

## **The Myth of Medicaid Spend-Down**

by

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### Abstract:

Conventional wisdom holds that large numbers of elderly Americans spend down their life savings in nursing homes before they qualify for Medicaid. Recent research indicates otherwise. This article demonstrates that most nursing home costs derive from direct government payments or income, not savings and that most elderly people who need nursing home care can qualify for Medicaid without spending down for care. Ramifications for public policy and new research directions are also discussed.

Key Words: Medicaid planning, transfer of assets, income and asset shelters, long-term care financing.

## **The Myth of Medicaid Spend-Down**

Medicaid asset spend-down is almost an article of faith in the long-term care financing debate (Congressional Research Service, 1988; GAO, 1988; U.S. Congress, 1987a). The opinion that nursing home costs impoverish large numbers of elderly people pervades the academic (Branch, et al., 1988; Gornick, et al., 1985; Kemper & Murtaugh, 1991) and popular (Frontline, 1985; Topolnicki, 1986; Wasik, 1990) literature. Although anecdotes of individual financial disasters are commonplace (Cronkite, 1989; Frontline, 1991), however, hard evidence of widespread spend-down is elusive. In fact, recent research places the incidence of Medicaid spend-down at one-half to one-third of earlier estimates (Adams, et al., 1990; Arling, et al., 1991; Burwell, et al., 1990; Gruenberg, et al., 1989; Liu & Manton, 1989, 1991; Liu, et al., 1990; Rice, 1989; Short, et al., 1990; Spence & Wiener, 1990).

Advocates of health care reform, whether they emphasize public initiatives (Ball, 1989; Pepper Commission, 1990; Shearer, 1989), private enterprise (DHHS, 1986, 1987; Meiners, 1983; Myers, 1988) or public/private partnerships (Mahoney, 1990; Meiners & McKay, 1989; Rivlin & Wiener, 1988), often base their divergent recommendations on the common goal of reducing catastrophic costs. For this reason, the question of how many people spend how much money for long-term care before they qualify for Medicaid is critically important. If widely

held assumptions about Medicaid spend-down were to prove incorrect, we would have to rechart the entire landscape of long-term care financing policy.

This article examines the spend-down issue from three hitherto unemphasized perspectives. First: what do the data on sources of nursing home spending tell us about asset spend-down? Second: to what extent do Medicaid nursing home eligibility rules, interpreted literally, compel people to spend down in order to qualify? Third: in what degree do Medicaid rules allow people to qualify, without spend-down, by rearranging their income and assets? The article also contemplates some public policy ramifications of the answers to these questions and suggests a course of further research.

### **"Out-of-Pocket" Costs**

The Health Care Financing Administration (HCFA) publishes data every year on the amount and source of nursing home expenditures in the United States (Lazenby & Letsch, 1990). Table 1 provides this information for calendar year 1989. If large numbers of individuals are spending down their life savings in nursing homes, we would expect this data to reflect that fact. Upon initial review, such a conclusion seems warranted. One can see, for example, that private financing of nursing home care is substantial. Patient out-of-pocket costs exceeded \$21 billion and accounted for 44.4% of total expenditures. But do these

**Table 1. Nursing Home Expenditures: Calendar Year 1989**

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Source	Amount (Billions)	Percent
Total	\$47.9	100.0%
Medicaid	20.6	43.1
Medicare	3.6	7.5 <sup>a</sup>
Veterans	0.9	1.9
Private Insurance	.5	1.1
Out of Pocket	21.3	44.4
Nonpatient revenues <sup>b</sup>	0.9	1.9
General Assistance	.1	0.1

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Source: Helen Lazenby, Office of National Cost Estimates, Office of the Actuary, Health Care Financing Administration, personal communication, March 5, 1991

<sup>a</sup> Medicare's share of nursing home costs grew sharply in 1988 because of expanded skilled nursing facility coverage mandated by MCCA. With the repeal of MCCA in December 1989, Medicare's share is expected to return to previous levels (approximately 2%).

<sup>b</sup> Includes philanthropy, and revenue from gift shops, parking lots, etc.

private costs reflect a spend-down of life savings? Or is a more complex dynamic at work?

We know that most people in nursing homes are elderly (Hing, et al., 1989) and that most elderly people have low incomes (Grad, 1990). Therefore, the judgment that these large out-of-pocket costs probably derive mainly from assets rather than cash flow is easy to make. In fact, many writers have adduced high out-of-pocket nursing home costs as prima facie evidence of severe spend-down liability (Hansen, 1987; King, 1990; U.S. Congress, 1985).

Upon closer analysis, however, one discerns a different and much more complicated reality. For example, according to HCFA (Lazenby & Letsch, 1990, p. 8): "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." Thus, \$8.7 billion of the \$21.3 billion in private funds expended for nursing home care in 1990 were actually a "spend-through" of a government entitlement instead of a spend-down of savings.

