otherwise eligible,” that is, entirely spent down and eligible but for the disqualifying transfer.\textsuperscript{114} Thus, DRA ’05 significantly expanded the scope of the look-back and effectively cut many people from Medicaid eligibility.

Proponents of the look-back are pushing to extend it even further to cut Medicaid rolls and costs and to keep the wealthy from taking advantage of the system by transferring assets in anticipation of needing long-term care. Stephen Moses, President of the Center for Long-Term Care Reform and a leading anti-Medicaid planning advocate, said that the five-year look-back period is “probably not enough” to prevent the practice of voluntary self-impoverishment.\textsuperscript{115} “Congress should consider extending the transfer of assets look-back period to at least eight years.”\textsuperscript{116} In an earlier publication, Moses had argued for extending the look-back even further, to 10 years.\textsuperscript{117} In August 2012, legislation was introduced in the House of Representatives that would require a study of the current look-back rule and whether Medicaid policy militates in favor of extending the look-back to 10 years.\textsuperscript{118}

The feeling in Congress against asset transfers was so strong in the past that in 1996 it passed the Kassebaum-Kennedy Bill, which made transfers of assets for the purpose of becoming eligible for Medicaid a crime.\textsuperscript{119} Under what became known as the “Granny Goes to Jail” act, people could theoretically wind up in jail for up to five years for making asset transfers to qualify for Medicaid.\textsuperscript{120} “Granny Goes to Jail” was repealed because of

\textsuperscript{112} DRA ’05 also prohibited certain other strategies widely used by those who studied the system. For example, it made withdrawals from a joint account a transfer; it included the transfer of income, as well as assets, as triggering a penalty; and it eliminated overlapping penalty periods. See Admin. Directive to Commrs. of Soc. Servs. regarding OBRA ’93 Provisions on Transfers and Trusts, N.Y. Div. of Health & Long-Term Care (Mar. 29, 1996), http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/96adm8.pdf.


\textsuperscript{114} The purpose of those who promoted these changes, led by Stephen Moses, president of the Center for Long-Term Care Reform, was to eliminate the “half a loaf” strategy, which would allow someone to protect roughly half of his or her total assets even if no action was taken until the first day of nursing home admission. Stephen A. Moses, Testimony Presented to the Small Business Roundtable on the Future of Long-Term Care and Medicaid, Hagerstown, Md. (July 10, 2006), http://www.aaltci.org/audios/pdf06/LTC303.pdf.

\textsuperscript{115} Id.

\textsuperscript{116} Id.


\textsuperscript{120} Proscribed asset transfers were punishable by a fine of up to $25,000, five years in jail, or both. 42 U.S.C. §1320a-7b(a)(6).
widespread opposition, but it was followed by a “Granny’s Lawyer Goes to Jail” act, which was not nearly as unpopular but was held unconstitutional, although it is still on the books.

Putting aside the policy question of whether long-term care should be means-tested at all, the problem with a long look-back rule — five or more years — is in its application. These long look-back periods have a significant negative impact on those needing long-term care who Medicaid policy would otherwise dictate should be qualified for benefits.

First, the burden is on the applicant to prove the negative (i.e., the absence of any disqualifying transfers), which is enforced by documentation requirements. Many people have trouble locating personal and financial records dating back five years, let alone 10, a problem exacerbated by the turnover in the banking industry in the past decade or two, so that banks can no longer reliably provide records on an account. The person who can show through tax returns that he or she had no significant wealth in the preceding five years might nonetheless be denied benefits because of the inability to provide monthly statements on each and every bank account owned during that period, no matter how modest the known balance or how long ago (within the five year period) that it was closed out.

Second, the burden is also on the applicant to prove innocent intent in the face of a presumption that any transfer was for the prohibited purpose, and lack of foresight becomes an impediment to eligibility. The generous actions that the elderly take all the time — birthday and holiday gifts for children and grandchildren, gifts of spending money or help paying school expenses, loans or outright gifts when a child is in serious financial difficulty or going through a difficult divorce — now become wrongs that cost them long-term care benefits when they are at serious risk if they remain in their homes.

