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Honoring Our Parents: Applying the Biblical Imperative in the Context of Long-Term Care

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ADDRESSES

HONORING OUR PARENTS: APPLYING THE BIBLICAL IMPERATIVE IN THE CONTEXT OF LONG-TERM CARE†

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It is incredibly appropriate that this Symposium was held on November 9, 2006, for it was almost exactly 100 years ago that the German psychiatrist and neuropathologist Dr. Alois Alzheimer presented his findings about the dreaded degenerative disease that now bears his name.[1] Alzheimer's Disease and dementia generally, as well as various other age-related disabilities, cast a baleful haze over the prospect of extended life that medical triumphs now enable because these conditions frequently precipitate a need for long-term care.[2] And such care is the topic of this Symposium.

Of the many agonizing issues surrounding long-term care, one of the most vexing is the first listed in the title of this Sympo-

† On November 9, 2006, the *Notre Dame Journal of Law, Ethics & Public Policy* hosted a symposium entitled "Long-Term Care for America's Elderly: Who is Responsible, and How Will it Be Achieved?". Professor Kaplan was the second speaker at the Symposium. His remarks have been revised for publication. At the author's request, all numbers in the article appear in numerical form.

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1. *See* David Shenk, Op-Ed., *The Memory Hole*, N.Y. TIMES, Nov. 3, 2006, at A27 (noting that Dr. Alzheimer presented his paper entitled "Regarding a Curious Disease of the Cortex" to the South-West German Psychiatrists on November 3, 1906).

2. *See generally* ROBYN I. STONE, MILBANK MEMORIAL FUND, LONG-TERM CARE FOR THE ELDERLY WITH DISABILITIES: CURRENT POLICY, EMERGING TRENDS, AND IMPLICATIONS FOR THE TWENTY-FIRST CENTURY (2000), http://www.milbank.org/reports/0008stone/LongTermCareMech5.pdf (discussing the growing demand for long-term care).

sium—namely, who is responsible? That is, how will the responsibility for caring and paying for this care be shared among the older person, that person's family, and society at large? I cannot pretend to offer an unassailable solution to this foundational dilemma, because the issue of long-term care encapsulates much of our country's ambivalence about who should pay for health care generally. Also implicated are our perennial paroxysms about the role of the state and the place of individual responsibility. Perhaps the only definitive conclusion that can be proffered is that when most people confront the reality of providing care for a disabled elder, their desired answer to the question of who is responsible is "someone else!"

Beyond such cathartics, it seems appropriate for a symposium sponsored by an overtly religious institution such as Notre Dame Law School to begin by looking at religious sources—specifically the Commandment to "Honor thy Father and thy Mother." Even this starting point is controversial, however, because no single version of this Commandment is accepted by Catholics, Protestants, and Jews. That is, despite all of the hoopla in the political sphere about whether the Ten Commandments may or may not be displayed in federal courthouses and other governmental facilities, the rarely considered next question is which version would be so displayed.

The Catholic version is the one set forth in the preceding paragraph, but both the Protestant and the Jewish versions have an additional phrase: "that thy days may be long upon the land which the Lord thy God giveth thee."[3] This phrase seems to suggest that the obligation to honor one's parents has implicit consequences for the children to whom the obligation is addressed—namely, honoring one's parents assures the honoring children of living longer themselves. Needless to say, this phrase has some troubling implications not only for children who do not display the degree of "honor" that the Commandment envisions, but also for those children who honored their parents and nevertheless lived short lives.

Among contemporary American Jews, the most widely distributed commentary on the Bible was published in 1936 by Dr. J. H. Hertz, who was the chief rabbi of the British Empire.[4] He addresses this latter conundrum by noting that the implication of

3. John Love-Jensen, *Which Ten Commandments?*, POSITIVE ATHEISM MAG., July 2000, at 9, *available at* http://www.PositiveAtheism.org/crt/whichcom.pdf (citing the King James Bible (Protestant) and the Bloch Publishing Company (1922) (Jewish) ("[T]hat thy days may be prolonged upon the land which the Lord thy God giveth thee.")).

4. *See* THE PENTATEUCH AND HAFTORAHS (J.H. Hertz ed., 2d ed. 1977).

extended life "is not always seen in the life of the individual; but the Commandment is addressed to the individual as a member of society, as the child of a people."[5] This notion of collective responsibility for a nation's elders, he notes, "is the ground of national permanence and prosperity. If a nation thinks of its past with contempt, it may well contemplate its future with despair; it perishes through moral suicide."[6] Thus, it might be argued that the responsibility for long-term care of the country's older population is broader than an exclusive focus on the elder's own family would imply.

The differing versions of the Ten Commandments already noted vary not only in their textual exposition but also in their numbering. That is, the Commandment to honor one's parents is number four in the Catholic version but number five in the Protestant and Jewish versions.[7] Does this different enumeration matter? Maybe not, but an interesting and pertinent *midrash,* or interpretation, of the Commandments' ordering is offered by Rabbi Hertz as follows: "The most natural division of the Ten Commandments is into *man's duties toward God* . . . the opening five Commandments engraved on the First Table; and *man's duties to his fellow-man* . . . the five Commandments engraved on the Second Table."[8] Accordingly, the Commandment to honor one's parents is considered an obligation to the Almighty, rather than a mere "best practice" for good relations with one's contemporaries. Perhaps, this designation further suggests that the requirement to provide long-term care for our parents is best seen in a collective light, as a society-wide obligation, instead of a family-specific responsibility that each family undertakes on its own. In other words, long-term care should be part of what a Commandment-observing community provides to its members.

This article begins by examining the continuum of arrangements that fall within the rubric of "long-term care" and then examines how Medicare, our society's effort to collectively provide for the health care of older Americans, applies to those arrangements. The article then considers the limitations of Medicare in light of the Commandment to honor one's parents and suggests how Medicare can be brought into better accord with this Commandment.

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5. *Id.* at 299.

6. *Id.*

7. *See* Love-Jensen, *supra* note 3.

8. THE PENTATEUCH AND HAFTORAHS, *supra* note 4, at 295.

I. THE NATURE AND COST OF LONG-TERM CARE

As Americans live longer, they are more likely to develop age-related disabilities that limit their autonomy and ability to live independently.[9] At that point, some type of long-term care becomes necessary, though the specific type of care depends upon the condition of the older person in question.[10] Many issues emerge when the need for long-term care arises,[11] including questions about where such care will be provided and by whom,[12] and who will pay for this care. Older Americans who can no longer live independently have several options, ranging from assistance in their current residences to a medically-oriented residential institution called a nursing home.[13] This section describes these alternatives, beginning with the least disruptive—namely, home care.

