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How Government Created and Shaped the U.S. Nursing Home Industry

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Abstract

Beginning in the 1960s, U.S. government policy largely created, and subsequently facilitated the corporatization of, a powerful, multi-billion dollar nursing home industry. Using data from trade publications, government agency reports, Congressional hearings, newspaper reports and existing scholarly research, I chart the relationship between the state and the U.S. nursing home industry over four time periods to reveal how, at different moments, government policy contributed to first the creation, then the corporatization and consolidation of the industry. I argue that the trajectory of Medicare and Medicaid policy is not wholly neoliberal but neither should it be considered progressive.

Keywords

corporations, health care, Medicaid, Medicare, neoliberalism, nursing home industry, political economy

Introduction

Beginning in the 1960s, U.S. government policy largely created, and subsequently facilitated the corporatization of, a powerful, multi-billion dollar nursing home industry. The history of government health care for the low-income elderly is a partial counter example to neoliberal program cuts and outsourcing that began in the 1980s. Neoliberalism typically refers to both an ideological stance and a set of policy initiatives emphasizing market solutions and deregulation that gained serious traction during the Reagan/Thatcher years and intensified with the fall of the Soviet Union (see Cahill and Konings, 2017; Flew, 2014). Overall, corporate power expanded, as governments sold off formerly public-owned enterprises, such as rail systems, to large firms and/or contracted with private companies for services once provided by government (Crouch, 2011). Neoliberal-inspired policies weakened the “post-WWII compromise” between business and labor that had provided a social safety net for large numbers of people (Duménil and Lévy, 2011).

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In many ways, government health insurance for low-income elderly runs counter to both neoliberal *and* progressive agendas. Medicare and Medicaid coverage of care for low-income elderly, which one might expect to be subject to neoliberal cuts or outsourcing, has not only persisted but vastly expanded. Following David Harvey (2005: 19), who contends that neoliberal ideology is primarily a “project to re-establish the conditions for capital accumulation and to restore the power of economic elites,” I suggest that specific Medicare and Medicaid program expansions are partially explained by the fact that a large industry benefitted from the status quo.

The case of U.S. Medicare and, especially, Medicaid policy also raises questions about programs typically considered antithetical to neoliberalism, namely the provision of social welfare and regulation of industry. I suggest that U.S. government provision of health care for the low-income elderly via Medicaid (and, to some extent, Medicare) has the paradoxical effect of facilitating capital accumulation and thus, by extension, exacerbates some of the very social and economic inequalities the program is meant to alleviate.

Academic work on Medicare and Medicaid is abundant; but sociological research on the nursing home industry is surprisingly limited, especially considering the enormity of its social and economic significance. Writing about the U.S. health care system as a whole, Fennell and Adams (2011: 207) explain that “the multiplicity of forms confuses not only practitioners and patients who directly interact with the system but also scholars who are left unable to develop conceptual schemes that capture its diversity.” A related question is how, under what types of sociological categories, we should think about nursing homes. Ethnographies of nursing homes examine the routines of non-physician workers, as well as the experiences of patients and family; such work documents how nursing homes extract profit by exploiting low-wage workers (Diamond, 1992; Rodriguez, 2014). Researchers consider nursing homes in the context of social welfare (Harrington Meyer and Bellas, 1995), as a part of the health care system (Harrington et al., 2015), and/or as a component part of a broad set of institutions dealing with aging (Estes and Associates, 2001). A number of scholars (e.g. Harrington et al., 2014) examine the effects of regulations on the quality of patient care or staffing levels; others ask whether quality of care varies depending on type of ownership (Grabowski et al., 2016; Stevenson and Grabowski, 2008). Charlene Harrington, a scholar-expert on the industry, argues that private, for-profit ownership of nursing homes is associated with deficiencies in services, including insufficient staffing (see Harrington et al., 2017). Carroll Estes (1979, 2014) considers nursing homes as part of a larger “aging enterprise,” which “assures that the needs of older adults will be processed and treated as a commodity (e.g., medical services) and sold for a profit” (Estes, 2014: 94). In examining how government policy facilitated the corporatization and consolidation of the nursing home industry, I build on Harrington’s and Estes’ critical research on the political economy of elder care.

Nursing homes are a central component of a multi-billion dollar elder-care industry; the approximately 15,600 nursing homes in the United States employ about 1.7 million people (IBIS World, 2017) and typically care for about 1.4 million residents at any given time (one-third of whom are permanent residents).¹ More than \$160 billion is spent annually on care in nursing homes and continuing-care retirement communities (Centers for Medicare and Medicaid Services (CMS) 2016). Medicaid payments for long-term services and supports (which include both institutional and home- and community-based services) reached \$158 billion in 2015 (Eiken et al., 2017). The lion’s share of this government funding finds its way to private, for-profit, companies. One of the largest U.S. nursing home companies, Genesis, reported earnings of \$5.7 billion in 2016 from nursing homes and other eldercare services (Yahoo Finance, 2017). The Health Care Association (AHCA), the powerful trade organization representing the industry, has close ties to lawmakers and regularly lobbies in the interest of its member institutions (see Viebeck, 2013).

