

NURSING HOMES: STATUS-BASED EVICTIONS AND THE MEDICAID CRISIS

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From their inception, the Nursing Home Resident Protection Amendments of 1999 have had a questionable effect on both nursing homes and their patients. Despite their admirable goal of protecting our nation's elderly from evictions based solely on the source of payment, the amendments have proven to be quite controversial and arguably ineffective. In this note, Cori Brown examines both the events leading up to the passage of these amendments as well as the impact they have had on the nursing home community. In doing so, she considers both the intended and actual results of the amendments. She concludes that in order to carry out in full the amendments' stated purpose, they must be redesigned to close a loophole which continues to allow for the eviction of Medicaid residents.

I. Introduction

You are ninety-three years old, suffer from severe dementia, and rely on feeding and oxygen tubes for daily

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sustenance.¹ After being dislocated for one year due to your nursing home's renovations, you are settling back into your surroundings.² Then your nursing home sends you a letter—they are renovating again, they tell you, and “need to discuss placement options outside of this facility.”³ The same day you get a second letter—a “Notice of Transfer or Discharge,” claiming that you are a danger to the safety of other residents, and must be relocated immediately.⁴ Confused and worried, your daughter starts talking to other residents and finds out that while part of the nursing home is being closed temporarily, private-pay residents are being offered rooms on other floors, while Medicaid residents, like yourself, are being discharged.⁵ Your daughter talks to one of your nursing home's administrators, explains that this nursing home is the only one close enough for the family to visit, because they do not have a car, and pleads for a room on another floor.⁶ The administrator answers that she does not make these decisions, that a team was sent down from the corporate office to handle the relocations, and that the only person in the area you can talk to is in a meeting.⁷ Frustrated, you come back the next day to talk to this other administrator.⁸ She gives you the same answer—that a corporate team is making these decisions and, moreover, that there are no

1. 145 CONG. REC. S2096, S2103 (daily ed. Mar. 2, 1999) (statement of Sen. Graham) (describing the Mongiovi's situation); Lindsay Peterson, *Nursing Home Backs Down, Apologizes*, TAMPA TRIB., Apr. 10, 1998, at 1 (describing the physical condition of Adelaida Mongiovi, an evicted resident of the Rehabilitation and Health Care Center of Tampa, a Vencor nursing home. Adelaida's son, Nelson Mongiovi, was a prime advocate for the Nursing Home Resident Protection Amendments of 1999) [hereinafter *Nursing Home Backs Down*].

2. *The Nursing Home Resident Protection Amendments of 1999: Hearing on H.R. 540 Before the Subcomm. on Health & Env't of the Comm. on Commerce*, 106th Cong. 33–34 (1999) (statement of Nelson Mongiovi, son of Adelaida Mongiovi, an evicted resident of the Rehabilitation and Health Care Center of Tampa) [hereinafter *Hearings*].

3. *Id.* at 35.

4. *Id.*

5. *Id.* at 10 (“Half of the people in nursing homes today who rely upon the Medicaid Program entered that nursing home paying out of their own pockets.”) (statement of Rep. Davis, cosponsor of the amendments). “Sixty-three percent of nursing home residents who enter a nursing home do so as a private pay patient and exhaust their personal savings in just thirteen weeks, and eighty-seven percent of them exhaust their savings in just [thirty-six] weeks.” 145 CONG. REC. H1029, H1031 (daily ed. Mar. 9, 1999) (statement of Rep. Davis).

6. *Hearings*, *supra* note 2, at 35.

7. *Id.* at 36.

8. *Id.*

available phone numbers or names for any of the corporate team members.⁹

Scared for your safety and believing that the number of Medicaid patients being evicted from this home would cause a shortage of beds in the area's other homes, your daughter spends the next few days visiting every nearby home, hoping for an opening.¹⁰ All homes reply in the same general manner—that “face sheets” have been sent to them on all of the evicted Medicaid patients, and either no Medicaid beds are available, or the home is evaluating and selecting which of the patients will be offered one of the few open Medicaid beds.¹¹ Meanwhile, your daughter is calling all interested regulatory bodies to inform them of the situation and ask for help.¹² They all respond in the same way—saying, “If the State approved it, then there is nothing that can be done about it,” or “we will check into the matter for you.”¹³ The above is the story of Adelaida Mongiovi, a ninety-three-year-old nursing home resident, and fifty-two other residents who were evicted from a Vencor facility because they were on Medicaid.

In the wake of press coverage of the situation, only eight days after first being notified of the new renovations,¹⁴ residents were being kicked out of the home.¹⁵ The situation was “utter chaos,” “residents were crying hysterically,” and families were devastated.¹⁶ At the end of the day, the risk of death tripled for the fifty-three patients evicted, the result of a phenomenon called “transfer trauma.”¹⁷

9. *Id.*

10. *Id.* at 37–38.

11. *Id.*; see also 145 CONG. REC. S2096, S2104 (daily ed. Mar. 2, 1999) (letter from National Senior Citizens Law Center, explaining that many nursing homes deny care to Medicaid residents by certifying only a small number of “Medicaid beds” and telling prospective residents that “no Medicaid beds are available”). *But see Hearings, supra* note 2, at 27 (statement of Mr. Michael Hash, Deputy Administrator, Health Care Financing Administration, claiming that “if there are waiting lists or shortages of beds for nursing facilities, they are isolated . . . [that] it’s not a systemic problem”).

12. *Hearings, supra* note 2, at 38.

13. *Id.*

14. Nursing homes that wish to decrease the number of beds available must give thirty days notice to the state and all affected residents. *Id.* at 19.

15. *Id.* at 35, 38–39 (statement of Nelson Mongiovi, reciting the timeline of events including the date of the first letter describing the new renovations—March 30, 1998—the press coverage, and the day residents were being moved out of the facility—April 7, 1998).

16. *Id.* at 38–39.

17. 145 CONG. REC. S2096, S2103 (daily ed. Mar. 2, 1999) (statement of Sen. Graham).

Out of desperation, some of the families, including the Mongiovis, went to lawyers.¹⁸ Circuit Judge Gregory Holder issued a temporary injunction against the nursing home, requiring it to cease the evictions of the remaining residents.¹⁹

These evictions were not isolated incidents; Vencor Nursing Homes, Inc., the home responsible for the above story, had withdrawn all of its 310 facilities from the Medicaid program and had begun evictions in at least one other home.²⁰ In addition, similar evictions were attempted at thirteen non-Vencor homes in nine states.²¹ Some feared an epidemic.²²

What followed was a legislative freight train. Within fifty days, a resolution forbidding what Vencor and others did was introduced in the Federal House of Representatives. It gained sixty cosponsors, passed by a 398 to twelve vote, was received in the Senate where it passed unanimously and without amendment, and was signed by President Clinton.²³ The resolution, entitled the Nursing Home Resident Protection Amendments of 1999 (NHRPA), an addition to Title XIX of the Social Security Act, prohibited a home that opted out of Medicaid from evicting current Medicaid residents and required homes to give notice to prospective residents that the home would not accept Medicaid.²⁴ The law itself is unremarkable, as it was narrowly tailored to the evil that was presented to Congress.²⁵ What is remarkable is the speed at which the bill passed and the apparent lack of resistance it received. If so many homes wanted to drop their Medicaid

18. Jeff Testerman, *Nursing Home Told to Eject No More*, ST. PETERSBURG TIMES, Apr. 8, 1998, at 1.

19. *Nursing Home Backs Down*, *supra* note 1, at 2.

20. 145 CONG. REC. S2105 (daily ed. Mar. 2, 1999) (statement of Sen. Moynihan).

21. *Hearings*, *supra* note 2, at 18 (statement of Michael Hash, Deputy Administrator, Health Care Financing Administration, reporting that Integrated Health Services, a nursing home not owned by Vencor, was evicting residents based on Medicaid status); 145 CONG. REC. E393 (daily ed. Mar. 10, 1999) (statement of Rep. Bachus).

22. *Hearings*, *supra* note 2, at 18.

