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# Assisted Living: The Politics of Medicaid and Medicare

Sarah Lim
*Colby College*

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By Sarah Lim
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**Introduction**

The elderly population in the United States has grown tremendously in the past decade, and is expected to grow even more as the Baby Boom generation begins to retire. This expanding demographic creates a problem of housing – where will all the seniors go? Families are increasingly unable to care for their elders; retirement homes are too expensive; and nursing homes unappealing to seniors and expensive for the state. Assisted living[1] is growing in popularity because these programs are flexible, low cost, and strive for client satisfaction. Seniors can utilize residential care housing as transition housing between independent living and a nursing home, or as aging-in-place housing. Assisted living housing is preferred and effective, and is a potentially lucrative market. For these reasons, it has the capacity to provide for the growing senior population.

Medicaid and Medicare politics have made the process of expanding the assisted living industry more difficult. Medicaid is a federal-state public insurance program for the poor, and is the largest provider of residential care in the nation. Medicare is a universal entitlement program for the elderly. It provides health care and nursing home care, but does not cover residential care. Medicaid carries the stigma of other social welfare programs carry, whereas Medicare is socially and politically supported. *If the following is true*: Medicare grants access to everyone; Medicare serves only the elderly population; Medicaid carries stigma; Medicaid is facing budget cuts; Medicaid serves a larger population; Medicaid and Medicare receive approximately the same amount in funding. *Then*: why does Medicaid, not Medicare, fund assisted living housing for the elderly?

[1] I will use the terms “assisted living” and “residential care” interchangeably.

In this paper I examine the structure of the current assisted living industry in order to explain how and why it is appealing and effective, as well as look at its limitations. I discuss the politics of Medicaid and Medicare, and how through these programs the federal and state governments are failing to provide adequate care for the nation's senior population. Like the rest of our health care system, these two public health insurance systems are fragmented, and consequently, financing long-term care is complicated and insufficient. Ultimately, this paper will function as a policy report and I will propose: standardized requirements for assisted living facilities; a stricter and new way to regulate assisted living on the state level; restructured models for the public insurance programs, including Medicaid, Medicare, and the State Children's Health Insurance Program.

## Section 1 Assisted Living

Assisted living (AL) is a form of residence for elderly and disabled peoples. Pynoos and Nishita define it as "a housing option that involves the delivery of professionally managed supportive services and…nursing services, in a group setting that is residential in character and appearance" (Pynoos and Nishita 2005:254). Most often, while AL facilities will provide personal care, supportive services, and housing, they will not provide the types of medical services that are associated with skilled nursing facilities. In this way, the residents maintain a high level of independence while having access to certain services and assistance.

There is a significant difference between assisted living, retirement, and nursing care homes. Retirement homes are typically condominium-style with selective admissions processes open only to seniors. Few, if any, services are offered. This type of

housing tends to be very expensive, and is intended for very able and independent adults. Nursing care homes are structured around medical care, are highly institutionalized, and more closely resemble hospitals. Nursing home residents typically require assistance with several Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), such as bathing and getting out of bed. Many have dementia, are completely disabled, and are low functioning. Residents have limited freedom, choice, social interaction, and independence.

Seniors have five basic options for housing: independent, with the family, retirement home, nursing care home, and AL facility. Independent living is the preferred option, but is difficult if the senior is not a homeowner and/or has one or more ADLs. Typically seniors will leave independent living situations upon the death of a spouse or with deteriorating health. Living with children or the extended family is an increasingly impractical option, as intergenerational geographic disparity makes it difficult for families to share responsibility for its elders. Rising medical costs, longer life spans, and dual wage earner households make it more difficult for the family to provide for its elders. Retirement homes are too expensive for most seniors, and so are also an impractical option. Nursing homes are unattractive for seniors in transition. If seniors have only a few ADL limitations, then the idea of living in a medicalized, institutional setting is unappealing. AL programs are becoming increasingly popular because they are flexible and have satisfied clients. However, because Medicaid is the only public funding available for AL, many seniors cannot afford this option.

Residential care housing became much more popular in the 1990s, and the demand continues to grow. Between 2000 and 2002 alone, the assisted living industry

grew 14.5 percent (Pynoos and Nishita 2005:254). It is an attractive option because it falls between independent living and nursing care. Many seniors are unable to live on their own because they need assistance with one or more ADLs or IADLs. If they are still cognitively able and physically fit enough to perform some or most ADLs, then the institutional, impersonal nature of nursing care makes it an unappealing option.

While demand and utilization of AL facilities has grown quickly in the past two decades, policy makers have shifted their attention away from age-based housing toward age plus need-based housing. In many facilities, retirement is not sufficient enough to qualify for admission. Because of this, political support and federal funding for AL as defined above has decreased, while the support for intensive care facilities has increased.

### 1.1 Background

Since the colonial period, families have been the primary caregivers to the elderly. Only recently have families begun to depend on public assistance for the care of seniors. The higher level of reliance on federal programs for elderly care and housing that we see today is a phenomenon of the past few decades. Housing assistance for the impaired does have a substantial history, harkening back to the stigmatized almshouses and poorhouses of Elizabethan and Puritan times. These social institutions have developed into the nursing homes of today.

In the first half of the 20$^{th}$ century, there was a movement to provide public housing assistance to the elderly who were considered financially needy but appealing tenants. In the 1950s and 1960s the federal government funded the construction of housing projects that could be utilized by the elderly population. Services were separately

funded, either by the tenants or from federal non-housing funds. These housing projects were intended for capable elders with low needs. Despite high demand, no new buildings have been constructed in the past decade. In 2003, approximately 600,000 to 700,000 seniors lived in public housing properties (Schuetz 2003:38). This sort of housing became policy as Section 202, as I will discuss in section 1.2 on affordable housing.

The AL housing industry grew rapidly in the 1990s. Demographic trends indicated that 100,000 to 300,000 additional post-retirement care homes would be needed annually (Schuetz 2003:26). These predictions led to overbuilding which contributed to a temporary collapse of the industry. Other factors were falling stock prices, declarations of bankruptcy, accumulating debt, drastic premium increases by insurance companies, and increasing liability. Despite these financial difficulties, the AL industry remained an important sector of the senior housing industry. There are bound to be fluctuations in the senior housing market, but overall the industry is expected to grow enormously as the baby boom generation ages. In the year 2000, the long-term care expenditures were about $123 billion, predominantly from Medicare, Medicaid and client out of pocket payments, and minimally from private insurance and other sources. The estimated cost for the year 2030, in 2000 dollars, is $295 billion (Desonia 2004:4-5).

It is difficult to generalize the specific conditions under which seniors choose to leave independent living situations. The factors that drive the general housing industry cannot be applied effectively to the senior housing industry. Seniors are more likely to leave independent living situations based on the death of a spouse, family proximity,

retirement, poor health, and home ownership.[2] Income, wealth, prices, and interest rates are factors that characterize the regular housing market (Scheutz 2003:31). Because it is difficult to generalize the conditions that drive the senior housing market, it is difficult to develop a model to predict future trends. However, effective demand is a more important consideration than potential demand.[3] The senior housing industry needs to keep on its toes in order to meet effective demand, but relying on potential demand can have the unfortunate consequence of over or under-preparing. It is also relatively safe to assume that the demand for AL will rise over the next few decades, due to cost,[4] financial assistance, growing elderly demographic, and decreasing ability of families to provide for seniors.

The family is the traditional caretaker for the elderly. However, "with major demographic changes…including more women in the workforce, intergenerational mobility, and increasing life span, the family is frequently unable to meet increasing care-giving responsibilities" (Cox 2005:42). The increasing cost of health care is another burden that many families cannot shoulder. Despite increasing reliance on public programs, the family remains a cornerstone of formal and informal seniors care, and is

[2] Home-owning seniors are more likely to sell their house upon retirement or the death of a spouse. In many of these cases, AL is the preferred housing option (Schuetz 2003:29).
[3] Potential demand is the number of seniors who have the ability to move into AL homes, measured by age, income, and disability-eligibility. It indicates the number of seniors who *could* move in. Effective demand is the product of potential demand and the annual move-in rate (estimated) (Schuetz 2003:32). It is the number of seniors who *will* move in.
[4] The cost of AL is high and most seniors require financial assistance in paying for it. However, the cost of AL is low relative to skilled nursing facilities. Annual AL costs tend to be approximately half as much as the annual nursing facility cost. However, AL facilities do not usually provide medical services, so residents must pay more (or rely more on public assistance) for health care.

still the dominant provider of total care for seniors. Although the current role of the family should not be underestimated, neither should the role of public assistance.

### 1.2 Affordable housing

There is a general lack of public housing in the United States. Around 600,000 to 700,000 seniors live in public housing, but most of those units and facilities were built in the 1960s and 1970s. No new public housing has been built in over a decade (Schuetz 2003:38-39). Though public housing is not always the preferred type of housing for seniors looking for assisted living situations, it is an important resource. The number of low-income seniors will continue to grow, so the public housing program needs to be reinvigorated and/or alternative programs need to become more accessible. Programs like Section 202 housing, Section 8 housing, and Home and Community-Based Service waivers[5] are examples of programs that have been created in part as a response to the growing demand for housing assistance. While these programs are certainly important, it is questionable how far-reaching and effective they really are.

Section 202 was established in 1959 as a part of the National Housing Act under the Department of Housing and Urban Development (HUD). It is a program that funds the construction of housing specifically for low-income elderly, other handicapped persons, and households with at least one senior or handicapped person. Again, the housing is oriented around and therefore gives preferential treatment and admission to active and independent elderly. Limited services are sometimes offered, in which case

[5] See section 3.3 on financing long term care.

202 housing is considered "supportive housing"[6] rather than carrying a legal label or license as an assisted living property (Schuetz 2003: 42). Section 202 has been a relatively successful government program, providing housing to 381,000 elderly persons in 2002 (Pynoos and Nishita 2005:246). It continues to be a popular program as the rents are low, buildings are well maintained, and residents are pleased with their quality of life. Though the demand continues to grow, the construction of these facilities has dwindled in the past few years, and applicants can spend years on the waiting lists. While federal commissions, such as the 2002 Commission on Affordable Housing and Health Facilities Needs for Seniors in the 21st Century, acknowledge the need to address the shortage of subsidized housing for the elderly, there has not been significant action taken to combat the growing needs. So while Section 202 has been successful in creating positive communities for capable seniors, it has failed in providing enough housing and meeting the consumer demand for these facilities.

Another program similar to Section 202 is Section 8 housing.[7] Established in 1974 as an amendment to the 1937 U.S. Housing Act, Section 8 is a federal program that targets low-income individuals and families, and is not oriented around a particular age group. Federal funding is distributed to public housing authorities, typically by county, in the form of vouchers. Similar to Section 202 payments, the vouchers are made directly to the landlords and reflect both the local cost of living and the resident's income. Counties may participate in the program if it can be demonstrated that the public housing

[6] Supportive housing offers supportive services, such as transportation, meals, and social services.

[7] It can be debated whether Section 8 housing can be considered assisted living. While it does not provide the services associated with AL facilities, it does provide financial assistance for senior housing.

authorities are meeting the housing needs of low-income persons and families. While several million vouchers are distributed each year,[8] there are still waiting lists for up to 10 years for Section 8 housing, indicating that the public housing authorities are not meeting the housing needs. Yet it is not clear whose is responsible – is the federal program not granting enough vouchers to the counties? Is it the county's responsibility to provide alternative and sufficient non-Section 8 housing for low-income persons? There are no clear answers because there is no clear regulation. For instance, the phrase "housing assistance needs" holds no official definition, so there is no way of knowing if "housing assistance needs" have been met. Further, Section 8 will cover up to 40 percent of the cost of rent so long as it stays within the defined cost cap, which varies by state.[9] This is problematic for many seniors because AL housing tends to have much higher rents than other housing, due to the services included. Because of this, many seniors do not qualify for Section 8, or do not have sufficient resources to pay for the difference. Section 8 has the potential to be an effective subsidizing program for AL facilities but cannot realize that potential due to regulatory obstacles. Overall, insufficient funding (e.g. not enough vouchers) and very long waiting lists indicate that Section 8 is neither effective nor thorough in providing senior housing assistance

It is important to consider the effectiveness of not-for-profit housing versus privately owned, for-profit housing. Section 202 housing is the only federal program that gives funding to not-for-profit housing subsidies, though both Section 202 and Section 8

[8] 2.1 million vouchers were distributed in 2003 (Cox 2005:99). In 2002, seniors made up 17 percent of voucher recipients (Schuetz 2003: 40).
[9] In 2000, the annual voucher spending per participating household varied from $2,892 (Arkansas) to $7,344 (District of Columbia), depending on the state, at an average of $4,729, for a total of $6.7 billion in federal spending. In 1998, the annual average was $5,652, for a total of $7.7 billion in federal spending (NCCP 2004).

housing may be considered under the not-for-profit housing label. On the whole, though overall housing needs are not being met, not-for-profit housing is more efficient and of a higher quality than privately owned senior housing facilities. The American Association of Homes and Services for the Aging (AAHSA) gives evidence to this statement. For instance, not-for-profit organizations that provide or fund senior housing: provide more hours of care per patient day (there are nurses on staff more hours of the day); invest more resources in resident care (more funds spent on direct and indirect resident care per day); and average significantly fewer deficiencies than for-profit homes (AAHSA 2006). The report did not indicate reasons why this might be the case. However, this illustrates that our current patchwork system of privately owned AL facilities could be much more efficient if we converted exclusively to not-for-profit housing or to housing established and maintained by the federal government.

