

Medicaid and Long-Term Care

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Abstract

How to provide and finance long-term care for a burgeoning elderly population bedevils scholars and policy makers. The existing service delivery and financing system, dominated by public funding, is highly dysfunctional, fraught with problems of access, quality, reimbursement, discrimination and institutional bias. Most long-term care scholarship analyzes these symptoms, without explaining their cause, and recommends expanding government's role, usually by means of a new or expanded mandatory, tax-funded social insurance program. This paper takes a different tack, first explaining why the long-term care market has the problems it does and then suggesting how to remove their causes. At the root of all long-term care problems is Medicaid, the dominant payer. By providing only nursing home care—including room, board, and medical care—funded with virtually unlimited federal and state matching funds, Medicaid (1) exploded in cost, (2) created institutional bias, (3) caused access and quality problems by paying providers too little, (4) enriched plaintiff's attorneys with the resulting tort liability cases, (5) crowded out private markets for home care and long-term care insurance, and (6) kept poor people poor with punishing spend down rules, while (7) letting the affluent save and benefit through eligibility loopholes. The key to fixing the problems that plague long-term care is to make Medicaid a better safety net for the poor while diverting the general public to private financing alternatives. This paper explains how to do that while reducing government funding and regulation, which arguably caused the long-term care problems in the first place.

Introduction

Like the drunk seeking car keys only under a streetlight, most scholars narrow their search for long-term care solutions to the funding source they know best, government. Countless special

commissions (Pepper Commission, 1990) (Medicaid Commission, 2006) (Commission on Long-Term Care, 2013),¹ studies, reports and articles have explored the same ground. Most made the same recommendation, more obligatory social insurance. Voluntary private sector solutions receive scant consideration. This paper identifies a missing link in conventional scholarly research, draws the logical inferences, and reaches a different conclusion.

Long-term care, also called long-term services and supports (LTSS²), includes health care and social services to help people with physical or cognitive disabilities to perform activities of daily living over an extended period (Thach and Wiener, 2018, p. 1). The probability of needing long-term care is high. Seventy percent of people who reach age 65 “develop severe LTSS needs before they die and 48 percent receive some paid care over their lifetime (Johnson, 2019, p. 3)” incurring average lifetime expenses of \$138,100 (Favreault, Gleckman, and Johnson, 2015, p. 2181). Monthly paid care is expensive whether provided in a nursing home (\$7,513 for a semi-private room; \$8,517 for a private room), assisted living facility (\$4,051), or at home (\$4,385) (Genworth, 2019). The need for long-term care increases with age. The U.S. 85+ population with the highest need will triple between 2015 and 2050 (Houser, Fox-Grage and Ujvari, 2018, p. 3). The United States spent \$366.0 billion on long-term care in 2016 (Colello, 2018, p. 1), not counting half-a-trillion dollars in unpaid caregiving value provided at enormous financial and

¹ From the Pepper Commission in 1990, which recommended universal health and long-term care coverage (p. 1), to the 2006 Medicaid Commission, which recommended “incremental measures to encourage individual planning for long-term care” (p. vi) to the 2013 Commission on Long-Term Care, which “did not agree on a financing approach” (p. 61), study after study has bewailed the condition of long-term care services and financing, insisted on the urgent need to address those problems, but achieved no meaningful results.

² Long-term services and supports or “LTSS” has replaced “long-term care” as the politically correct term of art among policy analysts. The awkward neologism evolved to emphasize the need for home and community-based care to replace nursing homes, the less desirable venue which had become synonymous with long-term care. The irony is that Medicaid, *i.e.* public long-term care financing, is responsible for the long-term care system’s nursing home bias. If Medicaid had not paid for nursing home care after the insurable event occurs for most Americans, including the middle class, since 1965, we would have had a healthier, private home-care-based service delivery system funded largely by personal savings, home equity conversion and private long-term care insurance. The same people who caused the problem of institutional bias by demanding more and more government financing and interference in the long-term care market are the ones insisting on “LTSS” and denigrating the traditional appellation “LTC.”

emotional distress by family and friends (Chari, Engberg, Ray, and Mehrotra, 2015, p. 871). The strain of providing and financing seniors housing and long-term care is huge already, bodes ill for the future, and attracts increasing scholarly and political attention, nearly all leaning toward a larger government role (Pearson, *et al.*, 2019, p. 851³).

Yet, the current structure of long-term care service delivery and financing, dominated by 70.3 percent government funding (Colello, 2018, p. 1), is dysfunctional. Problems include high and rapidly increasing costs (Eiken, *et al.*, 2018, p. 1⁴); persistent nursing home bias (Gleckman, 2013⁵); limited access to the home care consumers prefer (Johnson and Wang, 2019, p. 1000⁶); provider reimbursements too low to ensure quality care (Hansen Hunter, 2018, p. 2⁷); doubtful quality in nursing homes (Wood, 2019⁸) (Ameriks, 2007, p. 22⁹) and home care (Gorges,

³ “We project that by 2029 there will be 14.4 million middle-income seniors, 60 percent of whom will have mobility limitations and 20 percent of whom will have high health care and functional needs. While many of these seniors will likely need the level of care provided in seniors housing, we project that 54 percent of seniors will not have sufficient financial resources to pay for it. This gap suggests a role for public policy and the private sector in meeting future long-term care and housing needs for middle-income seniors.”

⁴ “Medicaid LTSS expenditures growth has returned to five-percent rates that occurred before FY 2011 after years of lower growth.”

⁵ “If, like millions of Americans, you need personal assistance and run out of money, you may be eligible for long-term care under Medicaid. But in order to get those safety net benefits, you may have no choice but to move into a nursing home.”

⁶ “Those who depleted their financial resources before qualifying for insurance benefits would have to turn to Medicaid, which offers limited home and community-based services to older adults with severe disabilities. However, beneficiaries often face long waiting lists for such services financed by Medicaid, and the income allowances that state Medicaid programs grant to home care beneficiaries are often too low to support community living. ... Consequently, some people who could no longer afford paid home care on their own might have to enter a nursing home to receive subsidized care.”

⁷ “With states setting the Medicaid rates paid to nursing centers, there is a wide variation in the percentage of costs covered by the rates. In 2015, the coverage ranged from a low of 73.5 percent to a high of 100 percent. A similar range exists with the 2017 projected shortfall across the states.”

⁸ “Low Medicaid reimbursement rates for nursing homes are hurting the quality of care, by keeping operators from offering high enough wages to attract and keep good workers, long-term care (LTC) experts told lawmakers at a recent Senate hearing. The squeeze can lead to pressure on the quality of care even for private-pay patients, witnesses said at the hearing, which was organized by the Senate Finance Committee. Sen. Chuck Grassley, R-Iowa, the chairman of the committee, kicked off the hearing by noting that about one-third of residents in federally funded nursing facilities suffer harm.”