If we add the portion of total nursing home costs accounted for by Social Security income to the portion already accounted for by sources other than patient funds, a new picture begins to emerge. Medicaid (43.1%), Medicare (7.5%), veterans benefits (1.9%), and General Assistance (.1%) pay 52.6% of the total. Nonpatient revenues and private insurance are reported to contribute another 3.0%. Adding in the 18.2%

of total nursing home costs paid indirectly by Social Security, we arrive at a total of 73.8%. Thus, according to HCFA (Lazenby & Letsch, 1990, pp. 8-9): "Third-party payments, including estimated social security benefit payments, are currently financing almost three-fourths...of all nursing home care." Only one-fourth of total nursing home costs remain to be explained, although private savings have not yet been touched.

We can attribute even more nursing home costs to income rather than savings by applying the same reasoning to additional sources of income. Approximately 70% of nursing home patients in the United States receive Medicaid benefits (U.S. Congress, 1987b, p. 68) and Medicaid pays the principal part of 63.4% of annual nursing home patient days (AHCA, 1987, p. 18). As a condition of eligibility, Medicaid requires nursing home recipients to contribute all of their income, except certain usually small exclusions, toward the cost of their care. This requirement applies to pension, investment, and other kinds of income, as well as Social Security (Carpenter, 1988). It is also likely that private pay nursing home patients use all of their sources of income first to finance care before turning to savings. Therefore, to understand the full contribution of income to nursing home expenditures, we must consider all forms of income available to elderly people in nursing homes, not only Social Security.

According to data compiled by the Social Security

Administration, 41.4% of the aggregate income of "aged units" 65 or older comes from government employee pensions (8.6%), private pensions or annuities (8.0%), or income from assets (24.8%). By comparison, only 37.9% of this group's income derives from Social Security benefits. ("An aged unit is a married couple living together or a nonmarried person. Using aged units...as the units of analysis [instead of aged persons as in Bureau of the Census publications] allows one to measure incomes of the entire aged population...separately from...other members of the families with whom they live.") (Grad, 1990, p. v)

We should resist the temptation to conclude from this data, however, that these additional sources of income contribute as much or more to nursing home costs as Social Security. Nursing home residents tend to be older, single, and female (Hing, 1987). We need to consider the distribution of income sources for these subgroups of the elderly, before reaching any conclusions. Table 2 provides this information. It shows that single, elderly women also receive a large proportion of their income from pensions and income from assets (40.6%), although not quite as much as from Social Security (45.9%). Similarly, units aged 80 to 84 derive 43.2% of their income from pensions and income from assets as compared to 48.4% from Social Security. Thus, even for those sub-groups of the elderly most likely to require institutionalization, pensions and income from assets



contribute nearly as much to their income as Social Security.

Still, we cannot assume that pensions and income from assets play a comparable role to Social Security in financing nursing

**Table 2. Shares of Aggregate Income of Aged Units 65 or Older by Selected Characteristics: Percentage Distribution of Money Income from Particular Sources of Income, 1988**

Unit Source of Income Aged	Total	Nonmarried Women	Units 80-84
Number (in Thousands)	22,260	10,148	2,901
Total Percent	100.0%	100.0%	100.0%
Percent of Income from			
Social Security	37.9	45.9	48.4
Government Employee Pensions	8.6	7.6	6.9
Private Pensions or Annuities	8.0	5.8	6.7
Income from Assets	24.8	27.2	29.6
Earnings and Other Sources	20.6	13.6	8.4

Source: Grad, 1990, pp. 99-100.

home care. Ninety-two percent of elderly units receive Social Security, whereas only 14% receive government employee pensions, 29% receive private pensions or annuities, and 68% receive income from assets (Grad, 1990, p. 1). Clearly, Social Security income is spread more broadly across the elderly population than other sources of income. Therefore, other sources of income would be less likely than Social Security to be available to finance nursing home care for any given individual.

Nevertheless, the fundamental point is incontestable. Other income sources are substantial. They surely account for a significant, although yet indeterminate, proportion of nursing home costs. Whatever this proportion is, it must be added to the 73.8% of nursing home costs already explained without recourse to asset spend-down, i.e. direct government payments plus nonpatient revenues plus insurance plus Social Security income spend-through. To identify the contribution of other income sources toward financing out-of-pocket nursing home costs would be a very fruitful line of inquiry for future research. Until this work is done, we will not know how much of total nursing home costs are financed by income.

Furthermore, income is not the only unknown we need to identify in this regard. At least two other significant sources of nursing home payments remain which do not involve spend-down of patient resources. The first is contributions

from others, usually children or spouses. According to the Bureau of the Census, 167,000 adults living in nursing homes--more than 10% of total nursing home residents--receive a mean annual support payment from other people of \$2,886 (U.S. Bureau of the Census, 1988, p. 20). Total support, much of which is paid directly to the nursing home for the cost of care, is nearly \$.5 billion per year. Although these donated funds are included in HCFA's reporting category of out-of-pocket payments, they do not represent a spend-down of patient assets.