### 1.3 Demographics

Because AL facilities vary so widely in size, financial ability, services offered, and geographic location, it is difficult to make broad generalizations about the residents. It is also difficult to determine exact numbers of facilities and residents. However, there are some consistent trends, determined by studies of the AL industry, that may be considered characteristic of the typical AL client.

In 2000, there were approximately 35 million persons over the age of 65, comprising 13 percent of the entire U.S. population. The average AL resident is female, widowed, white, and 82 years old.

*Gender:* Women have a tendency to live longer than men, and to marry older men, so there are many more females in the senior population. 66 to 75 percent of AL residents are women. The gender ratio is more balanced with younger residents, and becomes more unequal as the facility population grows older.

*Marital Status:* Overall 10 percent of residents are still married, 70 percent are widowed, and 20 percent are single (Zimmerman et al. 2001:148). Increasingly, the reason for unmarried residents is divorce. A senior is less likely to move into residential care facility or nursing home if his or her spouse is still alive and the couple is still married.

*Race:* The racial makeup of the senior population in the United States is expected to change dramatically in the next few decades. In 2000, minorities made up 16.4 percent of the senior population. That number is predicted to be 25.4 percent in 2030. Of the senior population, Latino/as are expected to grow by 328 percent, African-Americans by 131 percent, and white non-Hispanic by 81 percent (Schuetz 2003:13).

The overwhelming majority of AL residents are white. In 1995, 91 percent of AL residents were white. State regulation may not be effective at monitoring discrimination that may occur during admissions processes, particularly in large facilities. Smaller facilities may be less expensive, more family-like, feel safer, or may feel more accountable and therefore might discriminate less. As a result, smaller facilities tend to house more nonwhite residents. It is not clear why such racial homogeneity is the case, "whether because of economic factors, discrimination, or cultural preferences…" (Zimmerman et al. 2001:149). One explanation is that minority cultures place more value on having their seniors at home with the family. Another explanation links minorities

with a culture of underperformance, leading to financial disability. However, explanations like these are nominal and essentialist. A more likely and realistic explanation is the wealth disparity among races, particularly between blacks and whites. Oliver and Shapiro note that in 1995 blacks had $8 to $19 of wealth for every $100 of wealth owned by whites. The black/white income gap is not a useful way to measure the wealth gap[10] because there are many other factors that contribute to the dearth of assets in the black community. Factors that have an influence over the wealth accumulation of blacks include: homeowning; education; job sector; employment stability; and family structure. Whites are far more likely and able to be homeowners and to pursue higher education. Blacks have less access to the core job sector and are less likely to have stable employment histories. Single or divorced whites and white families typically have more financial security and assets than blacks in the same situations.

Oliver and Shapiro also discuss the phenomenon by which a person's income and assets accumulate until retirement, at which time income plummets. Many seniors are well off even when their wealth is declining. However, because whites accumulate more assets throughout their lives,[11] black seniors feel the financial decline more acutely. Not only do black seniors tend to have less financial security and wealth than their white counterparts, they also have lower Social Security coverage and benefits. Black families

[10] Income is measured by the amount of money earned each year through employment, before taxes. Wealth is measured by consumable assets (such as real estate and vehicle ownership) and financial assets (such as business ownership, stocks, IRAs, and bonds) (Oliver and Shapiro 1995:106).

[11] Assets acquired during middle age accrue value more quickly than during any other time of life. Whites are more likely to encounter assets during this age because of inheritance. Because blacks perpetually lack wealth, they are unable to pass on or gain wealth in the form of inheritance. Age and income are not useful ways to measure senior's wealth, because many other social and economic factors that lead to wealth accumulation are at play (Oliver and Shapiro 1995:113).

are therefore more pressured to provide for their elderly, which perpetuates the black wealth cycle.

Patterns of black wealth accumulation may be an important indicator for the lack of diversity in AL facilities. For blacks who do not qualify for Medicaid, living in an AL facility is an unlikely option as it is expensive and Medicare does not cover residential care. Both Medicaid and Medicare cover nursing facilities,[12] and consequently the number of blacks and minorities in nursing homes is a more accurate representation of the racial makeup of minorities in the United States. In AL facilities only 9 percent of the residents are minorities, whereas in nursing facilities 12.3 to 14.3 percent were minorities in 1998-1999 (Jones 2002:5). The racial disparity between AL and nursing homes indicate that nursing homes may be a more financially viable option for minority seniors.

*Age:* Age is a large factor in deteriorating health. Though seniors over the age of 65 make up only 13 percent of the population, they make 24.3 percent of all visits to physicians' offices (Cox 2005:5). Because most individuals prefer to live independently or with their families, many residents enter AL homes only when they begin to lose the ability to perform all ADLs. Limitations caused by chronic conditions can be strongly associated with age, and typically intensify with age. In 2000, 26.1 percent of persons aged 65 to 74 had limitations due to chronic illness; as well as 45.1 percent of persons aged 75 and over; and 73.6 percent of persons aged 80 and over (Cox 2005:2).

*Limitations:* Limitations can be grouped into four categories. Variations in frequency occur based on the size of the facility. Different sized facilities tend to attract different clientele groups, and/or may be specialized for particular impairments.

[12] Medicare has restrictions on nursing home care, and puts more funds toward home health care.

Cognitively sound and physically disabled is the smallest percentage of AL residents, at 6 to 11 percent. Those with significantly cognitive and physical impairments are the second largest group, at 9 to 21 percent. Cognitively disabled and physically sound persons are the third largest group, at 14 to 20 percent.[13] Those who are somewhat impaired cognitively and/or physically are the largest group of AL residents, at 48 to 71 percent (Zimmerman 2001:165). These statistics indicate that AL facilities are intended for seniors who are capable of having some independence though may need assistance with ADLs.

Considering that AL facilities do not offer 24-hour nursing or doctors' services, there is a relatively low utilization of hospitals and emergency rooms. A survey of facilities showed that over a 12-month period, 32 percent of residents had an overnight hospital stay, and 28 percent were treated in an emergency room (Zimmerman 2001:155).

Medical conditions most frequently experienced by AL residents include: degenerative joint disease, circulatory and heart problems, hypertension, arthritis or rheumatism, high blood pressure, diabetes, vision or eye problems, asthma or other lung problems, fractures, mental or psychiatric illnesses, balance problems, urinary incontinence, and hearing problems (Zimmerman et al. 2001:154-55).

*Other characteristics:* Residents tend to be educated. In larger to smaller facilities, respectively, 27 to 38 percent completed only high school, and 30 to 40 percent went to and/or completed college or beyond (Zimmerman et al. 2001:148).

[13] 25 percent of AL facilities have a unit dedicated to Alzheimer disease or dementia. As of 2003, at least 30 states had requirements and regulations for the admissions of persons with Alzheimer disease or dementia (Mitty 2003:37).

Isolation is often problematic with residents. Residents usually have no spouse, and may not have supportive family and friends, or have family and friends nearby. While telephone calls are increasingly used as a means of keeping in touch with residents, this type of contact is still not frequent (Zimmerman et al. 2001:161). Participation in formal activities organized by the facility, and in informal activities (such as shopping or getting a haircut) also occurs at low rates. The latter varies depending on the type of transportation services offered by and the location of the facility, as well as by the budget, size, and policy of the facility.

*Discharge:* Approximately two-thirds of residents come to AL facilities from independent living situations. The rest come from hospitals, nursing homes, and other AL situations. When residents leave AL facilities, 33 percent are discharged to a nursing home; 28 percent die in the facility; 14 percent are discharged to another AL facility; 12 percent are discharged home; 11 percent are discharged to a hospital; and 2 percent are discharged to another destination (Mitty 2003:36).

*The Olmstead Decision:* In 1999 the Supreme Court ruled on *Olmstead v. L.C.*, a landmark decision that shapes access to public and community services by disabled persons. The case began with two mentally disabled women who were institutionalized, and who wished to and demonstrated the ability to live in a community. Their argument was based on Title II of the Americans with Disabilities Act, which made illegal discriminatory practices by public services or entities based on disability. The court ultimately ruled that states were required to make moderate or reasonable modifications in order to accommodate disabled persons in integrated care facilities – assisted living facilities included – if those persons were capable of living in a lower-care environment

(Rosenbaum 2000:229). A fundamental alteration means a change in the basic services or structures as they previously existed. A rise in cost is expected, and is not considered a fundamental alteration.

The responsibility to conform to this decision lies with the states. If the states fail to conform, they potentially face repercussions. It is unclear what those repercussions may be, though it would most likely be the withholding of funds or a fine. It is also unclear whether states will be punished for long waiting lists. Waiting lists indicate that the needs of the AL-eligible populations are not being met. Excluding people from the waiting list (due to disability, for instance) would be against the federal regulations under *Olmstead* but the presence of extensive lists appears to be condoned.

In include the *Olmstead* decision in the demographic section because it has the potential to alter the resident diversity of AL facilities, in terms of the variety and levels of ability and illness. The decision opens up all admissions processes to persons with disability, at least for consideration. Disabled persons are taking a risk by choosing to live in an AL facility, which is why facilities may be reluctant to admit them. Many of the medical and social services that are available at institutions are not in AL housing, including basic care and 24-hour nursing. It is possible that disabled persons who opt for AL will have their needs met, however most are taking a risk due to the absence of care (Rosenbaum 2000:231). Under this new policy, facilities can employ professionals to evaluate the safety in admitting disabled individuals. In this way, the facilities can avoid having to make fundamental changes while also avoiding discriminating against potential residents.

It is not clear what effects the *Olmstead* decision has or will have on AL housing. Likely the level of integrated care has increased somewhat, so that aging in place is put into practice. The diversity of the resident pool in terms of physical and mental abilities has probably increased as well, though the increase may be minimal. The policies are also vague in terms of setting deadlines and time frames for implementation and in providing official definitions of terms such (like "fundamental alteration" and "reasonable modification"). In this way, both states and AL programs have quite a bit of latitude in implementing the new *Olmstead* policies (Cox 2005:50).

### 1.4 Current Industry

Most AL facilities are privately owned and privately funded,[14] but all are subject to state regulation. Many states require that all residential care facilities be licensed, conform to minimum requirements, and practice non-discriminatory admissions policies. However, because of widespread regulatory oversight and inconsistent regulation, facilities are largely free to do what they wish without punitive measures. The construction, maintenance, and benefits offered by facilities occur within state regulatory limits but are largely driven by the market, the economy, demographic changes, and consumer demand (Zimmerman et al. 2001:10, 271). Because of this, AL should be understood as an industry, rather than a state system.

The variables surrounding elderly housing are many. The most appropriate housing choice for seniors is contingent on their health conditions, physical and cognitive

[14] AL facilities tend to have private investors because it is a growing industry and is expected to be a lucrative one. The funds received from or for clients are often public funds from programs like Medicaid and Home and Community-Based Service waivers (see section 3.3 on financing long term care).

abilities, and housing conditions.[15] I am choosing to focus on AL housing because of its integral and underestimated role in the elderly housing system. AL facilities are important for transitioning between independent living and nursing care. Because people in this transition stage require less assistance and fewer services than those in nursing care, this type of housing is economically efficient. It is empowering and/or less degrading for the residents, because they still have a high level of autonomy, as well as power as residents and as consumers. Indeed, AL facilities are built for independent seniors, and are driven by clients, consumers, and the market. It is a comforting system for the families of seniors because they know that services and emergency assistance are available when needed, and removes the burden of caretaking from the families. As families are becoming less able to take care of their elderly, AL is becoming a more appealing option to all family members. If AL housing were covered by insurance or provided for by federal law, then the elderly and their families would be more able to provide for other goods and services (e.g. medication, food, health care) out of pocket, which puts less stress on other parts of the safety net. A healthy and well-cared for elderly population means a stronger safety net, which benefits the population as a whole. AL is one key component for a healthy elderly population, so the maintenance and improvement of AL housing is in the nation's best interest.