Third, and more serious, a lengthy look-back period permits the government to tell people what they can and cannot do with the money they saved over their lifetime. The same generous actions that we normally encourage in family members now become highly risky. And the problem is not that all of those people who made gifts end up claiming Medicaid benefits. Most will not. But not having a crystal ball, many otherwise generous

122 See 42 U.S.C. § 1320a-7b(a)(6), which made it a crime to “counsel” people to transfer assets to qualify for Medicaid.
123 See William Shakespeare, King Henry VI, Part 2, Act 4, Scene II (speech of Dick the Butcher).
125 At the time, the act’s real drawback was that a crime occurred only when the attorney’s advice resulted in imposition of a penalty period, which normally would occur only in cases in which the attorney gave bad advice or the good advice he or she gave was not followed. With DRA changes, however, one common strategy, “gift and return,” turns on triggering a penalty period and then reducing it. The gift and return strategy is possible pursuant to 42 U.S.C. § 1396p(c)(2)(C)(iii). For additional details on how the gift and return strategy operates, see Jason A. Frank, The Case for Asset Protection, 205 Elder L. Advisory 1 (Mar. 2008); Jason A. Frank, Elder Law in Maryland 10–65 (3d ed., 7th rev., Lexis 2011).
126 This view is reflected in the question asked 50 years ago whether “the modest equities possessed after a lifetime of struggle should not have to be sacrificed to meet the expenses of circumstances over which [the elderly] have no control.” U.S. Sen., supra n. 4, at 13.
people — especially if they consult knowledgeable Elder Law attorneys — might be deterred from making gifts even though relatively few of them would eventually need care.

Finally, the most serious effect of an extended look-back period would be the inevitable reduction in access to care for people who need it. Individuals denied benefits because of actions taken eight or nine years earlier, no matter how innocent, would find themselves without benefits and without recourse. In many cases, the family members who received funds in now-penalized transfers will have already spent the money by the time the impoverished applicant is denied, and cannot afford to pay for the care of their elderly parents. Still, with nowhere else to turn, families and local institutions will have to shoulder the burden of caring for the impoverished individual needing long-term care.127

D. Conclusion

Cutting spending on Medicaid directly, as with the block grant proposal or managed care, or indirectly by cutting eligibility through lengthening the look-back period, would severely restrict access to long-term care for those in need and place a greater responsibility on families and local institutions. The goal of such proposals is to save money. What the advocates of cost-cutting fail to address is the wisdom of such a course when its cost is greater in lost access to care and strain on friends, family, and local institutions. Given the severe consequences, the relevant question is whether there are reforms that would better solve the cost problem without gutting long-term care services.

III. OTHER ALTERNATIVES FOR FINANCING MEDICAID AND/OR LONG-TERM CARE

The problems resulting from the proposed cost-cutting approaches make them poor solutions. The question becomes whether there are other alternatives with less drastic consequences for those needing long-term care.

A. Federalizing Medicaid

Federalizing Medicaid — where the federal government takes on the entire cost for Medicaid and administers the program without interference from the states128 — has been suggested to help curb state spending, and not just by wide-eyed liberals.129 The federal

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127 Interestingly, a popular Elder Law blog dubbed the DRA of 2005 the “Nursing Home Bankruptcy Act of 2005,” since nursing homes are more likely to be burdened with penalized residents who cannot pay for the care they need. See Elder Law Answers, Congress Passes Bill Containing Punitive New Medicaid Transfer Rules, http://www.elderlawanswers.com/resources/article.asp?id=5221&section=4 (accessed Oct. 26, 2012). Nursing homes burdened with such non-paying clients may well be the ones to invoke filial responsibility laws in order to get reimbursement from residents’ family members. Cf. Health Care & Ret. Corp. of Am., 46 A.3d 719.

128 This option — federalizing Medicaid — is effectively the opposite of the block grant proposal, which significantly decreases the federal share of Medicaid over time and permits the states to take the lead in administering their programs. See supra pt. IIA.

government now provides more than half the cost of Medicaid, and the states provide the balance.\textsuperscript{130} Federalizing would save the states approximately $172 billion annually.\textsuperscript{131} No longer burdened by crippling Medicaid costs, states could turn their fiscal attention to other important matters such as education and improving infrastructure.\textsuperscript{132}

Moreover, federalizing Medicaid would mean uniformity in standards of care and other Medicaid rules. One federal standard would control, and recipients would not have to worry about states deviating from the norm.\textsuperscript{133} After the Supreme Court’s ACA ruling in July,\textsuperscript{134} varying state deviations are even more likely, since states are free to opt out of the ACA’s new Medicaid expansion. Indeed, some states have already indicated that they will opt out.\textsuperscript{135} This risk of dramatically different Medicaid standards cropping up from state to state militates in favor of federalizing Medicaid. As Timothy Noah, senior editor at \textit{The New Republic}, opined, “if states can no longer be counted on to provide health insurance to their poorest citizens, then it’s time to take this responsibility away from them.”\textsuperscript{136}

But given the heavy expense of a complete federal takeover of Medicaid, this plan is unlikely to happen in the current fiscal environment, although it might be a plan worth seriously considering in a better day.

