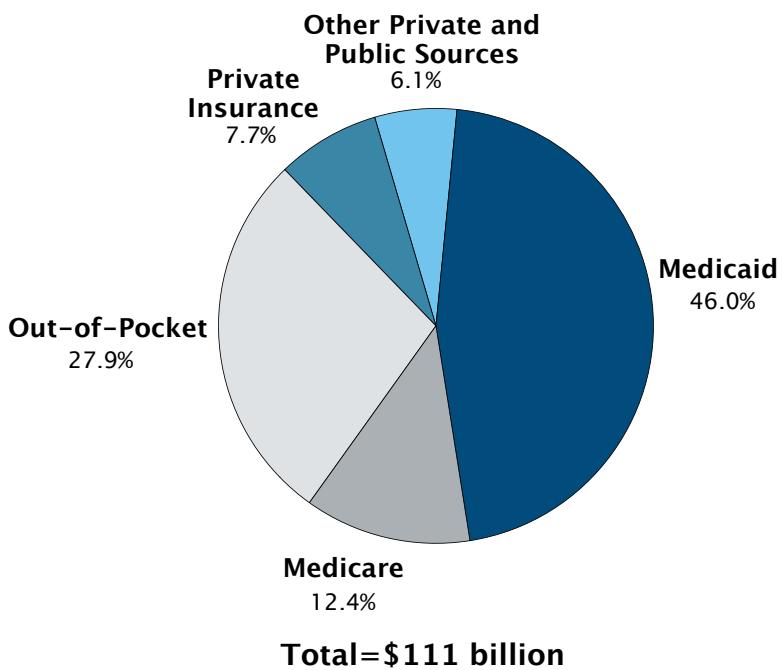


# Medicaid's coverage of nursing home costs: Asset shelter for the wealthy or essential safety net?

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One of the most persistent questions in U.S. social policy concerns the mix of personal and public responsibility for long-term care. Although most long-term care is provided by family members on an unpaid basis, most of the nation's long-term care spending (three-fourths) is concentrated on nursing home care, and Medicaid, the nation's health care program for poor and low-income Americans, is the largest source of payment for that care.<sup>1</sup> Nearly half of the nation's nursing home bill was paid by Medicaid in 2003, while just over a quarter was paid out-of-pocket, and less than 10 percent was covered by private insurance (see Figure 1). For some, this distribution of financial responsibility raises concerns about who is, and who should be, paying for long-term care. Most especially, critics contend that Medicaid has been stretched beyond its original purpose of providing a safety net for the poor, and has evolved into a middle class entitlement and an asset shelter for the rich.

**Figure 1**  
**Distribution of National Spending on Nursing Home Care, by Source of Payment (2003)**



SOURCE: Centers for Medicare & Medicaid Services (CMS), National Health Expenditures by Type of Service and Source of Funds, Calendar Years 1980-03, <http://cms.hhs.gov/statistics/nhe/default.asp>.

As the nation's safety net for long-term care, Medicaid provides assistance to the poor, and to those who are impoverished by high medical and long-term care spending. To be eligible for Medicaid assistance with the costs of nursing home care, individuals must have limited assets, and must contribute all of their available income toward the cost of that care. The widows who make up the bulk of the nation's nursing home population must reduce their "countable" assets to \$2,000 or below, and contribute all of their monthly income (with the exception of a \$30 to \$90 "personal needs allowance") toward the cost of their care.<sup>2</sup> Special rules allow married couples to set aside income and assets for a community spouse (within federal guidelines), but many states allow community spouses to keep only the federal minimum levels of income (\$1,561 per month) and assets (\$19,020)—hardly enough assets to assure financial security in retirement.<sup>3</sup>