A. *Home Care*

The phrase "home care" applies to an enormous range of accommodations, all of which involve some version of bringing assistance into the residence of an older person.[14] This assistance may consist of home health nurses or aides who administer medications or perform medical procedures, such as injections and insertion of feeding tubes, catheters, or breathing devices.[15] On the other hand, home care can also consist of homemaker and personal care services with no medical component at all, such as meal preparation, housekeeping, home maintenance, and simple repairs.[16] Many of these services are provided without charge by family members, friends, members of a religious

9. *See* Lawrence A. Frolik & Alison P. Barnes, *An Aging Population: A Challenge to the Law*, 42 HASTINGS L.J. 683, 694–96 (1991).

10. *See generally* ROSALIE A. KANE ET AL., THE HEART OF LONG-TERM CARE (1998) (noting the need for long-term care programs that provide consumers with options for individualized treatment).

11. *See* ALWAYS ON CALL: WHEN ILLNESS TURNS FAMILIES INTO CAREGIVERS (Carol Levine ed., 2000).

12. *See generally* EMILY K. ABEL, WHO CARES FOR THE ELDERLY?: PUBLIC POLICY AND THE EXPERIENCES OF ADULT DAUGHTERS (1991) (reviewing who provides long-term care and how this care is provided). These issues are often significantly affected by the ethnicity of the older person who requires long-term care. *See generally* ETHNIC ELDERLY AND LONG-TERM CARE (Charles M. Barresi & Donald E. Stull eds., 1993).

13. *See generally* LAWRENCE A. FROLIK, RESIDENCE OPTIONS FOR OLDER OR DISABLED CLIENTS (3d ed. 2001) (discussing residential options for senior citizens).

14. KANE ET AL., *supra* note 10, at 119.

15. *Id.* at 120–21.

16. FROLIK, *supra* note 13, ¶ 11.04, at 11-19.

community, or some other affinity group.[17] Indeed, a report published by the National Alliance for Caregiving estimated that such informal care constitutes almost 80% of all long-term care provided to older Americans.[18]

Other services typically entail some out-of-pocket expense. For example, the popular Meals-on-Wheels program and similar efforts are provided at a nominal charge by various public and community-based organizations, such as the local Area Agency on Aging.[19] Similarly, adult daycare allows an older adult to be brought to a special center that offers various services to impaired senior citizens.[20] Some adult daycare centers provide physical therapy and personal grooming services, in addition to a midday meal, activities appropriate to the elder's abilities and interests, and the companionship of persons of similar age.[21] These centers seek to address the social isolation and loneliness that advanced age can often bring. But adult daycare centers usually operate on a fairly limited schedule, typically from early morning to late afternoon, and are not open every day of the week. Thus, adult daycare still requires the older patient to have a supportive network of family and friends to fill in the gaps in the daycare center's schedule. Finally, medically oriented services are usually provided by home health agencies that specialize in these services and have been certified by state and federal regulators.[22] The common thread in these arrangements is that they enable the older person to remain in his or her home to "age in place."

Most home care is part-time only, typically provided in segments of 8 hours or less per day, and usually not every day. Around-the-clock home care would require 3 shifts of caregivers every day and would quickly become very expensive. According to the most comprehensive survey of home health costs, the average hourly charge in 2006 for homemaker services was $17.09

17. KANE ET AL., *supra* note 10, at 14–15.

18. NAT'L ALLIANCE FOR CAREGIVING, CARING TODAY, PLANNING FOR TOMORROW 3 (1999), *available at* http://www.caregiving.org/data/archives/nacguide.pdf. *See also* Richard L. Kaplan, *Federal Tax Policy and Family-Provided Care for Older Adults*, 25 VA. TAX REV. 509, 513 (2005).

19. *See* NAT'L SENIOR CITIZENS LAW CTR., PLANNING CARE AT HOME: A GUIDE FOR ADVOCATES AND FAMILIES 79–83 (2000); UNITED SENIORS HEALTH COUNCIL, LONG TERM CARE PLANNING: A DOLLAR AND SENSE GUIDE 12–14 (rev. ed. 2001).

20. *See* UNITED SENIORS HEALTH COUNCIL, *supra* note 19, at 15.

21. *Id.*

22. FROLIK, *supra* note 13, ¶ 11.04[1][d], at 11-22 to 11-23; *see also* NAT'L SENIOR CITIZENS LAW CTR., *supra* note 19, at 89–93.

and $25.32 for home health aides.[23] Moreover, "certified" home care providers charge even more, an average of $36.22 per hour for home health aides.[24] In addition, there are significant variations across the various states and within states as well.[25] But even using an average rate of $21 per hour translates into a charge of $504 per day for around-the-clock care, or almost $184,000 on an annual basis. Indeed, the development of nursing homes is partly a response to the prohibitively high cost of providing home care on a constant basis.[26] Thus, home care is an appropriate arrangement for older persons who require assistance with some activities of daily living, but who do not require such assistance all day and night. Home care can also be appropriate, however, when family members are willing and able to supplement the services of paid caregivers.[27]

A variation on this approach of coordinating paid and unpaid home care is private care management. Under this increasingly popular arrangement, a geriatric care manager assesses what an older person requires to remain at home, provides specific recommendations in accordance with that assessment, and then monitors the actual provision of those services.[28] Geriatric care managers are usually nurses or licensed social workers and typically work with families who live some distance from the older person in question or who otherwise want a professional to oversee the home care process.[29] In-home assessments can also be performed by certain public agencies,[30]

23. GENWORTH FINANCIAL, GENWORTH FINANCIAL 2006 COST OF CARE SURVEY: NURSING HOMES, ASSISTED LIVING FACILITIES AND HOME CARE PROVIDERS 3 (2006).

24. *Id.*

25. *See id.* at 12–30 (detailing regional differences); *see also* METLIFE MATURE MARKET INSTITUTE, THE METLIFE MARKET SURVEY OF NURSING HOME & HOME CARE COSTS 15–17 (2006).

26. *See* LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 160 (4th ed. 2006).

27. FROLIK, *supra* note 13, ¶ 12.01, at 12-3.

28. *See id.* ¶ 11.04[1], at 11-20 to 11-21; J.C. Conklin, *For Hire: Geriatric-Care Manager (Also Friend, Counselor, Matchmaker)*, WALL ST. J., Apr. 27, 2000, at B1; Mary Lynn Pannen, *A Win-Win Partnership: The Elder Law Attorney & Geriatric Care Manager*, NAT'L ACAD. OF ELDER LAW ATT'YS Q., Spring 2000, at 25.

29. Christine Gorman, *Guardian Angels*, TIME, Mar. 26, 2001, at 75; Georgette Jasen, *When Crisis Strikes: Caring for an Elderly Parent*, WALL ST. J., May 29, 1993, at C1; Tracey Longo, *When Distant Parents Need Your Help*, KIPLINGER'S PERS. FIN. MAG., Dec. 1995, at 91. Geriatric care management is also an integral part of employee fringe benefits. *See* Kelly Greene, *A Renewed Push to Help Workers with Elder Care*, WALL ST. J., Mar. 29, 2001, at B1.