23. Bill Summary & Status for the 106th Congress, H.R. 540, available at <http://thomas.loc.gov/bss/d106query.html> (tracking the Nursing Home Resident Protection Amendments of 1999).

24. Nursing Home Resident Protection Amendments of 1999, 113 Stat. 7 (codified as amended at 42 U.S.C. 1305).

25. Christopher Julka, *The Nursing Home Protection Amendments of 1999: A Feel-Good, Painless Cure of a Symptom 9* (Spring 1999) (unpublished manuscript, on file with author) (describing the legislation as "limited in its effect to the type of incident which spawned it").

residents, why did they not attempt to delay or stop this bill? What was the cause of those homes' decisions to evict Medicaid residents, and has that cause been addressed? After more than four years since its passage, has the bill been effective at protecting our nation's elders from status-based evictions? These questions and others are the basis for this note.

Over the course of this note, this author will analyze the actions of Vencor and other similarly acting nursing homes and the NHRPA. Part I grazes the background of both Vencor and the Medicaid program, introducing the situation in which the nursing homes and their residents found themselves. Part II analyzes the political tides surrounding the bill and asks why homes so quick to evict Medicaid patients were silent, and even supportive, when their actions were condemned and prohibited. Part III assumes the bill is effective and discusses the potential economic ramifications. Part IV takes an in-depth look at the bill's legal technicalities, revealing an apparent loophole in the system through which nursing homes can still evict residents based solely on their payment status. In addition, Part IV briefly discusses the cause of Vencor's actions and a possible remedy to that cause. Part V recommends the NHRPA be reopened by Congress, that the loophole be closed to prevent the eviction of Medicaid residents, and that alternatives to Medicaid be fully considered.

II. Background

A. Medicaid

At its most basic level, Medicaid provides a sort of welfare for the aged, blind, and disabled.²⁶ When a nursing home resident is no longer able to pay for his or her care, the Medicaid program kicks in.²⁷ As of 1999, 1.6 million elderly and disabled Americans availed themselves of the approximately 16,800 nursing homes nationwide.²⁸ Most

26. LAWRENCE A. FROLIK & RICHARD L. KAPLAN, *ELDER LAW IN A NUTSHELL* § 5.1 (3d ed. 2003).

27. David McGinty & Harold J. Adams, *Once-Soaring Vencor Struggling to Stay Aloft*, THE COURIER-JOURNAL (Louisville, Ky.), Apr. 4, 1999, at 01A; see also Walter M. Cadette, *Public Policy Brief: Financing Long-Term Care*, 59 THE JEROME LEVY ECON. INST. OF BARD C. A13 (2000) (arguing that many wealthy persons transfer money to family and friends in order to qualify for Medicaid and retain their assets) [hereinafter *Financing Long-Term Care*].

28. See *Hearings*, *supra* note 2, at 19 (statement of Michael Hash, Deputy Administrator, Health Care Financing Administration).

of those residents entered those homes as private-pay patients.²⁹ Unfortunately, their funds were quickly depleted; in 1999, “63 percent of nursing home residents who enter[ed] a nursing home [did] so as private-pay patients and exhaust[ed] their personal savings in just thirteen weeks, [87] percent exhaust[ed] their savings in just [thirty-six] weeks.”³⁰ This leaves homes and residents dependent on government funding for continued support.³¹

Initially, states were “required to set Medicaid rates at a level that was adequate to insure quality care.”³² That requirement, however, was repealed.³³ Now, Medicaid rates are substantially lower than private-pay rates.³⁴ Medicaid rates in general are described as “woefully below actual costs for medical care.”³⁵ For instance, at the Floridean Nursing and Rehabilitation Center, Medicaid residents cost the facility upwards of \$133 per day/per patient (\$3990/month), but the State of Florida reimburses the home only \$87 per day/per patient (\$2610/month).³⁶ Studies have estimated reimbursement rates between forty and seventy percent of costs.³⁷ Facilities stay in business through a balance of Medicaid and private-pay patients, having as few Medicaid patients as possible.³⁸ Depending on the geographic location and economic situation of the surrounding area, this balance may be impossible to achieve or maintain.³⁹ These homes are therefore caught in a catch-22 situation; “their facilities are filled with

29. 145 CONG. REC. H1031 (daily ed. Mar. 9, 1999) (statement of Rep. Davis) (“[Sixty-three] percent of nursing home residents who enter a nursing home do so as a private-pay patient.”).

30. *Id.*

31. *See id.*

32. *Hearings, supra* note 2, at 16 (supporting the Nursing Home Resident Protection Amendments of 1999).

33. *Id.*

34. “[H]alf of the people in nursing homes today who rely upon the Medicaid Program entered that nursing home paying out of their pockets.” *Id.* (statement of Rep. Davis, cosponsor of the amendments).

35. Katherine Pflieger, *Medicaid Bill Backers Say Care Won't Suffer*, ST. PETERSBURG TIMES, Mar. 7, 1999, at 3A.

36. *Hearings, supra* note 2, at 46 (statement of Kelley Schild, Administrator, Floridean Nursing and Rehabilitation Center, on behalf of the American Health Care Association) (describing the Medicaid situation at the nursing home she runs).

37. *Id.* at 39 (statement of Nona Bear Wegner, Senior Vice President, The Seniors Coalition, describing the Medicaid situation in general).

38. *Hearings, supra* note 2, at 48.

39. *Id.* at 45 (statement of Kelley Schild, Administrator, Floridean Nursing and Rehabilitation Center, on behalf of the American Health Care Association, describing the Medicaid situation in general).

Medicaid residents, they can't afford to subsidize their care and they cannot afford to go without them."⁴⁰ Consequently, an average of fifty-eight nursing homes a year withdraw entirely from the Medicaid system.⁴¹

B. Vencor

Once a giant in the industry, Vencor found itself trapped in the Medicaid catch-22 and was struggling to survive. Founded in 1995, Vencor started out by finding a niche in the health care industry: long-term acute care.⁴² The company went public in 1989, and in just two years its stock price increased 500%.⁴³ Vencor was named one of the nation's 200 best small companies by Forbes magazine.⁴⁴ In retrospect, it should have stopped there.⁴⁵

In a massive expansion plan Vencor purchased Hillhaven Corp., a \$1.6 billion company (more than four times Vencor's revenues at the time). With the purchase of Hillhaven came 311 nursing homes.⁴⁶ The trouble started when the top executives of Hillhaven decided not to join Vencor, an event for which Vencor apparently was not prepared.⁴⁷ The transition from acute care to long-term care was not an easy one, and according to Bruce Lunsford, Vencor's Chief Executive in 1997, it was a mistake to take on the industry without experienced leaders.⁴⁸ Exacerbating the problem, federal renovation of the Medicare program changed the landscape of nursing home operation. A once case-by-case payment system was changed to a flat rate, and the budget for those rates was cut by seventeen percent.⁴⁹ This change affected Vencor in two ways: first, the nursing homes it operated which

40. *Id.*

41. *Id.* at 57 (letter from Michael Hash, Deputy Administrator, Health Care Financing Administration).

42. McGinty & Adams, *supra* note 27.

43. *Id.*

44. *Id.*

45. *Id.* (commenting that Vencor's touted success would take a sharp turn for the worst and end in bankruptcy).