Although the law requires Medicaid beneficiaries to contribute or spend down their income and assets, critics contend that "impoverishment is a fallacy"<sup>4</sup> and that Medicaid pays for the care of most nursing home residents because people with the resources to afford their own care—middle-income and wealthier people, even "millionaires"<sup>5</sup>—transfer their assets to qualify for public subsidies intended for the poor. Critics argue that a veritable cottage industry of elder law attorneys has sprung up whose mission is to advise clients with sizable assets about how they can preserve those assets and get Medicaid to pay for nursing home care when they need it. They claim that, rather than spending down (actually impoverishing themselves), the elderly hire estate-planning lawyers and artificially impoverish themselves by establishing trusts, giving cash gifts to children and grandchildren, or otherwise concealing their ability to pay for their own care by converting countable assets to exempt forms (by spending assets on a car or on a home or home renovation, since those assets are not counted in making a Medicaid eligibility determination).<sup>6</sup> Federal law imposes a penalty period (denying Medicaid eligibility for a period of time) for those who shelter or divest assets for the purpose of qualifying for Medicaid, but critics say those penalties are avoided—in whole or in part—by those who get good legal advice.

This reliance on Medicaid, the critics suggest, creates a number of short-term and long-term problems. In the near term, they claim that the middle- and upper-income elderly who seek Medicaid subsidies for nursing home care are drawing finite resources away from other Medicaid beneficiaries (needy children and families) by passing resources to their heirs that could have been used to pay for nursing home care. In the longer term, they argue, a middle class "sense of entitlement" to Medicaid's nursing home benefits creates a significant barrier to the ex-

pansion of private long-term care insurance and a more rational financing system for long-term care.<sup>7</sup> To correct this imbalance, they advocate that Medicaid eligibility be restricted—by, for example, stiffening penalties for those who transfer assets.

Most of these claims about Medicaid's incentive effects are supported only by anecdotal accounts of abuses by the rich. Empirical research paints a very different picture. Research demonstrates that a large proportion of the disabled elderly in the community (who are at risk of nursing home placement) have limited assets. Many qualify for Medicaid in the community, and most would qualify for Medicaid at admission to a nursing home. Most of the elderly with disabilities in the community have too little wealth to warrant hiring an attorney to arrange an asset transfer. Moreover, studies that look at who pays for nursing home care find that, even though they have limited resources, a large proportion of the elderly pay their own way throughout their nursing home stays, and that the elderly are less likely to rely on Medicaid than would be predicted given their resources.

There is little evidence that large numbers of the elderly are planning their estates for the purpose of gaining easy access to Medicaid in the event they need nursing home care. There is no evidence that they use transfers or trusts to significantly shift cost burdens to Medicaid, and little evidence that those who do transfer sizable assets gain eligibility for Medicaid. Furthermore, there is little evidence that Medicaid interferes with savings for future needs, or that it prevents people from purchasing private long-term care insurance. The elderly who expect to need nursing home care—and especially those of modest financial means who are likely to qualify for Medicaid—save more not less than those who do not expect to use nursing home care. Finally, generous Medicaid eligibility explains very little of the very low demand for private long-term care insurance.

This paper reviews the empirical evidence on the prevalence and magnitude of asset transfers to achieve Medicaid eligibility, and the evidence on whether Medicaid's means-testing creates a disincentive to save or purchase private long-term care insurance.

## **Do the elderly transfer assets to qualify for Medicaid?**

In theory, Medicaid's means-testing creates financial incentives for the elderly to hide or transfer their assets to obtain Medicaid eligibility. In reality, most of the elderly at risk of nursing home placement have limited resources and little reason to pursue legal advice to divest their assets.

### ***Most of the elderly lack the financial resources to pay for extended nursing home stays***

Much of this debate is fueled by the perception that the elderly are more affluent than younger households and thus less deserving of Medicaid subsidy. Most elderly households, however, are far from affluent. Although it is true that elderly households are less likely than younger households to live in poverty, the median household income of elderly Medicare beneficiaries is only about \$25,000. Among elderly women living alone (those who are most likely to become nursing home residents), median household income is less than \$12,000.<sup>8</sup>