The nursing home industry evolved and vastly expanded as a result of government funding and industry dependence on government programs persists (Harrington et al., 2016; Kaffenberger, 1998; Vladeck, 1980). In *Unloving Care*, social insurance advocate and industry expert Bruce Vladeck (1980: 4) wrote: “The existing nursing home industry is almost entirely a creation of public policy.” Harrington (1984: 481) echoes this assessment, explaining that “Nursing homes were a cottage industry until the early 1960s when they began to expand with the infusion of public funds from Medicaid and Medicare.” More recently, an administrator for a state nursing home trade association explained: “We sink and swim based on government funding” (Interview, 21 March 2017).

Over half of nursing home revenues derive from government-funded Medicare (national health insurance for the elderly) and Medicaid (national- and state-funded health insurance for low-income citizens) (Harrington et al., 2016). In 2012 Medicare spent \$62 billion on “nursing and therapy for patients in rehabilitation facilities, nursing homes, long-term care hospitals and in their own homes” (Rau, 2013). Medicaid spent \$43.8 billion on long-term care in nursing facilities in 2016 (Kaiser Family Foundation, 2017). Almost 63% of long-term care users in nursing homes pay with Medicaid (Harris-Kojetin et al., 2016).

To analyze and document the evolving government–nursing home relationship, I draw from trade publications, government agency reports, Congressional testimony, newspaper reports, and existing scholarly research. Initial information on current trends derive from approximately 20 hours of interviews (recorded and transcribed) with a primary informant, who is a skilled-nursing facility-specialist physician, as well as hour-long informational interviews with a nursing home trade association administrator and a physicians’ group administrator. Interviews were initially coded, following Strauss and Corbin (1998), as were notes from government reports and trade publications, to identify, among other things, important organizational actors and policy developments. Through an iterative process, I revisited and revised the categories, and identified four time periods, each characterized by specific policy structures and trends. Though these four time periods are not completely distinct, they are useful to illuminate policy and industry trends and reveal how policy initiatives align (and fail to align) with neoliberal chronologies.

First, in the early part of the 20th century, care occurred largely in people’s homes, often paid for with government stipends to low-income elderly. Second, in creating government-funded – but mostly privately operated – health and custodial services for the elderly in 1965, the U.S. state set the stage for the growth of large for-profit nursing homes chains (Vladeck, 1980). This industry, in turn, subsequently worked to influence regulations and ensure continued government funding (see Kaffenberger, 1998). Third, the period from the late 1980s to 2010 was one of both increased regulation as well as governmental belt tightening. Finally, today, the nursing home industry is increasingly integrated into the larger health care system and is experiencing further consolidation. In addition, a home health care industry is rapidly expanding in conjunction with the same government funding sources.

1930s to the mid-1960s

Care for the frail and infirm elderly, like care for children, represents a dilemma in capitalist societies where people – especially women – work away from home. Early solutions consisted of alms houses and also payment to other community members to house and/or care for the frail elderly. A provision of the 1935 Social Security Act that provided funds to low-income elderly led to the creation of a fledgling nursing home “industry,” consisting mainly of small home-based businesses. Hawes and Phillips (1986: 495) explain that,

the new flow of income to older people allowed private homes to provide some health services or supervision for those in need—rather than just board and care. In addition, the economic problems

engendered by the depression encouraged many individuals [...] to enter the business of providing “nursing” care in their homes.

In the post-WWII era, additional changes in public policy and in the health care sector contributed to the growth of both small-scale nursing facilities as well as free-standing nursing homes. Among other things, amendments to the Social Security Act allowed states to use public assistance funds to pay for health care. States were allowed to reimburse nursing homes or other providers directly; however, if they did so, states were required to license institutional providers. State licensing regulations had the effect of making nursing homes more hospital-like and institutional (Watson, 2010). Nonetheless, most nursing home care was still paid for by individuals out-of-pocket.

1960s to 1980s – Rapid Expansion

In 1965 additional amendments to the Social Security Act created Medicare and Medicaid. Medicare, a federal program, provided health insurance for all elderly citizens. Medicaid, designed for low-income citizens, was funded by both the federal and state governments and administered by states. Medicare does not provide long-term care but Medicaid always has, so long as the recipient is low-income (specific requirements have always varied by state). Though this was to change, Medicaid initially covered long-term care only if it was received in an institution; home care was not covered. This emphasis on institutionalized care facilitated the rapid growth of a new nursing home industry that profited from Medicaid dollars (Vladeck, 1980). As of 1960 only about 20 percent of nursing home funding was public; by 1982 that had risen to 56 percent, largely due to the establishment of Medicaid (Harrington et al., 1988).

Industry Growth

The availability of funding, the methods of reimbursing facilities, growing demand, and lax health and safety regulations caused the supply of nursing home beds to increase rapidly and large nursing home chains quickly established themselves (Hawes and Phillips, 1986). From the time Medicare and Medicaid were established until the early 1980s, federal government actions expanded both eligibility and coverage; the nursing home industry likewise expanded. A 1974 U.S. Senate subcommittee report stated:

The growth of the industry has been impressive. Between 1960 and 1970 nursing home facilities increased by 140 percent, beds by 232 percent, employees by 405 percent, and expenditures for care by 465 percent. Measured from 1960 through 1973, expenditures increased by almost 1,400 percent. (U.S. Congress, Senate Subcommittee, 1974: XII)

This growth in the number of nursing facilities resulted both from the availability of funds from Medicaid coupled with the rapid growth of the elderly population due to increased life expectancy. The number of people over 65 grew from 16,560,000 (9.2 percent of the total population) in 1960 to 25,549,000 (11.3 percent of the total population) in 1980 (U.S. Census Bureau, 2014). Projections showed that the number and percentage of the elderly would continue to increase rapidly.