\textbf{B. Including Long-Term Care in Medicare}

A second idea for solving the long-term care financing problem is to include long-term care in Medicare, the federal health insurance program that covers Americans aged 65 and older (and other specified groups), but which does not now cover long-term care. At most it covers 100 days of skilled nursing, but not so-called “custodial care” — help with activities of daily life that the aged can need over a period of years (personal hygiene, cooking, cleaning, etc.).\textsuperscript{137} What if, rather than paying for long-term care via Medicaid, the federal government updated Medicare to include long-term care coverage?

In 1988, Congress passed health care reform expanding Medicare coverage to include

\textsuperscript{130} See supra text accompanying n. 52.
\textsuperscript{131} This savings is calculated based on a 57 percent contribution from the federal government. See id.
\textsuperscript{132} The idea of federalizing Medicaid is not new. The concept emerged in the early 1980s, when then Tennessee governor and now Sen. Lamar Alexander proposed that the federal government take over Medicaid in exchange for eliminating federal funding for K–12 education, thought to be of a roughly equal value. President Reagan proposed a similar “swap” in 1982, in which the federal government would take over Medicaid in exchange for ending welfare funding to the states. Lamar Alexander, \textit{Time for a Medicaid-Education Grand Swap}, Wall St. J. (May 15, 2012), http://online.wsj.com/article/SB10001424052702304371504577405782138051376.html.
\textsuperscript{133} There are hundreds if not thousands of examples of efforts to get states to meet federal standards. For one ultimately successful effort, requiring Maryland Medicaid to drop its use of a skilled care standard as an eligibility test for Medicaid “nursing facility services,” see \textit{Md. Dept. of Health & Mental Hygiene v. Brown}, 177 Md. App. 440, 935 A.2d 1128 (2007).
\textsuperscript{135} E.g. Florida. See Goodnough, supra n. 54.
\textsuperscript{137} \textit{Medicare and Long-Term Care}, Georgetown U. Long-Term Care Financing Project, Fact Sheet (Feb. 2007), http://ltc.georgetown.edu/pdfs/medicare0207.pdf.
more long-term care than had previously been the case.\textsuperscript{138} MCCA’s financing scheme, however, led to its near-instant failure.\textsuperscript{139} MCCA ’88’s failure suggests that including long-term care in Medicare might be tweaked to broaden the base of beneficiaries paying for the change. Japan employs a “social insurance model,” which imposes an income tax on workers over age 40 specifically for the purpose of financing long-term care.\textsuperscript{140} This social insurance model might be a better alternative than the MCCA ’88 scheme because it is financed by a broader base of workers. Such an expansion of Medicare to include more long-term care would lessen the financial burden currently shouldered by the states and the federal government to provide for long-term care through Medicaid.

\section{C. Modifying and Reactivating the CLASS Act}

Rather than making contributions by workers mandatory, as would be the mechanism for including long-term care in Medicare, voluntary contribution to a government long-term care insurance program is another possible option for financing long-term care. Here, because people would voluntarily enroll and buy long-term care insurance themselves, the burden on government to pay for long-term care via Medicaid would decrease.

Such a voluntary scheme was contemplated by the Community Living Assistance Services and Support (CLASS) Act, which passed in 2010 as Title VIII of the ACA, but was later permanently postponed.\textsuperscript{141} Under the CLASS Act, workers could voluntarily enroll in long-term care insurance by paying a monthly premium.\textsuperscript{142} In exchange, if those contributing premiums ever needed long-term care, they would receive a daily benefit of $50 or more per day — depending on the level of care needed — to pay for their long-term care.\textsuperscript{143} Such a system would inevitably have reduced the government burden of paying for expensive long-term care, since workers, themselves, would have financed long-term care.