30. *See* UNITED SENIORS HEALTH COUNCIL, *supra* note 19, at 14–15; *see also* Andreas E. Stuck et al., *A Trial of Annual In-Home Comprehensive Geriatric Assessments for Elderly People Living in the Community*, 333 NEW ENG. J. MED. 1184 (1995)

particularly for persons who meet those agencies' financial criteria or are otherwise in their targeted clientele.

As this brief overview suggests, many people may not be appropriate candidates for home care. Individuals who lack informal support networks, or persons whose medical needs require more than a few hours of professional intervention per day, will find that home care does not work well. Still, other older people may resist home care because they do not want strangers coming into their homes, invading their privacy, and making them feel vulnerable. This concern is not trivial. Elder abuse, financial exploitation, and theft of personal assets can flourish in the essentially unsupervised environment of home care.[31] Nevertheless, in the right circumstances, home care can enable an older person to remain at home as long as possible, which is the desire of an overwhelming majority of older people.[32]

Newer technologies are also expanding the population that can be accommodated by home care arrangements. Off-site monitoring of vital signs and other medical indicators, telephonic checks, special alert systems, and even Internet-based services are enabling family members to supervise the care and condition of older relatives who live many miles away.[33] But even these options will not be adequate for some older people.

B. *Assisted Living Facilities*

For persons whose needs cannot be met by home care but who do not require the level of medical attention that a nursing home provides, a mid-level living arrangement called "assisted living" might be appropriate. These planned developments, usually called "assisted living facilities" (ALF), were developed as successors to more traditional "board and care homes" and "continuing care retirement communities" (CCRC). Board and care homes are fairly small, with 25 residents or less, and include foster homes, personal care homes, rest homes, homes for the aged,

(discussing "the effect of annual in-home comprehensive geriatric assessments"). *See generally* KANE ET AL., *supra* note 10, at 143–49.

31. *See* FROLIK, *supra* note 13, ¶ 11.04[6]. *See generally* MARTHA D. NATHANSON & CAREL T. HEDLUND, HOME CARE FRAUD AND ABUSE: CRITICAL QUESTIONS, ESSENTIAL ANSWERS (1999) (discussing abuse and fraud in senior home care situations).

32. FROLIK & KAPLAN, *supra* note 26, at 189 ("According to survey data . . . 86% of older adults want to stay in their current residence as long as possible . . . .").

33. *See* Sue Shellenbarger, *Taking Care of Parents: New High-Tech Links Can Offer Some Relief*, WALL ST. J., Mar. 8, 2000, at B1.

and similarly denominated institutions. The level of care provided at board and care homes is rather basic and rarely extends beyond meal preparation or assistance with certain activities of daily living, such as bathing, toileting, and dressing.[34] Assistance with medication may be available, but it is limited to ensuring that residents take the correct dosage at the correct time.[35] CCRCs, in contrast, represent combination arrangements that typically have senior-oriented independent living apartments and a nursing home at the same location. Although some CCRCs provide assistance with daily activities, especially meals,[36] any significant nursing assistance is almost always provided in the CCRC's nursing home unit.

In the 1990s, major corporations began building assisted living facilities for older people who require some assistance with daily living, but not the full medical complement of nursing homes.[37] Similar in concept to board and care homes, ALFs are generally larger developments, often housing several hundred residents or more. Restaurant-style dining is the norm, and the individual residential apartments often include small kitchenettes. In addition, ALFs have various safety features that address the needs of older adults, such as pull-cords, grab-bars in the bathrooms, and alert systems. Organized social activities, group outings to movies and cultural events, and planned shopping trips are typical as well. Most ALFs offer a range of convenient services on the premises, including a pharmacy, barber and beauty shops, a post office, and a bank or cash machine.[38] Housekeeping and laundry services are usually provided, sometimes for an additional fee.[39] Although some ALF residents have their own automobiles, many residents rely on the ALF's transportation service to go to houses of worship, doctors' offices, and the like.[40]

ALFs generally have formal admission contracts that set forth the conditions of residency in their facilities. These contracts detail which services are included in the monthly fee and

34. *See* FROLIK & KAPLAN, *supra* note 26, at 182.

35. *Id.*

36. FROLIK, *supra* note 13, ¶ 8.02[1][b], at 8-4 to 8-5.

37. *See* ERIC M. CARLSON, LONG-TERM CARE ADVOCACY § 5.07[1] (2006); FROLIK & KAPLAN, *supra* note 26, at 185–88; *see also* NAT'L CTR. FOR ASSISTED LIVING, FACTS AND TRENDS: THE ASSISTED LIVING SOURCEBOOK (2001), *available at* http://www.ahca.org/research/alsourcebook2001.pdf; *Can Your Loved Ones Avoid a Nursing Home?: The Promise and the Pitfalls of 'Assisted Living'*, CONSUMER REPS., Oct. 1995, at 656.

38. *Cf.* FROLIK, *supra* note 13, ¶ 9.06, at 9-11.

39. KANE ET AL., *supra* note 10, at 177.

40. FROLIK & KAPLAN, *supra* note 26, at 187.

which services bear additional charges.[41] This distinction is very important, because the monthly fee itself in 2006 averaged $2,691.20 for a 1-bedroom unit, or $32,294 on an annual basis.[42] Once again, there are wide national and regional differences.[43] Some facilities require that residents be able to eat in the dining room, and residents who cannot do so may be asked to leave the ALF. Similarly, ALFs cater to older people without extensive nursing care requirements.[44] Most ALFs have nurses on staff,[45] but some utilize an on-call nursing service, which is accessed when the need for nursing assistance arises.

Within these constraints, ALFs provide assistance with personal care needs, bathing, and dressing.[46] They can monitor residents' use of prescription drugs and even treat minor health problems.[47] For many older Americans, ALFs become their new bases of operations, with only occasional stays in a hospital or nursing home as circumstances require. In short, ALFs strive to maintain a resident's current functional ability, but they generally do not undertake recuperative or therapeutic measures.

C. *Nursing Homes*

Residential facilities that provide long-term care with a substantial medical component are called nursing homes.[48] Some nursing homes offer very sophisticated medical treatment and common recuperative therapies,[49] such as postoperative rehabilitation following hip replacement. Others provide care for chronic conditions, such as Alzheimer's Disease, that are not expected to improve over time.[50] But all nursing homes have medical and nursing care as their primary mission and provide other services, like meals and housing, incidental to that mission.[51] Nursing personnel are on the premises at all times, although actual patient care is often assigned to nursing assist-

41. *See* FROLIK, *supra* note 13, ¶ 9.07.

42. GENWORTH FINANCIAL, *supra* note 23, at 2.

43. *Id.* at 10–11.

44. *See* FROLIK, *supra* note 13, ¶ 9.04.

45. *Id.* ¶ 9.06, at 9-11.

46. *Id.* ¶ 9.05[1].

47. *Id.* ¶ 9.05[2].

48. *See generally* FROLIK & KAPLAN, *supra* note 26, at 158–78 (discussing the functional and financial aspects of nursing homes).