Sanghavi, and Konetzka, 2019, p. 1110¹⁰) and the tort liability that comes with deficient quality (Aon, 2018¹¹); worsening shortages among both paid (Bryant, 2019¹²) and unpaid caregivers (Schulz and Eden, 2016¹³); and dwindling private financing sources exemplified by declining private payers in nursing homes (NIC, 2019, September¹⁴), the near absence of home equity conversion to fund care (Bell, 2018¹⁵), and poor long-term care insurance take up (Favreault and Dey, 2016, p. 8¹⁶). To understand why this market performs so badly, we can follow the money.

⁹ “However, using Medicaid restricts your choice of facility, on average results in inferior care, and requires you to surrender all income to the government.”

¹⁰ “The benefits of expanding funding for Medicaid long-term care home and community-based services (HCBS) relative to institutional care are often taken as self-evident. However, little is known about the outcomes of these services, especially for racial and ethnic minority groups, whose members tend to use the services more than whites do, and for people with dementia who may need high-intensity care. ... Our findings suggest that home and community-based services need to be carefully targeted to avoid adverse outcomes and that the racial/ethnic disparities in access to high-quality institutional long-term care are also present in HCBS. Policy makers should consider the full costs and benefits of shifting care from nursing facilities to home and community settings and the potential implications for equity.”

¹¹ “The sixteenth published edition of the Aon General and Professional Liability Benchmark for Long Term Care Providers estimates ultimate loss rates, or the cost of liability for skilled nursing providers on a per-bed basis. The projected national 2019 loss rate is estimated to be \$2,410. This means that a skilled nursing facility with 100 occupied beds can expect approximately \$241,000 in liability expenses in 2019.”

¹² “The nationwide shortage of caregivers continues to be one of the biggest industry-wide problems for home health and home care agencies, with no end in sight. And in the future, the employment crunch could become even worse than previously expected.”

¹³ “There is a growing gap between the demand for and supply of family caregivers for older adults. The demand for caregivers is increasing significantly not only because of the dramatic increase in numbers of older adults but also because the fastest growing cohort of older adults are those age 80 and older—the age when people are most likely to have a significant physical or cognitive impairment or both. At the same time, the size of American families is shrinking and the makeup of families is changing as more people do not have children, never marry, divorce, or blend families through remarriage. Moreover, half of family caregivers are employed.”

¹⁴ Nursing homes’ private revenue mix declined from 12 percent in 2012 to 7.6 percent in the third quarter of 2019, whereas Medicaid’s share of nursing home revenue has continued to increase from 47 percent to 51.5 percent.

¹⁵ “In theory, many older people could cope with their lack of annuities, long-term care insurance and other retirement saving and insurance vehicles by taking out reverse mortgages to tap their home equity. But, in the real world, only about 50,000 U.S. homeowners take out new reverse mortgages each year, Brown said. The result, he said, is that older, single Americans are doing poorly.” Medicaid’s large home equity exemption—which ranges from \$595,000 to \$893,000 as of 2020 depending on the state—is the main obstacle to the use of reverse mortgages, or other forms of home equity conversion, to finance long-term care.

¹⁶ “Private LTSS insurance has only a modest reach, and it predominantly covers costs for those high in the income distribution.”

Who Pays for Long-Term Care?

Government financing dominates the long-term care market covering \$257.4 billion of total \$366.0 billion 2016 expenditures. Medicaid, a means-tested public assistance program jointly funded by the federal and state governments, is the largest contributor at \$154.4 billion (Colello, 2018, p. 1). But Medicaid's contribution of only 42.2 percent of long-term care dollars understates its influence. The program covers 62 percent of all nursing home residents (Harrington, Carrillo, Garfield, and Squires, 2018¹⁷), 19 percent of assisted living residents (AHCA/NCAL¹⁸) and makes a rapidly growing contribution to home and community based care (Landers, *et al.*, p. 265¹⁹).

How can Medicaid pay only two-fifths of long-term care costs, but cover three-fifths of the most expensive, *i.e.*, nursing home, patients? Three factors principally account for this incongruity. First, cost shifting from private patients makes up part of the difference. Medicaid provider reimbursements are notoriously low, roughly 80 percent of private-pay rates (Lieberman, 2018²⁰) and often less than the cost of the care (*Ibid.*²¹ and Hansen Hunter, 2018²²). Second,

¹⁷ "Medicaid is the primary payer source for most certified nursing facility residents, with more than six in ten (62%) residents—about 832,000 people—having Medicaid as their primary payer in 2016."

¹⁸ "Medicaid pays for ... about 19 percent of assisted living residents, and this number is only expected to increase over the next few decades."

¹⁹ "In 2013, in the context of Medicaid long-term services and supports, there were more home- and community-based service providers than institutional providers, an 18% increase since 1995. Medicaid expenditures for home- and community-based services have also grown significantly, reflecting the rise in use of home-based services as opposed to institutional care, more than doubling from \$25.1 billion in 2002 to \$55 billion in 2012."

²⁰ "According to the [4Q2017 NIC Skilled Nursing Report](#), Medicaid reimburses skilled nursing properties at an average national rate of \$206 For private payors, the reimbursement rate was \$257 at the end of the fourth quarter 2017."

²¹ "According to AHCA's [research](#), the rate paid by Medicaid for long-term care of nursing home residents may be inadequate. In some states, AHCA contends, the rate is actually less than the cost of care, leaving providers to leverage the other payor sources (Medicare, managed Medicare, and Private) to offset losses."

Medicaid long-term care recipients are required to contribute most of their income to offset the program's cost for their care (Musumeci, Chidambaram and O'Malley Watts, 2019, p. 15²³).

Third, Medicare, which pays far more generously than Medicaid for nursing home and home care (MedPAC, 2018, p. 206²⁴), enables long-term care providers to survive financially while most of their patients' care is reimbursed at meager Medicaid rates. (Lieberman, 2018²⁵).

These facts matter because the impact of public financing on long-term care is substantially greater than the raw numbers suggest in ways almost never acknowledged in the literature. Most of the income Medicaid recipients contribute to offset Medicaid's cost for their care comes from Social Security. Although Social Security is not usually considered to be a financing source for nursing home care, the fact is that it contributes very significantly, albeit indirectly as "spend-through." Social Security spend-through refers to income most seniors collect in the form of Social Security benefits which they must contribute toward their cost of care when they receive long-term care services paid for by Medicaid. There is very little in the literature about this source of long-term care financing even though research from 20 to 30 years ago indicated it accounts for nearly half of reported out-of-pocket nursing home costs. The amount is substantial,

²² "With states setting the Medicaid rates paid to nursing centers, there is a wide variation in the percentage of costs covered by the rates. In 2015, the coverage ranged from a low of 73.5 percent to a high of 100 percent. A similar range exists with the 2017 projected shortfall across the states. ... If all costs of operations were considered—not just Medicaid allowable costs—the shortfall would be significantly greater."