The current AL system is, like many other aspects of our health care system, a fragmented patchwork. The size of the industry is unclear because there is so much variation in AL housing, and there is no single definition of what AL housing entails.

[15] Many elderly persons who live independently own or reside in homes that are in need of repair, and/or require the installation of assistive technology (e.g. emergency call buttons, grab bars, lever door handles, etc.).

Even the name is not universal – dozens of terms are used to describe AL or AL-like facilities. For example, residential care homes, board and care homes,[16] personal care homes, domiciliary care homes, boarding homes, adult homes, and homes for the aged (Cox 2005:96; GAO 2004:8). Some facilities have multiple capabilities, with both AL and nursing services on the same grounds. Other facilities will take both elderly and younger disabled persons as residents. Still others offer housing but few or no services.

Because regulations for AL housing are determined on the state rather than the federal level, the result is inconsistent and confusing regulation. If the state has difficulty regulating the industry and developing AL legislation, then it is the clients that suffer. For instance, the performance and quality of care delivered by various AL facilities is often questionable because the state has difficulty setting and enforcing standards. As another example, a state that is suffering economically will have poorer quality AL facilities than its wealthy neighbor. This occurs because the state cannot and does not enforce regulation, and because businesses within the state cannot compete within the market. It should be noted that nursing care housing is highly regulated by the federal government (GAO 2004:8). The quality of nursing homes is therefore much easier to regulate and standardize, though nursing homes also have their share of deficiencies (Feder et al. 2000:11).

[16] Board and care is used interchangeable with assisted living in many government documents and reports. Even though it is sometimes understood to be the same thing, there is a significant difference between the two types of housing. AL tends to be in apartment-style buildings and provides some health-related, supportive, and social services. Board and care tends to resemble independent living much more. The facilities might be small individual houses or suites, usually with two residents. No services are offered, and the number and scope of staff is limited (Mitty 2003:33-34).

A number of state governments express philosophies regarding the establishment and maintenance of AL housing. That states embrace philosophies indicates that the states see the value in residential care, and in providing for seniors in transition. Unfortunately, because of regulatory oversight, it is difficult for the states to implement these philosophies. While states should have control over the AL industry, the dearth of regulation means that states have very little practical control.

State philosophies tend toward the consumer and the residential model rather than the medicalized model. The residential model tries to imitate independent living as much as possible, and the rooms have minimal but necessary accessories (such as grab bars and emergency call buttons). The philosophy of the residential model prioritizes client satisfaction, independence, freedom, autonomy, individual needs, and mobility. Another core part of many AL philosophies regards aging in place. In facilities that promote aging in place, the clients have access to more services (quantity and type) as their needs become greater. This sort of flexibility means that clients are required to change facilities less frequently. Many clients of AL housing will die there, while many others will continue on to nursing homes with higher levels of care. While aging in place is a part of the AL philosophy and promise, it is not clear to what extent that flexibility is practiced and is practical. AL facilities, most of which are privately owned and for-profit, are reluctant to practice aging in place "because of the operation burdens and risks associated with supervising, monitoring, and providing care to increasingly frail and ill people" (Mitty 2003:35).

States vary in regulation of AL facilities, despite the fact that tight regulation regarding aging in place would benefit state budgets. AL tends to be much less costly

than nursing care, even though they could potentially provide similar services for many elderly (Chapin and Dobbs-Kepper 2001:43-44). Facilities may have strict admissions and retention qualifications and policies regarding age, abilities, and needs. Overall, the goal of the residential model is to resemble independent living, while avoiding the institutionalized feel of nursing care and the medicalized model, both of which are highly institutionalized. In nursing homes, efficiency and safety are priorities, while the values associated with the residential model are only secondary. The physical residence resembles a hospital, with extra wide doors and corridors, and standardized rooms. Nurses and aids are trained to perform as they would in a regular hospital (Zimmerman, et al. 2001:55-56).

In short, because the residential model is associated with assisted living facilities and services, the facilities must meet the needs of the residents, not the residents that must meet the needs of the facilities. This translates poorly into practice and policy, and is difficult to regulate. In order to regulate effectively, specific guidelines must be set forth, but the state cannot set guidelines (such as room capacity, payment policies, admissions policies, and services offered) if the residents' needs are to dictate what happens. Unfortunately, this inability to regulate the residential model leads to questionable quality of practice, care, and housing. Even if state philosophies are driven by client satisfaction, the amount of input and control that residents actually have is questionable. Ultimately, the absence or limits of consumer power and state regulation leads to inconsistent performance, quality, client admission, and client retention (with changing needs).

Another problematic aspect of assisted living is confusion about its role. To what extent is community care the responsibility of the family, community, state, and federal government? How much and what type of care should assisted living facilities provide for its clients? What is the relationship and interaction among other care facilities, like nursing homes and hospitals? Because the assisted living industry is so unregulated, there are no clear answers to any of these questions. Further, there is debate over the answers to these questions. Some are opposed to housing segregated by age. Others want AL to serve the elderly and younger disabled persons. Still others argue about the transfer of clients when their needs require services beyond what the facility provides. While there seems to be a consensus that AL is a good thing, there is disagreement over details, implementation, funding, and regulation.

## Section 2 Medicaid and Medicare

### 2.1 Origins

The health care debate is an historically polarized one. There have been a number of attempts by health reformers to establish a universal health care system in the United States, yet efforts have been frustrated each time. Why did we fail to create a universal system while we had the chance? However much politicians and experts place our current fragmented partially privatized system on a pedestal, there is a lot of indication that a universal system is more equitable and effective. Rather than debate the merits of different health systems, it is more useful to examine how and why our system evolved.

Efforts to establishing universal health insurance began during the Progressive era in the late 1800s. Health reformers wanted universal health care as it would ensure not

only better access to medicine but also economic security. However, once the American Medical Association (AMA) made their stance against such broad health reform, the debate died, moving from talk about state initiative to ineffective academic discourse.

Many reforms that included topics like welfare, unemployment, and child health, resulted from Franklin D. Roosevelt's New Deal. In 1935, a cabinet committee called the Committee of Economic Security (CES), was formed to examine and assess these sorts of issues, and to ultimately make suggestions for positive change. Though this was an opportune chance to change the face of health insurance in America, this group ultimately decided to avoid making suggestions for universal health insurance. The AMA, which historically opposes the notion of universal insurance, could have easily jeopardized any steps made toward establishing a universal system. Previous AMA action precluded any efforts to change the system of insurance.

During the 1945 election, President Truman ran on national health insurance even though he was met with ideological criticism regarding socialism, communism, and the Soviet Union. Truman, too, was unable to establish a universal system because of the lack of broad support. Though socialized medicine was appealing to many people (as indicated by polls taken during that time period), the anti-Communist political climate of the time made people afraid to voice their opinions. Further, what was known as the "conservative coalition – concentrated opposition from powerful conservative Southern Democrats and their ideological counterparts among the Republicans – was enough to defeat every attempt at government health insurance…until 1965" (Marmor 1996:674). Finally in 1965 there was just enough of a majority in the House of Representatives to approve a public insurance for those receiving social security benefits, which eventually

turned into Medicare. This was the closest to national health insurance as could be achieved.

Medicaid (Title XIX) and Medicare (Title VIII) are sister programs, emerging simultaneously in 1965 as amendments to the Social Security Act of 1935 enacted by President Lyndon Johnson as a part of his Great Society programs. Medicaid was established as a federalist welfare program that would cover all who qualified. The populations who most frequently receive benefits are children, pregnant mothers, low-income families, the disabled, and the elderly. Medicare is a singular program fully funded, regulated, and administered by the federal government. Its target population is limited to the elderly (those over 65 years of age) and to some non-elderly disabled persons. It is a social insurance program, meaning that eligibility (for the most part) and benefits are universal. All seniors qualify for the program only if they have been paying income taxes for the past ten years.

Neither further reform nor a universal system occurred during the Nixon and Clinton years. This failure is attributed to "cycling negative majorities," which were coalitions that supported and frequently shifted support for various health insurance proposals (Marmor 1996:675). These coalitions defeated any potential compromises on universal health care.

### 2.2 Medicaid: The 21st Century

Over the years, Medicaid has moved from being a federal welfare program into being the nation's largest public health insurance program. It is a "public assistance program." While it is federally funded and supported, Andersen et al. considers it a

collection of 51 variable programs under one title (Andersen et al. 2001: 42). The federal government sets broad guidelines and policies, so the state governments have a lot of latitude to tailor their own rules and regulations. Each State: establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program (Hoffman et al. 2005:15). Experts at the National Health Policy Forum refer to Medicaid as three individual programs under one umbrella program, because of the broad types of coverage it extends to three broad populations. As outlined by the George Washington University National Health Policy Forum (NHPF), the Medicaid sub-programs are as follows: Low-income children, families, and pregnant women receiving health care services; elderly and disabled persons receiving long-term care services; and the low-income elderly receiving assistance covering the out-of-pocket costs associated with Medicaid and Medicare (NHPF 2004:1).

*2.2.1 Benefits:* The NHPF also outlines the mandatory services that states are required to offer through Medicaid. Expansions, alternatives, and more specific guidelines regarding services and eligibility are determined by the state.

| Mandatory Services | General or Optional Services |
|---|---|
| • Inpatient and outpatient hospital services<br>• Physician services<br>• Medical and surgical dental services<br>• Nursing facility services<br>• Home health care for eligible persons<br>• Family planning services and supplies<br>• Health clinic services and other ambulatory services<br>• Laboratory and x-ray services<br>• Pediatric and family nurse practitioner services<br>• Early and periodic screening, diagnosis and treatment for individuals under age 21 | • Prenatal care<br>• Vaccines for children<br>• Rural health clinic services<br>• Nurse-midwife services<br>• Prescribed drugs and prosthetic devices<br>• Optometrist services and eyeglasses<br>• Transportation services<br>• Rehabilitation and physical therapy services<br>• Home and community-based care to certain persons with chronic impairments |

Sources: NHPF 2004:2-3; Hoffman et al. 2005:19.

*2.2.2 Who and How:* Medicaid is the primary source of health insurance in America today. The program covers the neediest people in the country, focusing on low-income families, the disabled, and the elderly. It provides health insurance, medical products (e.g. medication), and health services, and is the nation's leading source for long-term care in the country, as well as the leading service-provider for births.[17] When Medicaid was established in 1965, there were just fewer than 15 million beneficiaries (7.7 percent of the population) and program funding was approximately $400 million (approximately $2.5 billion in 2002 dollars). In 2002 there were 51.6 million Medicaid beneficiaries (18.1 percent of the population), and program funding (federal and state) was $276.8 billion. Following is a look at some statistics and trends regarding the enrollees, funding, and guidelines.

[17] Medicaid pays for more than one-third of all births nationwide (Holahan et al. 2003:3).

The number of beneficiaries enrolled in Medicaid has grown dramatically since its founding in the 1960s. Because the intent of programs like Medicaid and Medicare is to create a healthy and flourishing population, it is a goal to enroll as many eligible persons as possible. This is problematic in the Medicaid program, however, in that there is not enough financial security to enroll everyone who ought to be enrolled. On the other hand, however, policy-makers may have reservations about making the program too attractive. A universal system or a system that can be easily abused would be far too costly, so there must also be disincentives for qualifying. An assumption that is frequently made regarding the welfare system that can also be applied to Medicaid is that people are so comfortable receiving benefits that there is no incentive to return to work. However, this stance also functions on the assumption that for all people who work, having or not having health insurance is a practical choice. However, many companies do not provide health insurance, and minimum wage workers cannot typically afford either employer-based health insurance or private insurance. This stance is also problematic because Medicaid recipients may be employed and still receive benefits.