The conventional wisdom also suggests that elderly households are better off financially—despite having lower incomes—because they have substantially greater wealth than younger households. In fact, although the elderly as a group have higher net worth than the nonelderly,<sup>9</sup> most of the elderly are not wealthy. For many, their primary asset is their home, but their housing equity is modest. In 2000, for example, the median total wealth (financial wealth including home equity of elderly households) was just \$108,885 for the elderly age 65 and older.<sup>10</sup> Excluding home equity, the median net worth of elderly households was just \$23,885. The elderly as a group have substantial resources, but that financial wealth is highly unevenly distributed: assets are almost nonexistent for the elderly in the bottom 30 percent of the wealth distribution, while the top 5 percent have financial wealth (excluding home equity) in excess of \$300,000.<sup>11</sup>

The elderly in poor health, and those with functional impairments (who need or may soon need long-term care), have even more limited financial resources than the non-disabled elderly and those in good health. The elderly in self-reported excellent health have more than three times the wealth of those in poor health; and when households in which two spouses are both in excellent health are compared to households in which both spouses are in poor health, the wealth disparity is ten to one.<sup>12</sup> Studies of the disabled elderly living in the community also show that most have few assets beyond a home, and, consequently, most are financially eligible for Medicaid at admission to the nursing home, or within six months of admission.<sup>13</sup> Few of the elderly have the ability to finance their own long-term care needs when those needs extend over many years.

***Of the elderly with any nursing home use, a substantial share pay their own way***

Despite limited financial resources, most elderly nursing home residents rely on private resources in part or in full to pay the costs of nursing home care. A study of the lifetime nursing home use of the elderly by Brenda Spillman and Peter Kemper reveals that 44 percent of the elderly nursing home users paid for their care using only private funds, 16 percent began as private payers, exhausted their own resources, and converted to Medicaid, and 27 percent were covered by Medicaid upon admission to the nursing home and throughout their use. (The remaining 13 percent of elderly nursing home users were covered by Medicare only or other sources).<sup>14</sup> Contrary to the critics' portrayal, a substantial share of the elderly pays their own way in full because they (or their families) have sufficient income and resources to do so. Moreover, even if they are receiving financial assistance from Medicaid, elderly nursing home residents do pay their own way to the extent that they can. Those who are covered by Medicaid are contributing all of their available income to cover the cost of their own care. The proportion of the elderly who qualify for Medicaid at admission to the nursing home is as high as it is (27 percent) because a large proportion of the disabled elderly in the community have few assets and exhaust what they do have in the community, not because they have transferred their assets.

***There is little evidence that nursing home residents transfer assets to gain eligibility for Medicaid***

Other research studies confirm that Medicaid-induced transfers are not widespread among current or likely nursing home residents. Frank Sloan and Mae Shayne find that people who have a relatively high risk of entering nursing homes (the disabled elderly) have too little wealth to warrant hiring an attorney to arrange an asset transfer.<sup>15</sup> Using data from the 1989 National Long Term Care Survey, Sloan and Shayne find that the majority of the disabled elderly in the community are either already financially eligible or would become eligible for Medicaid immediately upon entering a nursing home. They found that an estimated 19 percent of the disabled elderly in the community were qualified for Medicaid in the community, and an additional 59 percent would have qualified financially for Medicaid at admission to a nursing home. The authors conclude that it is a lack of any significant wealth accumulation beyond a home that accounts for the high likelihood of qualifying for Medicaid, not asset transfers.

Further, in an analysis of the 1985 National Nursing Home Survey, Edward Norton found that nursing home residents spend down to Medicaid at a much lower rate than would be expected given their income and assets.<sup>16</sup> Rather than transferring assets to become Medicaid eligible, some of the elderly may be receiving transfers from children or others, or voluntarily converting housing equity into liquid assets, to extend the period before they become Medicaid eligible. Norton concludes that there is a “strong aversion to welfare,” contradicting the conventional wisdom that Medicaid’s nursing home subsidy creates a strong financial incentive to divest assets.