The CLASS Act did not last for several reasons. Because there were no pre-existing conditions requirements, people feared that workers would simply enroll in long-term

\begin{itemize}
  \item Medicare beneficiaries were to pay for these long-term care expansions; therefore, Medicare premiums for those 65 and older significantly increased to finance this change. The beneficiaries vehemently objected, and MCCA ’88 was repealed within months. T. Rice et al., \textit{The Medicare Catastrophic Coverage Act: A Post Mortem}, 9(3) Health Affairs 75, 76 (1990), http://content.healthaffairs.org/content/9/3/75.full.pdf. The only part of MCCA ’88 that remains on the books is the protection against spousal impoverishment at 42 U.S.C. § 1396r-5.
  \item \textit{Id.}
\end{itemize}
care insurance when they became sick and not before. This would result in significant losses for the care providers, and budget experts concluded that the CLASS Act would create an “insurance death spiral” — that is, insurance/care providers would never be able to provide the necessary level of care because the costs of care would far outweigh the contributions coming in from contributors’ premiums. Overall, the system contemplated by the CLASS Act was actuarially unsound and the Act was permanently postponed. The idea behind it may nonetheless be salvageable. The structure of the Act could be tweaked and reactivated, this time made mandatory instead of voluntary and perhaps limited to those with no pre-existing conditions.

D. Including Long-Term Care in all Health Insurance

Another idea for financing long-term care which has not been formally proposed in this country, but which might be considered, is the “social insurance” model, which would operate by simultaneously mandating that everyone buy health insurance, and that long-term care be included in that insurance. In this country, we are halfway there; the ACA already mandates that every American carry health insurance. Were we to simply include long-term care insurance in all health insurance, the cost of providing for long-term care would be spread over the greatest possible base, and the burden on governments to provide such care would be diminished.

Adding long-term care to all health insurance plans would not be prohibitively expensive, approximately $63.49 per person monthly. Given that Americans are at a higher risk of needing long-term care than of developing cancer or heart disease, two

144 Book, supra n. 141.
146 Id. at 3–4.
147 Book, supra n. 141.
149 This number is calculated simply by dividing the annual overall cost of long-term care in the United States ($240 billion) by the number of people living in the country (315 million), which equals $761.90 per person annually, and dividing this amount by 12 (months in the year), which equals $63.49 per person monthly. The overall cost of long-term care in the United States and the current U.S. population number come from the following sources, respectively: Kaiser Commn., supra n. 60, and U.S. Census Bureau, Current Population Clock (updates in real time), http://www.census.gov/main/www/popclock.html (accessed Oct. 16, 2012).
illnesses typically covered by health insurance plans, including long-term care in all health insurance makes good financial sense.

Similar social insurance type models of financing long-term care are used successfully in other countries. Germany, for example, instituted a mandatory universal long-term care system in 1995. Under the German model, workers pay a mandatory payroll tax (1.7 percent of the worker’s income) toward their long-term care premiums, and their employers cover the balance of the premium. In Japan, which based its model loosely on the German system, workers over the age of 40 pay a mandatory payroll tax towards long-term care. Japan adopted its program to address the strains its aging population placed on government resources. Taiwan plans to implement a similar program in 2016. The “social insurance” model is working in other countries to finance long-term care.

E. HUD-Like Eligibility

A final possible long-term care financing reform involves adjusting the Medicaid long-term care eligibility rules to consider income only, as opposed to considering both income and assets. Under our current system, an applicant must fall below certain income and asset levels — which may vary by state — to qualify for Medicaid long-term care. Generally, an applicant cannot have more than $2,000 worth of assets if he or she wants to receive Medicaid long-term care. Applicants thus must voluntarily or involuntarily rid themselves of most of their assets to qualify for these public benefits.

The purported purpose of this requirement is to exclude individuals who can afford long-term care with their own assets, but this purpose is undermined by the high cost of long-term care. Most individuals end up on Medicaid’s rolls anyway, having quickly involuntarily impoverished themselves by paying for their own expensive care. Once on Medicaid, these individuals have only their meager monthly income — most likely from

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151 Heart disease typically is covered by health insurance. See generally, Am. Heart Assn., Insurance Coverage and Heart Defects, http://www.heart.org/HEARTORG/Conditions/CongenitalHeartDefects/TheImpact ofCongenitalHeartDefects/Insurance-Coverage-and-Heart-Defects_UCM_307116_Article.jsp (updated June 25, 2012). See also HHS, Fighting Back Against Cancer: Health Insurance Reform & Cancer in America, (noting that the implementation of the ACA will likely mean more insurance coverage for cancer) (copy on file with author).