Because of financial security and/or the fear of system abuse, restrictive guidelines for qualification are imposed on populations, and often eligibility is limited to children, women, the disabled and the elderly, within a specified income range. Despite federal regulation, Medicaid plans vary widely from state to state, there is no way to generalize qualifications. For instance, in some states the qualifying income level for working parents for enrollment is 19 percent *below* the federal poverty level (Arkansas; 20 percent FPL in Louisiana). In other states, the qualifying income is 200 percent *above* the poverty line (Arizona and District of Columbia; 275 percent FPL in Minnesota) (KFF

2006). So while Medicaid programs focus on outreach to those who qualify under the state-specific guidelines, as the number of beneficiaries grows, so do problems with finances. Particularly in the past two decades or so, state budgets have had difficulty providing full coverage for Medicaid beneficiaries. Further, federal and state budget cuts have had the effect of decreasing enrollment in Medicaid. Currently the Bush administration is trying to cut $10 billion from the federal budget for Medicaid. Potential consequences include an estimated 13 million or one-fifth of Medicaid beneficiaries will be forced to pay higher co-payments. This is a burden that could make even Medicaid unaffordable for many people. Benefits will be cut or reduced for many people. Most of the money saved is expected to come from the reduction in medical services utilized. The consequences undoubtedly will be harmful, less so for children because the have expanded access.

*2.2.3 Children:* In 1994, there were 11 million uninsured children in the United States, 2.3 million of whom were eligible for Medicaid (Andersen et al. 2001:43, 45). At that time, health reform advocates and children's rights advocates together fought for expanding public health insurance and coverage to more children. Children's rights are easier to fight for than adult's and senior's, because there are long-term benefits, and it is more utilitarian, politically appealing and supported, and cheaper to insure children. (Andersen et al. 2001:45). As a result, there have been expansions across the board in eligibility requirements, for instance higher income levels, which have the association of Medicaid with cash assistance. According to NHPF, federal regulation required that all states cover all children under the federal poverty line, which was $15,670 for a family of three in 2004. Broader coverage was available for children under 6 years of age, who

could be Medicaid beneficiaries if their family income was below 133 percent of the federal poverty line, which was $20,893 for a family of three in 2004. Coverage was also extended to pregnant women and to children: from families who received cash assistance; from families who were in upward transition mode between income groups; and in foster homes (NHPF 2004:1; Hoffman 2005:16).

The projected benefits of providing health care coverage for children far outweigh the costs. Basically, healthy children grow into healthy adults. With the exponential increases in the cost of health care, healthy adults cost far less. There is a general acknowledgement of this fact and so efforts, to different extents, are being made on both the federal and state levels. One of the results of this effort to expand health care for children is the State Children's Health Insurance Program (SCHIP). This program, Title XXI, was established in 1997 and is another component of the Social Security Act. In short, SCHIP expands health coverage to children from broader income brackets, including children from families that earn up to 200 percent of the federal poverty line ($31,340 for a family of three in 2004) (NHPF 2004:2) and created incentives for states to enroll children by giving larger matching funds than Medicaid receives. Unlike Medicaid which covers all who qualify, federal funds for SCHIP are capped. However, because SCHIP does receive more funds than Medicaid, the states have more flexibility and control over the program (Holahan et al. 2003:3).

Like Medicaid, SCHIP is a federal program that is put to work at the state level. SCHIP was the first measure to try to effectively decrease the number of uninsured children, and did so with debatable success. The program enables enrollment for children up to 19 years of age, including unborn children in some states. It does, however, exclude

children who *could* be enrolled in their parent's private employer-based insurance. This is unfortunate because – due to increasing premiums, insufficient income even for those above the federal poverty line, and the rising cost of health care – many parents cannot afford the insurance option offered by their employer.[18] So while SCHIP has had positive effects and has greatly increased the number of children under some insurance plan, there have been some negative consequences and there are still large numbers of children who remain uninsured – about 9 million children or 20 percent of all uninsured non-elderly persons in 2003-04 (KFF 2006). SCHIP had immediate positive outcomes. Results showed that the program immediately reduced family stress and increased children's access to medical services. In the year following the launching of SCHIP, statistics show that of those children enrolled: 99 percent had a usual source of medical care; 85 percent had a regular dentist; and unmet need or delayed care decreased to 16 percent (Andersen et al. 2001:13).

While SCHIP has certainly made significant and important improvements for enrolled children's health, it is not clear that the program actually led to a decline in the number of uninsured children. It likely kept the number of uninsured children consistent, preventing a rise in the number of uninsured children. By 2000, 2 million children had been enrolled in SCHIP, though the number of uninsured had not diminished. Geyman

[18] It is difficult to measure how many parents cannot afford employer-based health insurance, but it is easy to measure the rates of uninsurance in parents. In 1994 for parents at or below the federal poverty level, 34 percent were uninsured. In 2000, 41 percent of poor parents were uninsured. For all low-income parents, in 1994, 30 percent were uninsured. In 2000, 34 percent of those parents were uninsured. These data indicate that it is increasingly difficult for parents to afford health insurance. Further, with expansions in Medicaid and SCHIP for children, parents are far more likely to be uninsured than children. In 2001, parents were 13.9 percent more likely to be uninsured than children (Dubay and Kenney 2004:227, 229).

attributes this sustained uninsurance problem to the "erosion of private sector coverage for low-income families, who cannot afford increasing employee shares of employer-based coverage…It is estimated that as many as 21 million children in the United States (of a 74 million total) are experiencing significant access problems" (Geyman 2002:274-75). My concern with this trend is the availability of Medicaid funds for adults, particularly parents. The federal regulations that are placed on SCHIP are not as restrictive as they are for Medicaid even though they are administered similarly. This indicates that the policy-makers who implemented SCHIP recognized the importance of insuring youth, which is certainly a progressive viewpoint. It is interesting that this sort off attitude and sense of imperative is not applied to the rest of the population. I cannot argue with the need to insure children, but ensuring a healthy future generation does not mean we can ignore the health of the current generation. Expansions in SCHIP have led to erosion in continuous coverage for working poor parents despite strong economic expansion in the 1990s.

*2.2.4 Non-elderly adults:* The demographic group that has the most difficult experience obtaining insurance is non-elderly non-disabled adults. In some states, the policies of Medicaid made it extremely difficult for single men to obtain public insurance. Uninsured women are also at high risk. They tend to have higher health care costs than men because of preventive, gynecological, and reproductive care, and as a result are more often unable to afford any or some health care. Much of the public discourse has been focused on children, despite the fact that there are far more uninsured adults than uninsured children, both above and below the federal poverty line. Far more children are covered by Medicaid than adults are. For all insured children under any

insurance plan, 17 percent had uninsured parents (Guendelman and Pearl 2004). In 2003-2004, 60 percent of enrollees in Medicaid were children, while only 40 percent were adults. During those same years, 3.5 percent of the total non-elderly population (255.1 million non-elderly) was uninsured children, while 14.3 percent of the population was uninsured adults (KFF 2006). States have been making efforts to expand Medicaid coverage for more adults, however, with climbing costs and decreasing federal aid, many states are finding it difficult to expand their welfare-based programs. The inequity among the states in terms of who is covered by Medicaid is increasing, and the chances an adult has of receiving benefits from a public program such as Medicaid is largely dependent upon the state within which he or she resides. Indeed, the number of uninsured adults in the United States has grown by 6 million between 2000 and 2004, while the number of uninsured children has remained relatively stable due to expanded eligibility requirements and SCHIP. In 2004 there were 45.8 million uninsured adults (KFF 2005b:1). Further, the safety net has not kept pace with the increasing number of uninsured Americans. Federal spending per uninsured person decreased by 8.9 percent, as the number of uninsured persons rose by 11.2 percent. Most of the money for the safety net is granted via Medicaid and Medicare, but those programs are facing budgetary pressures, so it is likely that federal funding for uninsured will decrease. This trend has potentially hazardous consequences as it is clear that uninsured adults have significantly worse health than insured. (KFF 2005c).

Texas and New York are useful to compare because the populations are relatively similar, and they have relatively similar income brackets, racial diversity, and distribution of types of insurance. In the 2002 fiscal year, 16.7 percent of non-elderly Medicaid

enrollees in Texas were adults, compared to 29.9 percent in New York. In 2003-2004, 28 percent of adult non-elderly persons were covered by Medicaid in Texas, compared to 48 percent in New York. New York enrolls and covers a higher percentage of non-elderly adults in its Medicaid program than Texas, but also has a higher percentage of uninsured adults than does Texas: 84 percent of the non-elderly uninsured in New York are adults, compared to 74 percent in Texas.[19] These data show that even in demographically similar states, access to Medicaid for adults can vary widely. Federalism is largely responsible for this variation. It gives states enough control over the Medicaid enrollment policies that there are significant discrepancies in terms of access among states. The different politics in both states likely have a large influence over how the state regulates Medicaid. Texas is more socially and politically conservative and may have other priorities when it comes to the budget, for instance business. New York is more liberal and may choose to invest more money in the health of the state. In this way, federalism is responsible for the negative consequences of access to Medicaid because of the freedom it allows states. Adults now will be unhealthier in Texas than in New York, because uninsured persons are less likely to utilize medical services. There are also implications for the future: because New York is caring for the current adult population, they may face fewer health problems as the population ages. For Texas, it may be the case that saving a little now will cost a lot later.

*2.2.5 Elderly and Disabled:* The elderly and disabled have somewhat better chances at being covered by Medicaid if they are low-income and/or receive cash assistance from the Supplemental Security Income (SSI) program or the State

[19] See KFF State Medicaid Fact Sheet for Texas and New York.

Supplemental Program (SSP). Individuals from these two demographics also qualify if they are employed and disabled; or are "indigent" or medically needy (e.g. have expensive medication). Some elderly are eligible to be on Medicare and Medicaid simultaneously, if their income is low enough (NHPF 2004:2-3). Again, these are federal minimum regulations. Individual states may choose to expand coverage benefits, eligibility, and patient expenses (e.g. premiums; coinsurance payments, also known as cost-sharing).

This demographic group is interesting, because even though it is growing in population, it remains the smallest portion of the population with one of the highest average costs per person in the Medicaid program.

**Table 2.2.5: Medicaid Population by Percent, Funding, and Average Cost, 2003-04.**

| Medicaid Population | Percent of Medicaid Population (%) | Percent of Medicaid Funding (%) | Average Cost Per Person ($) |
|---|---|---|---|
| Children (0-18) | 49.6 | 16.9 | 1,400 |
| Adults (19-64) | 25.6 | 11.0 | 1,782 |
| Disabled | 14.2 | 39.7 | 11,547 |
| Elderly (65+) | 10.5 | 27.9 | 10,971 |

Source: KFF 2006.

As shown in Table 2.2.5, it is clear that the elderly receive a disproportionate amount of Medicaid funding. One reason for this is that they are sicker and require more care – medical, social, and otherwise – than do other segments of the population. Another significant reason is that Medicaid funds much of what is not covered by Medicare. In 2003, there were 7,468,000 or 14 percent of elderly and disabled were dual eligibles, or enrolled in both Medicaid and Medicare (KFF 2006). Until 2006 when Medicare introduced a new drug coverage plan, Medicaid covered much of costs of medication for its older beneficiaries. Medicaid is also the nations largest provider of assisted living, home, and nursing home care. As long-term care is extremely expensive, in 2003, 40

percent of all Medicaid spending was spent on dual eligibles (KFF 2006). I find this problematic (and will take up the issue later) because Medicaid spends so much money on the elderly when Medicare is dedicated solely to seniors and a small number of disabled persons. It is only recently that Medicare began to cover some of the costs of medication, and still does not cover assisted living or home care for any of its beneficiaries. If Medicaid and SCHIP were capable of covering all low-income uninsured adults and children, then spending so much on seniors would not be questionable. However, that the elderly receive so much funding for things that should be covered by Medicare that funds are taken away from other needy segments of the population.

*2.2.6 Federalism:* The Medicaid system of organization – shared responsibility between the federal and state governments – is referred to as federalism. Though federalism may actually weaken some social welfare systems, it appears to function equitably in Medicaid due to state regulation. It is, in a way, a compromise between those who value big government and those who advocate localized control. Proponents say federalism is a power check for the central government, strengthens community, inspires citizen activism, and can respond to different populations' specific needs. Opponents dislike the inequity among states, as well as the slowness with which challenges are met and policies are made (Nathan 2005:1458). In a federalist system, the responsibility for and power over administration and financing is shared between the federal and state governments. For the Medicaid program, the state is highly accountable for both financial and administrative considerations, but the federal government provides most of the funds – between 50 and 77 percent, with an average of 57 percent – and has broad power and supervision (Andersen et al., 40).