***There is little evidence that the elderly in general transfer assets to gain Medicaid eligibility***

Critics contend that the middle-class elderly may give large gifts or establish trusts to preserve their assets for heirs. Assets placed in certain kinds of trusts are not treated as financial resources available to pay for care, provided they meet certain criteria. The trust must be irrevocable (meaning the terms of the trust cannot be changed at any time), it must be established well in advance of the application for Medicaid (federal law imposes a 60-month lookback period for assets placed in trust), and the trustor may not have access to the principal, though she may receive income from the trust. However, recent analysis of empirical data reveals that trusts are established by a relatively small proportion of the elderly, and mostly for purposes other than establishing eligibility for Medicaid.

In one paper, economists Donald Taylor, Frank Sloan, and Edward Norton found that approximately 4 out of 10 elderly individuals could potentially alter their Medicaid eligibility status by establishing a trust, but fewer than 1 in 10 (7.8 percent) had a trust, and most of those trusts were not irrevocable (and thus would not meet the standard for a Medicaid trust).<sup>17</sup> The trusts that are established are used primarily by the wealthy to reduce tax burdens and avoid probate. Trusts were not more common among those who believed they might one day need nursing home care: the subjective probability of needing nursing home care within five years did not have a significant effect on existence of a trust. The authors observe that “the vast majority of the group most likely to benefit from the use of trusts to spend down did not have one.” There is “limited rationale for further public policy efforts designed to limit the use of trusts to achieve spend down,” they suggest, “because such behavior is rare.”

The same authors also assessed whether elderly households gave gifts large enough to potentially alter their Medicaid eligibility. Again, they found that the use of gifts to achieve Medicaid eligibility is quite

limited. Analysis of transfers made by the elderly over time out of their accumulated assets show that only 1 in 100 of the elderly gave gifts to children that would be large enough to qualify them for Medicaid nursing home coverage.<sup>18</sup>

Another recent analysis of asset transfers confirms these findings. William Basset finds that 29 percent of the “middle-class” elderly gave gifts to children or grandchildren of \$500 or more, and most of those gifts were relatively small; the typical gift (conditional on having given a gift of \$500 or more) was \$2,000 and the average gift was \$5,000.<sup>19</sup> The largest transfers were made by those with low self-assessed probability of entering a nursing home in the next five years.

Though not specifically focused on Medicaid, another study provides compelling evidence that the wealthy transfer assets to avoid estate taxation, but finds no evidence that those with more modest resources increase their gift giving to qualify for Medicaid. Jonathan Feinstein and Chih-Chin Ho find that asset transfers are more common among those with assets exceeding the estate tax filing threshold than for those with assets below the threshold.<sup>20</sup> The elderly who are relatively wealthy are much more likely to give gifts than those with modest assets, and they are substantially more likely than those with modest assets to give gifts if they are in poor or declining health. Being in poor health apparently spurs the wealthy elderly to increase gift giving to avoid estate taxation. By contrast, the elderly with relatively low wealth who are in declining health hold on to their assets. On average, they don’t give them away to qualify for Medicaid. The authors suggest that the elderly with relatively modest assets who are in poor health may be unwilling to part with assets because they are worried about future medical costs and have a strong precautionary motive to safeguard their assets. Thus, although the estate tax appears to alter the asset allocation decisions of some relatively wealthy individuals, there’s little evidence in this study that Medicaid distorts the decisions of those with more modest resources.

### ***Relatively few Medicaid applicants have transferred assets***

Audits of Medicaid applications also reveal that only a small fraction of individuals who applied for Medicaid, and an even smaller share of those found eligible for Medicaid, transfer assets for the purpose of qualifying for free care under Medicaid. In 1993, the U.S. General Accounting Office (GAO) reviewed more than 400 applications for Medicaid nursing home assistance in Massachusetts (a state thought to have a high level of estate planning).<sup>21</sup> The GAO found that only a small fraction of applicants (1 in 8) had transferred assets (the average amount transferred was \$46,000). Further, about half of the applicants who had transferred

assets were subsequently denied eligibility for Medicaid. A significantly larger share of Medicaid applicants, 50 percent, had *converted* countable assets to exempt forms. Typically, they used “excess” assets to prepay funeral expenses. The amount of assets protected in this way, however, was very small (\$4,700 on average).