Finally, insurance payments may account for a larger proportion of nursing home costs than previously believed. A widely cited statistic, supplied by the Health Care Financing Administration, is that private insurance pays only \$.5 billion or 1.1% of total nursing home expenditures (Lazenby & Letsch, 1990, pp. 21, 24). This figure, however, is "just a guess....No hard numbers give us how much [is expended] for nursing home care [by insurance]." (Lazenby, personal communication, March 11, 1991) The HCFA private insurance estimate does not include a measurement of payments by policies commonly referred to as private long-term care insurance. These policies, of which over 1.9 million have been sold (Van Gelder & Johnson, 1991, as updated), usually pay a daily indemnity amount directly to an institutionalized policy-holder. Because these payments are made directly to policy-holders, who then use the income to pay for care, they

are reflected as out-of-pocket payments in the HCFA data. Thus, HCFA underestimates the private insurance contribution toward nursing home costs and overestimates out-of-pocket costs. Future research should attempt to correct this discrepancy.

Clearly, the nursing home expenditures reported by HCFA as out-of-pocket payments are somewhat misleading. What at first appeared to be evidence of catastrophic asset spend-down has turned out to be largely the contribution of income toward cost of care. This problem has been caused in part by the way HCFA estimates out-of-pocket costs. They report a derivative, not a computed, amount. In other words, HCFA starts with total nursing home expenditures, which are known, and subtracts out all known sources of payment. What remains, the agency reports as out-of-pocket costs. If one starts from the other end and builds a patient payment estimate from the bottom up as we have done in this article, a completely different picture emerges based predominantly on income, not asset spend-down.

### **Medicaid Nursing Home Eligibility**

Now we have to explain an apparent anomaly created by the foregoing analysis: If most private out-of-pocket expenditures for nursing home care come from income, and if personal savings remain relatively untapped, then how do so many people qualify for Medicaid, i.e. means-tested, nursing

home benefits? We will begin to answer this question by estimating the proportion of aged Americans who could qualify for these benefits if they needed care under current law without creative legal planning.

Medicaid eligibility rules have a reputation for incomprehensibility. Several distinguished jurists have called the program a "Serbonian bog" of "bureaucratic complexity" which is "almost unintelligible to the uninitiated" (Dobris, 1989, p. 12). The following analysis attempts to plot a course between this morass of complexity and the pitfall of oversimplification. The reader is fairly warned, however, that much more complicated analysis and further research still need to be done.

Medicaid is a means-tested public assistance program, i.e. welfare. To qualify, people must be "categorically eligible." The major eligibility categories are "families with dependent children" and the "aged, blind, or disabled." If one belongs to the latter group, has less than \$2,000 in assets, and receives income at or below the Supplemental Security Income (SSI) limit of \$407 per month (as of 1991), one qualifies for Medicaid. Very few elderly people would qualify for Medicaid without spending down if they had to meet these standards.

### **The Income Test**

People who need nursing home care, however, are not

covered by the same Draconian income limit. Their income must conform to one of two different, and far more generous, standards. Which of these standards is applied depends on the patient's state of residence. We will start by analyzing the more lenient "medically needy" income standard which is used in most states.

According to Edward Neuschler's treatise Medicaid Eligibility for the Elderly in Need of Long Term Care:

Most states (30) have no absolute upper limit on income for applicants residing in nursing homes....In these states, as long as the applicant's current monthly income is insufficient to cover his medical expenses, including the cost of care in the nursing home..., the applicant is eligible for Medicaid. (Neuschler, 1987, p. 17)

The average cost of nursing home care in the United States as of 1988 was \$72 per day or \$2160 per month (Office of National Cost Estimates, 1990, p. 15). It follows that, on the average, people with incomes below this amount who require nursing home care will qualify for Medicaid under the medically needy income criteria. If they have medical expenses above the cost of the nursing home, their income can be even higher. Obviously, asset restrictions must also be met, but we will discuss the treatment of resources separately

later.

The key question, therefore, is how many people have incomes below \$2160 per month or \$26,000 per year. According to data published by the Social Security Administration (Grad, 1990), 91.3% of nonmarried persons aged 65 or older have incomes of \$25,000 or less. The subgroup of the elderly most likely to enter a nursing home (nonmarried women aged 75-79) has similar numbers: 93.2% have incomes below \$25,000. Married couples have higher incomes, but a married individual's income is treated separately for purposes of determining Medicaid eligibility after one month in the nursing home. Furthermore, only 16.5% of newly admitted nursing home patients are married (Hing, et al., 1989, p. 62).

Thus, income limits in medically needy programs interfere with Medicaid eligibility for very few people.

What can we say about the impact of income limits in "income cap" states? States that do not use medically needy criteria for nursing home eligibility place a ceiling on income of 300% of the SSI limit or \$1,221 per month (as of 1991). How many elderly people have incomes below this level, i.e. \$14,652 per year? Of nonmarried persons aged 65 and older, 74.8% have incomes of \$14,000 or less. Among the nursing home vulnerable group, nonmarried women aged 75-79, 79.4% have incomes of \$14,000 or less (Grad, 1990).