46. *Id.*

47. *Id.*

48. *Id.*

49. *Hearings, supra* note 2, at 16 (letter from Vencor, Inc. in support of the Nursing Home Resident Protection Amendments of 1999). "The Balanced Budget Act of 1997 changed Medicare nursing home reimbursement to a prospective payment system and reduced Federal funding by 17%. Congress had previously rescinded the Boren Amendment which required states to set Medicaid rates at a level that was adequate to insure quality care." *Id.*

relied on Medicare to supplement Medicaid reimbursements suffered; second, other nursing homes, fearful of the effect the recent Medicare changes would have on their bottom-lines, were hesitant to sign contracts for Vencor's therapy and acute-care services.⁵⁰

Vencor began trying to save its company. In 1998, Vencor split into two companies, Vencor and Ventas.⁵¹ Vencor continued health care operations.⁵² Ventas owned and ran the properties in which Vencor operated.⁵³ The split later led to suspicion about the nature of lease agreements between the two companies and how much value Vencor should have been claiming on its financial reports.⁵⁴

Vencor then tried to take back the reigns by solving its Medicaid problems. Medicaid residents were costing Vencor upwards of \$18,000 per year/per patient.⁵⁵ Its Medicaid/private-pay balance, touted as critical to survival by the American Health Care Association,⁵⁶ was dismal, with 73% of its revenue coming from government sources.⁵⁷ In a strategy to cope with shrinking government reimbursements,⁵⁸ Vencor began evicting Medicaid residents, sometimes claiming that the company was renovating a nursing home.⁵⁹ The negative press which followed, and ultimately led to the NHRPA, tarnished Vencor's reputation, brought the company \$370,000 in federal and state fines and a class action by the evictees and their families.⁶⁰ Wall Street analysts warned that the evictions might "cut profits[,] if admissions begin to drop because hospital social workers lose faith in Vencor and quit referring people to its homes."⁶¹ While Vencor later

50. McGinty & Adams, *supra* note 27.

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.*

55. *Nursing Home Backs Down*, *supra* note 1.

56. *Hearings*, *supra* note 2, at 47 (statement of Kelley Schild, Administrator, Floridian Nursing and Rehabilitation Center, on behalf of the American Health Care Association) ("Fortunately, my facility has a balance between Medicaid and private-pay residents. Because of that balance, I'm able to provide quality care to all of my residents regardless of their pay source, but other facilities face a crisis. If they have 80 to 90 percent Medicaid, those residents may be very sick and have high, acute needs. Medicaid is not paying for the kind of care these residents need.").

57. Lindsay Peterson, *Vencor Evictions Watched Closely*, TAMPA TRIB., Apr. 26, 1998, at 1.

58. McGinty & Adams, *supra* note 27.

59. *Id.*

60. *Id.*

61. Peterson, *supra* note 57.

claimed the evictions were just “a mistake,”⁶² press coverage, including internal documents that reprimanded its administrators who admitted Medicaid patients, indicate that Vencor had corporate wide “anti-Medicaid practices.”⁶³

It was downhill from there. Despite the compliments Vencor received for its eviction scheme from financial analysts familiar with the flaws of the Medicaid system,⁶⁴ and the short-term rise in its stock price,⁶⁵ Vencor’s losses eventually caused the value of its stock to drop dramatically, with no rebound in sight.⁶⁶ Two of Vencor’s top three executives were removed from the board and eventually resigned entirely.⁶⁷ Next, a battle over rent came to a head, with Vencor asking for a rent reduction (from \$18.46 million) and Ventas questioning whether Vencor was soluble enough to maintain the lease.⁶⁸

The end of the line was near. Outraged at plummeting stock prices, stockholders filed suit against Vencor, alleging that “false and misleading financial statements [had] misrepresented and understated the impact the Medicare changes were having on the Company’s services and profitability.”⁶⁹ At the same time, the Service Employees International Union, which represented some of Vencor’s employees, was battling with Vencor over benefits and hours, motivated by Vencor’s attempt to eliminate benefits for part-time employees and reduce the number of vacation days.⁷⁰ Unable to recover from the wrong turns, Vencor filed for Chapter 11 bankruptcy protection on September 13, 1999.⁷¹ Notably, Vencor reemerged from the bankruptcy process in a year and a half with a new name, Kindred Healthcare, and \$120 million in new operating credit.⁷²

62. *Nursing Home Backs Down*, *supra* note 1.

63. *Id.*

64. Peterson, *supra* note 57.

65. *Id.*

66. McGinty & Adams, *supra* note 27.

67. *Id.*

68. *Id.*

69. Peterson, *supra* note 57.

70. *Id.*

71. Shanon D. Murray, *Goodbye Vencor, Hello Kindred Healthcare*, DAILY DEAL (New York, N.Y.), Apr. 23, 2001, at Bankruptcies.

72. *Id.*

III. Analysis

A. Political Atmosphere and Ramifications

1. VENCOR

Arguably, the evictions proved to be a political and public relations nightmare for Vencor. Nevertheless, Vencor had reason to go through with them. It was a purely bottom-line decision, made when the company faced serious losses and had run out of options.⁷³ In addition, Vencor saw the opportunity to send a loud message to Congress that the inadequacies of Medicaid could not be ignored.⁷⁴

While Congressmen and special interest groups for the elderly admonished Vencor for its bottom-line attitude, many praised it for the courage to bring national attention to the Medicaid crisis.⁷⁵ Low Medicaid reimbursement rates and recent congressional action taking away nursing homes' right to appeal inadequate rates had rendered many nursing homes looking for a new way to stay afloat.⁷⁶ Vencor's decision to evict Medicaid patients not only provided a new business strategy to cut costs, it shined inescapable light on the Medicaid crisis. Unfortunately, Congress only prohibited the evictions. It did not address the larger problems presented by Medicaid, despite prodding from special interest groups and members of Congress.⁷⁷ In the end,

73. *See id.*

74. Peterson, *supra* note 57.

75. *Id.* (reporting that "investors and health care managers across the country were watching with interest, some even cheering Vencor on, and [a]nalytsts say . . . it could be good for business" and noting that "[Vencor's] stock had remained stable, even climbed a little" since the story broke). *But see id.* (speculating that the decision could be bad for business because social workers may lose faith in Vencor, and thus stop referring patients to them, which will lower the number of admissions).

76. *Hearings, supra* note 2, at 39.

[I]t is a fact of life that Medicaid currently pays—estimates say as much as 70, others say as much as 40 percent—of all care. We in no way condone the outrageous activities that led to Mr. Mongiovi and other families undergoing the things they experienced and therefore, the writing of this bill, but we must face the simple fact that when any operator is asked to provide care for half or more of their population at a reimbursement rate which does not allow them to meet their costs, they are going to look for an alternative. That is the real crux of this issue.

Id. (statement of Nona Bear Wegner, Senior Vice President, The Seniors Coalition).

77. *See, e.g.*, 145 CONG. REC. S2096, S2103 (daily ed. Mar. 2, 1999) (letter from the American Health Care Association stating that the bill addresses a "troubling symptom of what could be a much larger problem").

Vencor supported the narrow prohibition, but continued to bring up the Medicaid and Medicare issues.⁷⁸

2. CONGRESS

When the Mongiovi family went to their Congressman requesting action be taken against Vencor,⁷⁹ a political tidal wave began which reached the President after only fifty days and twelve dissenting votes.⁸⁰ But why, with so many nursing homes attempting these evictions,⁸¹ was there not more resistance to the bill that prohibited them? One possible explanation is that the thought of our grandmothers and grandfathers on the street was indefensible in the political market. It is also possible that the legislature saw this as an unnecessary and overly narrow bill, so that voting for it gave them political capital without raising any concerns. Most likely, it was a combination of the two that allowed the NHRPA to flow through Congress with the ease that it did.

The political capital of the elderly is powerful. Experts predict that the sixty-five and older age group will compose twenty percent of the population by 2030.⁸² When that group's safety and well-being are threatened, Congress is wise to address the issue quickly.⁸³ Unlike the Medicare and Medicaid dilemmas, which cause a conflict between government resources and elderly care, the NHRPA was a financially costless resolution for Congress.⁸⁴ Although Vencor claims that the

78. *Hearings, supra* note 2, at 16 (letter from Vencor saying, "This letter is to express my support for the legislation you are sponsoring that prohibits transfers or discharges of nursing home residents as a result of a facility's voluntary withdrawal from participation in the Medicaid program." But, also stating "that the continued participation of nursing homes in Medicaid is now less certain than it has ever been," due to the inadequacies of Medicaid.)

79. 145 CONG. REC. H1029, H1030 (daily ed. Mar. 9, 1999) (statement of Rep. Davis) (thanking the Mongiovis for bringing the problem to light and saying he is "proud to represent them").