²³ "Once eligible for Medicaid, individuals in institutions generally must contribute most of their monthly income to the cost of their care, with the exception of a small allowance used to pay for personal needs that are not covered by Medicaid, such as clothing."

²⁴ "In 2016, the average Medicare margin for freestanding SNFs [skilled nursing facilities] was 11.4 percent—the 17th year in a row that the average was above 10 percent. ... The marginal profit, a measure of the relative attractiveness of treating Medicare beneficiaries, was at least 19.6 percent for freestanding facilities."

²⁵ "According to the [4Q2017 NIC Skilled Nursing Report](#), Medicaid reimburses skilled nursing properties at an average national rate of \$206, less than half the rate paid by Medicare and Managed Medicare, \$503 and \$433, respectively."

nearly half of the \$57.0 billion (15.6 percent) total otherwise reported as “out-of-pocket” costs in 2016 as inferred based on (Lazenby and Letsch, 1989, p. 8²⁶; McCall, 2001, p. 19²⁷).

Thus, in addition to the 70.3 percent of long-term care financing contributed directly by Medicaid, Medicare and other public sources, the public funding role is enhanced by spend-through of Social Security and other private income and by Medicare’s more generous reimbursement rates offsetting providers’ losses from Medicaid. This added dependency on two financially vulnerable social insurance entitlement programs contributes to the fragility of the long-term care financing system. If Social Security and Medicare trust funds expire as expected in 2035 (Board of Trustees [Social Security], 2019, p. 5²⁸) and 2026, (Board of Trustees [Medicare], 2019, p. 6²⁹) respectively, resulting in substantial cuts to those programs, Medicaid and the long-term care providers dependent upon it will be hard-pressed to make up the loss.

Medicaid Long-Term Care Financing in Perspective

U.S. national health expenditures (NHE) increased 4.6 percent to \$3.6 trillion in 2018 or 17.7 percent of Gross Domestic Product (GDP) (Hartman, *et al.*, 2020, p. 8). Medicaid spending grew 3.0 percent to \$597.4 billion, 16 percent of total NHE or 2.9 percent of GDP (CMS, 2019).

Combined institutional and non-institutional Medicaid long-term care spending was \$167 billion in 2016, 30 percent of total Medicaid expenditures (Eiken, *et al.*, 2018, pp. 2, 5). This 4.5 percent

²⁶ According to the Health Care Financing Administration (HCFA), the predecessor of the Centers for Medicare and Medicaid Services: “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.”

²⁷ Later research confirmed that Social Security spend-through is almost half of nursing home out-of-pocket costs. “As shown in this table, Social Security income is a substantial contributor to financing long-term care.” The table referenced here shows that 15.3 percent of all nursing home expenditures for 1997, more than half of the total 31 percent out-of-pocket expenditures for that year, came from Social Security income that Medicaid recipients were required to contribute to offset Medicaid’s cost of their care.

²⁸ “Under the intermediate assumptions, the projected hypothetical combined OASI and DI Trust Fund asset reserves become depleted and unable to pay scheduled benefits in full on a timely basis in 2035.”

²⁹ “In 2018, HI expenditures exceeded income by \$1.6 billion. The Trustees project deficits in all future years until the trust fund becomes depleted in 2026.”

increase over the \$159 billion spent in 2015 (*Ibid.*, p. 2) was over half again as much as the 2.9 percent increase in GDP for that year (Duffin, 2019).

Medicaid spending is not evenly proportioned among enrollment groups. The program is constantly in the news because of controversy over expanding the program under the Affordable Care Act. But the ACA, or “ObamaCare,” principally addresses acute health care for young mothers, children and working age adults. While these groups comprise 77 percent of Medicaid enrollees (Kaiser Family Foundation [KFF], enrollees), they consume only 38 percent of Medicaid spending (KFF, spending). The aged and disabled who are most likely to use long-term services and supports are 23 percent of enrollees (KFF, enrollees), but they account for 61 percent of Medicaid expenditures (KFF, spending). Likewise, long-term care users, who are 5.9 percent of enrollees, consumed 41.8 percent of total Medicaid benefit spending for both institutional and non-institutional long-term services and supports (Thach and Wiener, 2018, p. 8). Its long-term care tail wags the Medicaid dog.

Medicaid spending on institutional (largely nursing home) care, which most people prefer to avoid (Riley, 2017³⁰), has abated in recent years remaining close to the amount spent in 2010 and actually declining two percent in 2016 (Eiken, 2018, p. i). Spending for home and community based care, which people greatly prefer (Lampkin and Barrett, 2015³¹), has accounted for almost all Medicaid long-term care spending growth in recent years, increasing 10 percent in 2016 alone (*Ibid.*). In fact, Medicaid home care spending for older adults and people with physical

³⁰ “Long-term care continues to be a rising concern, and 61 percent of older Americans say they would rather die than live in a nursing home, says a new survey from The Nationwide Retirement Institute.”

³¹ “The vast majority of people age 45+ want to ‘age in place’ rather than relocate ... A full 78 percent of the respondents stated that they ‘strongly’ agree with the statement: ‘What I’d really like to do is stay in my current residence as long as possible.’”

disabilities reached 45.2 percent, up from 40.2 percent in 2013 (Eiken, 2018, p. 13 and Table AS).

How Did Medicaid Become the Dominant Long-Term Care Payer?

Social services and benefit programs in the United States evolved gradually in the country's first two centuries from a system based on British poor laws—"indoor relief" with many poor houses—toward a system based on cash relief payments (Senior Living: 1776-1799). Cash payments from programs like Old Age Assistance and Social Security gave people funds to spend on residential long-term care enabling the nursing home industry to grow rapidly (Senior Living: 1930-1939). In 1960, the Medical Assistance for the Aged (MAA) program made health care available to people sixty-five and older with low or moderate income and required state matching funds (Senior Living: 1960-1969). The same [Kerr Mills](#) statute radically changed eligibility for nursing home care by adding people who "were not sufficiently needy to qualify for cash assistance to cover their ordinary expenses, but who were unable to pay their medical expenses" (*Ibid.*). In 1965, the new Medicaid program dropped strict eligibility criteria, transfer of assets restrictions, and mandatory liens which were commonplace previously. For its first 15 years, Medicaid explicitly permitted asset transfers for the purpose of qualifying for long-term care benefits (Carlucci, 1986-87, p. 372-3³²). Finally, Medicaid paid exclusively for nursing home care, incentivizing its use by covering "[housing](#), food, housekeeping, and laundry, services" which were not covered for in-home services (Senior Living: 1960-1969).

