Stephen A. Moses, "The Long-Term Care Partnership Program: Why It Failed and How to Fix It," in Nelda McCall, editor, *Who Will Pay for Long Term Care?: Insights from the Partnership Programs*, Health Administration Press, Chicago, Illinois, 2001, pps. 207-222.

Introduction

The Partnership for Long-Term Care Program was conceived as a noble experiment. It boldly attempted to reconcile the seemingly irreconcilable arguments and advocates for public versus private financing of long-term care. The idea of linking government and private enterprise in a common effort to solve an intractable social problem quickly captured the imagination of many politicians, public administrators, and insurance executives. For a while, as the Partnership approach snowballed, it looked like a huge success was in the making. After a decade of trial, however, the consensus of thoughtful analysts and critics is that the Partnership for Long-Term Care Program has failed to achieve its main objectives. The purpose of this chapter is to examine why the Partnership program failed and to suggest an approach that can empower it to succeed.

Background

Mark Meiners and Hunter McKay wrote an article titled “Private Versus Social LTC Insurance: Beware the Comparison” in the spring 1990 issue of *Generations*. In this seminal piece, they debunked the “myth … that social insurance and private insurance are competing strategies for solving this country’s long-term-care financing problems” (Meiners and McKay, 1990). They observed that social insurance, by helping everyone at the expense of all, was seductively attractive but unaffordable and politically infeasible. This was a reasonable

conclusion given that the Pepper Commission proposals had recently failed and the Medicare Catastrophic Coverage Act of 1988 had just been repealed. On the other hand, they noted that private insurance, by appealing to the self-interest of individuals to protect themselves, could relieve the burden on public programs of providing long-term care but that it would never be a general solution. Unfortunately, they explained, private insurance is voluntary, expensive, limited in coverage, and available only to those who can qualify medically. Meiners and McKay concluded that neither public nor private financing of long-term care could succeed independently. Would it be possible, they asked, to combine the benefits of a public financing approach with the benefits of a private financing approach to neutralize the negatives associated with both systems?

They decided that such a partnership was not only possible, but also highly desirable. At that time, "individuals and their families [paid] nearly half the cost of nursing home care out-of-pocket with the other half covered by the Medicaid program but only after an individual has become impoverished" (Meiners and McKay, 1990). Clearly, America already had a public/private partnership for long-termcCare based on a more or less equal balance between catastrophic spend-down and means-tested public assistance. "In effect," the analysts noted, "people who need long-term care are faced with a deductible equal to most of their assets and with co-payments equal to most of their income if Medicaid is to be their long term care insurance program" (Meiners and McKay, 1990). Could it be, they wondered, that embedded here, deep among the roots of the problem, was the germ of a solution?

Perhaps more people could be encouraged to insure privately if they were offered, in exchange for taking on this personal responsibility and expense, some forgiveness of their obligation to spend down into impoverishment. If part of the long-term care financing burden

were taken over by Medicaid, maybe more people could afford private insurance because they would not need to buy as much coverage. On the other hand, if more people had at least some private insurance protection, Medicaid would benefit significantly because fewer people would come to need its expensive services. Such was the crux of the Partnership origins.

From this simple idea grew some ambitious objectives. As summarized in the same *Generations* article, the Partnership program's goals were to:

- Assist elders in avoiding the impoverishment required by Medicaid for those using long-term care services;
- Promote greater access to insurance protection by working with insurers to develop products affordable to a large segment of the elderly population;
- Encourage development of coordinated long-term care delivery systems that combine both private and public funding sources;
- Allow elders to plan for their long-term care needs in a manner that maximizes personal choice;
- Encourage development of a unified long-term care system in which all elders are treated equally;
- Conserve public resources for those truly in need by alleviating middle-class elders' reliance on Medicaid; and
- Remove the incentives for elders to transfer assets or otherwise "game" the system to gain Medicaid eligibility (Meiners and McKay, 1990).

It would be unreasonable to expect the Partnership program to have solved all of these problems and to have reached all of these goals in the past ten years. Nevertheless, we are justified in asking to what extent these grand objectives were actually achieved by America's

long-term care service delivery and financing system during that period. Answering this question may help shed some light on how the Partnership program could be modified to accomplish these goals more effectively.