Therefore, as Neuschler explains, "...meeting the income test for Medicaid eligibility for nursing home care is usually

not too difficult...all but relatively higher income elderly are eligible." (Neuschler, 1987, pp. 17, 20) In fact, we are amply justified to conclude that the vast majority of senior citizens in the United States who need nursing home care can meet the income test for Medicaid eligibility without using special legal planning techniques. What about the effect on Medicaid eligibility of owning resources?

### **The Asset Test**

At first, the asset test seems much simpler and far more restrictive than the income test for Medicaid nursing home eligibility. An eligible individual may usually have no more than \$2,000 in countable resources. If all resources were "countable," this restriction would disqualify nearly every senior citizen. Median net worth for all households headed by an elder is \$73,471. Even single, elderly females have a median net worth of \$47,233. Among aged householders in the lowest quintile of national income, i.e. under \$939 per month, as many have net worths over \$25,000 as under (U.S. Bureau of the Census, 1990, p. 6). Thus, a \$2,000 limit on resources is very severe and accounts for the widespread presumption cited earlier that Medicaid requires impoverishment.

As we back out resources which are not countable, however, the data begin to suggest a very different interpretation. For example, a home and contiguous land are



exempt from the computation of Medicaid resource eligibility regardless of value. If we remove the value of the home, the median net worth of the groups cited in the previous paragraph drops to \$23,856 for all aged households, to \$10,693 for single, elderly females, and to only \$3,536 for aged households in the lowest income quintile. Thus, excluding the home brings the net worth of the median elderly household much closer to Medicaid limits without any spend-down of assets.

The amounts cited above which remain after exclusion of the home still exceed Medicaid's \$2,000 resource limit substantially. Many other non-countable assets remain to be deducted, however. Such assets are exempt in differing amounts in various states. To simplify the analysis, let us examine one state in particular. In Massachusetts, for example, non-countable assets include "household belongings, furnishings, personal effects and jewelry, **regardless of value**; a segregated burial account of up to \$2,500; an irrevocable burial trust **of any value**...; burial plots for the individual or members of the family; prepaid non-cancellable burial contracts; cash value life insurance with face value of up to \$1,500; term life insurance policies (with no cash value) **up to any amount in face value**; one automobile **of any value** for use by the individual and his family; inaccessible assets **of any value**." (Bove, 1990, p. 10, emphasis added) An

applicant for Medicaid in Massachusetts may possess all of these things in addition to the \$2,000 resource limit and still qualify for assistance.

Information on which kinds of assets are non-countable is available from many sources. The Medicaid application or the eligibility worker who takes the application should explain which assets are exempt. State law, regulations and policies cover the subject. Legal services attorneys and other publicly financed advisers within the aging network routinely provide such information gratis (Office of Inspector General, 1989, p. ii). Few applicants or their personal representatives will fail to understand that very considerable assets, if of the proper kind, may continue to be owned while still qualifying for Medicaid.

Most senior citizens have at least some additional assets beyond their home which are non-countable. For example, 75.0% of householders over the age of 65 own automobiles which have a median value of \$3,834 (Census, 1990, p. 15). The majority of their assets after excluding the home and car, however, are probably not exempt. For example, 78.8% of households headed by someone over 65 have interest-earning assets at financial institutions in the median amount of \$14,560 (Census, 1990, p. 14). Smaller proportions of the elderly have checking accounts, stocks and bonds, rental property, businesses or other kinds of countable property.

Because a large proportion of seniors have enough

countable resources to disqualify them for Medicaid, the following point is critical to make. Uncommon perspicacity is not required to discern that a countable asset like cash is convertible to a non-countable asset like an automobile very easily. In fact, many Medicaid eligibility workers, nursing home admissions officers, hospital discharge planners, medical doctors, social workers, as well as private attorneys routinely advise their clients of this fact and recommend such a conversion of assets to qualify for Medicaid (OIG, 1989, pp. 6-11).

Purchase of an exempt asset is the simplest and most common method to eliminate countable resources without spending down. We have no hard data on how widespread this practice is. We can safely assume, however, that a prudent consumer faced with spending down resources on nursing home care or buying an exempt asset such as home improvements, a new car, jewelry, or insurance may seriously consider the latter as the more attractive option. Keep in mind that the infirm elder is usually not the only party concerned about protecting assets from spend-down. The spouse and heirs, who are often the financial representatives as well as the health care decision-makers for an institutionalized loved one, also have a strong pecuniary interest in the disposition of funds.