These projections, together with continued government funding, led more large-scale investors into the nursing home business. In pre-Medicaid days, a free-standing nursing home would likely have been financed by a local bank but after Medicaid was introduced companies increasingly raised capital on the stock market (Kaffenberger, 1998). In 1966, only a few companies owning nursing homes were registered with the Securities and Exchange Commission but that number

reached 90 by 1970 (Hawes and Phillips, 1986). As of 1972, “106 publicly traded corporations controlled 18 percent of the industry’s beds and accounted for one-third of the industry’s 3.2 billion in revenue” (U.S. Congress, Senate Subcommittee, 1974: XVI). An additional boon for corporate-owned chains was a Federal Housing Administration bond guarantee, which allowed companies to combine loans for facilities and sell them as bonds (Kaffenberger, 1998). With access to capital from the sale of bonds and the stock market, the industry quickly consolidated. The three leading chains dramatically increased their control of nursing home beds and facilities.² In 1973, the largest three chains owned just over two percent of all beds; 10 years later, the top three chains owned almost 10 percent of beds – a 54% increase (Hawes and Phillips, 1986).

Regulation

As the industry grew and consolidated during the 1960s and 1970s, news reports revealed patterns of negligence and abuse in many nursing homes, including over-use of drugs, unsanitary conditions, unnecessary use of restraints, poor food, and inadequate fire protection. The 1974 Senate sub-committee report concluded that over 50% of nursing homes were substandard and that

the United States has no consistent policy with respect to treatment of the infirm elderly. In addition, State public assistance formulas contain financial incentives which guarantee poor care; doctors avoid nursing homes; the enforcement system is not working; and 80 to 90 percent of patient care in nursing homes is being given by untrained aides and orderlies. (U.S. Congress, Senate Subcommittee, 1974: 205)

Some standards and regulations existed since Medicaid began funding nursing home stays; enforcement, however, had been almost universally lax. As a result of increased scrutiny (including the Senate Subcommittee investigation), by the mid- to late-1970s states began to enforce existing standards more strictly and adopted new regulations to improve quality of care. These changes, including enforcement of building and fire safety standards, had the effect of pushing the small nursing homes out. Hawes and Phillips (1986: 504) explain that

through enforcement of building and fire safety standards, government policy contributed to the demise of the “mom and pop” nursing home. However, the nursing home chains, particularly those that sold stock on the open market, had entered the business with Medicare, and most of their facilities were newly built. So, enforcement of new building and fire safety code standards did not represent a serious problem for most of them. Indeed, enforcement of these standards helped the chains by eliminating some competitors (closing from 10 to 20 percent of the homes from state to state) and giving them an opportunity to construct new, larger facilities.

Such an interpretation is in line with social historian Gabriel Kolko’s (1963) argument that large firms may welcome or even seek government regulations, which solidify their power relative to small firms.³ Kolko explained that in the early 20th century, the large meat packing firms welcomed government regulations rather than wishing to avoid them; such regulations served the interest of large firms while pushing out smaller competitors.⁴

To summarize, Medicare and Medicaid are most often categorized as social welfare programs that expanded health care coverage to those in need. Critical scholars contrast the post-WWII era as a time of increased social welfare programs and regulatory expansion that ended with the advent of neoliberalism in the 1980s and 1990s (e.g., Duménil and Lévy, 2011; Mercille, 2016). In the U.S., however, Medicare and Medicaid – government provision of health care to the elderly – largely created the nursing home industry, then contributed to its consolidation. The augmentation of benefits and accompanying availability of investment capital sparked the growth of a nursing home industry that

quickly became largely corporatized. Initial lax regulation of nursing homes allowed for a variety of players; yet increasing regulation and enforcement permitted the larger companies to consolidate their power in the field. Though it has always been somewhat volatile, once the industry initially consolidated, it was comparatively stable until the 1990s (Zinn et al. 2000).

Late 1980s to 2010 – Slower growth

The third phase I identify spans the late 1980s up to the passage of the Affordable Care Act in 2010. This period saw the institution of new and important government rules and oversight, while the industry experienced slower growth, increased consolidation and volatility. Between 1987 and 2010, three specific governmental actions⁵ reshaped the nursing home industry: 1) the Omnibus Reconciliation Act of 1987 (OBRA 1987); 2) changes in the Medicare payment system in 1997; and 3) a Supreme Court decision in 1999.