Evaluation

Other chapters in this volume examine whether and to what extent any or all of the Long-Term Care Partnership Program's goals were achieved in the individual states where the program was implemented. The purpose of this section is to observe that none of the problems addressed in the Partnership's goal statement has been resolved at the national level as of the end of 1999.

America's long-term care service delivery and financing system remains fragmented and dysfunctional despite an avalanche of literature and programs intended to address these difficulties. Access and quality problems are commonplace despite constantly rising public and private expenditures. Institutional bias in favor of nursing home care prevails despite most seniors' preference for home- and community-based services. Medicaid and Medicare's share of nursing home costs has increased while the share contributed by private out-of-pocket expenditures has declined, despite the conventional wisdom that widespread catastrophic spend-down is wiping out many older Americans' savings (HCFA, 1999). Medicaid estate planning, the practice of artificially impoverishing a senior to achieve Medicaid eligibility, remains commonplace, despite concerted efforts by three presidents and eight Congresses to discourage the practice. The American public remains in denial and largely ignorant about the risk and cost of needing long-term care, despite a growing barrage of media coverage and insurance marketing addressing this issue. Private long-term care insurance has penetrated less than 10 percent of the senior market and virtually none of the critical baby boomer market, despite the well-

documented fact that its cost has dropped and its quality has improved significantly[1] (Moses, 1999)

Why have we failed to correct these problems? What can we learn from the Partnership for Long-Term Care Program to help us plot a better course? How should we proceed to build on the proud, but shaky, foundation of the Partnership? These are the questions the remainder of this chapter will attempt to answer.

Flawed Logic

The fundamental premise of the Partnership for Long-Term Care Program was that consumers would be more likely to purchase private long-term care insurance if they received in exchange a reduction in their spend-down liability for Medicaid eligibility. This assumption underlay all of the program's goals and strategies. The reasoning was explicit. Coordinating private insurance benefits with Medicaid eligibility was expected to:

- Reduce the cost of long-term care protection for the middle class;
- Capture the public's attention for an education campaign about long-term care risk and cost;
- Encourage private insurers to offer high-quality, government-approved, private long-term care insurance;
- Diminish the lure of Medicaid estate planning; and
- Contribute to solving the crisis in long-term care service delivery and financing.

One could hardly fault the Partnership's reasoning that these objectives could be achieved if the underlying premise were correct. Who would pass up the carrot of subsidized long-term care protection while confronting the stick of catastrophic spend-down?

If it were not true, however, that Medicaid requires impoverishment before providing free or deeply discounted long-term care benefits, all of these presumed benefits of the Partnership program would disappear. For example, what if most Americans could ignore the risk of long-term care, avoid the premiums for private insurance, wait to see if they ever needed formal long-term care, and still obtain Medicaid and Medicare benefits without spending down their savings? If this were true, sensible consumers would see no incentive to purchase private long-term care insurance in the promise to forgive a spend-down liability that did not exist. Their sensitivity to the risk and their interest in the subject of long-term care would not increase. The popularity of Medicaid planning would not decline. The problems in the long-term care system would not improve. In other words, if the Partnership's assumption about the catastrophic nature of nursing home spend-down were mistaken, then the reason for the program's failure would be obvious and clues to its rehabilitation nearly self-evident. Was the Partnership for Long-Term Care Program based on a false assumption?

The Myth of Medicaid Spend-Down

In the late 1980s, when the Partnership for Long-Term Care Program was conceived, most experts assumed that America faced an epidemic of catastrophic nursing home spend-down. One often read in those days that half to three-fourths of all persons in nursing homes on Medicaid had begun as normal middle-class people, but had spent down their life's savings before qualifying for medical assistance benefits. Congress promulgated the estimate that an average family spent down into impoverishment within thirteen weeks if confronted with long-term nursing home expenditures. In 1990, I argued in a *Gerontologist* article titled "The Fallacy of Impoverishment" that these doleful statements about Medicaid spend-down were highly

dubious (Moses, 1990). My argument was based on reasoning logically from the explicit generosity and elasticity of Medicaid eligibility rules: Why would people need or want to spend down? To support this reasoning, I supplied extensive anecdotal evidence that Medicaid nursing home eligibility was much easier to achieve than most people assumed or the law seemed to require. Unfortunately, at that time we had no hard, empirical data to prove or disprove any conclusions about the impact of catastrophic spend-down.