We can now return to the key question: what proportion of the elderly would the Medicaid asset test compel to spend down? Single, female heads of household over 65 years of age

have a median net worth of \$47,233. Their male counterparts have \$48,883. Excluding the value of their exempt homes, median net worth drops to \$10,693 for women and \$15,914 for men (Census, 1990, p. 10). These amounts exceed the Medicaid asset limit by only \$8,693 for women and \$13,914 for men. Clearly, countable assets in such small quantities are easily convertible to exempt resources in order to avoid spend-down. A new roof, a moderately priced car, a stereo system, a diamond ring, a burial account, trust, and/or plot would protect these assets and much more. This is not creative legal planning. It is a common sense measure readily available to all Medicaid applicants and their representatives.

The rules are somewhat different for married couple households. To ameliorate the problem of spousal impoverishment, the Medicare Catastrophic Coverage Act of 1988 permitted an institutionalized spouse to transfer a limited amount of resources free of penalty to the community spouse. The amount of freely transferrable resources is limited to the "Community Spouse Resource Allowance" (CSRA) (Title XIX, Section 1924[f][2] of the Social Security Act). The CSRA as of 1991 is half of the couple's joint assets but not less than \$13,296 nor more than \$66,480.

Married couple households headed by someone over age 65 have a median net worth of \$124,419. Excluding the home as an exempt resource leaves a net worth of \$45,890 for couples. At

least half of this amount may be transferred to the community spouse as a CSRA which leaves \$22,945 in potentially countable assets for the institutionalized spouse. This remainder exceeds the Medicaid resource limit by \$20,945. Although larger than the potentially countable median resources belonging to single persons, this amount is still easily converted to exempt status with no more inventive strategy than purchasing non-countable assets.

We have shown in this section that the vast majority of senior citizens who need nursing home care can qualify for Medicaid benefits based on the income test. We have also shown that half of all seniors, i.e. the median individual or couple, can qualify based on the asset test without creative legal planning. If the remaining half of all elders were excluded from Medicaid by the asset test, however, spend-down would be far more common than current research shows it to be. Therefore, it remains to explain how people with much larger assets qualify for Medicaid nursing home benefits without spending down.

### **Medicaid Planning**

Medicaid planning is the legal sheltering of income and assets from state and federal eligibility restrictions. Lawyer-assisted or do-it-yourself Medicaid planning is an easy and inexpensive way to qualify for publicly financed nursing home benefits without spending down. For example, an attorney

in Washington state offers guaranteed Medicaid eligibility within 30 days regardless of income or assets (OIG, 1989, p. 7) for a fee of \$1150 (personal communication, May 19, 1990). Dozens of books and articles, many of which are targeted to a lay audience, explain the techniques of qualifying for assistance without spending down (Moses, 1990a, p. 25; 1990b, pp. 47-50). A rapidly growing number of attorneys practice Medicaid planning (American Bar Association, 1985a; Gilfix & Strauss, 1988; Regan, 1990) and they are readily accessible to seniors and their families through referrals from public and private social service agencies (AARP, 1990; ABA, 1985b; Brown, 1989; OIG, 1989).

Attorneys who offer Medicaid planning services target elderly individuals and couples who have net worths in the range of \$100,000 to \$600,000 plus a home. For holdings over \$600,000, estate tax avoidance is more important than planning for nursing home costs. Very few elderly people in America have net worths above this level. In fact, 92.1% of married-couple households headed by someone over 65 have net worths under \$500,000. The comparable percentages for single male and single female householders are 97.5% and 98.7% respectively (Census, 1990, p. 19). Thus, only a small fraction of elderly Americans fall outside the reach of Medicaid planning strategies.

What are the most common techniques used in Medicaid planning and how are they promulgated? A good way to answer

this question is to cite an example from one state of the many and rapidly proliferating training programs available to attorneys throughout the country. The California ElderLaw Institute has published a loose leaf book of several hundred pages entitled Medi-Cal [i.e., Medicaid in California], Asset Preservation and Your Clients or Estate Planning is Not Enough! (Gilfix & Woolpert, 1990). According to a review in The ElderLaw Report, a monthly newsletter that disseminates Medicaid planning techniques to over 2500 subscribers, "the meat of the book...is 50 pages on asset-preservation planning strategies" (Margolis, 1991). These 50 pages include the following suggestions among others:

1. "Spend Money on Non-Assets: While there are rules against giving away most assets, there are no prohibitions against simply spending money...options might include travel to visit relatives or see the world, or one last tour of Reno's finest establishments." (p. 42)

2. "Convert Non-Exempt Assets to Exempt." An example is given of a couple with no home and \$240,000 in cash savings. When one member of the couple needs nursing home care, they buy a condominium for \$140,000, shelter half the remainder of their cash in the well spouse's CSRA, and spend most of the other half on home furnishings. Finally, to avoid the risk of discrimination against low-paying Medicaid recipients, they

save out \$25,000 "which is likely enough to ensure access to most nursing homes, even those that might not accept a new resident who is already eligible for Medi-Cal." (p. 43) When the remaining cash drops to \$2,000, the ill spouse applies for Medi-Cal.