These features of the new Medicaid program—medically needy eligibility exclusively for nursing home care, including normal costs of living as well as health care, funded with virtually

³² "Prior to an amendment to the SSI program in 1980, applicants were expressly permitted to transfer resources that otherwise would have disqualified them from receiving any benefits. A number of decisions confirmed that states were not permitted to deny Medicaid eligibility to an applicant who had divested himself of resources for less than fair market value."

unlimited federal and state matching funds and with no limits on asset transfers to qualify—guaranteed Medicaid would explode in cost from the outset, perpetrate a nursing home bias in long-term care services, discourage development of a private home and community-based care market, and crowd out private long-term care financing sources. That is exactly what happened (Bernard and Feingold, 1970, p. 745³³) and policymakers have been trying to reverse the damage ever since. But their efforts to tame Medicaid long-term care funding growth by capping supply and price, controlling financial eligibility, rebalancing services from institutional to home care, promoting private insurance, and enforcing federal rules on state programs have failed.

A Litany of Failed Interventions

From the beginning, efforts to fix the problems Medicaid created have addressed the symptoms—exploding costs, nursing home bias, and poor quality—not the causes—strong financial incentives for states to maximize Medicaid spending and perverse incentives for consumers to rely on the safety net program rather than prepare to pay privately for long-term care. Inevitable, if unintended, consequences followed a long series of policy errors.

In the 1970s, central health planners tried to control skyrocketing Medicaid nursing home costs by capping bed supply, requiring “Certificates of Need” (CONs) (NCSL, 2019³⁴) before allowing new construction on the premise “they can’t charge us for a bed that doesn’t exist.” Nursing homes gratefully took advantage of this new government-imposed monopoly which excluded new entrants from their market. But to compensate for their impeded growth, the

³³ “Spending under Medicaid, which has continued to rise since 1968, is clearly greatly in excess of the expectations of Congress and of the states. A major factor contributing to this unexpectedly high expenditure has been the unusually high increase in medical care prices since 1965, an increase to which Medicaid and Medicare contributed by suddenly adding large sums of money to the demand for medical care without substantially increasing or efficiently organizing the supply of medical services available.”

³⁴ “Certificate of Need (CON) laws are state regulatory mechanisms for establishing or expanding health care facilities and services in a given area. In a state with a CON program, a state health planning agency must approve major capital expenditures for certain health care facilities. CON programs aim to control health care costs by restricting duplicative services and determining whether new capital expenditures meet a community need.”

nursing home industry raised the rates they charged Medicaid. In response, Medicaid capped nursing home reimbursement rates, which remain to this day only about four-fifths of private-pay rates (Lieberman, 2018). But low Medicaid rates created a strong incentive for higher paying private-payers to convert to Medicaid. Consumers sought more and more creative ways to qualify for assistance, sometimes relying on the advice of specialized Medicaid planning attorneys to divest or shelter otherwise disqualifying resources.

Consequently, private-pay nursing home revenue declined from 49.2 percent in 1970 to 26.7 percent in 2017 while Medicaid funding increased from 23.3 percent to 30.2 percent in the same period (CMS, 2018, Table 15). The problem of declining private-pay and increasing Medicaid nursing home revenue is much worse than these numbers suggest due to a change in the definition of National Health Expenditure Accounts (NHEA) categories CMS made in 2011. CMS added Continuing Care Retirement Communities (CCRCs) to the category Nursing Care Facilities. Because CCRCs are much more likely than nursing homes to involve private payments, this misleading change had the effect of reducing Medicaid's reported contribution to the cost of nursing home care from over 40 percent in 2008 to under one-third (32.8 percent) in 2009.³⁵

The federal government responded to the growing Medicaid dependency with a long series of laws attempting to restrict asset transfers and close other eligibility “loopholes” while requiring recovery of benefits paid from recipients’ estates. In 1996, President Clinton and the Gingrich Republicans even criminalized asset transfers for the purpose of qualifying for Medicaid.³⁶ But this “throw Granny in jail law” was repealed a year later and replaced with a “throw Granny’s

³⁵ For definitions of all NHEA categories, see <http://www.cms.gov/NationalHealthExpendData/downloads/quickref.pdf>.

³⁶ The Health Insurance Portability and Accountability Act of 1996 (HIPAA '96), also known as the Kennedy/Kassebaum Act, made it a crime, punishable by a fine of up to \$10,000 and a jail term of as much as a year, to transfer assets for less than fair market value for the purpose of qualifying for Medicaid.

lawyer in jail” alternative, which quickly proved unenforceable.³⁷ These efforts to target Medicaid long-term care resources to people most in need largely failed, though for correctable reasons discussed below. But the main failure was that these measures did not address the larger problem, financial eligibility rules that permit people with median and higher assets and income to qualify even without legal assistance.

By capping the supply and price of nursing home care without effectively controlling financial eligibility, Medicaid caused demand to skyrocket, filling nursing homes in the 1980s with too many recipients at too low reimbursements resulting in serious quality problems (Hawes and Phillips, 1986, p. 508³⁸). By accepting Medicaid recipients, nursing homes could fill their beds no matter what quality of care they offered. Instead of addressing this problem’s cause, easy access to under-financed nursing home care, the government simply demanded higher quality care, requiring tougher care standards, extra staff and training in the Nursing Home Reform Act of 1987, but without appropriating extra funds to pay for the new mandates (Klauber and Wright, 2001³⁹). So this measure failed to improve care quality (*Ibid.*⁴⁰). Caught between the rock of

³⁷ The Balanced Budget Act of 1997 (BBA '97) repealed the part of HIPAA '96 that made Medicaid asset transfers a crime and replaced it with a provision aimed at Medicaid planning attorneys. It threatened a year in jail and/or a \$10,000 fine for recommending, in exchange for a fee, that a client transfer assets to qualify for Medicaid. Janet Reno, who was Bill Clinton's Attorney General at the time, concluded it would be unenforceable. How could they hold an attorney legally culpable for recommending a practice that was legal again after the "throw-granny-in-jail law" was repealed?

³⁸ “The average occupancy rate in nursing homes nationwide [1986] is at least 95 percent, and many facilities, particularly the better ones, have long waiting lists.”

³⁹ “In a 1986 study, conducted at the request of Congress, the Institute of Medicine found that residents of nursing homes were being abused, neglected, and given inadequate care. The Institute of Medicine proposed sweeping reforms, most of which became law in 1987 with the passage of the Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987.”

⁴⁰ “The Nursing Home Reform Act of 1987 [part of the Omnibus Budget Reconciliation Act of 1987] established quality standards for nursing homes nationwide, established resident rights, and defined the state survey and certification process to enforce the standards ... Ten years after the passage of the Nursing Home Reform Act, however, a series of research studies and Senate hearings called attention to serious threats to residents' well-being. These problems were attributed to weaknesses in federal and state survey and enforcement activities.”

inadequate reimbursement and the hard place of mandatory quality, state nursing home trade associations sued for higher reimbursements under the 1980 Boren Amendment and usually won (MacPAC⁴¹). Government responded by repealing the Boren Amendment in 1997 leaving no legal floor under Medicaid nursing home reimbursements, thus exacerbating the quality problem and causing nursing homes' reputation to disintegrate (Wiener and Stevenson, 1998, p. 1⁴²).