OBRA 1987 established new quality standards and revamped inspection and enforcement processes (Wiener et al., 2007). This law resulted from years of reports of abuse and scandals in nursing homes. OBRA 1987 significantly increased staffing regulations, requiring nursing homes to have a registered nurse as director of nursing, and it instituted training and competency exam requirements for certified nursing assistants. In order to be Medicaid or Medicare certified, facilities had to demonstrate compliance on a range of issues, including the formulation of a comprehensive care plan for each resident and regular periodic assessments of each resident. Facilities were also required to provide dietary, rehabilitation, and social work services. The Act mandated states to inspect nursing homes (unannounced) and subjected non-compliant facilities to sanctions. Although OBRA 1987 resulted in many real improvements in the lives of residents, by 1998–99 between 25 and 33 percent of all facilities still had “serious or potentially life threatening problems in delivering care and were harming patients” (Harrington, 2001: 507).⁶ Thus, while no panacea for improving patient care, OBRA 1987 did significantly alter the regulatory environment of nursing homes.

The price of regulation, though difficult to quantify, was high for federal and state governments and for the industry. The Centers for Medicare and Medicaid Services, together with state agencies, spent \$382.2 million in 2000 on licensing and certification, about \$22,000 per nursing home or \$208 per bed (Walshe, 2001). And though it is not possible to know how much nursing home companies themselves spend, it is clear that the stricter regulations are costly for the industry (Walshe, 2001). It is possible that, just as initial regulations in the 1970s hastened the demise of many small nursing homes, OBRA 1987 contributed to greater consolidation, as small businesses were bought by larger ones better equipped to handle the changes called for by the new regulations (Walshe, 2001). During the 1990s the percentage of corporate, chain-owned facilities grew from 39 to 54 percent of the total number of approximately 16,500 nursing homes. Most nursing home chains had been fairly small but in the 1990s they consolidated rapidly. In 1997 there were 4,770 chains, 89 percent of which had only two to 10 facilities; only 2.6 percent owned 51 or more nursing homes. By 2001, almost 20 percent of beds were controlled by the eight largest chains (Kitchener et al., 2008).

Second, the Balanced Budget Act of 1997 altered the way Medicare paid for services in nursing homes (CMS, 2017). While in the 1960s and 1970s most nursing home revenues came from Medicaid, beginning in the 1980s, nursing homes expanded their services to provide post-acute care, which was covered by Medicare. The Balanced Budget Act of 1997 resulted in lower payments for these post-acute services, which were now a larger portion of nursing homes’ revenues. This change in Medicare reimbursement may have contributed to increased industry volatility (Kitchener et al., 2005).⁷ The industry saw an increase in mergers and also in bankruptcies (Kitchener, O’Neill and Harrington, 2005; Kitchener, O’Meara, et al., 2008). Zinn et al. (2009) identified the new Medicare payment system as one important reason why numerous nursing

facilities failed between 1996–2005. They explain that as a result of the new payment system “a number of firms sustained major losses. For example, Genesis Health Ventures, a major nursing home chain, reported a 25% drop in average daily payments” (Zinn et al., 2009: 933).⁸ A study of nursing home bankruptcies in California (Kitchener et al., 2005) found that chains were more likely than independently-owned facilities to enter bankruptcy. Bankrupt chain facilities rarely closed but rather continued to operate, often with quality-of-care problems, or were sold. Failing facilities were often those serving vulnerable and low-income populations and an unintended consequence of the Medicare policy change may have been to reduce nursing facility access to those who needed it most (Zinn et al., 2009).

A third important event to shape the trajectory of the industry was the 1999 Supreme Court decision in *Olmstead v. L.C.*, which held that when possible “public entities must provide community-based services to persons with disabilities” (ADA.gov, 2018). In response, some state Medicaid programs began offering, and even encouraging, “aging in place” by funding in-home nursing and other types of in-home and community-based care. This trend, which had begun slowly in the 1980s, accelerated after the 1999 *Olmstead* decision. Home-based care allows patients who might have spent time in nursing homes (or longer stretches of time in nursing homes) to be cared for at home, which states usually prefer, as home care is typically less expensive (Musumeci, 2014). Between 1997 and 2007, the number of nursing home residents per 1,000 people aged 75 and older decreased by 19.9 percent (Wiener et al., 2009). In 2002, the percentage of Medicaid payments for long-term care going to institutional care was 68 percent, compared with 32 percent to home- and community-based care (Musumeci, 2014). By 2015, home- and community-based care had grown to 55 percent of Medicaid spending (about \$87 billion) for long-term services and supports (Eiken et al., 2017).

Overall, from the late-1980s to 2010 the nursing home industry entered a phase of much slower growth and, by the early 2000s, a number of facilities and companies were in financial trouble (see Zinn et al., 2009). While the 1960s, 1970s and early 1980s saw persistent expansion, growth slowed in the 1990s. The number of beds available in U.S. nursing homes totaled 1,624,200 in 1985, peaked around 1995 at 1,770,900 and by 2000 was going down. Occupancy rates (the number of beds occupied) declined from 91.8 percent in 1985 to 87.4 percent in 1995 and down to 86.3 percent in 2004 (Centers for Disease Control, 2016a, 2016b).