80. Bill Summary & Status for the 106th Congress, H.R. 540, at <http://thomas.loc.gov/cgi-bin/bdquery/D?d106:1./temp/~bdtrnY:@@X1/bss/d106query.html> (last visited Aug. 30, 2004) (tracking the Nursing Home Resident Protection Amendments of 1999).

81. 145 CONG. REC. H1029, H1031 (daily ed. Mar. 9, 1999) (statement of Rep. Davis).

82. Jennifer L. Williamson, *The Siren Song of the Elderly: Florida's Nursing Homes and the Dark Side of Chapter 400*, 25 AM. J.L. & MED. 423, 425 (1999).

83. See 145 CONG. REC. H1029, H1030 (daily ed. Mar. 9, 1999) (statement of Rep. Davis).

84. 145 CONG. REC. S2692, S2693 (daily ed. Mar. 2, 1999) (statement of Sen. Bayh) (averring "this bill will not cost anything").

residents' safety was never at risk,⁸⁵ the press depicted the situation as dramatically different, often saying that residents were out on the streets.⁸⁶ Supporters of the NHRPA took their cue from those stories, urging Congress to protect the nation's most vulnerable from "flat out wrong"⁸⁷ evictions based solely on payment status.⁸⁸ Also frequently mentioned was a University of Southern California study which indicated that seniors transferred from their homes have a tripled likelihood of death, so-called transfer trauma.⁸⁹ The combination of these factors made the bill unstoppable.

There were, however, dissenters in Congress. Although the *Congressional Record* does not reveal one special interest group against the bill,⁹⁰ a few members of Congress voiced concerns.⁹¹ Congressman Tom Coburn, a Republican from Oklahoma, who voted against the bill, said that the bill would have two main harmful effects.⁹² First, it would cause states to lower Medicaid rates, free of the fear that homes which withdraw will kick out their Medicaid residents.⁹³ Second, care would suffer because the homes that cannot cut costs by evicting Medicaid residents would need to cut costs in other areas, namely in

85. *Nursing Home Backs Down*, *supra* note 1 (quoting Bruce Lunsford, Vencor Chief Executive Officer during the evictions, who stated, "While we should have done a better job of notifying residents and their families in advance, medical care for these patients was never compromised.").

86. 145 CONG. REC. S2096 (daily ed. Mar. 2, 1999) (quoting from a *Wall Street Journal* article describing the evictions at the Indiana facility, "[O]n Monday, January 26, [1998], right after lunch, Betty Nelson and dozens of other residents of Wildwood Health Care Center in Indianapolis were brought into the activity room and told they were being evicted.").

87. *Hearings*, *supra* note 2, at 15.

88. 145 CONG. REC. H1029, H1030 (daily ed. Mar. 9, 1999) (statement of Rep. Bilirakis).

89. 145 CONG. REC. S2096, S2103 (daily ed. Mar. 2, 1999) (statement of Sen. Graham).

90. 145 CONG. REC. S2692 (daily ed. Mar. 15, 1999); 145 CONG. REC. H1029 (daily ed. Mar. 9, 1999); 145 CONG. REC. S2096 (daily ed. Mar. 2, 1999).

91. *Hearings*, *supra* note 2, at 29 (statement of Rep. Coburn, stating that "I'm extremely concerned, Mr. Chairman. I see here a problem that the law already applies to, that we have demonstrated that we have fined, that we have the ability to control, and we don't have the data to know, one, how big the problem is; two, the number of people who have actually withdrawn. We don't even know, we don't have any testimony to tell us that and we're going to pass a new law without the knowledge of knowing how big the problem is, the severity or the frequency of the problem all because it's a feel-good law.").

92. *Id.* at 56 (stating that "the more the Government gets into [regulating nursing homes], the more care will be rationed [to compliance] and the less care there will be [for residents]").

93. *Id.*

nursing staff, maintenance of facilities, and staff training.⁹⁴ Other Congressmen voiced concern that the prohibition would force nursing homes to accept fewer Medicaid residents for fear that they would be stuck with them.⁹⁵ In addition to the above concerns, there was a general fear in Congress that the bill did not address the root cause of Vencor's actions: the Medicaid system's inability to provide adequate payment to nursing homes.⁹⁶

The narrow, perhaps too narrow, breadth of the bill probably contributed heavily to its easy passage through Congress. While the bill does prohibit the situation Congress was faced with—nursing homes withdrawing from Medicaid and “dumping” their Medicaid residents—it leaves other possibilities open.⁹⁷ As will be discussed further in Part IV of this note, the bill does not prohibit nursing homes from another form of Medicaid dumping—deeming a small number of beds for Medicaid patients and evicting residents when they run out of private funds by claiming no Medicaid beds are available.⁹⁸ In light of this option, the nursing home industry's support of the NHRPA is hollow. In essence, the bill only took away one option for “dumping.” Thus, the special interest groups representing nursing home executives had little motivation to fight the bill.

Further, many Congressmen felt the bill was superfluous, citing the fines Vencor received and injunction granted against it as a sure sign that what Vencor did was already illegal.⁹⁹ Although no Congressman taking this view or its opposite could point to the law or regulation Vencor was breaking,¹⁰⁰ the almost half a million dollars in fines levied against Vencor provided a strong argument.¹⁰¹ Opposition to this argument stated that Vencor was fined only because it did not follow proper procedure when it withdrew from Medicaid,¹⁰² be-

94. *Id.*

95. *Id.*

96. *See id.*; 145 CONG. REC. S2103 (daily ed. Mar. 2, 1999) (statement of Bruce Yarwood, Legislative Counsel, American Health Care Association, stating, “This bill addresses a troubling symptom of what could be a much larger problem. The desire to end participation in the Medicaid program is a result of the unwillingness of some states to adequately fund the quality of care that residents expect and deserve.”).

97. *Hearings, supra* note 2, at 14.

98. *Id.*

99. *Id.* at 26 (testimony of Michael Hash).

100. *Id.*

101. *Id.*

102. *Id.*

cause it did not give residents the legal amount of time (thirty days) to relocate, often evicting them after only eight days.¹⁰³ On the other hand, the superfluousness argument was supported by the fact that another home that tried to evict Medicaid patients using the proper procedure was being fined \$6,000 a day and was placed on the “fast-track” to Medicaid termination.¹⁰⁴ Whether the evictions were illegal for substantive violations or whether the fines were levied because of improper procedure, the argument that the NHRPA was unnecessary was prevalent.¹⁰⁵ Taken together, the lack of effectiveness of the bill and the adverse publicity were most likely the major reasons for the bill’s quick passage.

B. Economic Ramifications

The question that begs to be asked then, is what would have happened if the bill was effective? In this section the author first considers the actual economic impact of the NHRPA and then assumes that the NHRPA eliminated all forms of Medicaid dumping and analyzes the probable effects of that change. It is important to note one other assumption necessary for this analysis. The author will presuppose the widely recognized assumption that corporations and people think rationally (i.e., that they take actions to maximize their gains).¹⁰⁶ This assumption is necessary for analysis because it allows the author to make predictions regarding the choices people and corporations will make in particular situations, without which an economic analysis would prove futile.¹⁰⁷

The NHRPA seems to be curing an imbalance of information between the consumers, the prospective residents, and the nursing homes. Specifically, the typical nursing home knows what its balance of private-pay to Medicaid residents is, how many Medicaid beds are available, whether it plans to cut that number, whether the company is financially soluble, and what the corporate policies are on Medicaid.¹⁰⁸ This creates informational asymmetry, where one party

103. *Id.*

104. *Id.*

105. *Id.*

106. ROBERT COOTER & THOMAS ULEN, *LAW & ECONOMICS* 15 (4th ed. 2004).

107. *Id.* at 21.