There is some debate over the efficacy of federalism and health policy. Holahan, Weil, and Wiener (2003) look at the shared financial responsibility; program flexibility; innovation in policy and service within states; and alternative federalist models. On the one hand, Medicaid and other shared-responsibility health insurance programs have been successful. The magnitude of the uninsurance problem has lessened, for without it, the 51.4 million (in 2002) people who are currently covered by Medicaid would certainly be uninsured. Access to health services has improved and increased overall, in that people are far more likely to utilize health services when covered by insurance. Out-of-pocket expenses are far less when covered by insurance. Program flexibility and the state control that accompanies federalist programs allow states to address population-specific and emerging problems, at least in theory. States with large immigrant, minority, or working class populations will have different health needs. Whether states take advantage of the federalist program to provide for the public is questionable.

The current federalist health care system appears effective when one examines only what it has done and can accomplish. However, looking at what it fails to do reveals the shortcomings, faults, and gaps in the system. Holahan et al. note that the current problems "make it hard to build upon and perhaps even to sustain…

> …Serious weaknesses in its allocation of federal-state responsibilities limit the nation's ability to meet the needs of low-income families. Millions of Americans remain uninsured, and variations in coverage across states are dramatic and difficult to justify. The current allocation of fiscal responsibility has created friction between states and the federal government, slowing progress toward meeting the needs of the uninsured. In addition, despite the range of policies states have adopted, the nation learns little from actual experimentation (Holahan et al. 2003:5).

There is criticism of the number of people covered, services offered, and inconsistency. When it was established, Medicaid was not intended to function as a

universal health care system, though it was intended to minimize the uninsurance problem. However, the system is insufficient, as there remain 40 million uninsured persons, many of whom are eligible. Holahan et al. note that 25 percent of poor children and 38 percent of adults within 200 percent of the federal poverty line are uninsured. Access is not guaranteed, enrollment is not complete, and the quality of care is debatable. The amount of variation among states is also a system flaw. Rates of uninsurance from state to state vary dramatically. Factors may include rates of employer-based insurance; percent of elderly in the population (Medicare); state's willingness and ability to fund the program.

Another negative consequence resulting from insufficient health care in America is the deterioration of the social safety net. The safety net is a loose collection of government and community institutions. It includes programs and organizations like welfare, Medicaid, hospitals, homeless shelters, and Supplemental Security Income. Trattner writes about the evolution of the safety net by describing how the United States moved towards a welfare state without ever achieving a universal health care system. An appreciation for population health did not emerge until the late 19$^{th}$ century in the United States. What is now referred to as "public assistance" was known as "poor relief" through the 1890s (Trattner 1999:304). Most health efforts were made by social workers, who are now known as "public health workers." In a large part, the notion of preventive health care for populations was rejected because people did not understand the benefits of public health. This misunderstanding of public health meant that there was little collective or government effort to create health initiatives. Therefore, any efforts to overcome health problems were done as small-scale projects by social workers. Further, public health was

not an explicit responsibility of the government, as were things like national defense, currency, and regulating commerce. Federal provision of pubic health came about slowly and indirectly through promoting general welfare and allocation of taxes (Turnock and Atchison 2002:70). In the meantime, social workers did the public health work.

During the turn of the century, community workers began to make the link between poverty, dependence, and disease, and tried to eradicate the conditions of poverty. In the early 20th century, state governments began to appreciate the benefits of preventive medicine and public health. The fields of medicine, hard science and social science merged together to create public awareness of these issues and solutions. Slowly, social welfare programs began to emerge, spurred on by the Great Depression. FDR's New Deal programs and Johnson's Great Society programs introduced many new initiatives targeting housing, nutrition, physical and mental health, and employment. These programs and initiatives merged together to form the social safety net.

The safety net is intended for the very poor and near poor. It provides security to that particular demographic and is assurance for the rest of the population because it (in theory) prevents people from becoming too destitute or from completely losing access to social services. There are many that "fall through the safety net" and rely on charity from individuals and hospitals, rather than accessing Medicaid.[20] Social conservatives worry that poor people develop dependency on the safety net, and learn to abuse the benefits awarded through these institutions. Social conservatives aside, however, it seems as though most people see the value of having a safety net. Proponents and critics of the safety net worry that people who need these services are not receiving adequate or quality

[20] Public education about social programs like Medicaid is often insufficient. Lack of outreach is one reason why people fall through the safety net.

care. Weissman et al. believe that teaching hospitals provide disproportionately more free care than non-teaching hospitals, which potentially indicates that those who receive free care are not receiving adequate care (Weissman 2003).

When any major component ceases working or drastically reduces the benefits offered, then the safety net is undermined. The federal government contributes to the safety net through programs like Medicaid and Medicare, but is failing to keep pace with the changing needs of the people. Adjusted for inflation, there was only a 1.3 percent increase in federal spending on the safety net between 2001 and 2004. However, there was an 11.2 percent increase in the number of uninsured persons during the same time (Hadley et al. 2005:1). Many people depend on the safety net, and its maintenance and reliability is imperative for the well-being of society.

The current system of balance between federal and state funding and regulation has worked very well for the past four decades, but it is becoming increasingly clear that the federal government will have to step up its contributions. The growing number of uninsured, decreasing access to health services for the public, and growing inequality in the United States, and states budget crises, are all compelling reasons to increase federal assistance to Medicaid programs, to establish a new relationship between federalism and health care,[21] or abandon federalism altogether.

[21] For example, shift fiscal responsibility to the federal government, or improve (expand and reduce variations in) Medicaid and SCHIP. Holahan et al. (2003) discuss these options more thoroughly.

## 2.3 Medicare: The 21st Century

Though the United States still lacks a universal health care system, there is universal health insurance for our nation's elderly, Medicare, which ensures health care and hospice care. The political attention to Medicare was stable for nearly three decades, but the terrain changed with the Clinton Administration in 1994. Oberlander refers to the 1965 to 1994 politics as a "politics of consensus". In other words, consensus indicated "the tacit acceptance of the notion that Medicare should be operated as a universal government program, that federal health insurance for the elderly should take the form, in essence, of a single payer health system" (Oberlander 2003:157). This represented the liberal values and principles that were at the core of the program when it was developed until 1994, and shaped the policies on benefits, regulation, and financing. Since then, conservative politics have dominated The White House and Congress, and have led to a restructuring of Medicare that includes privatization, a failure to control rising costs of health care, reducing funding, and a focus that turned away from "the politics of management, characterized by incremental efforts to enhance program efficiency, to the politics of transformation, characterized by attempts to overhaul a public program's foundation and its core philosophy" (Oberlander 2003:160).

*2.3.1 Benefits:* Medicare is composed of four sub-programs. Initially there were only parts A and B, but since then the program has expanded to include parts C and D. Anyone who is covered by any Medicare subprogram(s) receives medically necessary items and services, for instance, ambulance services, diabetic supplies, durable equipment, kidney dialysis services, mental health care (with restrictions), transplant services, and some diagnostic tests (CMS 2006:13-14).

Part A is hospital insurance. It is available to everyone and is free for most. Those who (or whose spouses) paid taxes for at least ten years prior to applying for Medicare do not have to pay the monthly premium, which is $393 per month in 2006 (CMS 2006: 6). Part A covers access to hospitals, inpatient care, services rendered during hospital visits with restrictions, pints of blood received during hospital visits, and some home health care and nursing home care (CMS 2006:7). Unemployed disabled younger adults also qualify for premium-free Part A benefits.

Part A is a contributory, social insurance program. It is a universal entitlement program with standards of benefits, not a means-tested welfare program like Medicaid. The philosophy behind social insurance programs is that all citizens buy into Medicare throughout their lives, by being employed and paying taxes, some of which fund the program. This way, the younger generation provides health security for the current older generation, knowing that they, too, will be provided for upon retirement.

Part B is supplementary medical insurance. It is available to everyone, but users must pay a monthly premium and a yearly deductible, and will incur cost penalties for not using Part B as soon as the user becomes eligible. Beneficiaries pay 25 percent of the cost, while the rest is paid for by federal general revenues. If eligible persons do not enroll right away, they are penalized and pay an additional 1 percent per year. The payments from beneficiaries are very reliable, as the cost is deducted directly from their Social Security payments (Andersen et al. 2001:410-11). In addition, recipients must also pay coinsurance and an annual deductible. In 2005, the monthly premium was $78.20, and the yearly deductible was $912 (KFF 2005e). Part B covers some physician, preventive, and outpatient services, including doctors' services, outpatient medical and

surgical services, durable equipment used during hospital visits with restrictions, other durable equipment (such as canes and wheelchairs), laboratory services, some home health care, and pints of blood received during hospital visits (CMS 2006:9). Part B also covers some preventive services including bone mass measurements, screenings for various diseases, flu shots and gynecological exams (CMS 2006:10-11).

Part C was renamed Medicare + Choice, and then given its current title, Medicare Advantage. It is only colloquially referred to as Part C. This option allows beneficiaries to receive Medicare benefits through private insurance plans. Part C is comparable to Part A plus Part D, or Part B plus Part D. In other words, seniors who subscribe to Medicare Advantage can buy into the benefits that are offered in Parts A, B, and D. People can utilize insurance through both Medicare and private insurers, including Health Management Organizations (HMOs), Preferred Provider Organizations (PPOs), and Private Fee For Services (PFFSs).

Part D is a new program that offers prescription drug coverage (as of January 1, 2006). Prior to 2006, Medicare did not cover any prescription medication. There are a large number of different drug plans from which seniors can choose, each plan covering a different list of prescription drugs. Only drugs on the chosen list will be covered, and brand-name drugs will only be covered if the generic ones are not an option. Part D plans are approved and regulated by Medicare, but are administered by private insurance companies. Plan D differs from the other three Medicare subprograms in that it is fully privatized and therefore *not public.* It is still considered public because the federal government grants large subsidies to and loosely regulates the drug companies. The private companies are then reimbursed by the Center for Medicaid and Medicare Services

(CMS). In order to use Part D, the beneficiary must pay an additional monthly premium, as well as coinsurance, co-payments, and deductibles. The plan will only cover drugs obtained from pharmacists on a list established by the Medicare drug plan (CMS 2006:27).

*2.3.2 Who and How:* While Medicaid is the largest source of health insurance in the nation, Medicare is the nation's largest purchaser and regulator of health care. The number of Medicare beneficiaries has more than doubled since its inception in 1965. Medicare currently serves 42.3 million elderly (86 percent) and disabled younger adults (14 percent). That number is expected to double again by the year 2030, due to the aging baby boomers and growing population (Cubanski et al. 2005:iv). Because Medicare is not a means-tested program like Medicaid, by nature the group it serves is quite diverse. Age, income, health status, chronic illness status, living situation, and mental abilities range quite widely throughout the beneficiary population. Because it is a universal entitlement program, it is very difficult to generalize the recipients. They can, however, be divided into like groups – for instance, non-elderly disabled, chronically ill, poor, middle income, high income, and so forth.

Medicare does not cover all the health needs for the elderly population. For a long time the program did not cover preventive care or early detection. Some screening tests are now covered, but other important preventive services are still not covered. For instance, recipients only receive one free physician exam in the beginning of their Medicare coverage. All other routine physician exams must be paid for out of pocket. Until January 2006, Medicare did not pay for prescription drugs for seniors. The rapidly rising costs of prescription drugs made it extremely difficult for many elderly and

disabled persons to purchase the necessary medication. In 2006, the federal government established a new prescription drug coverage component for Medicare, Part D. The program, however, has been widely criticized for being too complex and limited for practical use by elderly persons. A third lack of Medicare coverage and one at the core of my argument is for nursing home and other long-term care services. There is some coverage for home care provided for but restricted to a short period of time following hospital stays. Elderly persons requiring long-term personal care, another service with rapidly rising expenses, must pay out of pocket. Some low-income elders have extra funding for long-term care due to their dual eligibility with Medicaid.

Even though Medicare is a universal entitlement program, there are still problems with unequal access and health outcomes. Some argue that Medicare cannot be faulted for unequal access and service, because there are substantial racial disparities along the lines of health status and treatment in the medical world *outside* of Medicare. Within the program, the disparities lessen some, but do not disappear. Even after adjustment for socio-economic status and other access-related factors, racial inequalities still remain. (Adler and Newman 2002:9). Medicare cannot be cited for providing unequal care, health status prior to retirement is a major determinant in geriatric health. Blacks, Latino/as, and members of the working class are more likely to have poor health due to socioeconomic status, and unhealthy children and adults turn into unhealthy elders. So while Medicare does reduce some disparities in health status, other system changes could make more of an impact. For instance, expanding coverage, eliminating Part B premiums, and focusing on health outcome rather than health care would all help to ease health inequality in Medicare and in society. Because it is the largest health care provider in the nation,

Medicare has the power and ability to really make a contribution to health equality. As with Medicaid, the difficulty comes with the rising cost of health care and federal budget (as opposed to payroll taxes or beneficiary premiums) cuts to the program.