Today, however, we know much more about the spend-down question. More than two dozen formal academic studies have concluded that Medicaid nursing home spend-down is much less significant than originally assumed. (Arling et al., 1988; Branch et al., 1988; Burwell, Adams, and Meiners, 1990; Deane, 1990; Liu, Doty, and Manton, 1990; Short et al., 1992; Spence and Wiener, 1990). For example, the data from one study showed that 72.9 percent of single people, 85.4 percent of married people, and 77.7 percent of all people are already eligible for Medicaid when they enter a nursing home (Sloan and Shayne, 1993). On average, the spend-down studies found that only 15 to 25 percent of Medicaid nursing home residents had begun as private payers and converted to Medicaid — less than a third of the former spend-down estimates. Furthermore, not one of these so-called spend-down studies distinguished between people who had spent down the old-fashioned way — by writing big checks to nursing homes for many months — and people who had spent down the new-fashioned way — by artificially impoverishing themselves with or without the help of an attorney. In other words, as small as the percentage of nursing home residents who converted from private pay to Medicaid is, it includes everyone who qualified without actually spending down assets by taking advantage of loopholes in Medicaid's eligibility rules.

If people are not spending down their life's savings for nursing home care in huge numbers, however, where is the money coming from to pay America's large and growing nursing home bill? The popular literature on long-term care still frequently reports that nursing home expenditures come half from Medicaid and half from patients' pockets. This has not been true for many years. As of 1997, according to the Health Care Financing Administration (HCFA), Medicaid still paid 47.6 percent of nursing home payments (HCFA, 1999) (almost unchanged from 47.2 percent in 1985[2)] but Medicare's share has jumped to 12.3 percent (up 10.8 percent since 1985). Total state and federal government expenditures for nursing home care are up from 51.2 percent of total nursing home costs in 1985 to 62.2 percent in 1997 (HCFA, 1999). The truly startling development, however, is the change in out-of-pocket nursing home expenditures. They have declined from 44.3 percent in 1985 to 31.1 percent in 1997 (HCFA, 1999). Even this huge drop in patients' private expenditures understates the actual decline in out-of-pocket costs, however. Upward of 40 percent of expenditures reported by HCFA as out-of-pocket are actually Social Security income received by Medicaid recipients and contributed toward their cost of care as required by law[3] (Lazenby and Letsch, 1990). This "spend-through" of Social Security benefits, reasonably estimable at 12 percent of total nursing home expenditures nationally, is technically an out-of-pocket cost, but it is definitely not a spend-down of assets as that term is usually interpreted. What does all this mean?

Clearly, public and private roles in financing nursing home care in the United States have turned upside down in the past twelve years. Today, direct government payments (Medicaid, Medicare, and the Department of Veterans Affairs) plus indirect government payments (Social Security spend-through) account for almost 75 percent of all nursing home payments nationally. Out-of-pocket expenditures (excluding Social Security spend-through) have dropped to less than

20 percent of the total, and a considerable portion of this remainder represents spend-down of personal income, not assets. In summary, based on official government data for 1997, there is no basis to assume that spend-down of residents' savings contributes more than 10 to 15 percent at most of nursing home payments in the United States. That is hardly enough to excite a lot of worry among the populace about spend-down risk. Nor is it enough to arouse a great deal of interest in private long-term care insurance protection, whether provided by a Partnership plan or any other kind of privately underwritten policy.

How Medicaid Really Works

Clearly, nursing home spend-down is not as big a factor in America's long-term care financing system as the Partnership program originally presumed. No wonder people did not leap at the opportunity to avoid a spend-down liability that probably would not occur for many years, might not occur at all, and would likely be inconsequential anyway. Before we can explore a way to correct this situation, however, a big question about nursing home spend-down remains: How do people qualify for Medicaid, a means-tested public assistance program, without spending down their assets? By answering this question, we may reveal the key to unleashing the full potential of the Long-Term Care Partnership Program.