108. Julka, *supra* note 25, at 7; *see also Hearings, supra* note 2, at 61 (letter of Sarah Greene Burger, Executive Director, National Citizens’ Coalition for Nursing

knows information that would be useful to the other party in determining whether or not to make a deal and, if so, what to pay for the deal.¹⁰⁹ One could argue that the prospective resident knows more about the care they will need than the typical home, balancing the asymmetry. However, given the availability of medical records, references from other nursing homes and hospitals, and its relative expertise with elderly medical care, a prospective resident's care needs are easily ascertainable by an interested home.¹¹⁰ The situation is likewise for the financial status of the prospective resident.¹¹¹

Moreover, nursing homes often attempt to control for the possibility that a resident will go on Medicaid through a variety of legal and not-so-legal techniques.¹¹² The Tampa division of the Tribune Corporation published an article to shed light on some of these tactics and to warn prospective residents and their families who may fall victim.¹¹³ For instance, some homes might require prospective patients to guarantee private payment for a period of time, agree to leave when their personal finances run out, or agree to waive their right to Medicaid.¹¹⁴ Unfortunately, some of these tactics are legal, leaving prospective residents in an uncomfortably ignorant position while being forced to make an extremely difficult decision.

Some information asymmetries are cured through regulation.¹¹⁵ For example, an owner of a home with termites or foundation damage cannot legally keep those defects a secret when selling his home.¹¹⁶ This asymmetry prevents otherwise viable deals from occurring, foremost because the party lacking the information is fearful of the lemon behind door number two that he or she may have just purchased.¹¹⁷ In the nursing home context, some of the information may be discoverable in certain situations. For instance, if the nursing home

Home Reform) (discussing nursing homes' reactions to changing financial situations).

109. COOTER & ULEN, *supra* note 106, at 47-48.

110. *See, e.g., Hearings, supra* note 2, at 45.

111. *Id.*

112. *See* Lindsay Peterson, *Nursing Homes Often Violate the Law*, TAMPA TRIB., Mar. 25, 1997, at 1 [hereinafter *Nursing Homes Often Violate*].

113. *See id.*

114. *Id.* ("When a patient waives their right to Medicaid, the nursing home can then legally evict for non-payment when the patient has run out of personal funds.").

115. COOTER & ULEN, *supra* note 106, at 47-48.

116. *Id.*

117. *Id.*

is publicly owned, its financial statements are public record.¹¹⁸ Likewise, the amount of government funding it receives is publicly available, giving the resident a crude picture of the home's Medicaid to private-pay balance.¹¹⁹ However, large chunks of information are held solely by the nursing home.¹²⁰ Its attitude toward Medicaid may be informal or expressed only in confidential internal documents.¹²¹ Its plans to withdraw from Medicaid may not even be contemplated until far after a resident decides to contract with the home.¹²² Moreover, most nursing homes are privately owned,¹²³ making financial information nearly impossible to find.¹²⁴ Overall, this information asymmetry is not otherwise curable and, for the resident, creates a severe fear of contracting,¹²⁵ especially if the resident is aware of the trauma he will face if forced to move when he spends down his or her personal finances.¹²⁶ This leads to the conclusion that it was economically wise for the government to step in through the NHRPA, forcing the nursing home to disclose its Medicaid status and keep Medicaid residents should that status change.

However, most nursing homes are for-profit entities, and their drive for the bottom-line is likely to impact the effectiveness of the NHRPA.¹²⁷ Like Vencor, when a nursing home decides to withdraw from Medicaid, it has decided that although it will lose the revenue from its Medicaid residents, the company cannot give adequate care given the low Medicaid reimbursements.¹²⁸ If a home cannot evict those residents, as the NHRPA prohibits, it will need to find other ways to combat those costs.¹²⁹ One potential choice, as mentioned in the congressional hearings regarding the NHRPA, is that homes will

118. SEC. & EXCH. COMM'N, THE INVESTOR'S ADVOCATE: HOW THE SEC PROTECTS INVESTORS AND MAINTAINS MARKET INTEGRITY, at <http://www.sec.gov/about/whatwedo.shtml> (last visited Aug. 30, 2004).

119. COOTER & ULEN, *supra* note 106, at 47-48.

120. *Id.*

121. *See, e.g., Nursing Home Backs Down, supra* note 1.

122. *Id.*

123. *Financing Long-Term Care, supra* note 27, at 15.

124. Stefanie Olsen, *SEC Rule May Nudge Google Toward IPO*, at http://marketwatch-cnet.com/2100-1030_3-5119504 (last modified Dec. 10, 2003).

125. COOTER & ULEN, *supra* note 106, at 221-30.

126. *Hearings, supra* note 2, at 2.

127. David Ruppe, *Nursing Home Abuse*, Aug. 8, 2001, at http://www.abcnews.go.com/sections/us/DailyNews/nursinghomes_elderlyabuse-0107230.html (last visited on Aug. 30, 2001).

128. *Hearings, supra* note 2, at 60.

129. *Id.* at 61.

accept less Medicaid residents.¹³⁰ Homes accomplish this in several ways. First, they may certify only a few number of Medicaid beds, giving them the excuse that Medicaid beds are unavailable to prospective residents.¹³¹ Second, the home may reject applicants on other grounds: medical needs, safety concerns, and so forth, with a payment status pretext.¹³² This discrimination is a truism in the nursing home industry,¹³³ and one can predict that it will only get worse if homes are not able to evict Medicaid patients upon withdrawal from the Medicaid program.¹³⁴ If not through discriminatory admissions practices, homes will need to distribute losses through cuts in staff, medical equipment, food, facility upkeep, and other costs, worsening the care that all residents receive.¹³⁵ As a last resort, homes that are not able to survive through discrimination or cutbacks will be forced into bankruptcy,¹³⁶ as was the case with Vencor,¹³⁷ and will then be evicting both private-pay and Medicaid residents when its doors are closed permanently.¹³⁸ As referenced in the dissenting congressional opinions,¹³⁹ the realities facing for-profit companies weigh against the NHRPA.

Fortunately, empirical evidence suggests that the NHRPA has not affected care standards or admissions practices.¹⁴⁰ In a study done by Christopher Julka, a University of Illinois College of Law student, it was found that no negative effects were felt in area nursing homes as a result of the NHRPA's passing.¹⁴¹ Nursing homes that participated in the study noted several reasons why they were not affected.¹⁴² One reason for the lack of an effect is that residents do not

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.* at 59.

134. *Id.* at 60.

135. *Id.* at 48.

136. *Id.*

137. Murray, *supra* note 71, at 1.

138. *Nursing Home Backs Down*, *supra* note 1.

139. *Hearings*, *supra* note 2, at 57-62.

140. Julka, *supra* note 25.

141. *Id.* at 3. Survey participants were: Jane Flewelling of the Care Centre of Champaign, 1915 S. Mattis Ave., Champaign, Ill.; Kim Basset of the County of Champaign Nursing Home, 1701 E. Main St., Urbana, Ill.; Pam Breitt of the Country Health Nursing Home, Route 136, Gifford, Ill.; Sara Monaghan of the Heritage Nursing Center Inc., 1315 Curt Dr., Champaign, Ill.; Dave Giessinger of Manorcare Health Care Services, 600 N. Coler Ave., Urbana, Ill.; and Don Patrick of the Urbana Nursing Home, 2006 Philo Road, Urbana, Ill.

142. *Id.* at 3-5.

often stay very long in homes,¹⁴³ meaning that after the home withdraws, Medicaid residents do not remain a financial burden on the home for an insurmountable amount of time. A second reason for the lack of any effect is that most nursing homes in the examined area are not filled to capacity, and a low reimbursement from Medicaid is financially better than an empty bed.¹⁴⁴ At the time of the survey, all participating homes had empty beds.¹⁴⁵

However, the limits of this empirical evidence are significant. Most notably, the homes surveyed had strong private-pay to Medicaid balances, receiving on average ten percent of their revenues from government sources.¹⁴⁶ This is important because it reveals that the homes are not reliant on Medicaid¹⁴⁷ and therefore would not feel the effects of a Medicaid bill as harshly as more reliant homes. And by admission, none of the participants were in the midst of debt problems, as was the case with Vencor,¹⁴⁸ which would most likely lead to a more pronounced effect from NHRPA. Ultimately, although the empirical evidence is a comforting counter to the economic predictions, the limits of that evidence must be considered accordingly.