49. *See* KANE ET AL., *supra* note 10, at 167–69.

50. *Id.* at 169–70; *see also* J.C. Conklin, *Nursing Homes Add 'Special Care'*, WALL ST. J., Aug. 7, 2000, at B1 (discussing the trend among nursing homes to add Alzheimer special care units for financial stability).

51. *See* FROLIK & KAPLAN, *supra* note 26, at 159.

ants and aides.[52] Some nursing homes also provide social programming and group exercise classes geared to the abilities of the residents.

Nursing homes are expensive to operate because they care for very impaired residents. According to the 2006 cost survey cited previously, the average cost of a private room in a nursing home is $194.28 per day or nearly $71,000 per year,[53] and in some parts of the country, it can be much higher.[54] Nevertheless, these facilities are more cost effective than hospitals,[55] which often are the only realistic alternative. Extensive federal and state regulations cover most aspects of operating a nursing home, including the size of rooms, nursing credentials and staff, meal hours and intervals, and medical supervision.[56] Because nursing home residents are often unusually vulnerable,[57] a nursing home resident's "bill of rights" was enacted to guarantee certain basic standards.[58] Included are a patient's right to select her own physician,[59] her right to be free of physical and chemical restraints,[60] her right to privacy,[61] confidentiality of clinical records,[62] and visitation by family and friends.[63]

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52. *See* CARLSON, *supra* note 37, § 2.07; KANE ET AL., *supra* note 10, at 165.

53. GENWORTH FINANCIAL, *supra* note 23, at 2. The average charge for a semi-private room was $171.32 per day or $62,532 per year. *Id.*

54. *See id.* at 6–7.

55. *See* FROLIK, *supra* note 13, ¶ 12.01, at 12-3 (quoting nursing home rates as high as $7,000 per month versus hospital rates of $1,000 or more per day).

56. *See* CARLSON, *supra* note 37, §§ 2.101–.152 (reviewing state regulations of nursing homes); CCH, INC., NURSING HOME REGULATIONS (1995) (reviewing federal regulations of nursing homes); *see also* Senator Charles Grassley, *The Resurrection of Nursing Home Reform: A Historical Account of the Recent Revival of the Quality of Care Standards for Long-Term Care Facilities Established in the Omnibus Reconciliation Act of 1987*, 7 ELDER L.J. 267 (1999) (examining The Omnibus Reconciliation Act of 1987, problems with its enforcement, and nursing home reform efforts).

57. Donna Myers Ambrogi, *Legal Issues in Nursing Home Admissions*, 18 L. MED. & HEALTH CARE 254, 255 (1990).

58. 42 U.S.C. §§ 1395i-3, 1396r (2000). *See generally* FROLIK & KAPLAN, *supra* note 26, at 169–78.

59. 42 U.S.C. §§ 1395i-3(c)(1)(A)(i), 1396r(c)(1)(A)(i); 42 C.F.R. § 483.10(d)(1) (2005).

60. 42 U.S.C. §§ 1395i-3(c)(1)(A)(ii), 1396r(c)(1)(A)(ii); 42 C.F.R. § 483.13(a).

61. 42 U.S.C. §§ 1395i-3(c)(1)(A)(iii), 1396r(c)(1)(A)(iii); 42 C.F.R. § 483.10(e)(1).

62. 42 U.S.C. §§ 1395i-3(c)(1)(A)(iv), 1396r(c)(1)(A)(iv) (2000); 42 C.F.R. § 483.10(e)(2) (2005).

63. 42 U.S.C. §§ 1395i-3(c)(3)(B)–(C), 1396r(c)(3)(B)–(C); 42 C.F.R. § 483.10(j)(1)(vii)–(viii).

In the context of long-term care, nursing homes are first and foremost medical institutions. That fact explains many of the operational requirements that are imposed on nursing homes. For example, a nursing home must assess each new resident's functional abilities and limitations within 14 days of admission.[64] The facility must then prepare a written plan for that person's care[65] and it must update this plan at least once a year or whenever a resident's condition changes significantly.[66] Patients must also be under the supervision of a physician or other medical professional[67] in accordance with state law.

II. MEDICARE AND LONG-TERM CARE

This section examines the financing of long-term care by Medicare, the federal government's health care program for older Americans.[68] Anyone who is at least 65 years old and meets certain work requirements is entitled to benefits under this program.[69] Eligibility is also extended to the spouse of a covered worker and to a divorced spouse as well, if their marriage lasted at least 10 years.[70] As a result of these rather expansive eligibility criteria, most older Americans are covered by Medicare.[71]

Medicare's coverage of long-term care is limited to home health visits[72] and "skilled nursing facilities,"[73] commonly called nursing homes. Each of these coverages, moreover, is subject to

64. 42 U.S.C. §§ 1395i-3(b)(3)(A), (C)(i)(I), 1396r(b)(3)(A), (C)(i)(I); 42 C.F.R. § 483.20(b)(2)(i).

65. 42 U.S.C. §§ 1395i-3(b)(2), 1396r(b)(2); 42 C.F.R. § 483.20(d).

66. 42 U.S.C. §§ 1395i-3(b)(3)(C)(i)(II)–(III), 1396r(b)(3)(C)(i)(II)–(III); 42 C.F.R. § 483.20(b)(2)(ii)-(iii).

67. 42 U.S.C. §§ 1395i-3(b)(6)(A), 1396r(b)(6)(A); 42 C.F.R. § 483.40(a)(1).

68. *See* 42 U.S.C. §§ 1395–1395ccc. *See generally* CENTER FOR MEDICARE ADVOCACY, INC., 2005–2006 MEDICARE HANDBOOK (Judith A. Stein & Alfred J. Chiplin, Jr. eds., 2006) (discussing Medicare in depth) [hereinafter MEDICARE HANDBOOK].

69. 42 U.S.C. § 1395c(1) (2000). The relevant work requirement is earning at least 40 "quarters of coverage" as that phrase is applied to establish eligibility for retirement benefits under Social Security. *See* FROLIK & KAPLAN, *supra* note 26, at 283–88.

70. FROLIK & KAPLAN, *supra* note 26, at 57–58.

71. Medicare also covers individuals who are younger than 65 years old if they have received disability benefits from Social Security for at least 24 months or have been diagnosed with "end stage renal disease." FROLIK & KAPLAN, *supra* note 26, at 59. But the vast majority of Medicare enrollees are at least 65 years old; therefore Medicare will be considered in this article from their perspectives.

72. *See generally* FROLIK & KAPLAN, *supra* note 26, at 71–73 (reviewing Medicare's home health coverage); MEDICARE HANDBOOK, *supra* note 68, §§ 4.01–.04 (describing home health coverage under Medicare).

several significant preconditions and restrictions, which are considered below. In other words, Medicare addresses only the 2 extremes in the long-term care continuum—home care and nursing homes—and not assisted living or any other alternatives.