Practically every article on long-term care financing that mentions Medicaid refers to the program as though it covers only "low-income" or "impoverished" people. For the program's acute care benefit, this is true. In fact, Medicaid covers only two-thirds of the elderly poor and less than half of poor children for acute, preventive, or emergency care. For the program's long-term care benefits, however, neither income nor assets are an obstacle to eligibility for most people who qualify medically. In most states, the "medically needy" are eligible for Medicaid

nursing home benefits if their medical expenses, including private nursing home care, exceed or approximate their income. In other states, an "income cap" applies but may be circumvented easily by means of a "Miller income trust" as authorized by the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). For couples, income eligibility is even easier still. A community spouse may retain up to $2,049[4] per month of income as of 1999 without affecting the institutionalized spouse's eligibility. The median income of older persons in 1997 was $17,768 for males and $10,062 for females (AARP, 1998). Less than 6 percent of people age 65 and over have incomes in excess of $50,000 per year (U.S. Census, 1998), which would barely cover the annual cost of private nursing home care. Income, therefore, does not interfere with Medicaid nursing home eligibility except for the very-highest-income elderly.

Ostensibly, assets are a huge obstacle to Medicaid nursing home eligibility. By law, a Medicaid recipient may retain only $2,000 in nonexempt assets.[5] This fact gives rise to the commonplace presumption that most people must be spending down catastrophically for nursing home care before they qualify for Medicaid. Both the popular and the academic media usually fail, however, to emphasize that Medicaid nursing home recipients may also retain unlimited exempt assets. For example, one home of any value including all contiguous property is exempt. A business of any value, including the capital and the cash flow, is exempt. One automobile of any value is exempt as long as it is used for the benefit of the recipient. An irrevocable burial trust fund of any value is exempt. Certain kinds of annuities are exempt. People who own a little too much nonexempt wealth can easily convert it to one of these exempt categories and are frequently encouraged to do so by Medicaid eligibility workers, financial planning professionals, and especially by public and private Medicaid estate planning attorneys. Of course, anyone can give away the equivalent of the average cost of a private nursing home every month without

incurring any transfer of assets penalty. For Medicaid nursing home applicants who possess hundreds of thousands of dollars more than the program's asset eligibility limit, more sophisticated artificial impoverishment techniques are readily available by retaining counsel. These include self-canceling installment notes (SCINs), life care or personal care contracts, irrevocable income-only trusts, guardianships, spousal refusal, transfer of the home with reserved special powers of appointment, charitable remainder trusts, various creative gifting techniques, and many others. As a last resort, elder law attorneys often suggest divorce as a means to impoverish the institutionalized spouse for purposes of qualifying for Medicaid benefits. The widespread practice of Medicaid estate planning has been thoroughly documented in a series of studies by Brian Burwell (Burwell, 1991, 1993, 1995) and in the "Magic Bullet" state-specific studies conducted by the author in Illinois, New Jersey, Maryland, Florida, and several other states (Moses, 1994, 1995a, 1995b, 1996).

The Long-Term Care Partnership Program's assumption that forgiveness of the Medicaid spend-down "requirement" would be a big incentive for the public to buy long-term care insurance was wrong. It was wrong because spend-down is not as big a problem as originally believed. Ironically, if it were, no additional incentive would be necessary to persuade the public to purchase long-term care insurance. People would seek out the protection if faced with genuine financial risk. Congressman Henry Waxman, D-California, sensed this fact when he pushed through legislation that terminally hamstrung the partnerships. He did not think that scarce public welfare resources, desperately needed to ameliorate conditions for the poor, should be used to indemnify upper-middle-class people against a predictable and insurable risk of growing old. Therefore, Congressman Waxman successfully persuaded Congress in OBRA '93 to deny the Partnership program an exemption from mandatory Medicaid estate recovery. When

assets protected by the Partnerships' spend-down feature became vulnerable to recovery from the Medicaid recipient's estate, the program's only unique incentive for purchasing its plan, however illusory, was rendered ineffectual.

Coordination of Benefits

The Partnership program's link with Medicaid contributed to its failure in another important way. Medicaid is a means-tested public assistance program. It is welfare. The program has an inferior and deteriorating reputation for access, quality, reimbursement, discrimination, and institutional bias. Gerontological literature is full of evidence substantiating (1) the difficulty Medicaid recipients and their families often face in finding open beds; (2) the quality of care problems frequently presented by nursing facilities with the highest Medicaid caseloads; (3) the program's low reimbursement rates, on average only 80 percent of private-pay rates; (4) the vulnerability of Medicaid recipients to discrimination regarding admission and services as compared to private payers; and (5) the continuing focus of Medicaid on nursing home care instead of on the home care, community-based services, and assisted living that seniors prefer[6] (Moses, 1999). Undoubtedly, many potential purchasers of Partnership plans looked askance at the idea of relying on public assistance to supplement their private insurance. Private insurance carriers must have wondered about the wisdom of coordinating their contractually guaranteed benefits with the political promises of a welfare program on the verge of bankruptcy. Finally, consumers and carriers alike shared a concern about the lack of portability of Partnership plans. Privately insured beneficiaries can receive their benefits anywhere, but Partnership policies tie clients to their Medicaid home state. In short, virtually

every aspect of the Long-Term Care Partnership's relationship with the Medicaid program turned out to be problematical.