3. "Repairing or Improving Exempt Assets: Repairs to exempt assets, such as a home or automobile, are permitted and exempt... For example: A \$140,000 project to add two (2) rooms to a residence...." (p. 46)

4. "Spend Down Includes Attorney Fees: Money paid to an attorney for asset preservation and estate planning is routinely accepted by the Department of Health Services as a legitimate use of an institutionalized spouse's assets." (p. 47)

5. "Gifting Exempt Assets." This technique involves giving away most of one's assets while retaining sufficient funds to pay privately for care during the transfer of assets penalty period which can be as long as 30 months. An interesting twist on this otherwise commonplace method, however, is the book's observation that by making small "consecutive" monthly gifts instead of giving away one lump sum, a donor can reduce the penalty period considerably. In the example given, "Generous George" qualifies for Medicaid in 8 months instead



of 19 months by doling out his \$80,000 in gifts in carefully calculated fractional amounts so that the penalty periods run simultaneously and offset one another. (p. 56)

6. "Converting Assets to Income...A single person could convert non-exempt assets into an annuity with a death benefit, elect periodic payments, and qualify for Medi-Cal/Medicaid..." or for "Married Persons...Unprotected assets can be used to purchase an annuity in the name of the community spouse." (pp. 58-59) Purchase of an annuity is not a transfer of assets, because the transferor receives fair market value, i.e. income. Under terms of the annuity, the income is kept to a level below the Medicaid income test, thus qualifying the annuitant for public assistance without penalty or spend-down.

7. "Retain Assets in Excess of CSRA or Income in Excess of MMNA [Monthly Maintenance Needs Allowance, Title XIX, Section 1924(d)(3)] by Court Order or Fair Hearing...The community spouse has the right to retain non-exempt assets in addition to the CSRA if they are needed to raise the community spouses' income to the MMNA level...The community spouse can be allowed to retain more than the MMNA by a fair hearing to establish 'exceptional circumstances resulting in significant financial distress'...." (pp. 60-61) Careful application of these techniques can sometimes increase the community spouse's

protected share of resources from the statutory limit of \$66,480 to over \$200,000.

8. "After Acquired Assets...The community spouse may acquire assets in excess of the CSRA after the institutionalized spouse achieves eligibility without any impact on eligibility... therefore...A well meaning brother should not send cash to his sibling--community spouse--until after the institutionalized spouse has become eligible. Children who may have received support from their parents in the past should not return the favor (with gifts of assets) prematurely." (p. 62)

9. "Divorce...Where a community spouse has sizable separate property assets...divorce may be on the list of planning options." (p. 62)

I cite this training manual at length to give a sense of the approach and perspective as well as the content and scope of a typical Medicaid planning source book. The following additional strategies are taken from a vast and growing Medicaid planning and legal education literature. Researchers and policy-makers who are concerned about rapidly increasing Medicaid costs should review these and other similar sources carefully.

A "how to do it" book by an attorney available in book

stores throughout the United States for under \$30 encourages readers to "hide money...juggle assets...transfer a home...change wills and title to property...set up a Medicaid trust..." to qualify for public assistance (Budish, 1989).

Another self-help book by an attorney, which is advertised on the radio with a toll-free phone number for orders, explains: "Our goal is to take countable assets (those that have to be spent to zero)..., and make them either non-countable, and therefore protected..., or inaccessible which means that Medicaid can't get them...." (Gordon & Daniel, 1990)

Many local Bar Associations sponsor seminars for lawyers on Medicaid planning. For example, on February 22, 1991, the Seattle-King County Bar Association hosted a meeting at which a prominent local attorney urged his colleagues to practice "entrepreneurial law" by aggressively testing experimental planning techniques on state Medicaid eligibility workers. He explained how to shelter one million dollars in cash for a client: put the money in an exempt home before the Medicaid eligibility "snapshot" and pull it out afterwards (Dussault, 1991).

The American Bar Association is also actively involved. For example, on February 28, 1991, the ABA's Commission on Legal Problems of the Elderly sponsored a seminar entitled "Health Care and Financial Planning Issues for the Elderly." It was televised live by satellite to over 50 locations

throughout the United States. On this program, the President of the National Academy of Elder Law Attorneys recommended diverting an institutionalized client's countable share of assets--up to \$66,480 or more--from private nursing home costs to exempt resources such as home improvements or a new car (Severns, 1991, p. 119). This planning technique defeats Congressional intent in the Medicare Catastrophic Coverage Act which was to protect half, not all, of a couple's joint assets from Medicaid spenddown requirements.

The following is a series of quotes spanning 10 years of serious legal scholarship on Medicaid planning:

Careful planning even under adverse state law will still be able to achieve the goal of excluding an applicant's resources for purposes of determining Medicaid eligibility. (Talis, 1981, p. 94)

With long-range planning, the cooperation of relatives, some good health, and maybe a little luck, couples will be in a position to negotiate between the rock and a hard place that Congress has placed in the Medicaid path. (Deford, 1984, p. 139)

The most common problem put to the elderlaw practitioner is how to keep an older person's assets within the family and yet allow the person to

qualify for Medicaid. (Regan, 1990, pp. 275-6)

A key element in Medicaid planning is to render property unreachable by the state either during the client's lifetime or after the client's death.