Trying to save money and give consumers more of the care they prefer, Medicaid encouraged states to rebalance from providing only nursing home care to supplying mostly home care. The premise of that policy was that home care costs less than institutional care. Unfortunately, combined institutional and home and community-based care expenditures usually exceed institutional costs alone. Medicaid long-term care costs for older adults and people with physical disabilities continued to grow from \$36 billion in 1995 to \$104 billion in 2016 despite, or because of, aggressive rebalancing (Eiken, *et al.*, 2016, p. 14⁴³). The evidence is overwhelming that changing from institutional care to home and community-based care does not save money in the long run. Home care delays but does not reliably replace nursing home care (Holahan and Cohen, 1986, p. 106⁴⁴) and home care is more desirable than institutional care so more people

⁴¹ "Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) enacts the Boren Amendment, which removes Medicaid's state plan requirement to pay nursing facilities according to Medicare cost principles. Instead, the Boren Amendment requires Medicaid payments to be 'reasonable and adequate' to meet the costs of 'efficiently and economically operated' facilities."

⁴² "The federal Balanced Budget Act of 1997 repealed the Boren amendment, giving states far greater freedom in setting nursing home payment rates. The nursing home industry warned that Medicaid reimbursement levels already are too low, and that further reductions would adversely affect quality of care."

⁴³ See "Figure 14. Medicaid LTSS Expenditures Supporting Older Adults and People with Physical Disabilities, by Service Category, FY 1995–2016 (in billions)." These totals exclude Medicaid LTSS benefits paid for the developmentally disabled, a unique and very expensive category of recipients.

⁴⁴ "An increasingly large number of studies, including the results of a national channeling demonstration program, have shown that non-institutional services typically do not substitute for nursing home care, but, rather, represent additional services most often to new populations."

come out of the woodwork (Ng, Harrington, and Kitchener, 2010, p. 27⁴⁵) to seek Medicaid eligibility (Grabowski, 2006, p. 3⁴⁶).

Attempting to divert consumers from Medicaid to private insurance, government encouraged the use of “long-term care partnerships” which enabled consumers who purchased qualified policies to protect extra assets from Medicaid’s spend down and estate recovery rules (McCall, 2001). But the real problem was that Medicaid’s spend down and estate recovery rules are ineffectual and often unenforced. Forgiving a liability that does not exist in the first place did not incentivize many people to purchase private long-term care insurance policies. A federal income tax deduction for private insurance introduced in the Health Insurance Portability and Accountability Act of 1996 also helped little as it applied only to people with medical and long-term care expenditures exceeding 7.5 percent of adjusted gross income. Few people healthy enough to qualify medically for private long-term care insurance had medical expenses high enough to qualify for the tax deduction.

Having largely crowded out a market for private insurance by paying for most expensive long-term care, the government added insult to injury by driving interest rates on carrier reserves to near zero, forcing premium rates up to compensate, upsetting policyholders and potential buyers, and effectively suppressing the market. Seeing that nothing they did seemed to work, Congress and President Obama tried to nudge the public into voluntarily buying government

⁴⁵ “In spite of the state savings reported on home and community-based services waivers over institutional care, policymakers are concerned that Medicaid participants who use waiver services may not have been willing to use institutional services. The result is a ‘woodwork effect’ of higher overall state costs as previously uncared-for people seek care—in effect, coming ‘out of the woodwork.’”

⁴⁶ “This article reviews the cost-effectiveness of Medicaid waiver programs, consumer-directed care, capitated models that blend acute and long-term care services, and case management and subsidized community services for individuals with dementia. Generally, these new care models were found to be associated with increased costs, but greater client and caregiver welfare.”

long-term care insurance with the unfunded and misbegotten CLASS Act that was quickly repealed (Kane, 2011⁴⁷).

The latest attempt by Medicaid to mitigate the rising cost of long-term care is to modify the reimbursement system. Huge changes in how the government pays for post-acute and long-term care are underway and about to revolutionize long-term care service delivery. The transformation to "managed care," whereby state Medicaid programs turn over responsibility for providing and paying for long-term care to the highest bidders, has long been sweeping the country. Most long-term care will still be provided by nursing homes and home care companies, but now a new middle-man, the managed care company, is coming between the payer (Medicaid) and the provider, which already stand between the patient and access to quality care.

The newest move toward centralized control of the long-term care market is even more significant. The Centers for Medicare and Medicaid Services (CMS) is changing the focus of long-term care financing in both of the programs for which it is responsible from paying for services (volume) to paying for value (as measured by new, vague and complicated "quality" metrics). "Prospective payment," "bundling," and "value-based" reimbursement are the watchwords of the day. Instead of consumers pursuing value by purchasing care from providers they prefer, bureaucrats and politicians will define value, reward providers who deliver it and punish those who do not. The new system will put care managers and providers at far greater financial risk. Experts worry the end result will be a two-tiered system with poor providers getting worse and becoming more dependent than ever on low Medicaid reimbursements.

⁴⁷ "CLASS — the Community Living Assistance Services and Supports program — was meant to offer a long-term insurance option that would allow the elderly and disabled to remain in their homes while still maintaining a middle-class lifestyle. But in a letter to congressional leaders Friday, [HHS Secretary Kathleen] Sebelius said that it's just not possible to make the insurance plan self-sustaining for the long haul, as required under the law."

Conventional Long-Term Care Scholarship

If government policy on long-term care has consistently addressed the symptoms of high cost and poor quality instead of the cause, excessive public financing, so has and does most scholarship. Building on decades of research and special commission reports, a scholarly consensus has formed regarding the long-term care problem and what to do about it. For example, a December 2015 article in *Health Affairs* (Favreault, Gleckman, and Johnson, 2015, p. 2190⁴⁸) assessed the problem as high and growing care needs, high and growing cost, inadequate private resources to pay for care exacerbated by the lack of private insurance, resulting in high, growing and unsustainable dependency on Medicaid. Without analyzing how or why these conditions obtain, the article recommends ever more government engagement in the market, specifically mandatory, comprehensive public insurance coverage for the catastrophic back end of the long-term care risk. In other words, we are advised to address the symptoms of the long-term care problem by adding more of the generous funding source that arguably caused them in the first place.