***Reforms designed to curb asset transfers would produce only small Medicaid savings***

Estimates of the likely impact of policy proposals to further restrict asset transfers also suggest that there is not a significant asset transfer problem. For example, William Bassett estimates that 220,000 households transferred assets totaling \$1 billion in 1993, largely, he asserts, because of the incentives provided by Medicaid eligibility rules.<sup>22</sup> Eliminating those transfers, he suggests, might have reduced Medicaid nursing home spending by 3 percent in 1993. This is an upper bound estimate, however, since only a portion (and the author cannot say how large or small a portion) of that \$1 billion in estimated “Medicaid-induced” transfers ends up as a cost to Medicaid. Not all of the people estimated to make transfers will actually enter a nursing home, or spend any length of time on Medicaid.

States have also estimated the cost saving potential of restricting asset transfers. Three states have submitted waiver proposals to the Centers for Medicare and Medicaid Services proposing to substantially increase the penalties for asset transfers.<sup>23</sup> By their own estimates, however, the impact on Medicaid expenditures would be small, with estimated savings (over a five-year demonstration period) of 0.6 percent of Medicaid nursing home expenditures in Massachusetts and 1.4 percent in Connecticut.<sup>24</sup>

A proposal in the President’s 2006 budget to tighten rules concerning asset transfers has also been estimated to produce only modest Medicaid savings over 10 years. The Office of Management and Budget estimates that federal Medicaid outlays would be reduced by \$4.5 billion between 2006 and 2015—a reduction of less than two-tenths of one percent in projected federal Medicaid expenditures.<sup>25</sup> State expenditures would also be reduced by an estimated \$3.4 billion.<sup>26</sup>

**Do Medicaid’s means-tested nursing home benefits interfere with future planning?**

Critics suggest that Medicaid eligibility rules create strong disincentives to assume personal responsibility for future long-term care needs. They argue that, because rich and middle class individuals know that

they can “easily qualify” for Medicaid while protecting their assets, they fail to plan for long-term care needs by saving or purchasing private long-term care insurance. They also argue that, for lower income households, the availability of Medicaid, in conjunction with the very sizeable costs of medical care, may make the option of relying on Medicaid preferable to engaging in precautionary savings. Once again, the empirical data—though limited—fail to support the claim that Medicaid deters savings or creates a significant barrier to the purchase of private long-term care insurance.

### ***Medicaid is not a barrier to saving***

A few recent empirical studies provide some evidence that certain means-tested programs reduce savings rates for certain low-income groups.<sup>27</sup> However, available studies do not suggest that the elderly at risk of entering a nursing home are dissaving at faster rates than the rest of the elderly, or failing to accumulate assets, because of an anticipated Medicaid-financed nursing home stay.

Frank Sloan, Thomas Hoerger, and Gabriel Picone investigated whether the prospect of receiving a Medicaid subsidy for nursing home care affected savings by the elderly.<sup>28</sup> The authors found that Medicaid did not crowd out savings (measured by non-housing assets). The wealth holdings of the elderly declined over time, but that asset divestiture (spending out of assets) had little relationship to the likelihood of gaining eligibility for Medicaid. The elderly who reduced their net wealth holdings the most were the wealthiest elderly—and therefore were unlikely to qualify for Medicaid. The elderly who were likely to qualify for Medicaid, in contrast, reduced their savings at a much slower rate. The authors also concluded that the elderly who enter nursing homes spend down their assets: each nursing home stay was estimated to reduce wealth by \$20,000 on average.