Regardless, there are many disparities within Medicare. Health policy makers are typically so concerned with finance, that they overlook other "concerns such as equity, adequacy, and quality" (Andersen 2001:210). The population of Medicare beneficiaries is becoming increasingly composed of minority groups – African Americans, Asian Americans, Latino/as, and Native Americans. In 2000, 16 percent of the elderly population was non-white. Because minorities are more likely to have health problems throughout their lives, they tend to need more and higher quality care than do their white counterparts. Various minority groups have a higher chance of having one or more chronic illnesses, earlier mortality rates, and having disabilities.

Despite this disparity in health prior to entering into Medicare, most Medicare programs are aimed at elderly white persons, and so are becoming inappropriate for the population they serve. Because health needs for minorities can be very different than health needs for whites, services must address the needs that fit a population. Medicare populations in California or New York are likely going to have very different health needs than populations in Minnesota or Oregon. Similarly, women make up a larger part of the Medicare population and have different needs and characteristics than do men. Class also makes a difference on health needs and characteristics. Predictably, persons from the working class have more health needs than persons from the upper class. When these three characteristics – race, gender, and class – interact, health needs intensify and access becomes more difficult. Elderly minorities tend to have lower median incomes

than elderly whites. Elderly women tend to have lower median incomes than elderly men. The lower the median income and the more the disabling characteristics, the more dependent on Medicare the individual is. Of Medicare beneficiaries in 2002, 35 percent had three or more chronic conditions; 51 percent were below 200 percent of the federal poverty line; 20 percent were below 100 percent of the federal poverty line; 45 percent lacked drug coverage either full year or part year; 17 percent were concurrently enrolled in Medicaid; 86 percent were elderly; and 6 percent were nursing home residents (KFF 2005d:1). "The term *multiple jeopardy* has been used to describe this cumulative disadvantage of age, race, gender, and class in regard to health and income (Andersen et al. 2001:211). Programs tend to use white populations as a model or as precedence, but assumptions on population makeup can lead to misinformed, detrimental, and unfair decisions.

*2.3.3 Gender:* Women make up 59 percent of the overall elderly population and 71 percent of the 85 years and older population (Andersen et al. 2001:211). Women are more likely to use a nursing home at some point in their lives, and they are more likely to have disabilities. Women's health needs are different from men's. Women need to have access to breast exams, gynecological services, and so forth. Because women typically outlive their husbands, they are often left alone, without the emotional, physical, communal, and familial support they offered their husbands. While women more typically take on the role of caretaker than do men, they are often left without a caretaker of their own (Andersen et al. 2001:212; Cox 2005:113-118). Health policy makers rarely take into account why it is that there are more women in nursing homes than men, and typically do not allow for adequate community support for this demographic group.

Indeed, there is even a dearth of literature on elderly women, health, and Medicare. The lack of a gender discourse in both Medicare and Medicaid is quite apparent. Under Medicaid, women sometimes have broader eligibility, but it is only because of children. It is interesting that the federal government and policymakers are so concerned with the health of children (insuring pregnant mothers, enacting SCHIP, expanding qualification around the federal poverty line) and yet seemingly unconcerned with the adults they turn into.

*2.3.4 Race and Ethnicity:* The elderly population is becoming increasingly nonwhite. In 2000, minorities made up 16 percent of the elderly population, and that number is expected to rise to 34 percent by 2050. Neither of those percentages are insignificant, so it is inappropriate that many of the programs and services offered through Medicare target the "types and levels of functional disability of elderly whites" (Andersen et al. 2001:210). Minorities (particularly black and Latino/a) have different patterns of health problems and higher morbidity and mortality rates.

Statistics regarding nursing home usage in terms of race and ethnicity are inconsistent. Some argue that minority elderly persons utilize nursing homes at a rate comparable to white elderly persons, after controlling for needs and resources. Others argue that white elderly persons are far more likely to utilize nursing homes. If the later is true, it is also unclear why that may be the case. Some suggested answers are: minorities are more likely to have families and communities that will ensure informal long-term care; nursing homes have discriminatory admissions policies; minority elderly persons are less likely to be educated on their formal long-term options; and doctors are less

likely to suggest formal long-term care for their minority elderly patients (Andersen et al. 2001:212).

*2.3.5 Class:* There does not appear to be equal treatment of Medicare recipients. For instance, recipients who also receive Medicaid have a much more difficult time finding a nursing home that will admit them, and typically are admitted into nursing homes with lower quality care. The Medicare and Medicaid reimbursement system for nursing homes means that the majority of nursing homes are privately owned and for-profit. Due to private ownership and the high occupation rate of nursing homes, the admissions requirements can be strict and covertly discriminatory. Elderly persons who can pay out of pocket are a more reliable source of finances than Medicaid and Medicare reimbursement programs, so out of pocket residents are highly preferred. In this way, class plays a significant role in the quality of care and ease of access available to elderly persons seeking nursing home care.

*Conclusion:* The policies of both Medicare and Medicaid are somewhat narrow in terms of the populations they serve. While it is difficult to create dynamic programs for such large populations, it is also morally reprehensible to have a federal program that benefits the privileged more than it benefits the needy. These programs are problematic in that they do not sufficiently account for diversity within the target populations. Programs that focus on the health outcome of the average population are doing a great disservice to the minority groups within that population.

## Section 3 Financing Public Health Insurance and Long-term Care

The costs of health care have risen exponentially over the past decade. In 2004, national health expenditures (NEH) totaled $1.9 trillion (Smith et al. 2006:186). Costs rose in part because the federal government has continually privileged big business and privatization rather than provide fully for the public. The annual budgets of Medicaid and Medicare are very high[22], and much of the burden of Medicaid falls on state budgets. The federal government chooses where to allocate funds, and unfortunately public assistance programs tend to receive budget cuts before things like tax programs and the military. Further, the failure to create a national health coverage plan means that the states take on a larger burden and responsibility to making health care reforms on the state level. The real losers in this situation are the beneficiaries of Medicare and Medicaid. The following are some explanations for the so-called budget crunch that has led to program cuts, restructuring, complexity, and privatization.

Population growth, economics, and technology are three major factors in the budget crunch on both the federal and state levels. There has been an explosion in the Medicare and Medicaid eligible populations due to a number of reasons, including among other things immigration, overall population health, and longevity. More particular to the Medicaid eligible population is the increasing cost of living and failure of the minimum wage to remain level with the living wage. Many people are simply not being paid sufficient salaries or wages. The types and amount of coverage and services available through Medicaid has also grown, which broadens eligibility requirements. Better

[22] In 2004, Medicaid and SCHIP expenditures comprised 8 percent of the federal budget, and 16 percent of NEH. Medicare expenditures comprised 12 percent of the federal budget and 17 percent of NEH (KFF 2006).

medical technology paired with an aging population leads to a very old population. The "Baby Boomers" are finally becoming elderly, and Americans in general are living longer lives because of better standards of living. As a result, we have a blossoming senior population. In 1999 there were 39 million elderly Medicare beneficiaries. That number is expected to rise to 69 million in 2025 (Andersen et al. 2001:413). The oldest segment of the elderly population (comprised of those over 85 years of age) is expected to grow the most over time. There is better technology, pharmacology, quality of care, and better overall health than in past senior populations. Even so, this population is rife with non-life-threatening conditions, like dementia. These types of conditions are likely to demand a lot of personal care and expenses. The costs associated with this trend will likely be extremely high. If better medical technology breeds an aging population, it will also allow the younger demographics to grow. Medical technology and access are also associated with declining rates of infant mortality and low-birth weight infants. Without family support or individual income, the state or federal government must pick up the tab for their care. And, despite its sole commitment to seniors, Medicare does not cover long-term care, so it will be up to Medicaid to support this aging group.

Despite current efforts to stem the flow of immigration, the immigration population (both legal and illegal) is expected to increase with time. Current politics might indicate otherwise, but it is unlikely that immigration rates will slow. They cannot be excluded from health care, particularly those who come via legal processes. There is a new bill in Congress that will allow many immigrants to begin the naturalization process. This will only increase the number of citizens that may need public health insurance coverage. Even without the current immigration debate, immigrants have had quite an

impact on the U.S. population. The U.S. fertility rate is at a below-replacement level, so longevity and immigration are major factors in maintaining a stable and/or growing population size. Immigration tends to be an overlooked or underestimated factor in population growth, and so can be omitted or missing from policy and action plans. This oversight is problematic in that policy is likely to fall short in terms of budget and resources predictions and allocations. Further, different racial groups are associated with different health patterns. Failing to predict the diversity of a population means that programs and policies will be unable to fulfill the needs of that population. The country's racial makeup is not likely to be turned on its head, but even so, policy makers need to be aware of demographics and demographic shifts.

Health insurance is another major aspect of the budget crunch. There are three major types of insurance – employer, private, and public (like Medicaid and Medicare). For all types of insurance, the cost of co-payments and premiums has risen dramatically. One consequence of the rise in cost is an increase in the number of families without insurance. Many of these families have one or both parents working. In 2003 there were 43 million uninsured persons, 80 percent of whom were employed at one or more jobs.

The numbers of companies offering employer-based health insurance have dramatically declined in the past few years. Companies that do offer insurance options often have premiums that are too high for the average family. Private insurance has become extremely costly, thereby excluding all but the very wealthy. Costs of federally subsidized or public insurance, like Medicaid, have also risen dramatically. Even so, public insurance is responsible for keeping millions of Americans from being uninsured. Between 2000 and 2004, the population covered by Medicaid rose by 8 million, while the

number of uninsured rose by 6 million. Though public insurance is not as effective as it could and should be in meeting the needs of all uninsured persons, it is certainly an important program for keeping us from a health care crisis (Krugman and Wells 2006).

Health insurance policies have also become increasingly structured for time and cost efficiency, not toward health outcome. "Moral hazard" is an idea that has been very influential in the ways that insurance companies and politicians understand and develop policy. Moral hazard is "a term economists use to describe the fact that insurance can change the behavior of the person being insured" (Gladwell 2005:46). In other words, insurers fear that patients will over-utilize medical services if they have access to unlimited and/or universal coverage. Over-utilization will cost the insurance companies a great deal of money for not much, if any, benefit to the patient. In this way, moral hazards can be seen as an umbrella term that accounts for medical losses[23] (which occur because of moral hazard) and unprofitable patients (who practice moral hazard). Insurance plans indicate that insurers view the patient as the enemy, something that needs to be controlled. For instance, one reason co-payments and premiums have skyrocketed is because, along with moral hazard, many insurance companies and policy-makers believe that making the consumer more responsible (particularly financially responsible) for his or her health care  then he or she will be less likely to abuse the system. Taking responsibility of one's own health is one important reason why the Bush Administration

[23] I find it problematic that the term "medical losses" refers to the loss of profit due to inefficiency in the health system. It does not refer to the loss of human lives as a consequence of this sort of efficiency that results in, medical oversight, wrong medications, botched procedures, and so forth. More people die each year from preventable medical errors in hospitals (between 44,000 and 98,000) than they do from automobile accidents, breast cancer, and AIDS. Yet policy makers and administrators are concerned with "medical losses" in terms of profit, not people (IOM 1999).

is advocating the Health Savings Accounts (HSAs). While in theory HSAs may promote financial responsibility and reduce abuse of the system (which occurs only in the minds of policy makers), they are extremely limiting and force the users to play by strict, unfair rules.

The types of insurance coverage that are influenced by a belief in moral hazards will not pay for, or will have restrictions on, things like routine checkups or preventive care. It is difficult, however, to find supporting evidence to the claim that patients will overuse their medical insurance irresponsibly (Gladwell 2005). These types of plans are also problematic because the underlying assumption is that all routine or preventive services are wasteful. Quite the contrary, the aim of preventive care is to preclude the need for expensive and/or prolonged treatment. If moles are checked today for a few hundred dollars, the patient will not need cancer treatment tomorrow for tens of thousands of dollars. As mentioned above, the likelihood of individuals abusing the system (having too many moles checked, for example) is highly unlikely. The uninsured tend to avoid treating health problems like diabetes and cancer, which leads to enormous costs. The uninsured also frequently use the emergency room as a source of primary care, which again is unnecessarily costly to everyone because emergency room care is paid for by tax dollars. So even though moral hazard claims are myths, they continue to drive policy that leaves millions of people uninsured or paying extremely high prices for not-very-good coverage.