A. *Home Care*

Medicare provides a range of home health services to enrollees who are confined to their homes.[74] Eligibility is restricted, however, to persons who require assistance from other people or who need wheelchairs, walkers, or canes to leave their homes.[75] The covered services include physical and occupational therapy,[76] medical supplies,[77] and "part-time or intermittent" nursing care.[78] This last phrase is defined as care of less than 8 hours a day and no more than 28 hours per week.[79] Thus, Medicare does not cover around-the-clock, or even all-day, in-home care.

For Medicare's coverage to apply, the nursing care must be provided or supervised by a registered professional nurse.[80] The services of home health aides can be covered as well, if a physician orders services that do not require a licensed nurse's skills.[81] In any case, the care must be provided by a Medicare-certified home health agency[82] pursuant to a written plan of care established by a physician,[83] and that physician must review the plan at least once every 60 days.[84] Thus, informal caregiving by friends, relatives, or even paid "helpers" is not covered by Medicare.[85]

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73. *See generally* FROLIK & KAPLAN, *supra* note 26, at 68–71 (reviewing coverage for nursing facilities under Medicare Part A); MEDICARE HANDBOOK, *supra* note 68, §§ 3.01–.03 (describing Medicare Part A coverage for nursing facilities).

74. 42 U.S.C. §§ 1395f(a)(2)(C), 1395n(a)(2)(A) (2000).

75. *Id.* §§ 1395f(a)(2)(C), 1395n(a)(2).

76. *Id.* § 1395x(m)(2).

77. *Id.* § 1395x(m)(5). Included are catheters and ostomy bags. *Id.*

78. *Id.* § 1395x(m)(1).

79. *Id.* § 1395x(m) (penultimate sentence).

80. *Id.* § 1395x(m)(1).

81. *Id.* § 1395x(m)(4). *See also* H. Gilbert Welch et al., *The Use of Medicare Home Health Care Services*, 335 NEW ENG. J. MED. 324, 328 (1996) (noting that home health aides account for almost half of Medicare's home health care visits).

82. 42 U.S.C. §§ 1395x(m), (o) (2000). *See generally* Brian E. Davis, *The Home Health Care Crisis: Medicare's Fastest Growing Program Legalizes Spiraling Costs*, 6 ELDER L.J. 215, 221–29 (1998).

83. 42 U.S.C. § 1395x(m).

84. 42 C.F.R. § 484.18(b) (2005).

85. Additional limitations under Medicare Part A include a preceding hospital or nursing home stay within fourteen days of beginning home health services and a cumulative limit of 100 visits. But if Part A's requirements are not

In summary, Medicare's coverage of home health care is based on a medically oriented model that only incidentally strives to maintain a senior citizen in his or her home. On average, this coverage is limited to only 4 hours of assistance per day[86] and requires ongoing coordination with a supervising agency and a physician. This coverage is not what most people think of when they envision home care.

B. *Nursing Homes*

Medicare covers care in a skilled nursing facility (SNF),[87] but only under 4 conditions, all of which must be met. Even then, Medicare's coverage is essentially limited to 100 days. This section will examine first the 4 preconditions for Medicare coverage and then the limitation on duration of stay.

1. Conditions for Coverage

First, the specific nursing facility must be approved by Medicare.[88] This status means that the facility meets various standards concerning quality of care, staff training, residents' rights, and similar matters. In addition, the facility must agree to accept Medicare's stipulated charges for the services that it provides. Most SNFs are approved by Medicare, so this particular requirement is not terribly restrictive in practice.

Second, a patient must be admitted to the SNF within 30 days of being discharged from a hospital.[89] If a patient goes to a SNF from his or her residence without this prior hospitalization, Medicare will not pay for the nursing home expenses incurred. In this regard, one commentator noted that "two-thirds of those who enter a nursing home are not coming from a hospital,"[90]

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satisfied, then Medicare Part B will cover the home health services anyway. If the patient in question does not have Medicare Part B, then the services are provided by Part A. *See* 42 U.S.C. § 1395d(a)(3); *see also* MEDICARE HANDBOOK, *supra* note 68, § 4.02[B]–[C] (explaining the requirements and limitations of Medicare Part A and Part B).

86. *See* 42 U.S.C. § 1395x(m) (2000) (penultimate sentence) (noting that Medicare generally limits home health services to 28 hours per week, which translates into an average of 4 hours per day for a 7 day week).

87. *See* 42 U.S.C. § 1395i-3(a) (defining "skilled nursing facility").

88. *See* FROLIK & KAPLAN, *supra* note 26, at 68.

89. 42 U.S.C. § 1395x(i)(A); 42 C.F.R. § 409.30(b)(1) (2005). Admissions to a SNF that occur more than 30 days after discharge from the hospital can be covered if it would not have been "medically appropriate" to begin SNF care during the 30 days immediately following discharge from the hospital. 42 U.S.C. § 1395x(i)(B); 42 C.F.R. § 409.30(b)(2).

90. Nathalie D. Martin, *Funding Long-Term Care: Some Risk-Spreaders Create More Risks Than They Cure*, 16 J. CONTEMP. HEALTH L. & POL'Y 355, 373 (2000).

which means that for the majority of nursing home residents, Medicare has no direct financial role.

Third, the required hospital stay must last at least 3 days,[91] not counting the day of discharge.[92] Thus, a trip to a hospital emergency room that does not require further hospital attention fails to satisfy this requirement. Likewise, an overnight stay in the hospital for observation does not meet this requirement.[93] In 1983, the federal government instituted a diagnosis-related groupings (DRG) program that effectively reduced the number of hospital days that Medicare would cover for many specified medical conditions.[94] The 3-day rule for SNF coverage, however, was *not* altered at that time to reflect the new DRG rules. As a consequence, a Medicare enrollee's hospital stay is increasingly likely to not meet the 3-day standard that Medicare requires for coverage of nursing home costs.

Finally, a patient must require "skilled nursing care" that only a SNF can provide.[95] Examples of such care include gastronomy feedings, catheterization, administration of medical gases, injections, and other procedures involving technical and professional personnel.[96] These services must be needed on a daily basis[97] to treat a condition that was treated during the preceding hospital stay.[98] Thus, even if a resident went to a hospital before going to the SNF, Medicare will cover the costs of the SNF only if that patient receives fairly intensive medical care in the SNF as a follow-up to the hospital stay in question.[99] This requirement effectively precludes most nursing home residents

91. 42 U.S.C. § 1395x(i).

92. 42 C.F.R. § 409.30(a)(1).

93. *See* Soc. Sec. Rul. 69-63, *reprinted in* [1969–1972 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 26,066 (noting that a hospital stay of 2 days did not qualify subsequent SNF charges for Medicare coverage).

94. 42 U.S.C. § 1395ww(d) (2000). The DRG system establishes a fixed dollar amount that Medicare pays for each of approximately 500 different diagnoses. *See* RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 159–61 (1997). As daily hospital rates rise, the effect of the DRG system is to reduce the number of hospital days that Medicare will cover. *See* KANE ET AL., *supra* note 10, at 35.

95. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b)(3) (2005).

96. 42 C.F.R. §§ 409.33(a)–(c), 409.31(a)(2).

97. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. §§ 409.31(b), 409.34(a)(1).

98. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b)(2)(ii).

99. Medicare does, however, cover costs for a condition that first arose in the SNF, if the patient was being treated in the SNF for a condition that arose during a preceding hospital stay. 42 U.S.C. § 1395f(a)(2)(B).

from Medicare coverage because their conditions do not necessitate this level of care.[100]

2. Duration-of-Stay Limitation

Even if a patient otherwise qualifies for Medicare coverage of SNF expenses, that coverage is not unlimited. Medicare pays the entire cost of the SNF for only 20 days in a "spell of illness."[101] A "spell of illness" is the period that begins with the patient's admission to the nursing home and ends when the patient has been out of a hospital, SNF, or other rehabilitative facility for 60 consecutive days.[102] In the context of long-term care, therefore, an admission into a SNF typically constitutes a single "spell of illness." As a result, Medicare's full coverage of long-term care in a SNF is generally no more than 20 days.

After these 20 days, Medicare covers the cost of the SNF for the next 80 days subject to a per-day deductible.[103] This per-day deductible remains the patient's responsibility and is adjusted annually for inflation. For 2006, this deductible was $119 per day.[104] In other words, if Medicare covers a nursing home stay at all, it pays all costs for the first 20 days and those costs in excess of the per-day deductible for the next 80 days. After the 100th day, Medicare's coverage ceases.[105]

C. *Medicare Managed Care*

In the context of long-term care, Medicare health maintenance organizations (HMOs) do not really provide any help. Medicare HMOs offer a variety of benefits, including prescription drugs outside a hospital setting, eyeglasses, hearing aids, and simplified paperwork.[106] These are all major benefits, although coverage for outpatient pharmaceuticals is now available with traditional Medicare through a stand-alone Medicare Part D

100. *See* Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL. L. REV. 777, 795 (1998).

101. 42 U.S.C. §§ 1395d(a)(2)(A), 1395e(a)(3).

102. 42 U.S.C. § 1395x(a)(2) (2000); 42 C.F.R. § 409.60(b) (2005).

103. 42 U.S.C. § 1395e(a)(3).

104. CENTERS FOR MEDICARE & MEDICAID SERVICES, MEDICARE & YOU 102 (2007), *available at* http://www.medicare.gov/publications/pubs/pdf/10050.pdf.

105. 42 U.S.C. § 1395d(b)(2).

106. *See* FROLIK & KAPLAN, *supra* note 26, at 104; Nancy Ann Jeffrey, *Sign of the Times: Medicare Users Turn to HMOs*, WALL ST. J., Oct. 20, 1995, at C1; Melynda Dovel Wilcox, *Choosing a Medicare HMO*, KIPLINGER'S PERS. FIN. MAG., Aug. 1996, at 73, 74.

plan, but these arrangements first became available this year.[107] The point remains that Medicare HMOs generally do not expand Medicare's rather restricted coverage of long-term care, regardless of the specific setting in which that care is provided.

The newest Medicare options are also essentially of no benefit with respect to long-term care either. Collectively denominated Medicare Part C,[108] these arrangements include variations on Medicare HMOs, such as provider-sponsored organizations, preferred provider organizations, church-based "fraternal benefit societies," and the like.[109] These alternatives have many intriguing and convoluted features,[110] but they all represent different approaches to delivering Medicare's traditional package of services[111] and do not extend Medicare's woefully limited coverage of long-term care.[112]

D. *Supplemental Medigap Insurance*

To fill some of Medicare's gaps and limitations, a private insurance product called "Medigap" has been developed.[113] Medigap policies receive no government funding, and patients bear the entire cost of the premiums. These policies come in 14 different packages, with ranges of benefits that correspond roughly to premium charges.[114] But with respect to home care, the only Medigap benefit applies exclusively to situations in

107. *See generally* Richard L. Kaplan, *The Medicare Drug Benefit: A Prescription for Confusion*, 1 NAT'L ACAD. ELDER L. ATT'YS J. 167 (2005).

108. *See* 42 U.S.C. § 1395w-21.

109. *See* FROLIK & KAPLAN, *supra* note 26, at 106–07.

110. *See* Karen Visocan, *Recent Changes in Medicare Managed Care: A Step Backwards for Consumers?*, 6 ELDER L.J. 31, 45–48 (1998); *see also* MEDICARE HANDBOOK, *supra* note 68, § 7.04[C] (discussing alternative options for financing Medicare covered services); JOHN J. REGAN ET AL., TAX ESTATE & FINANCIAL PLANNING FOR THE ELDERLY § 9.17 (2005) (same). *See generally* DAVID A. PRATT & SEAN K. HORNBECK, SOCIAL SECURITY AND MEDICARE ANSWER BOOK 19-1 to 19-37 (Supp. 2006) (discussing Medicare Part C options, rules, and features).

111. 42 U.S.C. § 1395w-22(a)(1)(A) (2000).

112. Funds in a "medical savings account" (MSA), however, may be used to pay premiums on a long-term care insurance policy. *See* I.R.C. §§ 138(c)(1), 220(d)(2)(B)(ii)(II), 7702B(b) (2000). But MSA holders face an annual deductible of up to $6,000 before their medical costs are covered. *See* 42 U.S.C. § 1395w-28(b)(3)(B). Accordingly, it is unlikely that an MSA holder would use MSA funds to pay for long-term care insurance when more immediate financial exposure looms in the form of the annual deductible.

113. *See generally* FROLIK & KAPLAN, *supra* note 26, at 95–103 (describing private Medigap insurance).

114. 12 packages, labeled A through L, are available, but plans F and J come in 2 different versions, one with, and the other without, an annual deductible. Accordingly, a total of 14 different Medigap policies exist. *See id.* at 95–98.

which the patient is already receiving Medicare-covered home health services.[115] In that circumstance, this benefit includes assistance with activities of daily living, such as dressing, bathing, and personal hygiene, for up to 8 weeks, with a dollar limit of $1,600 per year.[116] As a result, this feature really does not help someone who has an ongoing need for in-home care.

With respect to nursing home care, the only pertinent Medigap benefit is coverage of the per-day deductible in a SNF for days 21 through 100.[117] This feature is available in the more comprehensive Medigap policies and enables a patient to insure against this particular expense. It must be noted, however, that Medigap policies do not change any of the other Medicare SNF requirements, such as a preceding hospital stay of at least 3 days or the receipt of "skilled nursing care." Nor do these policies extend beyond day 100.[118] Thus, Medigap insurance plays a fairly limited role in the nursing home context—namely, covering the per-day deductible for up to 80 days in a nursing home stay that otherwise qualifies for Medicare coverage. Medigap policies do not go beyond that specific coverage.