That article spawned three major reports in 2016 promoting its analysis and recommendations. Leading Age, a long-term care provider trade association, reviewed the usual symptoms and concluded “a mandatory, universal insurance approach that covers catastrophic events is the most effective pathway to pursue” (Leading Age, 2016, p. 12). The Bipartisan Policy Center, a Washington, DC think tank, concurred with a now rare nod to cost control, recommending: “Pursue the concepts and elements of a public insurance program to protect Americans from catastrophic LTSS expenses, while assuring that it does not add to the federal

⁴⁸ “Policy makers will have to choose between imperfect options that achieve different goals. If the primary purpose is to significantly increase insurance coverage, the mandatory programs we modeled would be far more successful than the voluntary ones. If the major aim is to reduce Medicaid costs, the comprehensive and back-end mandatory programs would be most beneficial.”

deficit” (BPC, 2016, p. 21). The “Long-Term Care Financing Collaborative,” a self-described “diverse group of policy experts and senior-level decision makers representing a wide range of interests and ideological views” proposed “A universal catastrophic insurance program aimed at providing financial support to those with high levels of care needs over a long period of time” (LTC Financing Collaborative, 2016, p. 2).

Nor has this emerging agreement on the problem (symptoms) and its preferred solution (more government) receded. Last year, a respected private long-term care insurance analyst teamed up with a researcher who favors public financing options to produce yet another proposal on the same theme. They recommend

A public catastrophic insurance program for LTSS costs that takes effect after an income-related waiting period has been met. ... Eligibility ... phased in over ten years, with people eligible for benefits once they work 40 quarters after the law’s enactment Benefits would become available once people incur impairments in 2+ ADLs [activities of daily living] and/or severe cognitive impairment Up to \$110/day cash benefit (2014 dollars) ... Paid out either daily or weekly ... Unlimited benefit once an income-related waiting period is met ... Waiting period of 1 year for people with lifetime incomes in the lowest two quintiles of the distribution and 2, 3, and 4 years for people with incomes in the third, fourth and highest quintiles, respectively. ... Annual benefits increase at the rate that hourly costs increase for home health aide workers (Cohen, Feder, and Favreault, 2018, p. 7).

Would consumers choose to participate in this complicated scheme? There is no need to ask. The paper does not contain the terms obligatory, involuntary, or compulsory, but

they all apply to this proposal. Like Social Security, Medicare and other plans to fix long-term care mentioned above and below, this one also forces people to pay up, take part and accept whatever the government delivers.

Two influential recent articles home in on special challenges facing the middle market and home care. In May 2019, "[The Forgotten Middle: Many Middle-Income Seniors Will Have Insufficient Resources for Housing and Health Care](#)" correctly assessed the plight of middle-income seniors whose resources will be inadequate to fund their senior living and long-term care and suggested "lawmakers could consider a new benefit that explicitly funds long-term care (for example, a Medicare 'Part E' that shifts funds from Medicare Part A acute care)" (Pearson, *et al.*, 2019, p. 8). In June 2019, "[The Financial Burden of Paid Home Care on Older Adults: Oldest and Sickest Are Least Likely to Have Enough Income](#)" argued that home care is desirable; too few people can afford enough of it; so "Government programs could be launched that cover LTSS expenses for the entire duration of an enrollee's LTSS" (Johnson and Wang, 2019, p. 1000).

Many similar examples from the past three decades could be adduced. Conventional long-term care scholarship is tediously consistent in these respects. It begins by recounting the dire service delivery and financing challenges consumers face, but without analyzing or commenting on how or why those problems came to be. Then it recommends an expansion of government's role, usually proposing a new or expanding an existing compulsory public financing program.

The Key: Medicaid Long-Term Care Financial Eligibility

The current paper takes a different approach to analyze the long-term care issue. It described and acknowledged the problems and dysfunctions in long-term care services and financing. But then it traced the history and evolution of those problems linking them causally to the early,

substantial and constantly expanding role of government financing and regulation in the long-term care market.

Having shown how and why long-term care problems exist, we can now ask: Why are analysts and policymakers caught in the trap of looking only for government solutions to problems government created? Why do most researchers obsess about the status quo without explaining how it came to be? Why do they despair of financing quality long-term care without vastly expanding government spending? Ideological bias is one explanation, but there may be something more basic and easier to resolve at work. The key to answer these questions lies in understanding how Medicaid long-term care eligibility really works as compared to how it is represented to work by the popular media, by most scholarship, and ostensibly by the federal law and regulations themselves.

The federal rules governing financial eligibility for Medicaid long-term care benefits sound draconian. “Medicaid eligibility depends primarily on income and assets. ... In general, aged, blind, and disabled beneficiaries may not have more than \$2,000 in countable assets for individuals and \$3,000 for couples, a level that has not changed since 1989” (Thach and Wiener, 2018, p. 4). No argument; that is poor. Income eligibility is more complicated than asset eligibility, because states may follow various “alternative or optional eligibility pathways to determine which groups qualify ...” (*Ibid.*). But income eligibility under all those pathways still sounds stringent when represented as allowing only \$723 per month of income (LTC Financing Collaborative, 2016, p. 19). These “official” financial eligibility rules seem to say that when it comes to paying for long-term care, you are on your own unless or until you spend down your income and life’s savings into impoverishment.

So quotes like these abound in the mass media:

People who exhaust their savings could wind up on Medicaid, the government health program for the indigent that pays for about half of all nursing home and custodial care (Weston, 2019) .

Essentially, you need to have spent practically all your assets before Medicaid will kick in (Eisenberg, 2017).

People may qualify for Medicaid after they have “spent-down” their assets (Lawrence, 2015).

Well-respected scholars often say the same.

The current program requires people to impoverish themselves (“spend down”) to qualify for coverage (Pearson, *et al.*, 2019, p. 858).

At the same time, public ‘insurance’ – through Medicaid – supports services only after people pay what might be called an ‘infinite deductible’ – that is, only after they expend most, if not all, of their personal liquid financial resources (Cohen, Feder, and Favreault, 2018, p. 2).

Medicaid (the federal-state health care program for the poor) covers long-term care costs for individuals below certain income levels, but the deductible for Medicaid is nearly all of an individual's income and assets. As a result, Medicaid is the long-term care coverage of last resort for those with no assets (Banerjee, 2012, p. 4).

Beneficiaries are subject to strict eligibility rules. While these vary from state to state and differ by care setting, they typically limit beneficiaries to \$2,000 in financial assets and \$723 per month in income (the monthly benefit level for the Supplemental Security Income program). As a result, millions of middle-income

families who face catastrophic LTSS costs must impoverish themselves before receiving public support (LTC Financing Collaborative, 2019, p. 19).

The reality of Medicaid long-term care financial eligibility is far more nuanced, generous, and elastic than these quotes convey. While scholars usually and the media sometimes explain (1) how Medicaid allows people with excess income to qualify by spending down privately for care until they reach the required level and (2) how some assets are non-countable and so do not affect eligibility and are not required to be spent down, generally both the media and scholars leave the strong impression that qualifying for Medicaid long-term care benefits is financially devastating and highly undesirable. Media articles usually point their readers to legal experts who can help families reconfigure their income and assets to qualify without spending down. Scholarly articles rarely take that alternative into account. This latter fact is the key to understanding why expanding government spending is usually the only option considered by analysts for reforming long-term care services and financing.