C. How Nursing Homes Can Continue to “Dump” Medicaid Patients

Over the course of the congressional hearings surrounding the passage of the NHRPA, two speakers mentioned the possibility that homes could still evict Medicaid patients by certifying only a few beds for Medicaid patients and claiming that the home “had no Medicaid beds left” when a resident spent down¹⁴⁹ his personal finances.¹⁵⁰ If nursing homes can still do this, then the NHRPA was not effective in

143. *Id.* at 4.

144. *Id.*

145. *See id.* Specifically, at the Care Center of Champaign, 43 out of 118 beds were empty; at County of Champaign Nursing Home, 22 out of 240 beds were empty; at the Heritage Nursing Center, 20 of 60; at Manorcare Health Care Service in Urbana, 16 of 100; at Urbana Nursing Home, 9 of 46, at County Health Nursing Home, approximately 7 of its 89 beds were empty.

146. *See id.* at 7–8.

147. *See id.* at 7.

148. *Id.*

149. A resident is said to have “spent down” when they have depleted their personal assets by paying for the cost of long-term care. *Financing Long-Term Care*, *supra* note 27, at A7.

150. 145 CONG. REC. S2096, S2104 (daily ed. Mar. 2, 1999) (letter from Toby S. Edelman, National Senior Citizens Law Center).

its goal of protecting our nation's most vulnerable from evictions based solely on source of payment,¹⁵¹ but instead only prohibited one way homes can commit this discrimination.¹⁵²

Two main counters were offered against the apparent loophole in the eviction prohibition. First, that in at least one state, Tennessee, nursing homes must certify the entire home for Medicaid or not receive Medicaid at all.¹⁵³ Unfortunately, this rule is the result of *Linton v. Tennessee*,¹⁵⁴ decided by a Tennessee court, and is only applicable in that state. *Linton* does not help elderly residents in the other forty-nine states. Second, regulators argued that this loophole was not a true possibility because nursing homes could only reduce the number of Medicaid beds once-per-year, according to a policy statement.¹⁵⁵ Unfortunately, this argument cannot provide much comfort either.

The "once-per-year" rule cannot be effective in eliminating this apparent loophole for several reasons. First, if a nursing home wants to lower its beds to get rid of Medicaid patients, making it wait a year is of little comfort to the current residents who will be evicted, to the residents who may enter the home and spend down within the year, or to their families. Second, this rule does not stop nursing homes from starting with a very low number of Medicaid beds and increasing that number as needed.¹⁵⁶ Lastly, and perhaps most importantly, although the regulation may deter or at least delay companies from taking advantage of the loophole, for the reason set forth in the next paragraph, the regulation would likely not stand up in court if challenged.¹⁵⁷

The once-per-year rule purports to be a policy statement¹⁵⁸ and was therefore issued without notice and comment. However, it is without flexibility or discretion, and therefore, cannot be upheld as a

151. *Id.* (letter from Horace B. Deets, American Association of Retired Persons).

152. *Hearings*, *supra* note 2, at 31.

153. *Id.* at 12.

154. *Linton v. Tennessee*, 65 F.3d 508, 512 (6th Cir. 1995).

155. *Hearings*, *supra* note 2, at 58. "Under HCFA policy, once a year nursing facilities are allowed to designate a specific number of beds to be Medicaid-only. Facilities must request the change in writing and identify its current configuration and the proposed configuration 120-days in advance of its cost reporting year." *Id.*

156. *Id.* at 14.

157. *See infra* text accompanying notes 162-68.

158. *Hearings*, *supra* note 2, at 58 (statement of Michael M. Hash, Deputy Administrator, Department of Health & Human Services, Health Care Financing Administration, stating, "This once-per-year restriction is a policy included in HCFA's manual instructions to States... This change in policy did not go through a notice or a comment period.").

policy statement.¹⁵⁹ Generally, administrative agencies charged with interpretation and enforcement of statutes have the power to issue policy statements—guides to the regulated public of what the agency is tentatively planning on doing in certain situations.¹⁶⁰ Those policy statements have positives and negatives. On the positive side, regulated industries generally attempt to comply with the rules, and guidance is appreciated.¹⁶¹ However, when policy statements are applied without exception, the regulated public does not have a chance to make its arguments against the rule, or for its modification when the rule is applied, and therefore, it should at least have that chance in a notice and comment period before the rule is adopted.¹⁶² The notice and comment period also helps agencies to obtain information about the effects that rules will have on segments of the industry and to entertain alternatives.¹⁶³ For this reason, policy statements cannot be inflexible, as the once-per-year rule seems to be. Invalidation of this once-per-year rule will eliminate even the minimal protection given to residents against the Medicaid eviction loophole.¹⁶⁴ Nursing homes will be able to evict Medicaid patients by reducing the number of beds at any time and frequency.

D. The Larger Problem: The Lack of Compensation from Medicaid

When Vencor chose to evict Medicaid patients, it received a lot of negative publicity from political action groups and governmental bodies.¹⁶⁵ However, it also received praise from other nursing homes for drawing attention to the larger problem—that Medicaid does not compensate homes at a rate high enough to cover the cost of treating patients.¹⁶⁶ This situation must also be addressed. Due to the increased life-expectancy rate and the aging of the baby-boom children,

159. See *Mada-Luna v. Fitzpatrick*, 813 F.2d 1006, 1013 (9th Cir. 1987).

160. *Id.*

161. *Id.*

162. *Id.*

163. *Id.*

164. See *Hearings*, *supra* note 2, at 58.

165. *Id. passim* (frequently condemning Vencor for its evictions).

166. Peterson, *supra* note 57 (reporting that “investors and health care managers across the country were watching with interest, some even cheering Vencor on ‘saying’ it can be good for business” and noting that Vencor’s “stock ha[d] remained stable and even climbed a little” since the story broke). *But see id.* (some stock analysts speculated that the decision could be bad for business because social workers may lose faith in Vencor, thus stop referring patients to them, which will lower the number admissions).

the Medicaid system has been spread too thin.¹⁶⁷ Consequently, nursing homes are being forced to bear the brunt of Medicaid's inadequacies by caring for patients whose expenses are not being covered.¹⁶⁸ Although the legislative solutions discussed earlier safeguard patients from being evicted when they spend down, they do not alleviate, and in fact exacerbate, the consequences of an inadequate Medicaid system.¹⁶⁹ Nursing homes left with fewer or no ways to release those patients who put a financial strain on their business will be forced to cut costs, lowering the quality of care provided to all patients, or to opt out of Medicaid entirely.¹⁷⁰

Long-term care insurance could partially remedy the shortfalls of the Medicaid system.¹⁷¹ Either as a supplement to Medicaid or a substitute for it, long-term care insurance could give peace of mind to elders who worry about the cost of nursing care and allow nursing homes to maintain higher levels of quality care.¹⁷² There are, of course, drawbacks to this option, including an increase in the disparate level of care for financially well-off elders as compared to those without the necessary funds to purchase insurance.¹⁷³ Ultimately, long-term care insurance, in order to be successful, must be studied much more carefully than this note allows.¹⁷⁴

Insurance allows people to cover the costs of tragic events such as death, fire, and auto accidents, by paying premiums periodically to an insurance company, which then pays the bills if and when those tragedies occur.¹⁷⁵ The insurance company can do this because it in-

167. *Financing Long-Term Care*, *supra* note 27, at 15.

168. *Hearings*, *supra* note 2, at 45–46.

169. *See supra* Part II.B.

170. *Hearings*, *supra* note 2, at 15 (letter from American Health Care Association, commenting that some homes withdraw from Medicaid to avoid lowering the level of care they provide). *But see id.* at 48 (commenting that nursing homes cannot lower the quality of care even though Medicaid does not provide adequate reimbursement).

171. *Financing Long-Term Care*, *supra* note 27, at A8.