III. ALLOCATING RESPONSIBILITY FOR FINANCING LONG-TERM CARE

Given the deficiencies examined above, this article proposes that the United States approach to financing long-term care be restructured to recognize the fundamental difference between medically-oriented services and more residential and social settings for such care. Under this restructuring, our society's health care program for older Americans—Medicare—would cover all care provided in nursing homes, but long-term care provided in other settings would remain a private responsibility. In fashioning this distinction, this proposal enables Medicare to better fulfill its intended role of covering the cost of serious medical care, while recognizing that the responsibility of arranging less medically-oriented types of long-term care is best handled by families.

115. *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE 47 (2006), *available at* http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf [hereinafter MEDIGAP GUIDE].

116. *Id.* This benefit, moreover, is available only in plans D, G, I, and J.

117. *Id.* at 46. This option is available in Medigap plans C–J. A similar benefit is available in Plans K and L, but it would pay only 50% and 75%, respectively, of the patient's daily co-payment obligation. *Id.* at 21.

118. MEDIGAP GUIDE, *supra* note 115, at 46.

A. *Nursing Homes*

Medicare's coverage of nursing home stays should be expanded by eliminating the requirement that a hospital stay precede a nursing home admission[119] and the limitation that Medicare covers only "skilled nursing care,"[120] and also by changing the length of a covered nursing home stay.[121] This section considers the rationale for these recommendations and their implications.

1. Eliminating the Need for a Preceding Hospital Stay

Many older Americans are admitted to nursing homes directly from their personal residences. Often, a visiting relative or friend notices that the older person is no longer able to live independently or is endangering her health in some way. For example, the older person may be skipping meals, leaving stoves or irons turned on, or otherwise engaging in potentially dangerous activities. In such circumstances, a nursing home placement may be appropriate, even though there is no need to go to a hospital.

At other times, an older person might go to a hospital before being admitted to a nursing home, but the hospital stay does not meet the 3-day requirement that Medicare demands.[122] Indeed, the ratcheting down of approved hospital stays by the Diagnostic Range Groupings (DRG) program makes this situation increasingly likely.[123] A typical example of this situation might involve an older person who suffered a bad fall and was rushed to the emergency room of a nearby hospital. There, X-rays were taken and various diagnostic tests were run, but the results showed that no bones were fractured. Consequently, the older person was released and sent home, or perhaps kept overnight for observation and then sent home the following morning. In either situation, the older person may be experiencing considerable pain and cannot cope on her own. She probably requires a nursing home or other convalescent facility for recuperative therapy and treatment. Nevertheless, her failure to meet Medicare's 3-day hospital stay requirement precludes coverage of these nursing home expenditures under current law.

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119. 42 U.S.C. § 1395x(i)(A) (2000); *see supra* text accompanying notes 89–94.

120. 42 U.S.C. § 1395f(a)(2)(B); *see supra* text accompanying notes 95–100.

121. 42 U.S.C. §§ 1395d(a)(2), 1395e(a)(3).

122. 42 U.S.C. § 1395x(i) (2000).

123. *See* EPSTEIN, *supra* note 94.

Eliminating the preceding hospital stay requirement would enable Medicare to cover the older person's nursing home costs in each of the scenarios set forth above. Moreover, this change would recognize that nursing home stays are increasingly used as substitutes for hospital stays, because medical care that previously could be provided only in a hospital can now be delivered in a nursing home. Extending Medicare's coverage to nursing homes, therefore, simply reflects recent developments in postoperative care and related aspects of medicine. In fact, some nursing home stays are a direct result of Medicare's budget-oriented DRG policy, which discharges hospital patients "quicker-and-sicker."[124] That is, when patients are released before they can cope at home, they often enter nursing homes to receive the care that they previously would have received in a hospital.[125] Accordingly, Medicare has a moral imperative to pay for nursing home stays that result from DRG-shortened hospital stays.

Be that as it may, the bottom line is that the existing requirement of a prior hospital stay for Medicare nursing home coverage should be discontinued. People enter nursing homes primarily for medical reasons, and there is no sound basis on which to discriminate between hospital coverage and nursing home coverage in many situations affecting Medicare enrollees. The requirement of a preceding hospital stay is increasingly a relic of the mid-1960s that no longer makes sense.

2. Eliminating the Skilled Care Limitation

Nursing homes today care for an increasing number of Americans whose cognitive skills have deteriorated. Indeed, some institutions have special units called "Alzheimer's Centers," which provide a wide range of services to maximize the cognitive capabilities of patients who are suffering from this disease and whose condition is not expected to improve.[126] In fact, for some nursing homes, such care is the predominant service provided, especially with regard to patients who have been in these facilities more than a year.[127] Almost none of this care is covered by Medicare because such care does not meet Medicare's requirement of "skilled nursing care."[128] The result of this limitation is that the Medicare program discriminates on the basis of disease: care required by a physical disability may be provided in a hospital or

124. KANE ET AL., *supra* note 10, at 35.
125. *See id.*
126. *See* Conklin, *supra* note 50.
127. *See id.*
128. 42 C.F.R. § 409.33(a)-(c) (2005). Moreover, Medicare does not pay for "custodial" care. 42 U.S.C. § 1395y(a)(9) (2000); 42 C.F.R. § 411.15(g).

"skilled" nursing unit, the costs of which Medicare will cover, while care required by a mental or cognitive impairment may be provided in a non-"skilled" nursing home, and Medicare will not cover those costs.

This distinction between skilled care and nonskilled care is a trap for the unwary that most nonmedical people find difficult to fathom and impossible to justify.[129] Consider the reaction when the family of Aunt Florence learns that Medicare will not pay to care for her Alzheimer's Disease, while Medicare covered her friend's care for emphysema. This stench of arbitrariness is further aggravated when one considers the pathogenic causation of the maladies affecting Aunt Florence and her friend. That is, there are no agreed-upon lifestyle factors, such as smoking, that might have precipitated Aunt Florence's cognitive impairment, in contrast to her friend's emphysema. In other words, Medicare currently pays to treat medical conditions that might have been prevented, but does not pay for care necessitated by medical conditions over which the patient had no control. The policy rationale for this dichotomy eludes most people.

Medicare essentially socializes the risk of enormous medical expenses in the hospital context, and it should do so in the nursing home context as well. There is no reason to condition a person's exposure to the financially ruinous costs of essentially medical care on the specific setting in which that care is administered. Accordingly, the skilled care limitation should be repealed and Medicare should cover the cost of nursing home care, regardless of the level of care that a patient requires.

3. Changing the Duration-of-Stay Limitation

In the context of long-term care, Medicare's current limit on the length of a nursing home stay cannot stand. A total of 20 days at full coverage and 80 additional days at partial coverage is inadequate for chronic care.[130] Precisely where the new limit should be is unclear. Three-quarters of older people's nursing home stays are less than 3 years,[131] but the longer stays are obviously the most expensive. Perhaps the best approach is to replicate Medicare's coverage of hospital stays—namely, a limit that

129. *See* CARLSON, *supra* note 37, § 8.05[3][a][i], at 8-18 (2006) (stating that "[t]he average resident or family member understandably believes that *every* resident of a nursing facility receives 'skilled' care . . . .").