153 Id.

154 Yoko Crume, Publicly-Mandated Long Term Care Insurance Programs: Japan Chooses a Modified German Model, Duke U. Ctr. for the Study of Aging & Human Dev. (1997), http://ltc.duke.edu/occupational_5.htm. See also generally, Frank, supra n. 140; Ihara, supra n. 140.

155 Crume, supra n. 145.

156 Tsao Yu-fan & Elizabeth Hsu, Taiwan Hopes to Introduce Long-Term Care Insurance in 2016: Minister, Focus Taiwan News Channel (May 25, 2012), http://focusntaiwan.tw/ShowNews/WebNews_Detail.aspx?Type=rLIV&ID=201205250031.


158 Excluding some assets, the most significant of which is the home in which an applicant resides. Id. at 6–7.
Social Security — to contribute to the cost of care, while Medicaid must cover the rest.\(^{159}\) Because they no longer have assets generating income to be used to pay a portion of the costs of care, the government is burdened with most of the cost. The amount the person spent down to reach eligibility, compared to the overall cost that Medicaid will cover over time, is inconsequential.

Changing the eligibility rules to consider only income in determining when eligibility for long-term care is appropriate, and imputing income from assets, would increase the number of people who get benefits. In turn, these beneficiaries could contribute income derived from their assets toward the cost of care, thereby lessening the burden of care for these individuals on the government. Under such an approach, then, Medicaid would cover individuals sooner, but would pay less over time.

The “income-only” test has been used in other federal programs, including for determining eligibility for public housing under HUD.\(^{160}\) A public housing applicant in the HUD’s income-only scheme could have $400,000 in the bank and still qualify for public housing, provided he or she has an income below the set qualifying amount.\(^{161}\) Moreover, HUD imputes income from assets, so that those with enough money to generate income from assets will contribute that income to the costs of their housing, thus relieving the burden of that portion from the government. Similarly, eligibility for community Medicaid (as opposed to long-term care Medicaid) under the ACA is based on income only.\(^{162}\)

If an income-only test similar to HUD’s or what the ACA mandates for community Medicaid eligibility were to be implemented for Medicaid long-term care, individuals receiving income from assets would be able to put that income toward the cost of care, inevitably lessening the amount the government would have to pay for care over time. In the current fiscal environment, where interest rates are low, this system may not reach its full potential because income derived from assets would be lower. When interest rates increase, however, an income-only approach is likely to have a positive effect on financing Medicaid and should be a prominent part of the Medicaid reform discussion.


\(^{160}\) See generally 24 C.F.R. § 5.609 (2012) (excluding assets from the definition of income from Department of Housing and Urban Development [HUD] eligibility purposes, but permitting income from assets to be considered as income).


\(^{162}\) Julie Rovner, Medicaid Expansion Goes Overlooked in Supreme Court Anticipation, NPR (June 27, 2012), http://www.npr.org/blogs/health/2012/06/27/155861308/medicaid-expansion-goes-overlooked-in-supreme-court-anticipation. See also Kaiser Comm. on Medicaid & the Uninsured, Policy Brief, Explaining Health Reform: New Rules for Determining Income Under Medicaid in 2014 (June 2011), http://www.kff.org/healthreform/upload/8194.pdf. Under the ACA’s Medicaid expansions, community Medicaid now will be provided to people who are at or below 133 percent of the federal poverty level, regardless of income. For an individual, this is $14,856. For a family of four, this is $30,656.
With long-term care costing individuals upwards of $80,000 annually, Lincoln’s maxim rings ever truer; it is the legitimate object of government to pay for long-term care, because people cannot do it themselves. Given its high costs, the question becomes how government will finance long-term care without bankrupting itself; a collapse of Medicaid would be so dire that it must be avoided at all costs. The block grant, the managed care approach, and the extension of the look-back period, although arguably cost cutting, reduce care and benefits such that Medicaid becomes only a shell of its former self, and any money saved is likely offset by the real-world, long-term costs. Because these prominent reforms fail to adequately provide for those needing long-term care, policymakers should seriously consider alternative reform proposals such as federalizing Medicaid or adding long-term care to all health insurance when meeting at the drawing board over Medicaid’s future.

163 A semi-private nursing home room costs an individual, on average, $81,030 annually. MetLife Mature Mkt. Inst., supra n. 38.