(Barreira, 1990, p. 1)

While a number of asset preservation strategies have been already suggested, numerous others exist and will undoubtedly be developed in the creative practice of elder law. (Gilfix, 1990, p. 46)

It is true, almost to the point of being a cliché, that benefit programs, whether public or private, are bonanzas for lawyers. (Frolik & Barnes, 1991, p. 715)

During a review I conducted in October 1990 for the Massachusetts Department of Public Welfare, various state staff complained: "long-term care units are barraged by [Medicaid planning] attorneys...it goes on all day...the system leaks all over the place...the laws and policy set us up for failure...the workers feel intimidated...it gets outrageous...." (Moses, 1990c, p. 5) State eligibility workers claimed that 30% to 50% of Medicaid nursing home applications from prosperous towns like Newton, Brookline,

Wellesley, Westin, Dover and Sherban involve income or asset shelters (Moses, 1990c, p.1). This information comports with similar statements by Medicaid workers in other states cited at length in a 1988 report by the Inspector General of the Department of Health and Human Services (OIG, 1988, pp. 12-14) and referenced in my earlier article "The Fallacy of Impoverishment." (Moses, 1990a)

Attorneys are not the only professionals, however, who recommend Medicaid planning strategies: "Physicians can make an important contribution to the welfare of their patients who are at risk by informing them of [Medicaid planning] services...." (Feinbloom & Schneider, 1988, p. 46) A recent survey found that "...a majority of [financial planners] felt that an individual with a catastrophic illness should consider transferring assets to family members in order to qualify for Medicaid." (Bacon, et al., 1989, p. 153) According to the Inspector General of the Department of Health and Human Services: "The experts who counsel Medicaid applicants to shelter assets include...social service agencies, the Medicaid agency staff, some nursing homes staff and private counselors." (OIG, 1989, p. ii) The American Association of Retired Persons sponsors a national outreach program to increase enrollment in Medicaid (Sternberg, 1991). Thanks to well-intentioned efforts such as these, virtually everyone has access to Medicaid income and asset sheltering techniques:

Ironically, those with higher incomes may benefit more from Medicaid, particularly the long-term care component, because they have easier access to the information needed to obtain eligibility.... (U.S. Congress, 1987b, pp. 50-51)

### **Critique of the "Spend-Down" Research**

Clearly, almost all elderly people in America can qualify for Medicaid without spending down if they need nursing home care. More than half can qualify without creative legal planning. Most of the remainder can qualify using simple, proven, widely available techniques with or without the help of paid professional assistance. If this is true, however, why does current research still indicate a significant incidence (approximately 10% to 25%) of Medicaid asset spend-down?

The recent spate of spend-down studies cited at the beginning of this article have two things in common: (1) they estimate the proportion of Medicaid recipients in nursing homes who were originally private payers at a level much lower than previously believed, and (2) they define "spend-down" as conversion from private pay to Medicaid status, ignoring the possibility that conversion can occur without spending down. As we have seen in this article, however, spend-down is a sufficient, but not a necessary cause of Medicaid nursing home eligibility. People can shelter income and assets in many

ways to qualify for Medicaid without spending down. Until a study is done which distinguishes between genuine spend-down and artificial impoverishment, therefore, all estimates of spend-down made so far must remain suspect. They are unquestionably too high, although we cannot say yet precisely by how much.

No matter how carefully we analyze the nursing home discharge or current resident data with respect to income and asset planning strategies, however, some amount of spend-down will remain. The aggregate data on sources of nursing home expenditures discussed at the beginning of this article indicate that some considerable, residual proportion of out-of-pocket nursing home costs probably come from assets rather than income. We still need to explain, therefore, why people would choose to spend down their assets in a nursing home when doing so is legally unnecessary.

There are many reasons why people might opt to spend their own money on nursing home care instead of relying on Medicaid. For example, Medicaid has a dismal reputation for problems related to access, quality, level of reimbursement, discrimination, and institutional bias (Bishop, 1988; GAO, 1990; Holahan & Cohen, 1986; Moses, 1990b, pp. 16-20; Nemore, 1990; Rivlin & Wiener, 1988, pp. 9, 203; U.S. Congress, 1986). Those who understand Medicaid and its problems, therefore, are less likely to seek its assistance. Some people believe it is wrong to accept welfare if they are not destitute. Other



people dislike the idea of relinquishing their personal independence to a social worker representing the government. Still others doubt the government's fiscal ability to provide in the future even the level and quality of services available in public programs today. Finally, Medicaid planning attorneys strongly recommend that clients not transfer or shelter all of their assets. They should rather retain enough cash to assure access to a quality nursing home, i.e. one with more private pay than Medicaid residents.