While consumer demand for nursing homes waned as home- and community-based alternatives grew, there was also less interest on the part of nursing homes in caring for long-term Medicaid patients, as financially strapped states offered relatively low Medicaid payments for long-term residential care. Nursing facilities thus turned their attention to Medicare. Medicare payments for post-acute care grew at an average yearly rate of 25 percent between 1988 and 1997 and post-acute care, much of which occurs in nursing homes, became the fastest growing category of Medicare spending. As they took on more Medicare-funded, post-acute care, nursing facilities integrated into the larger health care system and moved from being primarily providers of *custodial care* to being providers of *health care*.

During this time period, new regulations improved care of residents but also increased expenses for the federal government, states, and nursing homes. As neoliberal policies and practices – including deregulation in certain sectors (such as energy and banking/finance) – took hold in other arenas during the 1980s and 1990s, the nursing home industry instead saw increased regulation.⁹ Meanwhile, state budgets increasingly limited Medicaid payments and state programs encouraged aging-in-place as an alternative to institutional care. The nursing home industry responded by consolidating even more than previously and by diversifying – purchasing home-care services and assisted living facilities and seeking more short-term, post-acute Medicare (rather than Medicaid) patients.

To summarize, changes in government policy led the nursing home industry to recreate itself, following government funding streams. The industry that had initially focused almost exclusively on long-term custodial care diversified into post-acute care and home care, continued to consolidate and was increasingly dominated by large, for-profit chains.

ACA (2010) to Present – Nursing Facilities Become “Mini-Hospitals”

The time period since the passage of the Affordable Care Act (ACA) has witnessed the ongoing integration of nursing facilities into the larger health care system and can be characterized by two important trends. First, from the industry perspective, the financial importance of long-term, custodial care in nursing facilities continued to decrease. The reduction of Medicaid payments by financially-strapped states made care for custodial residents less lucrative and funding for home-based care allowed an expansion of home-based opportunities. Home health care, 77% of which is paid for by Medicare and Medicaid, has now grown to a multi-billion dollar industry.¹⁰ Second, as nursing facilities have become central to short-term, post-acute care funded by Medicare, the importance of short-term post-acute care for nursing facilities' bottom lines has continued to increase.

The director of a state nursing home trade association discussed the transition away from custodial care and toward post-acute services, explaining that

continued pressures of the reimbursement system that really is budget-driven as opposed to quality-driven or staff-driven has put immense pressure on providers', our members',¹¹ ability to make sure that we can provide high quality services. ... [Medicaid], which pays for the care of 68% of long-term care residents in [this state], has ... had an awful decade of underfunding nursing facility care ... [M]any facilities did try to be very efficient by seeing what they could do by trying to squeeze costs out of their budget, but they also needed to look at other payers and another source of revenue. And that's really when the facilities saw the opportunity to take care of Medicare rehab patients. (Interview, 21 March 2017)

Medicare pays \$500 to \$600-a-day for a post-acute care, while Medicaid pays an average of about \$125 a day for a long-term care resident (Gleckman, 2013). Thus, following a trend that began in the 1990s, nursing facilities continue to provide more post-acute and rehabilitation services, which are paid for by Medicare. Between 2008 and 2012, the number of Medicaid-only facilities (those that do not provide rehab or post-acute care) dropped by 25.9 percent, to 536 (CMS, 2013). In essence, nursing facilities are becoming hospital-like, handling more complicated medical conditions than they did in the past and increasingly providing ancillary care, such as wound management and respiratory therapy.

As insurers call upon hospitals to reduce patient stays, post-acute care, required by patients unable to care for themselves while recovering from a major illness or accident, increasingly occurs in nursing homes. In 2012, Medicare spent \$62 billion for post-acute care, a large percentage of which (\$27 billion – over 40 percent in 2013) went for services in nursing facilities (Mechanic, 2014). Post-acute care spending has grown faster in recent years than other categories of payments (Mechanic, 2014). The CEO of a major skilled nursing company, explained “if you're an operator continuing to take care of custodial patients, you're going to get killed” (quoted in Spanko, 2018). According to the American Health Care Association (n.d.), the powerful national trade association of long term and post-acute care providers,

the integration of post-acute care services in America's skilled nursing and rehabilitation facilities has changed the healthcare delivery system. Without a doubt, the state of post-acute care in nursing facilities

is evolving as facilities continue to treat more short-stay patients and provide intensive medical care for patients requiring a greater variety of complex care services.

The post-acute care and rehabilitation that nursing facilities now provide necessitate higher-level staffing and often call for facility upgrades, both of which are costly investments. The need for such investments may disadvantage small, locally-owned nursing homes, which have less access to capital. The shift may similarly be problematic for non-profit homes. *Skilled Nursing News*, a trade publication, reports that “non-profits have felt particularly squeezed by recent skilled nursing pressures on multiple fronts, prompting them to sell off their skilled facilities — typically to for-profit entities” (Flynn, 2018).

Indeed, the industry not only continues to consolidate but, like other parts of the economy, is undergoing important changes in ownership structure. As of 2014, about 70 percent of skilled nursing facilities were for-profit and about three-fifths were chain-affiliated (Government Accountability Office, 2016). While the total number of beds remained about the same, this reflects change in control over those beds. In 2009, the biggest company, HCR ManorCare, owned 277 facilities with 38,140 beds. By 2016, the largest company, Genesis HealthCare, had 512 facilities and 56,575 beds (Provider Magazine, 2016). Thus, as usage trends and reimbursement levels changed, the nursing home industry adapted in order to continue profiting from government-funded programs.