### 3.1 The Federal Government

In late 2005, as a result of questionable policy choices made by the Bush Administration such as tax cuts and the expensive Iraq war, the country faced an $8.3 trillion deficit (up from $6.2 trillion in 2002) (Bureau of the Public Debt 2006). The administration made decisions to cut costs wherever possible. Social insurance programs like Medicaid were negatively affected, and it is quite possible that conservative politicians jumped at the chance to move away from a welfare state. Krugman similarly refers to "the conservative dream of dismantling the welfare state" (Krugman 2006). The federal Bush Administration is now trying to pass bills to cut over $10 billion from the Medicaid program. Because of the current rate of growth and cost of Medicaid, experts predict that the program has a lifeline of approximately 10 years. It is understandable, therefore, that the federal government wants to reform the program. Further, the costs of maintaining Medicaid are huge, growing nearly 20 percent between 1999 ($180.9 billion, federal and state combined) and 2002 ($216 billion). However, the sorts of reforms suggested refer mostly to a reduction in funding, which is neither a positive solution for Medicaid, nor will significantly reduce the federal deficit. The costs of cutting funding far outweigh the benefits. Reforms likely also will mean further privatization of the system, increased complexity, and fewer benefits for fewer people. The type of reforms that would be successful will include systemic change, increased federal control over health care, hospitals, insurance companies, and pharmaceutical companies.

The Bush Administration is also proposing cuts for the Medicare program. In his most recent proposal, President Bush aimed to cut $36 billion from Medicare over the next five years. This is problematic in that it is unlikely to stem the cost growth in any

significant way, but it will hinder hospitals and doctors from providing the services that people need (Rovner 2006). For several decades now, the cost of Medicare has grown more per year than the national GDP. This means that each year, Medicare is taking up a larger portion of the federal budget. Longevity and technology will mean increased volume of utilization, extended time of utilization, and higher costs of medical services. Per capita cost will increase as the population of beneficiaries increases. This brings up the issue of so-called "moral hazards." In 2000, the annual report by Medicare trustees predicted that the Medicare Part A Trust Fund would go bankrupt by 2025 at the current and predicted rate of growth. These sorts of predictions are difficult to make, and the annual reports are not very reliable. Regardless, it is a strong indication that it will be difficult for the program to continue indefinitely with the current and predicted growth trends. These reports are also important because they can frame policy debate and decisions (Andersen et al. 2001:416).

### 3.2 State Governments

The cost of health care is rising far more quickly than general inflation. It is increasingly difficult for states to find the funds for Medicaid, in part because there are many social programs that compete for funding and demand access and quality, for instance education. And, as "Medicaid cost growth is projected at rates that exceed even healthy budget growth," the states face much more budgetary pressure with the anticipated $10 billion in federal Medicaid cuts, and during times of economic downturn (Holahan et al. 8). The federal government matches state expenditure for certain persons, goods, and services, up to a certain amount of money. It is important to note that if states

expand eligibility for Medicaid, it is the state that must cover the extra cost. The federal government will only provide matching funds for those who are eligible under the minimum federal qualifications.

Medicaid is an entitlement program, meaning that anyone who is eligible can receive the benefits, with no cost cap. However, if the state does not use the amount of money allocated by the government, then the state will lose the extra funds. Conversely, if the state uses all of the federal funds before the fiscal year is over, then the state must supply the rest of the funds on their own state budget. Both scenarios can result in high costs for the state. In some cases, states have come up with financial schemes that fool the federal government into providing matching funds for expenses that would not ordinarily receive matching funds.

> Under these [accounting schemes], Medicaid agencies have obtained money from providers through donations or taxes or from state and local government agencies through intergovernmental transfers. States have used these funds to make…payments to providers under Medicaid, thereby obtaining federal matching funds (Holahan 8).

The result is a growing distrust toward the state by the federal government. Yet it is difficult to place blame upon the states, especially as the federal government is planning to impose budget cuts. The states are, in effect, being asked to provide the same services and cover a growing population with fewer funds in an economy where the cost of health care is growing much faster than general inflation. This expectation is neither fair nor feasible for the states. While the federal government continues to grant more tax cuts that benefit the wealthy, the states are being forced to make big cuts into their social insurance programs that help the needy. Beneficiaries are being burdened with more financial responsibility, but paying a higher co-insurance payment is something many beneficiaries

are simply not able to do. In addition, many beneficiaries are being cut, restrictions are tighter, and other forms of insurance are increasingly difficult to obtain.

Apart from the decreasing federal funds and rising costs of health care, there are a number of other reasons for the budget crunch. Some argue that expanded coverage mean that beneficiaries are over-utilizing their benefits (the moral hazard argument). However, statistics show that recipients of Medicaid use medical services at a rate comparable to higher-income counterparts, after adjusting for differences in health (poor or low income people are more likely to have poor health and therefore require more medical services) (Andersen et al. 2001:40). So while the access to, cost of, and numbers of services may increase, it is not clear that Medicaid recipients will abuse their benefits. Further, it is not clear that the quality of these services is comparable to services available through private insurance, and quality is typically correlated with cost. Another reason for rising health care costs are advances in technology, including services, machines, and prescription drugs. Such advances can be extremely expensive, particularly when there is a coinciding increase in availability (Hoffman 2004:21-22).

States have also tried to find other ways to reduce Medicaid costs. States are now widely using Health Management Organizations (HMOs), but it is not clear that HMOs are beneficial or cost effective. HMOs have enabled Medicaid to cover more people, but there are financial and quality issues that need to be considered. There are no Medicaid revenues when the states use HMOs. This, combined with declining federal grants, threaten community health centers and not-for-profit health centers. Community health centers are concerned that they will lose all of their state Medicaid funding if states

continue to go through HMOs at this rate. If funding for these health centers continues to decline, then the centers will be unable to continue covering the uninsured.

The quality of care is also a major concern when using HMOs. Because HMOs create incentives for health centers to reduce care, Medicare beneficiaries may see a reduction in available health services, and providers who are unwilling to offer anything beyond the minimum service. HMOs also tend to offer poorer care than fee-for-service practices, while fee-for-service practices tend to provide more needed care and more patient satisfaction. Overall, there is little evidence that HMOs reduce the cost of health care for the state (Andersen et al. 2001:44-45).

### 3.3 Long-term Care

Long-term care is expensive. Because senior housing facilities must also include extra services, both necessary (medical) and comfort-based (e.g. creation of community) ones, the monthly and annual costs can be quite high. Though rates will vary widely throughout the nation, the national average monthly fees for assisted living housing are between $2,400 and $3,000 (Schuetz 2003:22, Figure 2.1). It is important to keep in mind that ADL/IADL care is included with AL housing, but medical care is not necessarily included. Medical care is an additional expense incurred by residents. Average annual AL costs are between $28,800 and $36,000. The average resident has an annual income of $19,250, and must still cover other expenses like medication, visits to the doctor, and clothing. In 2000, the median per capita income was $13,769 for all seniors, $19,168 for senior men, and $10,899 for senior women (Schuetz 2003:14). Senior Hispanic and African-American households also have significantly lower income per capita. These

facts mean that most, around two-thirds, of all seniors would require financial assistance and subsidies to help cover the high costs of AL facilities and services.

While most residents can pay for some of their housing expenses, most also rely on informal financial support (e.g. family) and formal financial support (e.g. private insurance or public assistance). Many seniors rely on Supplemental Security Income (SSI). Out of pocket payments account for approximately 26 percent of annual long-term care expenditures. Medicaid accounts for 40 percent, and Medicare for 17 percent[24] (Feder et al. 2000:4). Medicare is not a reliable source of funding for AL housing because these services are funded only as short-term rehabilitative service.[25] Medicaid, on the other hand, consistently subsidizes the services included in AL housing, though the housing itself may not be covered. Medicaid funding for AL housing is relatively recent, beginning in 1981. Previously, Medicaid subsidized long-term care only if it was given in institutional settings like nursing homes. Since then, community care and AL facilities receive Medicaid funding and are preferred to institutions due to their lower cost, flexibility, and client satisfaction.

Home and Community-Based Service (HCBS) waivers are increasingly used as a way for states to fund AL housing and services.[26] By using waivers, the state may be reimbursed by the federal government if the funds were used for "health-related and personal services provided to residents who are eligible for Medicaid and who require a

[24] Alternatively, Desonia cites the following distribution of long term-care expenditures: Medicaid at 35 percent; Medicare at 25 percent; out of pocket at 33 percent; private insurance at 4 percent; other sources at 3 percent (Desonia 2004:5).
[25] Medicare allows 100 days of care following a 3-day minimum hospital stay. Under some circumstances Medicare will provide home health care.
[26] Waivers do not cover the cost of rent in some states, and the types of services and housing covered vary among states. In 2002, 5 states provided no assisted living coverage. See Figure 4.3, "State coverage of assisted living, 2002."

nursing-home level of care" (Mitty 2003:34). While this is financially beneficial for states, clients who fulfill the waiver qualifications may suffer in some AL facilities if "the facility lacks 24-hour RN supervision and monitoring" (Mitty 2003:34). Regardless, states try to use waivers as much as possible in an effort to limit the growth of Medicaid costs. The caveat with the federalist waiver program is that the states adhere to the "budget neutrality test," which means that "spending under the waiver program will not exceed the amount that the state would have spent without the waiver for long-term care benefits" (Schuetz 2003:57). In 2001, $14 billion was granted in HCBS waivers, up from $10.6 billion in 1999. Overall spending on nursing homes by Medicaid remains high, however, at $42.7 billion (Schuetz 2003:62). Though waivers do help states pay for long-term care costs, the soaring costs continue to strain state budgets.

The relative absence of public subsidies for AL housing combined with the high costs of AL means that only a narrow slice of the elderly population has access. As a result, the demographics associated with AL lack diversity. For instance, in 1998 approximately 97 percent of AL residents were white, and 63.9 percent of residents had incomes below $25,000 (compared with 76.1 percent total in 2000) (Schuetz 2003:24). It is interesting that there is a correlation between the low-income seniors and access to assisted living. Medicaid accounts for much of AL funding, and so it follows logically that most residents would require financial assistance. What does not fit into this correlation is the disparity among races. Minorities are more likely to be low-income, so why is it that they do not make up a larger portion of the AL demographics? An explanation lies in the fact that the AL industry, despite large amounts of Medicaid funding, is a private-pay industry. Personal wealth and income remains a huge source of

payment for AL services.[27] Much of the industry is aimed at higher income seniors, which limits access for low-income seniors and for many minority seniors who lack substantial income and wealth. Further, even in housing that is intended to be low cost, low-income seniors may not be able to pay for what is not covered by Medicaid.

An NHPF report (Desonia 2004) puts faith into long-term care insurance (LTCI). Currently, LTCI covers only a small portion of total long-term care expenditures, about 4 percent. LTCI covered 4 million seniors in 2000 (AAHSA 2006). However, if LTCI sales continue to grow, then they could provide a substantial portion of total expenditures. LTCI is one of the newer types of private health insurance, emerging in the 1970s. An increase in sales could indicate that people are thinking ahead and will be prepared when need arises. These preventative steps could reduce the costs of long-term health care. There are downsides to LTCI, however. For instance, private insurance can be costly, and excludes lower-income persons from the more comprehensive plans. It also adds confusion to the already complicated patchwork health care system. Some of these lower income persons will qualify for Medicaid, but there is a significant segment of the aging population who will be unable to qualify for Medicaid and unable to afford private insurance. With the continuing decline of employer-based insurance, the middle and working classes will much more likely to fit into this "tweener" category. As I also contend, Medicaid should not carry so much responsibility in providing care and particularly housing for the elderly population. Other problems with LTCI include increasing premiums, complexity of plans, and an even less cohesive national health care system.

[27] Refer to section 1.3 on demographics and AL for the discussion on race and wealth.

**Conclusion**

The following is my opinion on assisted living and the policy affecting AL. While I do have high ideals about universal health care, I do not believe that it is a practical proposal for the United States. There is too much federal and professional resistance to the notion of a universal system, and such a major upheaval or extensive reform of any federal program is unlikely. In light of this, I propose a shift within the current AL framework.