What Went Right With the Partnerships?

In spite of these problems, the Partnership for Long-Term Care Program has made a very important contribution to the long-term care financing issue by encouraging the public and private sectors to cooperate on a potential solution. Although the Partnership's long-term care insurance policies have been criticized as having benefits too rich and premiums too high, the process of developing and negotiating the policies has forced government staff and insurance company employees to learn about each other's expectations and constraints. Today, the public officials who were involved in developing the Partnerships have a better understanding of the legitimate underwriting and marketing issues that influence insurance companies. Similarly, industry staff who worked on the Partnership plans have a better conception of the political and advocacy issues that public officials must take into account. Next time these groups work together, the results can reasonably be expected to be easier to achieve.

The decade of the Partnership's existence has seen a vast improvement in the quality, coverage, cost, and popularity of private long-term care insurance in general. The program's unstinting publicity efforts regarding the risk of long-term care and the value of private insurance surely have contributed to these advancements. Many insurance agents and executives have observed that it is often the Long-Term Care Partnership's educational efforts and reputation that open a client's door, even if the insurance policy ultimately written is not a Partnership plan. Finally, the large and ever-growing popularity of the Partnership concept among politicians, public administrators, and private insurance personnel alike has built an extraordinary foundation

on which to construct a more successful program. The big question remains, then, how should the Partnership for Long-Term Care Program be modified so that it can achieve its full potential?

Recommendations and Analysis

The Partnership for Long-Term Care Program was based on one false and one correct assumption. The assumption that appreciably more people would buy long-term care insurance to avoid Medicaid spend-down and to qualify for Medicaid nursing home benefits proved to be false. The assumption that public and private organizations working together could contribute toward the improvement and public awareness of long-term care insurance products proved to be true. The way to save and improve the Partnership program is to drop the portions of it that are based on its false assumption and to build on the portions based on its correct assumption. Fortunately, that will be fairly easy to do by implementing the following suggestions.

- Eliminate the Partnership's Medicaid spend-down forgiveness feature;
- Terminate the Partnership's coordination of benefits between private long-term care insurance and Medicaid;
- Modify the Medicaid program to create a total, but less immediately onerous, spend-down requirement;
- Educate the public that everyone must either buy long-term care insurance or commit to spending down all assets as a requirement for receiving public assistance;
- Mitigate the immediate financial impact of spending down by empowering uninsured seniors to purchase long-term care services in the private marketplace with a line of credit on their estates;

- Maintain and expand the cooperation between private insurers and state/federal officials;
- Retain the government's seal of approval on quality LTC insurance products;
- Permit a wider range of products to qualify for government approval by allowing inexpensive, basic coverage as well as expensive, comprehensive coverage; and
- Convert the Partnership from a state-by-state to a fully national program.

These recommendations are not as radical or unrealistic as they may seem. Dropping the Partnership's spend-down forgiveness feature will not detract from the program's effectiveness. The forgiveness feature did not work because Medicaid spend-down is not a common or serious problem. If it were, spend-down forgiveness would not be necessary because people would buy insurance to avoid having to spend down catastrophically. In the presence of a strong spend-down liability, affordability of private insurance will not be a problem because new premium funding sources, such as home equity conversion and contributions from potential heirs, will be drawn to long-term care insurance. The word will get around quickly that private insurance is a necessity if estates and inheritances are genuinely at risk.

Terminating the Partnership's coordination of benefits between private insurance and Medicaid will remove one of the most serious and valid criticisms of the program. No longer will scarce public resources be used to indemnify middle-class people against the risk of long-term care while Medicaid fails to provide adequately for the acute and preventive care needs of the truly poor. No longer will people have an incentive to buy less private coverage than they really need, while leaving themselves vulnerable to an inadequately financed welfare program in the end. More people will buy long-term care insurance. Fewer people will need Medicaid. Here again, nothing important is lost and many benefits are gained.