In another recent working paper, Anthony Webb uses data from the 1993 and 1995 waves of the Asset and Health Dynamics of the Oldest Old (AHEAD) survey to analyze how eligibility for Medicaid, marital status, and expectations about long-term care use affect the savings and consumption behavior of the elderly.<sup>29</sup> Since both ability to save and Medicaid rules differ for married couples and single people, Webb examines these groups separately. He finds no evidence that people expecting to need long-term care reduce their assets to qualify for Medicaid. In fact, married couples across all asset classes save more if they expect to enter a nursing home. Among married couples, a belief that the wife is likely to enter a nursing home leads to an increase in savings and a reduction in consumption. This occurs regardless of the initial level of the household’s financial assets. That is, Webb finds no evidence that

couples with limited financial assets who expect to enter long-term care consume more of their assets than those with significant assets. Unmarried or widowed women who expect to enter nursing homes care do not increase their savings rate, but, in general, they have accumulated more savings than those who don't expect to need nursing home care (suggesting that they plan to rely on those savings to pay for care). Overall, Webb finds that there is a strong precautionary motive for savings. If they have enough income to do so, the elderly who expect to use long-term care continue to accumulate assets; they don't divest them.

***Medicaid is not a major barrier to the purchase of private long-term care insurance***

Similarly, studies do not reveal Medicaid to be a major barrier to the purchase of private long-term care insurance. Frank Sloan and Edward Norton use data from the 1993 AHEAD survey and the 1994 Health and Retirement Study (HRS) to study the demand for private long-term care insurance.<sup>30</sup> The study, which assessed decisions by both elderly and nonelderly individuals, found that the availability and generosity of Medicaid benefits had no effect on the demand for private long-term care insurance among the younger age group (workers age 51 to 61) and very weak evidence that Medicaid affected purchases by the elderly (age 70 and over). The elderly were somewhat more likely to buy private long-term care insurance in states with more restrictive Medicaid coverage. That is, the elderly were more likely to purchase private insurance: (1) the lower the Medicaid payment for nursing home care; (2) the lower the likelihood of qualifying for Medicaid; (3) the lower the home maintenance allowance (the amount of monthly income nursing home residents can set aside for the upkeep of their home while they are living in the nursing home) and (4) if Medicaid recovered the value of a home of single nursing home residents.<sup>31</sup> However, the marginal effects were too small to explain the very low proportion of elderly with long-term care coverage.

Since Medicaid's effects are small, the study suggests that other factors must mostly account for the low demand for private long-term care insurance. Many potential purchasers—those who can afford long-term care insurance policies and pass underwriting screens—may reject them because they question the value of policies with thin coverage and rigorous exclusions. Restricting Medicaid's role for people with modest means who cannot afford private long-term care insurance is thus unlikely to expand the private insurance market.

## Conclusion

The argument that something needs to be done about abuses of the Medicaid eligibility rules is not supported by the facts. The studies reviewed in this paper do not support the claim that asset transfers are widespread or costly to Medicaid, or that restricting Medicaid eligibility would substantially increase savings or purchases of private long-term care insurance. Certainly, some Medicaid planning for nursing home care occurs. Some families try to protect modest assets (and, very infrequently, substantial assets) for future needs or for inheritances. But policy reforms designed to close down remaining loopholes are not going to make much of a dent in Medicaid's nursing home spending because most people who end up on Medicaid are already paying what they can. The fact is that Medicaid is what it was intended to be, a safety net for those who cannot afford to pay for long-term care.