The Fallacy of Impoverishment

Income Eligibility

How does Medicaid long-term care eligibility really work? Most states use “medically needy” eligibility rules, which means people who have too much income can pay privately for their care until their net income level is reduced to the accepted limit (Thach and Wiener, 2018, p. 5⁴⁹). Other states apply “income caps,” usually 300 percent of the Supplemental Security Income (SSI) limit, currently \$2,313 per month (Thach and Wiener, 2018, p. 5⁵⁰). But income cap states

⁴⁹ “Thirty-two states included older adults and younger adults with disabilities in their ‘medically needy’ option, which covers individuals whose incomes do not meet standard eligibility criteria but who have high medical expenses. This is a common eligibility pathway for people in nursing homes.”

⁵⁰ “For people who need an institutional level of care, 44 states (including some that provide for the medically needy option) use the ‘special income rule’ to provide Medicaid eligibility for individuals with incomes up to 300 percent of the SSI level. This standard is used for eligibility for institutional care and Medicaid HCBS waivers.”

may allow people with excess income to qualify by setting up special “Miller income diversion trusts,” into which the recipient transfers excess income until the income eligibility level is reached. Then, the trust pays out the money to offset Medicaid’s cost for the recipient’s care (Musumeci, Chidambaram and O’Malley Watts, 2019, p.14⁵¹). The result is the same as under the medically needy system. The rule of thumb in all states, whether “medically needy” or “income cap” standards apply, is that anyone with income below the cost of a nursing home can qualify for Medicaid long-term care benefits based on income. As nursing home care is very expensive (roughly \$7,500 or \$8,500 per month on average and much higher in many urban venues) (Genworth, 2019), people with substantial incomes qualify routinely for Medicaid long-term care benefits throughout the United States. For example, someone with income of \$7,500 per month or \$90,000 per year would fall in the 84th percentile of income nationally (PK, 2018), but would nevertheless qualify for publicly financed long-term care based on income if that income is expended for medical and/or long-term care expenses including home care, assisted living, or nursing home residency. Medicaid long-term care income eligibility requires a cash flow problem, *but not low income*.

Asset Eligibility

Similarly, Medicaid’s seemingly harsh asset spend down rules are much less so as applied. Most of the wealth seniors hold is not counted in determining eligibility. Home equity is entirely exempt if a spouse remains in the home. Between \$595,000 and \$893,000 of home equity,

⁵¹ “Qualified Income or ‘Miller’ Trusts: About half (25 of 51) of states allow an individual residing in an institution to qualify for Medicaid LTSS with income higher than 300% of SSI if their excess income is administered through a special type of trust, called a qualified income or Miller trust ... Eighteen of these states do not cap the amount that can be put into a Miller trust when establishing eligibility for institutional LTSS. Income from a Miller trust can be used to fund the Medicaid beneficiary’s personal needs allowance as well as a monthly allowance for the beneficiary’s spouse who remains in the community under the spousal impoverishment rules ... Any additional income from the trust goes toward the beneficiary’s cost of care, and states can recover funds remaining in the trust after the individual’s death to reimburse the cost of care.

“Nearly all states allowing Miller Trusts for institutional care (22 of 25) also allow individuals to use Miller trusts to qualify for Medicaid HCBS”

depending on the state (Musumeci, Chidambaram and O'Malley Watts, 2019, p. 15⁵²), continues exempt as of 2020 even if the home is unoccupied as long as the Medicaid recipient expresses a subjective, medically unverified intent to return to the home (Thomson/MEDSTAT, 2005, p. 3⁵³). Additional exempt assets, all without any dollar limits, include

- one income-producing business,⁵⁴ including the capital and cash flow (Hales and Shandrick, 1992, p. 15⁵⁵)
- individual retirement accounts (IRAs) (CANHR, 2019)⁵⁶ if generating periodic income⁵⁷ as most are required to do by age 70 ½ in compliance with the required minimum distribution rules (IRS, 2019)⁵⁸

⁵² “Home Equity Limits: Over three-quarters of states (40 of 51) limit home equity to the federal minimum of \$552,000 for Medicaid beneficiaries seeking eligibility for LTSS, while nine states allow the upper limit of \$858,000 ... Wisconsin limits home equity to \$750,000, and California has no limit on home equity for the individual’s principal residence.” The Medicaid home equity limits increase annually with inflation. The limits cited in this source were actually effective during 2016. The limits cited in the current text are correct for 2020.

⁵³ “Federal Medicaid guidelines instruct states to use the same subjective test of intent to return that is used by the Supplemental Security Income program (SSI). A home is not counted as an available asset in determining Medicaid eligibility as long as the recipient expresses an intent to return home from a nursing home or medical institution, regardless of how long he or she has been institutionalized or whether there is any reasonable expectation that the individual could possibly return home.”

⁵⁴ “Property Excluded Regardless of Value or Rate of Return

This category encompasses:

- property used in a trade or business (effective 5/1/90).”

(Social Security Administration, Program Operations Manual System [POMS], <https://secure.ssa.gov/apps10/poms.nsf/lrx/0501130500>. Cited January 7, 2020.)

⁵⁵ “A new amendment to the Social Security Act allows an exemption for the family business, farm or ranch from countable assets for Medicaid eligibility. The advocate should take maximum advantage of this exemption to achieve immediate or very rapid eligibility for clients in need of Medicaid assistance. A considerable amount of resources can be excluded including the value of land and buildings, equipment, livestock, inventory, vehicles, and liquid resources used in the business. The attorney should also counsel his clients on the best method of transferring the business, farm or ranch to avoid the imposition of liens and recovery from the estate for amounts spent for Medicaid.”

⁵⁶ “The following property is generally exempt and, therefore, not counted in determining eligibility: ... IRAs and work-related pensions:

- In applicant's/beneficiary's name: The balance of the IRA or the pension is considered unavailable if applicant/beneficiary is receiving periodic payments of interest and principal.
- In spouse's name: The balance of the IRA or Pension fund is totally exempt from consideration and is not included in the community spouse resource allowance (CSRA).”

- term life insurance,⁵⁹
- prepaid burial funds for the immediate family,⁶⁰
- one automobile,⁶¹
- household goods and personal effects including heirlooms.⁶²

⁵⁷ “A retirement fund owned by an eligible individual is a resource if he/she has the option of withdrawing a lump sum even though he/she is not eligible for periodic payments. However, if the individual is eligible for periodic payments, the fund may not be a countable resource. . . . If an individual is eligible for periodic retirement benefits, he/she must apply for those benefits to be eligible for SSI. If he/she has a choice between periodic benefits and a lump sum, he/she must choose the periodic benefits.” (Social Security Administration, POMS, “SI 01120.210 Retirement Funds,” <https://secure.ssa.gov/apps10/poms.nsf/lrx/0501120210>. Effective Dates: 12/04/2012 - Present) Cited January 7, 2020.