The Affordable Care Act, meanwhile, called for two innovations in health care payments with serious implications for nursing homes: bundled payments and accountable care organizations (ACOs). Both of these are designed as cost-saving measures and both are organizationally complex. Bundled payments entail paying one fee for a “health episode” (for example, a hip replacement). Rather than reimbursing separate fees for each test, procedure, physician consultation, etc., Medicare would pay one fee that would then be divided among providers (see Shay and Mick, 2013).¹² Accountable care organizations are groups of providers who together agree to provide care to a group of patients over time for a set cost. Both of these new structures require large amounts of data collection and sharing. Upgrades in IT and staff training are expensive and also necessary for the new types of relationships called for by these structures.

As the economic incentives change around them, nursing facility executives look for new financial streams. One profit-enhancing mechanism involves the creation of complex, often labyrinthine, ownership and management structures, which create tax advantages and/or allow companies to move capital from one entity to another. Nursing home owners often outsource goods and services to multiple entities in which they also have an ownership or financial interest. According to a Kaiser News Service report, “Nearly three-quarters of nursing homes in the United States – more than 11,000 – have such business dealings, known as related party transactions” (Rau, 2017). These “related” companies provide physical therapy, food service, management, drugs, or other services. According to the Kaiser report, “owners can establish highly favorable contracts in which their nursing homes pay more than they might in a competitive market. Owners then siphon off higher profits, which are not recorded on the nursing home’s accounts” (Rau, 2017). In 2015, nursing homes paid related companies \$11 billion (Rau, 2017). As nursing facilities increase the number and types of post-acute therapies and services they provide, the ability to engage in related-party transactions expands.

In addition, buildings may be owned by real estate trusts, then rented or leased back to the nursing home by a management company. Complex ownership and management structures exist in other sectors of the economy but the separation of real estate from operations is particularly marked in the nursing home/assisted living sector. Ownership may be decentralized “across distinct sub-companies.” Many nursing facilities have been converted into real estate investment trusts, further complicating ownership structure (Blankenhorn, 2013). This complexity is purposeful. Since the

1990s, lawsuits are routinely brought against nursing homes, often by children of residents, claiming injury or/and negligence (Stevenson and Studdert, 2003). Rau (2017) explains that

... at a 2012 Nashville conference for executives in the long-term health care industry, a presentation slide from nursing home attorneys titled “Pros of Complex Corporate Structure” stated: “Many plaintiffs’ attorneys will never conduct corporate structure discovery because it’s too expensive and time consuming.” The presentation noted another advantage: “Financial statement in punitive damages phase shows less income and assets.”

The Affordable Care Act incorporated the Nursing Home Transparency and Improvement Act of 2009, which called for increased transparency and reporting “because complex ownership, management, and financing structures were inhibiting regulators’ ability to hold providers accountable for compliance with federal requirements” (Kaiser Family Foundation, 2013: 4). Transparency and accountability have, however, proved elusive, in part because “knowing the proprietary status of a nursing home provider is insufficient to discern how organizational assets are structured and the operational approach of the company managing the delivery of nursing home services” (Stevenson et al., 2013: 30). Finally, the private equity purchases of nursing home companies as well as large-scale mergers can render the system even more obscure. Industry observers stated that “2017 ended with a flurry of blockbuster [merger and acquisition] activity, including insurer Humana acquiring a stake in the home health, hospice, and community-care operations of Kindred Healthcare (NYSE: KND) for \$4.1 billion” (Spanko, 2018).

To summarize, partially as a result of the ACA and partially due to trends underway prior to 2010, nursing homes are rapidly integrating into the larger health care system; they provide more short-term rehabilitation and post-acute services than in the past and they are less focused on long-term residential care, though they remain key providers of long-term care for people with dementia (a rapidly growing population). The industry has transformed in order to continue to take advantage of government funding streams. A for-profit home-care industry is expanding rapidly, based largely on the same funding sources (Medicare and Medicaid). And, in its for-profit form, home care similarly provokes complaints of fraud and abuse (see Nelson, 2016). Meanwhile, ownership structures and use of subsidiaries maximize profits but are complex and often difficult to trace. Complicated arrangements allow companies to hide assets and shield owners from liability. Private equity companies, whose reporting requirements are limited compared with publicly-traded equities, buy nursing homes and nursing-related firms to profit, ultimately, from government dollars.

Discussion/Conclusion

The for-profit nursing home industry (now connected with assisted living and home health care sectors) that was born with the institution of Medicare and Medicaid has shape-shifted numerous times in relation to government policy, always in the interest of extracting profit. This policy evolution differs in terms of timing and content from what neoliberal ideology would suggest. Yet U.S. policy vis-à-vis health care for the elderly should also not be considered progressive. While social welfare provision is typically viewed as a means of decreasing insecurity and inequality, the case presented here points to the simultaneous potential of such programs to produce inequalities.