Eliminating the Partnership's links with Medicaid will require creating a new and stronger reason for people to buy private insurance. No later than age 65, at a time when the public is highly sensitive to retirement issues, the public and private Partnership should (1) educate everyone about long-term care risk and cost; and (2) require either (a) proof of private long-term care insurance coverage or (b) a signed affidavit acknowledging that all assets including the home are at risk before Medicaid will pay for long-term care. Establishing a real Medicaid spend-down liability will provide a strong incentive for people to purchase as much private long-term care insurance as they can afford.

What about people who cannot or will not buy insurance even when faced with a true spend-down liability? They should have a better option than to qualify for a welfare nursing home by means of real or artificial impoverishment, which is the fate they face today. Why not permit them to spend down gradually for top-quality home care, assisted living, or nursing home care purchased in the private marketplace? Let them use their estates as collateral for a government-backed but fully collateralized line of credit to supplement their income so they can afford these services. Deduct public expenditures from the ledger of their estates and recover the balance plus interest after the last surviving exempt relative dies. This approach assures access to quality care at the appropriate level for anyone with too much income and assets to qualify for Medicaid but not enough cash flow to pay privately for long-term care without help. Simultaneously, this option creates a new incentive for families to pull together and find creative ways to avoid spend-down by purchasing long-term care insurance early.

With these changes in place, all objections to making the Long-Term Care Partnership into a national program would fall away. Unburdened of its ties to Medicaid, the program could focus on what it does most successfully. Such priorities include educating the public about long-

term care risk and cost, facilitating development and certification of high-quality long-term care insurance products, and fostering cooperation between public officials and private companies in enhancing the market for private coverage. Medicaid, on the other hand, unburdened of its role as long-term care re-insurance for the middle class and girded with a real spend-down liability, will be reinvigorated financially and able to focus its scarce resources on the genuinely needy. No one will be hurt by this change. Those with income and assets, but no insurance, will spend down gradually through a line of credit on their estates. Those with little income or assets will qualify for Medicaid as before. But the newly established real risk of actually having to spend down savings and home equity will cause most people to opt for private insurance while they are still young, healthy, and affluent enough to afford it.

Conclusion

The Partnership for Long-Term Care is a great idea scuttled by one bad assumption. The program's founding hypothesis, that consumers would buy a lot more long-term care insurance if they did not have to worry so much about Medicaid spend-down liability, was mistaken. In the first place, most people were not worried about Medicaid spend-down because their elderly friends and relatives usually qualified for Medicaid nursing home benefits without spending down. In the second place, the prospect of going on welfare and dying in a nursing home was not a consummation most people wanted to include as part of their long-term care planning. To reinvigorate the Partnership program, it will be necessary to sever its ties with Medicaid. This can be done by establishing a strong Medicaid spend-down liability mitigated by a new program to empower seniors to spend down gradually by means of a line of credit on their estates. With this new incentive in place to take the risk and cost of long-term care seriously, the public will be

much more receptive to the Long-Term Care Partnerships' educational efforts and much more likely to purchase its approved and certified long-term care insurance policies.

End Notes

1 All of the assertions in this paragraph are thoroughly discussed and documented in a new report published by the Center for Long-Term Care Financing titled "The Myth of Unaffordability." See References.

2 Although Medicaid pays less than half the cost of nursing home care, the program contributes at least some portion of the payment for over two-thirds of all nursing home patient days in the United States. The difference comes from Medicaid recipients who must contribute most of their income, usually Social Security benefits, toward their cost of care.

3 According to HCFA, "An estimated 41 percent ... of out-of-pocket spending for nursing home care was received as income by patients or their representatives from monthly social security benefits." See also Lazenby and Letsch, 1990, in References.

4 This amount increases with inflation each year. It was originally established at $1,500 per month in the Medicare Catastrophic Coverage Act of 1988.

5 A community spouse of an institutionalized Medicaid recipient may retain up to an additional $81,960 in otherwise nonexempt assets as of 1999. This Community Spouse Resource Allowance (CSRA) was originally established at $60,000 in MCCA '88 and it too increases annually with inflation.

6 Comprehensive discussion and citations to the evidence in the gerontological literature for these propositions is provided in the Center for Long-Term Care Financing's "Myth of Unaffordability" report. See References.

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