It is substantially easier to obtain placement of a patient in a well regarded nursing home if the patient is or appears to be able to pay privately for six months to a year, than if a patient is unable to do so. Therefore, the goal of financial planning may be to leave the potential patient with adequate funds to pay privately for at least six months. (Delbaum, 1984, p. 373)

In this carefully orchestrated scenario, the Medicaid planning client "spends down" the remaining unsheltered cash quickly and then transfers the burden of financing care to the government and the nursing home (which subsequently receives the lower Medicaid level of reimbursement.) Note that all clients who use this technique, even if they start with a million dollars, would be counted as though they had spent

down by all of the spend-down studies published to date.

## **Discussion**

Most thinking and writing about the long-term care financing crisis until recently has assumed widespread catastrophic asset spend-down in nursing homes. Concern about spend-down has focussed the attention of scholars and policy-makers on asset protection. Therefore, we have seen an almost endless stream of proposals to expand public benefits and/or enhance private sector risk-sharing solutions. If asset spend-down is not as big a problem as we thought, adequate corrective action may be much simpler and cheaper to achieve.

Recent research has shown Medicaid nursing home spend-down to be much smaller than previously thought. This article has substantiated that conclusion, but it has also proceeded much further. We have seen that the vast majority of nursing home costs come from direct government payments or income, not from savings; that most elderly people who need nursing home care qualify for Medicaid without sophisticated legal planning; and that the remainder can qualify quickly and inexpensively by obtaining easily available information on Medicaid planning techniques. How do these findings affect the main players in the long-term care financing arena and what are the implications for public policy?

If the problem of asset spend-down is not as serious as we thought, because of generous Medicaid eligibility criteria

and creative legal planning, then:

Pressure for expanded, tax-funded, public benefits may abate. This would please taxpayers.

The vulnerable elderly can rest more easily concerning their savings, but they should be increasingly wary about access to and quality of care under Medicaid because of fiscal pressures straining the program.

The Medicaid program, already shrugging under massive and rapidly increasing costs, may incur growing expenses as more people take advantage of legal planning techniques to qualify for nursing home coverage without spending down.

The nursing home industry can expect greater numbers of Medicaid patients and fewer private payors, with downward pressure on reimbursement rates as Medicaid costs increase.

The long-term care insurance industry will continue struggling to sell asset protection against catastrophic nursing home costs to people who can, if the need arises, hire an attorney to qualify them for Medicaid for approximately the cost of one year's insurance premium.

## **Conclusion**

There are two logical, inexpensive ways for lawmakers to solve the underlying problem and avoid these ramifications. One is to eliminate all of the exclusions and "loopholes" in Medicaid nursing home eligibility and force people to spend down their assets as private payors. In other words, create

intentionally the catastrophic spend-down problem that we incorrectly thought existed already. Medicaid costs would plummet. More patients would receive the special access and quality which private payment status assures. The remaining, genuinely destitute Medicaid patients would benefit from a larger private payor base for cost shifting. Nursing home profitability would increase. Everyone would obtain long-term care insurance or face bankruptcy. This "solution" is not palatable politically; it would mean going backwards.

Another approach might achieve the same benefits with less discomfort. Lawmakers could remove the obstacles to publicly financed care, but require a pay-back from estates. This is the approach recommended by the Inspector General of the Department of Health and Human Services and described in my earlier article (Moses, 1990a):

(1) Change Medicaid rules to permit families to retain and manage property while their elders receive long-term care.

(2) Strengthen the transfer of assets rules so that people cannot give away property to qualify for Medicaid.

(3) Require a legal instrument as a condition of Medicaid eligibility to secure property owned by

applicants and recipients for later recovery.

(4) Increase estate recoveries as a nontax revenue source for the Medicaid program while steadfastly protecting the personal and property rights of recipients and their families.

These measures would eliminate the need for people to hire attorneys to qualify for welfare. Everyone would have unrestricted access to long-term care.

The quid pro quo, however, is that people with assets would have to offer security for the loan they ask the government to make in financing their care. The opportunity to pay this loan off after the death of one's last surviving exempt dependent relative instead of facing immediate financial devastation would be a very attractive, new government benefit.

Most people faced with the risk of estate recovery, however, would plan ahead instead of relying on Medicaid and surrendering their estates. They would buy long-term care insurance or position themselves financially to pay privately without risk-sharing. If they could not afford the insurance, they would consider home equity conversion to finance the premiums. Heirs, seeing their inheritance newly vulnerable, would have an incentive to purchase insurance for their parents. More people with insurance would mean more private

payors in nursing homes. More private payors would mean greater nursing home cash flow. More cash flow would mean more funds available for cost shifting to support access and quality levels for the remaining public patients. All players in the long-term care financing arena would benefit.

This article has argued that our failure to find a politically viable solution to the long-term care financing problem is partly a function of misunderstanding the problem.

Hopefully, expanded research along the lines recommended will elucidate the problem further and suggest new approaches for corrective action. In the meantime, the Inspector General's proposals should receive serious consideration in the public policy debate.

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