Policy changes subsequent to the institution of Medicare and Medicaid run counter to neoliberal tenets of deregulation and privatization. First, the nursing home industry has seen increased regulation, rather than less. In the 1960s and 1970s, nursing homes were loosely regulated. Regulations were instituted and strengthened from the late 1980s to the present, an era that often saw weakening of regulations in other sectors, such as banking and energy. Nursing home regulation resulted from

truly horrific conditions and was much needed. At the same time, increased regulation may have benefited large companies, which disproportionately have the human and capital resources to implement new rules, at the expense of smaller companies and non-profits. Second, the primary neoliberal justification for promoting privatized solutions for institutions such as schools, prisons or health care is cost savings for taxpayers. In these cases, governments supposedly award contracts to the most attractive bidder. In the case of schools or prisons, companies lobby lawmakers in favor of privatization; in the case of nursing homes, companies typically support the current system, which is already privatized in the sense that government funds private, for-profit entities to provide nursing care rather than providing that care directly. The result may be higher profits for industry and higher costs for taxpayers.¹³ The fact that the nursing home industry has historically benefitted from the status quo may be one reason Medicare and Medicaid have survived certain neoliberal-inspired cuts. By contrast, Medicaid's related program, Aid to Families with Dependent Children (AFCS), with no corporate lobby to advocate for Congressional support, was ultimately dismantled.¹⁴ The evolution of the nursing home industry indicates that neoliberal initiatives can unfold differently depending on whether and to what extent corporate interests already have a foothold in any given sector.

The history of the government–nursing home industry relationship also challenges progressive interpretations of certain social welfare policy, especially Medicaid. The creation of Medicaid and Medicare in 1965 coincides loosely with the time period in which governments, to some degree at least, reined in excesses of capital and reduced inequalities (Duménil and Lévy, 2011; Mercille, 2016). However, the mechanisms of U.S. provision of long-term care for the elderly allowed for-profit companies to flourish. Though social welfare and health-care programs are typically said to reduce economic and social insecurity (see, e.g., Wagnerman, 2018), Medicare and Medicaid payments to for-profit nursing homes (and, more recently, home care) foster capital accumulation. If capital accumulation produces inequalities, then Medicare and Medicaid, by providing funding to for-profit companies, contribute to growing inequality and insecurity. While these programs assist infirm elderly in the short term, in the long run they may foster the need for more Medicaid (and other social safety-net) funds as a result of this growth in inequality.

The government–nursing home industry relationship has always had a neoliberal *leaning* in that Medicare and Medicaid target individuals and facilitate “market” solutions. In instituting Medicare and Medicaid, the U.S. did *not* create a system of government-run nursing homes or specifically incentivize the development of not-for-profit nursing homes, as it might have done. Purposefully or not, lawmakers created a system of large, for-profit, chain nursing homes. Early (pre-Medicaid) arguments in favor of a private, for-profit system of elder care focused in part on the premise that such a system could ultimately provide services at a lower cost (see Kaffenberger, 1998). But potential cost-savings, if they exist, have come at the expense of patients and workers (Diamond, 1992).¹⁵ Even the former CEO of the national nursing home lobby has questioned the U.S. model. In a letter to the editor of the *New York Times*, Paul Willging (2007: 411) wrote:

as past chief executive of the American Health Care Association, I began to suspect a possibly inherent contradiction between publicly traded and other large investor-operated nursing home companies and the prerequisites for quality care. Can the investor's focus (short-term profitability) simultaneously allow a comparable focus on the patient? I think the answer has to do with time frames. Unfortunately, for many investors, those time frames are short. Earnings growth, quarter after quarter, is often paramount. Long-term investments in quality can work at cross purposes with a mandate for an unending progression of favorable earnings reports.

That it comes as a surprise to anyone that the needs of elderly health care consumers and the low-wage workers who care for them might not be best served by for-profit entities illustrates the pervasiveness

of a belief in the power of “the market.” Corporate entities exist to make profits and, thus, seek to provide goods and services in such a way that maximizes their growth and financial bottom line. As Baran and Sweezy (1996/1966: 25) explain in their classic work on monopoly capitalism: “The major goals of modern large-scale business are high managerial incomes, good profits, a strong competitive position, and growth.” These goals conflict with those of the general public not only in the political realm; externalization of costs in the interest of profit maximization harms workers and communities.

The case presented here provides evidence in support of the claim by critical scholars that neo-liberal ideology operates mainly as a means to legitimate the capital accumulation and power of an economic elite (Harvey, 2005; Mercille, 2016). The status quo is neither in the best interest of elderly clients nor those who care for them. Research shows that not-for-profit entities provide better care for elderly people in nursing homes (see, e.g., Harrington et al., 2012). Neither is for-profit care likely to be the lowest-cost option. Medicare and Medicaid policies have allowed for-profit, corporate entities to earn billions of dollars. While non-profits or government-owned entities provide no panacea, they are likely better options than the current, profit-dominant model. Future research should continue to investigate the differences in quality of care between for-profit and not-for-profit nursing homes and might also investigate whether (and how) government policy might prioritize non-profit care providers.