It is the role of the government to provide for the people and to enact policies for the good of the people. With regards to health care, the government is largely failing to provide adequate insurance and services. While the provision of health care is not an explicit task for the government, ensuring the health of the public is important for a successful nation. Paul Wise suggests that it is more useful to talk about health care as a public good, rather than a right.

> Health care is now widely considered a public good but is being administered as if it were a private commodity…The term 'public good'…expresses more constructively the general consensus that health care should be provided on the basis of shared, collective interest, like police, rather than on the basis of individual, natural entitlement" (Wise 2005).

Seniors in particular ought to have easy and adequate access to health care, housing, and other social services. They have contributed to and been productive members of society, and deserve the security of public insurance. What is particularly frustrating about the current AL industry is that it reflects the inequalities and discriminations that exist in society at large. That so many seniors remain in inappropriate or inadequate housing and experience discrimination is inexcusable. Assisted living is a sensible solution because it

saves money and could be implemented easily through legislation or public health programs.

**What should residential care housing entail?**

Public assistance for senior housing is for the public good. AL housing and nursing care are both necessary programs that benefit the whole society. Families are relieved of the burden of caretaking, and adults can exercise more freedom with their income and wealth.[28] Age segregated housing is appropriate so long as the residents do not become stigmatized, which means the facilities need to interact with and be integrated into the rest of the society and infrastructure. Doing so could also lead to communities that are more senior-friendly. It is also appropriate to integrate the elderly with other disabled groups, so long as the needs of all populations fall within the services provided by the facility. The role of the family should certainly be taken into consideration, but its presence or absence should not affect seniors' access to care and housing. Integration into the community and easier access to AL housing would also make AL more appealing to elderly who are living independently. Those who do live on their own are more likely to be injured and less likely to ask for help, resulting in costly medical attention. AL housing, in this way, is similar to preventative medical care. Small expenses now saves us from large expenses in the future.

Because AL falls in between independent living and nursing care, the services provided and clients accepted should also fall in the middle of the continuum. Once a

[28] If all people had the assurance that they would be cared for by the government in their old age, adults may be more willing and able to engage in conspicuous consumption, to circulate more wealth and money in the economy, and pass on more wealth as inheritance. This is beneficial to the society as a whole.

client develops needs beyond the scope of services and care offered by the AL community, then they will be moved to a nursing care facility.[29] Maintaining a relatively healthy clientele means that AL can avoid becoming medicalized and institutionalized. This would also create a more standardized, efficient, quality, reliable, consistent, and appropriate long-term care system. It is possible to regulate and standardize AL without institutionalizing it.

There are two major components to regulating AL housing. One is a clarification and standardization of language. A clear and official distinction between retirement, AL, and nursing homes will help determine which programs fall under what regulation. Consistent language use across states will result in fewer health disparities. A second component is federal regulation. If the federal government chooses not to own and operate its own AL facilities, it can impose regulations or guidelines on privately or state-owned facilities. For instance, there can be a required minimum of services offered; qualifications for admission can be standard (non-discrimination policies should be enforced within those guidelines); facilities can be standardized without feeling institutional; and finances can be simplified even in the absence of a universal health system. A standardization of language and regulation across states will result in a simpler, consistent AL system (rather than industry).

While cost and quality will always be issues, the market for long-term care has the potential to boom in the next decade or so. Demand should rise dramatically as the baby boomers become seniors. A new market study called "The Long-term Care Market: Nursing Homes, Home Care, Hospice Care, and Assisted Living" predicts $110 billion in

[29] Both physical and cognitive fitness should be taken into account, including Alzheimer's and dementia.

long-term care revenue in 2009 (Health & Medicine Week 2006). What I have suggested above is not beyond the funds and means of the federal government. While implementation may be difficult, it is not without benefit, and reforming any program is never easy. It is not necessary for the government to fund everyone for everything, as some people will be able to pay out of pocket, and others will have informal and formal funds. It is clear that there is a market for residential care, so as long as the federal government does not allow the AL market to be privatized, some revenue might actually be gained.

Placing the AL industry under more stringent federal control would be a smart and effective way to control the costs of senior housing while providing the senior population with care and housing. The guarantee of housing paired with Medicare benefits would be very close to universal care for seniors, which is a public good.

**Why Medicaid?**

The recent policy changes in national health care programs have brought up the major question: why Medicaid? Medicaid is the primary provider of health insurance in the nation, as well as the largest provider of nursing homes and long-term care. 36 percent of the US population lived below 200 percent of the federal poverty line in 2003-2004 (KFF 2006), and Medicaid should, ideally and in theory, provide full coverage for this entire demographic. One of the fastest growing expenses that Medicaid incurs is due to holes in Medicare, the federal social insurance program for the elderly. In other words, Medicare ought to cover long-term care, nursing homes, assisted living, personal care,

and prescription drugs, all of which are the most expensive and fastest growing of all types of care, but it does not, or does insufficiently.

At the beginning of 2006, Medicare received the addition of a prescription drug program, while Medicaid received proposals for massive budget cuts. Why is it that Medicaid is so politically and socially unappealing? First, it might be useful to consider why Medicare is so appealing. Medicare is considered by the public to be a universal entitlement, something that everyone has a right to regardless of income. It is a health care program that is funded by the young for the old, a system that is perceived as having strong ties to socialism. The young are willing to fund a social insurance program like this because they know that when they are old, the young will in turn fund their health care, and so it continues. "Medicare is governed by uniform national standards, has strong public support, and is politically stable" (Grogan 2005: 219). It is also interesting to note that other programs that are health insurance subsidies – essentially welfare programs – are not stigmatized perhaps because they are not associated with welfare, or perhaps because the beneficiaries of such programs are those in higher income brackets. For example, tax exemption programs fall into this category but lack the stigma attached to official welfare or welfare-based programs. "The tax exemption of employer-paid health insurance for largely middle and upper income workers…cost the federal government about $79 billion in 1998" (Andersen et al. 2001:43).

Medicaid, on the other hand, is means tested, and a welfare program. In other words, recipients must fit certain guidelines in order to qualify. In this society, individuals who do not or cannot fit into a prescribed (though unrealistic) demographic face stigmatization. "Medicaid, our health care program for 'the poor' defines the lower

tier [of our two tiered health care system]. Medicaid is a targeted, means-tested program that is often considered to be stigmatizing, institutionally fragmented, and politically vulnerable" (Grogan 2005:219). Medicaid is a program whose target populations are the poor, politically powerless income brackets. Some of the demographics and income tiers not covered by Medicaid are also unable to afford private or employer-based insurance and so go uninsured. Discriminating on the basis of who can or cannot pay, or who makes too much or too little money, is a question of equity (Holahan et al. 2003:7). The groups who cannot pay are considered unappealing, and sometimes are believed to "abuse" the welfare system, "manipulate" the Medicaid system, or develop a dependency on one of these systems, supposedly at the taxpayers' expense. The American constituency has no immediate interest in sustaining programs like Medicaid, and the recipients are too powerless to fight for the maintenance of these public programs.

It is also a concern that public good and welfare programs are receiving budget cuts while the upper income tiers are benefiting from tax cuts and federal subsidies for businesses. The Bush administration has granted excessive tax cuts, which only truly benefit the very wealthy. The administration is making other questionable decisions that have major financial impacts, such as: the expensive Iraq war; failing to implement reconstruction efforts after Hurricane Katrina; and allowing further privatization of health insurance and Social Security. The efforts of social and political conservatives continue to benefit the wealthy and discriminate against the poor. It is inexcusable for the federal government to continue to implement inequitable policies.

**A proposal for the restructuring of public health insurance**

Ensuring public health is for the good of the nation. I believe it is both an imperative and a realistic proposal that every citizen of the United States should have access to some form of health insurance. The federal government should have full responsibility for regulating and providing access to health insurance. All of the following proposals must meet requirements of simplicity, efficacy, and equity. Respect for consumer rights, clear regulation, consistent coverage, and low barrier access must also accompany the proposals and implementation.

My initial proposal was to abandon the federalist organization of the public health insurance programs. All three programs (Medicaid, Medicare, and SCHIP) would be fully funded by the federal government. Each program would represent an age group, so individuals would graduate to a different program with age. Disabled persons would be covered equally under all three programs and would shift between programs just like the rest of the population. All three programs would provide fully for their beneficiaries, including preventive, hospital, physician, eye, dental, nursing home, and residential care, and for prescription medication. A program similar to Medicare Advantage would be available, so people who do not qualify for public assistance can buy into the benefits via private insurance plans.

I am skeptical of the federalist model because it is too complicated. Because it produces inconsistency and inequity, federalism does not appear to be an effective way to organize the public health insurance system. However, the balance between federal and state governments is an important one, and would be difficult to abolish. Federalism is intended to prevent excessive centralization of power, as well as fragmentation of the

Union. It is likely that local and state governments are more willing to put resources into public health programs and commissions, because these smaller governments have more at stake and may also bear more blame for an insufficient public health system. Federalism's potential efficacy has not yet been realized in the realm of public health, but neither should it be overlooked.

Instead of suggesting a complicated restructuring of the current public insurance programs, it is more useful to recommend two shifts in responsibility: the federalist insurance model needs to become more federally centered (rather than state-centered); and Medicare must cover all long-term care costs for the elderly. The state-centered federalist model causes much of the inconsistency among states and puts a heavy burden on the state governments. Resulting is a misunderstanding and an under-appreciation of public health, as well as a stressed local safety net. A more federally centralized structure of public insurance would make it easier to assess programs and to ensure quality of care. Implementing and maintaining regulation can help accomplish a federally centered framework.

The second shift involves making Medicare more responsible and accountable for the provision of senior long-term care. Medicaid and SCHIP may remain under the federalist model, but there should be the breakdown of age between Medicaid and Medicare. I find this a particularly important point, because Medicare should cover the entire senior population, for *all* services, while accounting for income and disability. Once a Medicaid beneficiary becomes a senior, Medicaid should cease covering him or her. Medicare will provide the same benefits, including financial, that Medicaid had. In this way, recipients who are financially needy still receive financial assistance, and those

who can afford to pay will pay. With these new responsibilities, both Medicaid and Medicare can provide comprehensive benefits to all their recipients.

In order for care to be considered comprehensive, the programs need to provide long-term care and AL housing in addition to medical and drug benefits. Currently neither Medicare nor Medicaid provides full and comprehensive coverage for any residential or institutional care. Both programs must ensure long-term care coverage – Medicaid for its disabled beneficiaries, and Medicare for all beneficiaries. Medicare recently added its prescription drug program, so a housing program is the logical next step in being an improved and more effective assistance program for the elderly.

Payment for the new system is twofold. Dual eligibles should receive the same or similar assistance as they would from Medicaid, Those who can afford to, may directly (out of pocket) or indirectly (private insurance plan) buy into the housing benefits. A graded system would make benefits more accessible, and we could achieve equity.

Funding the new system should not incur additional costs. Currently, Medicaid takes up approximately 8 percent of the federal budget, and Medicare 12 percent (KFF 2006). In advocating an additional housing program for Medicare, I am not necessarily asking the federal government to allocate more funds to the program. AL housing is cost-effective and cheaper than nursing homes. It is clear that there is a market for residential care, and it could be quite lucrative. Because AL housing is also preferred over nursing homes, there may be a large nursing home population that would choose to shift down to less-costly AL housing. Many seniors who are in independent living or family situations may choose to shift up to AL homes, because they are appealing as residential communities. Because of the potentially large AL population, AL homes may act as a

preventative measure for medical costs. All residents have frequent access to nursing services, and live in a more physically appropriate environment (e.g. there are strategic grab bars and emergency call buttons). Both of these conditions would decrease the utilization of emergency and hospital care. I predict that successful AL facilities will pay for themselves in revenue and reduced medical losses.

There is no realistic chance that a universal health care system will be implemented in the United States. The current public insurance system could be more effective and quality with a few small shifts in responsibility, and the addition of a housing program. My proposal is a viable option because it does not require additional federal funds or large changes to the public insurance framework. There are still many issues to be addressed regarding the health care and health insurance system in the United States. That there are over 45 million uninsured Americans is an indication that something needs to change about the way our country provides and consumes health care. 28 percent of Medicaid costs go to dual eligibles, and shifting the burden of dual eligibles entirely to Medicare means that Medicaid will save nearly $60 billion. These additional funds would double the amount already spent on adults and children, which could provide Medicaid coverage to nearly 39 million more uninsured adults and children. So while my proposal does not strive to provide health insurance for the entire population, it has the potential to drastically reduce the number of uninsured with a simple shift in responsibility.

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