130. 42 U.S.C. §§ 1395d(a)(2)(A), 1395e(a)(3) (2000). These limits pertain to a "spell of illness." *See supra* text accompanying notes 126–30.

131. Computation by author based on data in ALBERT NORMAN ET AL., LONG TERM CARE INSURANCE: A PROFESSIONAL'S GUIDE TO SELECTING POLICIES 9 (3d ed. 1995).

covers almost all stays, with a significant co-payment requirement for the latter portion of that limit.[132] Medigap insurance could then cover the required co-payment and even provide additional nursing home days as it does currently for hospital care.[133] In any case, the length of a nursing home stay that Medicare covers must be changed to reflect the realities of long-term care in today's America.

B. *Other Long-Term Care Settings*

For several important reasons, Medicare should probably not be extended to long-term care settings other than nursing homes. First, there is the significant problem of induced demand called moral hazard or the "woodwork effect."[134] This concern suggests that if a third-party payer, like Medicare, covers a service that was previously not covered, then potential claimants will come out of the woodwork, and the program will collapse from its own weight. With respect to nursing homes, there might be some increased demand if Medicare covered the cost of these facilities, but the overall impact will likely be limited.[135] After all, the decision to place a loved one in a nursing home is usually very traumatic quite apart from the related financial considerations.[136]

Long-term care settings other than nursing homes, however, are seen as more appealing, and the possibility of induced demand could therefore be much more significant. In fact, when Medicare's standards for covering home health care were made less restrictive by the 1988 decision in *Duggan v. Bowen*,[137] the demand for home health care rose dramatically.[138] Moreo-

132. *See generally* FROLIK & KAPLAN, *supra* note 26, at 66–67. The National Academy of Elder Law Attorneys has recommended a long-term care benefit that consists of an inflation-indexed number of dollars, which would be subject to a deductible of $10,000 and a 20% co-payment requirement. NAT'L ACAD. OF ELDER LAW ATT'YS, WHITE PAPER ON REFORMING THE DELIVERY, ACCESSIBILITY AND FINANCING OF LONG-TERM CARE IN THE UNITED STATES 21 (2000).

133. *See* MEDIGAP GUIDE, *supra* note 115, at 18.

134. Marshall B. Kapp, *Options for Long-Term Care Financing: A Look to the Future*, 42 HASTINGS L.J. 719, 734 (1991).

135. *See id.* at 734 n.109.

136. *See* CARLSON, *supra* note 37, § 3.02[1]; *see also* KANE ET AL., *supra* note 10, at 164–65 (noting that nursing homes often involve "sharing rooms with successions of not necessarily compatible strangers, crowded conditions, rigid routines, patronizing attitudes, healthful but unappetizing meals presented unattractively"); 1 PETER J. STRAUSS ET AL., AGING AND THE LAW ¶ 2409, at 3007 (general ed. 1999) (discussing the emotional difficulty of placing a loved one in a nursing home).

137. 691 F. Supp. 1487 (D.D.C. 1988).

138. *See* Davis, *supra* note 82, at 230–32.

ver, many elders and their families are genuinely attracted to assisted living facilities (ALF) and continuing care retirement communities (CCRC).[139] These facilities offer companionship, entertainment opportunities, and convenience, all in relatively modern settings. The image they convey is of "places to live,"[140] drawing an implicit—if somewhat unfavorable—distinction with nursing homes. As a result, if Medicare covered ALFs or CCRCs, then the increased demand might well be overwhelming.

Second, arranging for long-term care in settings other than nursing homes is usually done with considerable care and planning. Typically, there is a lengthy process of interviews, reference checks, site inspections, and cost comparisons to determine the best environment for the particular elder. In contrast, a nursing home admission is often arranged at the behest of a hospital discharge planner with only a few days warning, if even that.[141] Thus, there is less need for Medicare to relieve the anxiety of sudden and unanticipated expenditures in the context of long-term care settings other than nursing homes.

Finally, Medicare has no current involvement with congregate living arrangements,[142] other than the nursing care units within CCRCs.[143] These arrangements, after all, are primarily residential and social facilities with much less attention to medical matters than nursing homes typically provide.[144] While these facilities are subject to various state statutes,[145] state provisions tend to focus on the financial aspects of congregate living arrangements, consumer protection, and the like.[146] Extending Medicare coverage to these facilities, therefore, would require new federal regulations appropriate to the particular features of these facilities.

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139. Melynda Dovel Wilcox, *Not a Place to Sit and Watch the Traffic*, KIPLINGER'S PERS. FIN. MAG., June 1996, at 62, 63.

140. *See, e.g.*, Aïda Rogers, *Continuing Care Retirement Communities: "You're Not Going There to Die; You're Going There to Live"*, SHEPARD'S ELDER CARE/LAW NEWSL., Dec. 1991, at 7; Wilcox, *supra* note 139, at 68–69.

141. *See* CARLSON, *supra* note 37, § 3.02[1], at 3-7.

142. FROLIK, *supra* note 13, ¶¶ 8.09[1], 9.08[2].

143. *See* 42 U.S.C. §§ 1395i-3, 1396r (2000), *added by* Nursing Home Reform Law, Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, §§ 4201–4218, 101 Stat. 1330, 1330-160 to 1330-221; *see also* 42 C.F.R. §§ 483.5–.75 (2005) (discussing the requirements for long-term care facilities). *See generally* 1–6 Medicare and Medicaid Guide (CCH) (on file with author).

144. *See generally supra* text accompanying notes 34–47.

145. CARLSON, *supra* note 37, §§ 5.101–5.152 (addressing state statutes on assisted living facilities), and §§ 6.101–6.152 (addressing state statutes on continuing care retirement communities).

146. *See* Michael D. Floyd, *Should Government Regulate the Financial Management of Continuing Care Retirement Communities?*, 1 ELDER L.J. 29, 33 (1993).

All these considerations underscore the key role of nursing homes in this country's health care system and suggest why they are fundamentally different from other long-term care settings. In brief, nursing home care often substitutes for hospital care, but other long-term care settings typically take the place of family-provided care. Accordingly, Medicare should cover the cost of nursing homes but leave the responsibility for other long-term care arrangements with the families of the older persons involved.

CONCLUSION

The provision of long-term care is an increasingly important societal concern as more Americans live long enough to require assistance with their daily routines. This Article proposes that all nursing home costs be covered by Medicare, the government's health care system for older Americans. By treating these costs as it does hospital expenses, Medicare would better fulfill retirees' reasonable expectations that their substantial medical expenditures will be covered by this program. Care in nonmedically-oriented settings, however, would remain a private obligation. This balanced approach best allocates the responsibility for long-term care among families and society at large, enabling all involved to honor our parents in their declining years.