## Notes

1. Centers for Medicare and Medicaid Services (CMS), "National Health Accounts," <http://www.cms.hhs.gov/statistics/nhe>.
2. Only certain assets are counted in determining Medicaid eligibility. Countable assets include funds held in checking and savings accounts, stocks, bonds, retirement funds from which withdrawals may be made, and real estate. Exempt assets include a home, a car, and funds designated for burial expenses. Under federal law, states have wide latitude in setting rules for how assets will be counted for the purposes of Medicaid eligibility determination.
3. The income protections for a community spouse range from a minimum of \$1,561.25 per month to a maximum of \$2,377 in 2005. A community spouse is allowed to keep at least half of the couple's joint assets, subject to minimum and maximum thresholds: at least \$19,020 and no more than \$95,100. A community spouse can also seek an increase in the community spouse resource allowance. See CMS, "2005 SSI FBR, Resource Limits, 300% Cap, Break-Even Points, Spousal Impoverishment Standards," <http://www.cms.hhs.gov/medicaid/eligibility/ssi0105.asp>.
4. Stephen A. Moses, "The Fallacy of Impoverishment," *The Gerontologist* 30, no. 1 (1990): 21-25.
5. See editorial, "Medicaid for Millionaires," *Wall Street Journal*, February 24, 2005, A14.
6. See Brian Burwell, *Middle Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage* (Cambridge, MA: SysteMetrics, 1991); James R. Cantwell, *Reforming Medicaid*. (Washington, DC: National Center for Policy Analysis, 1995), <http://ncpa.org/studies/s197/s197.html>; and Stephen A. Moses, "The Long-Term Care Partnership Program: Why It Failed and How to Fix It," in *Who Will Pay for Long-Term Care? Insights from the Partnership Programs*, ed. Nelda McCall (Chicago: Health Administration Press, 2001).
7. Stuart Hagen, *Financing Long-Term Care for the Elderly* (Washington, DC: Congressional Budget Office, 2004).
8. Robert L. Clark and Joseph F. Quinn, *The Economic Status of the Elderly*, Medicare Brief, no. 4 (Washington, D.C.: National Academy of Social Insurance, 1999). Figures are for 1996. More recent data indicate that little changed between 1996 and 1999. Median household income for elderly Medicare beneficiaries was \$24,817 in 1999; for those over age 85 it was \$17,287; for elderly women it was \$15,615. See Kaiser Family Foundation, *Medicare Chartbook* (Washington, DC: Kaiser Family Foundation, 2001).
9. Shawna Orzechowski and Peter Sepielli, *Net Worth and Asset Ownership of Households: 1998 and 2000*, Current Population Reports, P70-88 (Washington, DC: U.S. Census Bureau, 2003), Table F.
10. Orzechowski and Sepielli, *Net Worth and Asset Ownership of Households*.
11. Clark and Quinn, *The Economic Status of the Elderly*.
12. Ibid.
13. Frank Sloan and Mae Shayne, "Long-Term Care, Medicaid, and the Impoverishment of the Elderly," *Milbank Quarterly* 71, no. 4 (1993): 575-99.
14. Brenda Spillman and Peter Kemper, "Lifetime Patterns of Payment for Nursing Home Care," *Medical Care* 33, no. 3 (1995): 280-96.
15. Sloan and Shayne, "Long-Term Care, Medicaid, and the Impoverishment of the Elderly."
16. Edward C. Norton, "Elderly Assets, Medicaid Policy, and Spend-Down in Nursing Homes," *Review of Income and Wealth* 41, no. 3 (1995): 309-329.
17. Donald Taylor, Frank Sloan, and Edward Norton, "Formation of Trusts and Spend Down to Medicaid," *Journal of Gerontology: Social Sciences*, 54B, no. 4 (1999): S194-201.
18. Taylor, Sloan and Norton, "Formation of Trusts and Spend Down to Medicaid."
19. William F. Bassett, "Medicaid's Nursing Home Coverage and Asset Transfers," (working paper, Board of Governors of the Federal Reserve System, Washington, DC, 2004), <http://federalreserve.gov/pubs/feds/2004/200415/200415pap.pdf>. The middle-class elderly are defined as those at risk of spend down to Medicaid in the event of nursing home admission. Bassett excludes the elderly who are likely to qualify for Medicaid (with non-exempt assets below the asset limit for their state), as well as those who are wealthy and unlikely to qualify for Medicaid (those with non-housing wealth greater than \$450,000, or total wealth greater than \$900,000). He also excludes the elderly with annual income from pensions, social security, and annuities above \$40,000.