172. *See generally id.*

173. The difference in care provided may not be more disparate than it is at present under Medicaid. *Hearings*, *supra* note 2, at 7–8. *But see Financing Long-Term Care*, *supra* note 27, at A13 (arguing that Medicaid allows economic disparity by allowing wealthy persons to transfer funds from their estate in order to meet the need qualifications, leaving a smaller pool of money available to those who simply cannot afford long-term care).

174. For further analysis on long-term care insurance as an alternative to Medicaid, see *Financing Long-Term Care*, *supra* note 27, at A4–A30.

175. *Id.* at A8 (explaining that long-term care is “almost perfectly suited to an insurance model” because it is a low-probability, high-consequence event).

tures a pool of people, whose payments allow the insurer to cover the costs of the probable number of people to whom these tragedies will come upon.¹⁷⁶ The cost of insurance is set by the risk of the event happening, according to measurable factors such as age, health, and location.¹⁷⁷ Long-term care insurance would behave much like health insurance, where the insureds pay periodically while in good health, so that if they later require nursing care, those bills will not be too much to bear financially.¹⁷⁸

Such an insurance program would have many benefits. First, those who found themselves in need of long-term care would not also find themselves relying on family or the government in the last and most vulnerable years of their life.¹⁷⁹ Instead, they would know that the financial support they receive is a product of their own independence and fiscal planning. For nursing homes, the benefit would be enhanced security in the financial strength of their operations.¹⁸⁰ Knowing that patients have insurance to cover their expenses if private funds run out would decrease the threat of a patient going on Medicaid.¹⁸¹ With this decrease in the nursing home's fiscal concern comes further benefit to the patients in the form of better-quality care and less intrusive background checks.¹⁸² In addition, emergence of a new field in insurance may provide public benefits in the form of new jobs, could increase our economic strength, and may lessen the burden on the government to provide Medicaid, consequently freeing up tax dollars.¹⁸³ Although these benefits are strong and many, long-term care insurance does have the potential of bringing negative consequences as well.

Long-term care insurance is not a simple solution. Its current limited availability and utility are evidence of the many problems fac-

176. *Id.* at A8 (explaining that pooling of risks through insurance is a "natural economic response").

177. Robert H. Jerry, II, *Insurance, Contract, and the Doctrine of Reasonable Expectations*, 5 CONN. INS. L.J. 21, 37 (1998) (noting that the insurance industry's ability to calculate risks depends on its ability to measure risk).

178. See *Financing Long-Term Care*, *supra* note 27, at A11-A12 (explaining that for long-term care insurance to work, the market would have to attract young and healthy consumers).

179. See *id.* at A4 (noting the loss of independence associated with receiving Medicaid, especially when an elder transfers wealth to others to qualify for Medicaid, and then is reliant on the transferees for financial support beyond Medicaid).

180. *Id.* at A16.

181. *Id.* at A15.

182. *Id.* at A18.

183. *Id.* at A17.

ing insurance companies wishing to provide long-term care insurance.¹⁸⁴ One hurdle is a lack of “federal subsidies in the form of the tax exclusion of employment-based health benefits,”¹⁸⁵ which has been a major force behind the spread of general health insurance.¹⁸⁶ Another hurdle is that the insurance company must combat two widely accepted insurance phenomena: moral hazard and adverse selection.¹⁸⁷ Moral hazard occurs in the case of health insurance when, because they have insurance, people take advantage of more health care than they would if they paid for it themselves.¹⁸⁸ In the nursing home example, moral hazard means people with long-term care insurance will spend more money on long-term care than they would if they paid for the care out-of-pocket.¹⁸⁹

A second phenomenon is adverse selection, which posits that people who purchase insurance are more likely to need it, thus decreasing the advantages of pooling and making it harder for insurance companies to make a profit.¹⁹⁰ The truth of adverse selection is evidenced in the fact that the average age of someone who purchases long-term care insurance is sixty-nine.¹⁹¹ A possible remedy to the above hurdles is attracting young and healthy buyers who do not know what their long-term care needs will be and thus cannot buy insurance in a pattern of adverse selection. Further, the length of time until a young person needs long-term care allows the insurance company to better pool the risks, thus providing for lower premiums and better payouts.¹⁹²

Although the above is meant only to outline the possible benefits and burdens of a long-term care insurance system, it may provide a helpful starting-off point for further inquiry. Whether long-term care insurance is a viable option, it is clear that Medicaid is a problem area for the federal government that will continue to require attention throughout the upcoming years.

184. *Id.* at A7 (noting that private insurance finances only seven percent of long-term care).

185. *Id.* at A10.

186. *Id.*

187. *Id.* at A11.

188. *Id.*

189. *Id.*

190. *Id.*

191. *Id.* at A10.

192. *Id.* at A11 (accepting younger customers does, however, increase the risk created by the passage of time).

III. Recommendation and Resolution

A. Short-Term Resolution: Close the Loophole

The Nursing Home Resident Protection Act was well intentioned and partially effective. As a result of the NHRPA, the residents evicted from the involved nursing homes were invited back into those homes.¹⁹³ The bill also sent a message to the nursing home industry that Congress was watching and would not tolerate mass-evictions based on payment status.¹⁹⁴ However, the bill fell short of providing nursing home residents full protection from payment-based eviction.¹⁹⁵ Nursing homes can still evict Medicaid residents by lowering the number of available Medicaid beds.¹⁹⁶ This section considers the possibility of prohibiting that action as well as the political and economic ramifications of such a change.

1. WHAT WOULD NEED TO BE DONE TO CLOSE THE LOOPHOLE?

Prohibiting nursing homes from reducing the number of beds they have dedicated for Medicaid patients so as to evict tenants who spend down is not a simple task. This task can be accomplished in several ways. They all have costs, however. A brief look into these options and their consequences is instructive.

First, Congress could eliminate a nursing home's ability to reduce the number of beds dedicated for Medicaid patients.¹⁹⁷ This, the simplest alternative, is however, quite dangerous. Homes facing this prohibition will accommodate in one of two ways. First, homes might always keep a very low number of Medicaid beds and never increase the number, even when they could feasibly take on more Medicaid patients. Because Medicaid patients cannot be placed in "non-designated" beds, this alternative would leave otherwise placeable elders without care.¹⁹⁸ Second, homes facing this prohibition might

193. *Hearings, supra* note 2, *passim*. Many residents were temporarily invited back to their homes before the Nursing Home Resident Protection Amendments of 1999 due to a court-ordered emergency injunction mandating that Vencor halt its evictions. Testerman, *supra* note 18. *But see id.* (reporting that Vencor officials "said the timing of the article was a bad coincidence and maintained that patients in Tampa were being discharged merely to facilitate a remodeling of the nursing home").

194. *Hearings, supra* note 2, *passim*.

195. *See id.*

196. *Id.*

197. *Id.* at 14.

198. *Id. passim*.

feel restricted enough to drop out of the Medicaid system entirely, leaving their current Medicaid residents searching for a new place to live and decreasing the number of facilities available to future Medicaid patients. Although the prohibition would be a simple fix, the very real consequences that would inevitably follow make it socially expensive and, therefore, not a real possibility.¹⁹⁹

A second alternative is to prohibit evicting residents who spend down.²⁰⁰ A possible cost of this program would be an increase in admissions phase transaction costs for nursing homes.²⁰¹ Due to the prohibition, homes would attempt to avoid being “stuck” with lower-paying Medicaid patients by screening prospective patients with more scrutiny, lessening the informational asymmetry.²⁰² This added investigation may include extensive medical and financial disclosure, investigation into the family’s financial position and willingness to give support, the prospective patient’s attitude toward receiving government assistance, and any other information the nursing home thinks will help it decide whether the patient will ever go on Medicaid. The nursing home may also come up with creative ways to contract out of the prohibition by pressuring applicants to “sign away” their right to stay after spending down.²⁰³ As a result of the more burdensome admissions process, both homes and residents will be forced to make adjustments.