The case of U.S. elder health care policy also indicates that even while taking actions (e.g. provision of social welfare and regulation of industry) that most would label “progressive,” the government facilitated capital accumulation and corporatization; future research should further investigate this dilemma. Scholars might address the question of when and how corporate elites welcome – or even seek out – increased regulation while other corporate actors seek to remove regulations (see Stigler, 1971). Progressives, who often want to ensure that business is strongly regulated in the interest of worker, consumer and citizen wellbeing, may be hesitant to take up the question of whether and how regulations benefit big companies at the expense of smaller enterprises. Regulations are important for myriad reasons; yet if they are constructed in a way that facilitates corporatization and consolidation, regulations might serve to increase corporate power and, by extension, inequalities. Activists interested in reducing inequalities should heed the lesson of U.S. policy and the nursing home industry. While compromises (such as the Affordable Care Act) that prioritize private, for-profit solutions might seem desirable as “a first step” toward a more just and equitable system, once large, for-profit companies have a foothold, their power to maneuver within – and to manipulate – existing policy structures increases and inequalities persist.

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Notes

1. According to the Centers for Medicare and Medicaid Services (CMS, 2018), “Nursing home is a term that includes both skilled nursing facilities and nursing facilities. Skilled nursing facilities (SNFs) are those that participate in both Medicare and Medicaid. Nursing facilities (NF) are those that participate in Medicaid only. Nursing homes primarily engage in providing residents skilled nursing care and related

services for residents.” Almost all nursing homes provide custodial care to low-income elderly, about 50 percent of whom suffer from dementia. SNFs also provide short-term, post-acute care to patients, mostly Medicare recipients, who have been discharged from hospitals (CMS, 2015).

2. Hawes and Phillips (1986: 501) write that, “Beverly Enterprises increased its facilities by 600 percent, ARA its holdings by approximately 250 percent, and Hillhaven by 200 percent. This growth pattern far outdistanced the growth rate in the total number of nursing home beds and facilities, which was only 18 percent during the same period.”
3. It is important to recognize that the national nursing home lobby – the American Health Care Association (AHCA) – as well as state trade associations lobbied lawmakers and contributed to policy construction (Kaffenberger, 1998). According to the Center for Responsive Politics (2019) the AHCA spent almost \$4 million on lobbying efforts in 2018. In addition, the fact that states administer Medicaid and are responsible for monitoring and inspecting nursing homes has had important implications for the development of the industry. To thoroughly understand how the industry contributes to shaping policy one would need to look state by state. Nursing home trade associations and lobby groups typically have a strong state-level presence. Walshe (2001: 138) writes that “nursing home providers have made large political contributions; in some states nursing home providers are prominent in the local political party hierarchies; and some state and federal legislators have substantial financial interests in nursing home care.”
4. Today the argument that regulations help big business at the expense of smaller enterprises is rarely considered by progressives but is discussed in right-wing circles (see, e.g., Rockwell, 2012).
5. I discuss these three events as major shapers of the nursing facility industry but it is important to note that other changes – for example: consumer demand, changes in private insurance, and state-level policies – occurred and were important during this time period as well.
6. Harrington attributes these nursing home deficiencies largely to the for-profit, corporate model, which maximizes profits in part by providing minimal staffing and paying low wages (resulting in high turnover). Harrington (2001: 510) states: “The government is reluctant to impose higher standards for staffing because of concerns over cost. Although the government pays 62% of nursing home bills ... financial accountability for expenditure does not extend to rules governing the services to be provided, the types of services, how much profit can be made, and how much is spent on administrative costs and other expenditures.”
7. Though, as Kitchener et al. (2005) point out, bankruptcies were likely due in part to strategic decisions by corporate leaders as well as Medicare reimbursement changes.
8. Other causes of nursing facility failure included poor investment decisions and malpractice lawsuits.
9. In large part, this is explained by the role of advocacy groups and reports by investigative journalists, who documented the appalling conditions of many nursing homes.
10. There were 12,400 home health agencies in the United States in 2014, 80 percent of which were for-profit (Centers for Disease Control, 2016a). An industry analysis (Harris Williams, 2013: 1) points to a “large, rapidly growing market” in home healthcare and states that while the market remains fragmented, “larger agencies are actively consolidating to spread fixed costs across broader populations.”
11. The members include virtually all for-profit (70%) and not-for-profit nursing homes in the state.
12. Medicare has used set fees for specific diagnostic categories (“diagnostic related groups” or DRGs) for inpatient hospital care since the 1980s. “Bundled payments” update DRGs by including care before and after hospitalization (and thus now pertain to care in nursing homes).
13. Discussing the medical-industrial complex as a whole, Estes and Associates (2001: 183) write, “After three decades devoted to market rhetoric, cost containment, and stunning organizational rationalization, the net result is the complete failure of any of these efforts to stem the swelling tide of problems of access and cost.”
14. The replacement of AFDC with the Personal Responsibility Act was the result of a number of complicated factors, among them racism and sexism (Mink, 1998). I suggest that in addition to these, AFDC lacked corporate proponents while Medicaid benefitted from corporate support via trade associations and business advocacy groups.
15. Certified nursing assistants, the main care providers in nursing homes, received an average annual salary of only \$27,510, just over \$13.00 per hour, in 2017 (Bureau of Labor Statistics, 2019).

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