20. Jonathan Feinstein and Chih-Chin Ho, "Elderly Asset Management and Health," in *Rethinking Estate and Gift Taxation*, ed. William G. Gale, James R. Hines, and Joel Slemrod (Washington, DC: Brookings Institution Press, 2001).
21. U.S. General Accounting Office, *Medicaid Estate Planning*, GAO/HRD-93-29R (Washington, DC: GAO, 1993).
22. Bassett, "Medicaid's Nursing Home Coverage and Asset Transfers."
23. Three states—Connecticut, Massachusetts, and Minnesota—have section 1115 waiver applications pending in CMS under which they seek to implement more stringent transfer of asset rules. All three seek to change the start of the penalty period, moving it from the date of the asset transfer to the date of institutionalization. This change could effectively remedy one of the chief problems with Medicaid eligibility. It would prevent people from circumventing the obligation to pay half their savings or three years of their care by transferring assets ahead of time; see CMS, "State Waiver Programs and Demonstrations," <http://cms.hhs.gov/medicaid/waivers/waivermap.asp>.
24. For the Connecticut, Massachusetts, and Minnesota "Transfer of Assets" 1115 waiver applications, see CMS, "1115 Waiver Research and Demonstration Projects," <http://cms.hhs.gov/Medicaid/1115>.
25. See Office of Management and Budget (OMB), *Major Savings and Reforms in the President's 2006 Budget* (Washington, DC: OMB, 2005), 188, <http://whitehouse.gov/omb/budget/fy2006/pdf/savings.pdf>. The 2006 Budget proposes to curb asset transfers by making it impossible for Medicaid applicants to circumvent Medicaid penalties. Under current law, individuals who make inappropriate transfers are subject to a penalty period that delays their Medicaid eligibility by the number of weeks (or months, or years) of nursing home care that could have been purchased had the transfer not been made. Under the proposed policy, the penalty period for inappropriate transfers would start on the date of eligibility for Medicaid nursing home services or the date of transfer, whichever occurs later.
26. State savings estimated in Victoria Wachino, Andy Schneider, and Leighton Ku, *Medicaid Budget Proposals Would Shift Costs to States and be Likely to Cause Reductions in Health Coverage* (Washington, DC: Center on Budget and Policy Priorities, 2005).
27. See, for example, Jeffrey Brown and Amy Finkelstein, *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market* (Cambridge, MA: University of Illinois and National Bureau of Economic Research, 2004). Brown and Finkelstein's simulation model demonstrates that Medicaid's nursing home subsidy is "sufficient" to explain the low rate of purchase of private long-term care insurance among the elderly. In their analysis, even highly risk averse consumers are unlikely to purchase insurance coverage for long-term care services which they could otherwise obtain for "free" from Medicaid. With regard to savings decisions, economists suggest that "programs with asset-based means testing can discourage saving by households with low expected lifetime income." See Peter R. Orszag, *Asset Tests and Low Savings Rates Among Lower Income Families* (Washington, DC: Center on Budget and Policy Priorities, 2001). Although Orszag identifies a few studies which demonstrate that welfare programs (such as the Aid to Families with Dependent Children and Temporary Assistance for Needy Families programs), Medicaid (for children and families), and Supplemental Security Income may create barriers to savings for low-income families, there are few studies that examine the impact of Medicaid's nursing home subsidy on the savings behavior of older workers and the retired elderly.
28. Frank A. Sloan, Thomas J. Hoerger, and Gabriel Picone, "Effects of Strategic Behavior and Public Subsidies on Families' Savings and Long-Term Care Decisions," in *Long-Term Care: Economic Issues and Policy Solutions*, ed. Roland Eisen and Frank A. Sloan (Boston, MA: Kluwer Academic Publishers, 1996).
29. Anthony Webb, *The Impact of the Cost of Long-Term Care on the Saving of the Elderly* (New York: International Longevity Center, 2001).
30. Frank A. Sloan and Edward C. Norton, "Adverse Selection, Bequests, Crowding Out, and Private Demand for Insurance: Evidence from the Long-Term Care Insurance Market," *Journal of Risk and Uncertainty* 15, no. 3 (1997): 201-19.
31. The crowd-out hypothesis suggests that people should be more willing to buy private long-term care insurance when Medicaid beds are in short supply, but the empirical data fail to support this hypothesis. The model indicates that purchases of private long-term care insurance fall with a reduction in Medicaid nursing home bed supply.

## About the Project

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