The adjustments forced on both nursing homes and prospective residents will be emotional, physical, and monetary, but are also minimal and repairable. The prohibition may not increase the time and expense of the admissions process by much. Nursing homes already check extensively into the financial and medical health of prospective residents because the longer the patient stays private-pay, the more profitable he is to the nursing home.²⁰⁴ Indeed, nursing homes may not be able to investigate further for a simple lack of places to look for instructive information. Unfortunately, any increase in time waiting to be admitted can be harmful to a prospective patient, especially because most families wait until they can no longer care for their

199. *See supra* Parts III.A.2, III.B.

200. *See supra* Part III.C.

201. *See supra* Part III.B.

202. *See supra* Part III.B.

203. Peterson, *supra* note 57.

204. *Hearings, supra* note 2, at 31.

elders themselves before beginning the process of placing them in a home.²⁰⁵

The problems of a prolonged waiting period can be alleviated, however. A nursing home can accept a patient on a temporary basis while their application is being reviewed, so long as the review period does not become a subterfuge to the eviction prohibition.²⁰⁶ By keeping the home from charging more than a heavily discounted rate while the resident is there on a probationary basis, the temptation to prolong the waiting period could be strongly discouraged. As an alternative to submitting to a review period, families may be able to hire in-home care while the application is being reviewed so that the elder patient is not transferred more than once. Finally, elders and their families can be educated to start application processes before nursing home care is immediately required. It is important to remember, though, that because nursing homes already require so much investigation, the probability that the waiting period will increase significantly is low.

A third possibility is to allow homes to decrease the number of beds so long as, at any given time, there is a set number of Medicaid beds empty. The set number could be fixed or proportionate. This would allow nursing homes to admit patients without additional investigation and increase the number of Medicaid beds without fear that the increase will be permanent. One of the costs of this alternative would be to the public, in the form of increased regulatory oversight. Regulatory bodies would need to be employed to frequently check the number of Medicaid beds available in their jurisdictions' nursing homes.²⁰⁷ However, the nursing home industry is already heavily regulated, and this information is easily obtainable, making the increase in cost to the public insubstantial.²⁰⁸

The other cost would be to the nursing home, in the expense of keeping beds empty. This cost would mostly show up as an opportunity cost. That is, the nursing home would have to turn away prospective private-pay and Medicaid patients that they have room for in order to keep the required number of beds empty. However, studies

205. *Id.* at 7.

206. By this I mean that the home reviews the application for long periods of time, waiting for the patient to spend-down and then denying their application.

207. FROLIK & KAPLAN, *supra* note 26, at 158.

208. *Id.*

have shown that nursing homes are infrequently full.²⁰⁹ It therefore seems that either nursing homes already turn away prospective patients even when they have the room, or that the industry's demand for beds is less than the supply. In addition, when a private-pay patient spends down, the patient will occupy a free Medicaid bed, and in turn his or her old bed will become a Medicaid bed in order to keep the required number of empty beds. The nursing home thus loses a private-pay bed. However, the high turnover rate in nursing homes suggests that the home will seldom be without an available private-pay bed.²¹⁰

In order to fully protect nursing home patients from Medicaid eviction, the loophole in the NHRPA must be closed. The options outlined above are not meant to be an exhaustive list, but rather, a brief analysis of a few possibilities. The first, prohibiting nursing homes from ever reducing the number of beds, is the simplest, but is also very troubling in its inevitable consequences. The second, prohibiting nursing homes from evicting a patient who has spent down, is comforting at the outset, but has several negative implications, some of which are health risks that cannot be completely ameliorated. The third option, requiring homes to, at any given time, have a set number of available Medicaid beds, is the least costly alternative, both fiscally and otherwise. However, it is not as comprehensive a solution as the second option. If implemented, nursing homes would lose one way in which they can evict patients who spend down, but a close regulatory eye would need to be kept on nursing homes to ensure new eviction rationales and procedures were not discovered.

2. TO ADDRESS THE LARGER PROBLEM

In the next thirty years, as the baby-boom generation heads into their later stages in life and the population continues to live longer due to medical advances, the nursing home industry population will more than double.²¹¹ The Medicaid system, initially meant to provide care to the indigent, is ill-equipped to pay for the added care required

209. See, e.g., Julka, *supra* note 25, at 4.

210. See Richard L. Kaplan, *Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, 2004 U. ILL. L. REV. 47, 84 n.335 (calculating that three-fourths of all nursing home stays are shorter than three years).

211. *Financing Long-Term Care*, *supra* note 27, at A6 (explaining that “[d]uring the next 30 years, the nursing-home population will more than double as the baby boom ages and as continued advances in medicine extend life expectancy”).

by the aging population.²¹² Long-term care insurance may ameliorate this impending problem.²¹³ A solid recommendation for an insurance program is outside the bounds of this note. However, the Vencor evictions should serve to bring the shortfalls of Medicaid to light. If they do, then the eviction of hundreds of elders like Ms. Adelaida Mongiovi will not have been in vain.

IV. Conclusion

Nursing home patients are at a constant risk of eviction from their nursing homes when they spend down private funds and are forced onto government subsistence. The Vencor story is not an isolated incident. Many homes followed Vencor's lead, and many homes continue to use smaller-scale tactics to rid their homes of Medicaid patients. The result of these evictions is a tripled death rate for those evicted. The true story of Adelaida Mongiovi, which was outlined in the background of this note,²¹⁴ is just one example of hundreds of reported cases. Many more probably go unreported. As a nation we must take action to prevent these evictions.

The NHRPA was a necessary step toward protecting our nation's elders. However, more must be done. First and foremost, homes must be kept from utilizing the loophole in the NHRPA by reducing the number of Medicaid beds and evicting private-pay patients after they spend down. The alternative ways of closing this loophole all have costs and benefits to the public, current and prospective patients, and to the nursing homes. The best alternative seems to be requiring that nursing homes, at any given time, have a requisite number of Medicaid beds available. This will ensure that private-pay patients cannot be evicted once they spend down and will allow the nursing homes to be flexible in their short and long-term planning for future growth and reduction. The cost of this program is minimal, requiring only regulation of easily obtainable information. However, a close eye would need to be kept on homes to ensure that while one avenue for evicting Medicaid patients is eliminated, another does not replace it.

212. *Id.* at A4.

213. *Id.* at A8.

214. *See supra* text accompanying notes 1–13.

It is unfair to depict the nursing home as the evil participant in an otherwise perfect system. The truth is that Vencor and other homes made the decision to evict Medicaid patients because they could not afford them without lowering the quality of care they provide to a substandard level.²¹⁵ Nursing homes cannot afford Medicaid patients because their care is not adequately compensated.²¹⁶ Thus, in order to truly affect the nursing home experience for our nation's most vulnerable, the Medicaid system must be fixed or replaced.²¹⁷ One possible way to achieve that end is long-term care insurance. Although not without its weaknesses, a long-term care insurance program seems to be a strong option and deserves further attention.

The NHRPA was an anomaly in the legislative process.²¹⁸ It sped through the political hierarchy quickly and received little negative commentary, even though it forbid an action taken by many in a strong special interest group.²¹⁹ One probable explanation for this is that nursing homes and their lobby groups knew that the bill would not eliminate their ability to evict new and current Medicaid patients. Unfortunately, that also means that the bill's overall goal went unattained. To protect our nation's most vulnerable, this must be remedied.

215. See *Hearings, supra* note 2, at 46–47 (statement of Kelley Schild, Administrator, Floridian Nursing and Rehabilitation Center, on behalf of the American Health Care Association).

216. *Id.* at 39 (statement of Nona Bear Wegner, Senior Vice President, the Seniors Coalition) (describing the percentage of a nursing home's actual costs that are covered by Medicaid, at forty to seventy percent).

217. *Financing Long-Term Care, supra* note 27, at A4 (stating that “[a]s the number of elderly increases and as medical advances extend the life span, there will be more and more people who require some form of long-term home or institutional health care. The nation is not equipped—with either private or public financing vehicles—to meet this need.”).

218. See *supra* notes 23–25, 79–89 and accompanying text.

219. *Id.*