What this means is that IRAs and other retirement funds are not countable if they are paying out periodically as is the case for most Medicaid long-term care patients because of the Required Minimum Distributions that begin at age 70.5 (recently changed by statute to age 72).

⁵⁸ “Your required minimum distribution is the minimum amount you must withdraw from your account each year. You generally have to start taking withdrawals from your IRA, SEP IRA, SIMPLE IRA, or retirement plan account when you reach age 70½. Roth IRAs do not require withdrawals until after the death of the owner.”

⁵⁹ “What not to count when determining total FV: When determining the total FV [Face Value] life insurance policies owned on a specific insured person, **do not count**: burial insurance policies; and term insurance policies because they do not generate a CSV [Cash Surrender Value].” (Social Security Administration, POMS, “SI 01130.300 Developing life Insurance Policies,” <https://secure.ssa.gov/poms.nsf/lrx/0501130300>. Effective Dates: 11/14/2013 - Present) Cited January 7, 2020.)

Why would a 90-year-old buy a million-dollar term life policy? Instantaneous self-improvement, eligibility for Medicaid long-term care and other medical services covered by Medicaid, but not by Medicare, and no estate recovery liability because the insurance benefits pass to heirs without going through probate.

⁶⁰ *Ibid.* California Advocates for Nursing Home Reform (CANHR, 2019) explains thus: “Term Life Insurance: totally excluded. Burial Plots: totally excluded. Prepaid irrevocable burial plan of any amount and \$1,500 in designated burial funds: There is no limit on the amount of the irrevocable burial fund, but the \$1,500 in designated funds must be kept separate from all other accounts and designated as a burial account. Accumulated interest on burial funds is also exempt.”

⁶¹ “Exclusion of one automobile regardless of value: Exclude one automobile per household, regardless of the value, if the eligible recipient or couple or a member of the eligible recipient's or couple's household uses the automobile for transportation. **ASSUMPTION**: Assume someone in the household uses the automobile for transportation, absent evidence to the contrary.” (Social Security Administration, POMS, “SI 01130.200: Automobiles and Other Vehicles Used for Transportation,” <https://secure.ssa.gov/apps10/poms.nsf/lrx/0501130200>.) (Emphasis in original.) Effective Dates: 05/31/2018 – Present. Cited January 7, 2020.

CANHR 2019: “Cars/motor Vehicles: one vehicle used for transportation is totally exempt.”

The “two Mercedes rule”: Because one vehicle is exempt, giving it away is not a penalizable asset transfer. So a Medicaid applicant can buy an exempt luxury car, give it away, buy another and carry on doing so until the \$2,000 asset limit is achieved.

⁶² “A change in the regulations, effective March 9, 2005, establishes that the resource exclusion for household goods and personal effects no longer has a dollar limit. As a result, beginning with resource determinations for April 2005,

Thus federal law and regulations, which state Medicaid agencies are supposed to follow, allow applicants and recipients to possess virtually unlimited assets while receiving benefits. It is true that state Medicaid programs are technically required to recover such sheltered assets from the estates of deceased recipients, but enforcement of that requirement is inconsistent, complicated by regulations severely limiting lien placement, and relatively easy to avoid, especially with legal advice.⁶³

Married applicants receive additional financial eligibility considerations. Community spouses of institutionalized Medicaid recipients may retain a “Minimum Monthly Maintenance Needs Allowance” (MMMNA) of between \$2,113.75 and \$3,216.00 per month (ACA, 2020, MMMNA⁶⁴) plus a “Community Spouse Resource Allowance” (CSRA) of half the couple’s joint assets not to exceed \$128,640 but no less than \$25,728 (ACA, 2020, CSRA⁶⁵). These allowances began at \$1,500 per month and \$60,000, respectively, when the Medicare Catastrophic Coverage Act of

SSA no longer counts household goods and personal effects as resources to decide a person’s eligibility to receive Supplemental Security Income (SSI) benefits.”

“Exclude household goods and personal effects from resources, regardless of their dollar value.” (Social Security Administration, POMS, “SI 01130.430 Household Goods, Personal Effects, and Other Personal Property,” <https://secure.ssa.gov/apps10/poms.nsf/lrx/0501130430>.) Effective Dates: 12/13/2013 – Present. Cited January 7, 2020.

CANHR 2019: “Household Goods and Personal Effects: totally exempt.”

⁶³ State Medicaid programs often refuse for extended periods of time to implement changes in federal law and regulations that limit these generous financial eligibility rules. For examples related to Medicaid financial eligibility and estate recoveries, see this July 7, 2014 letter report to Congress from the DHHS Office of Inspector General: http://centerltc.com/OIG/IG_LetterReport.pdf.

California is a classic example: “Medi-Cal [California’s name for Medicaid] planning for long-term care is unlike Medicaid planning in any other state. These differences arise from California’s halting and erratic implementation of changes in federal Medicaid law over the past quarter of a century. Many of the differences are profound opportunities for applicants and their families. California’s unique planning opportunities include the use of waiver programs to remain home and avoid transfer penalties, the shorter look-back period, the favorable start date for the penalty period, the permissibility of gift stacking, and the ability to transfer exempt assets to persons other than the spouse without penalty” (Miller and Stroud, 2015, p. 379-80).

⁶⁴ CMS also reports the new 2020 numbers here: https://www.medicaid.gov/sites/default/files/2020-01/ssi-and-spousal-impoverishment-standards_0.pdf.

⁶⁵ CMS also reports the new 2020 numbers here: https://www.medicaid.gov/sites/default/files/2020-01/ssi-and-spousal-impoverishment-standards_0.pdf.

1988 established them. By law, they increase annually with inflation. The MMMNA and CSRA were created to end the “spousal impoverishment” that could occur previously when the institutionalized recipient’s (usually the man’s) income was captured as required by federal law to offset Medicaid’s cost of his or her care.

Although there is considerable variation in state Medicaid eligibility rules, DeNardi, *et al.* concluded there was “little practical difference in Medicaid eligibility across the different states” due to medical and long-term care expense deductions. They explain that “most individuals in nursing homes incur medical expenses far greater than 300 percent of the SSI level,” thus achieving eligibility (De Nardi, French, Jones and Gooptu, 2011, p. 26).

Are Consumers Planning to Use Medicaid for Long-Term Care?

Do consumers deliberately plan to take advantage of Medicaid if they ever need long-term care? Do they know the rules on how to qualify for Medicaid long-term care benefits while minimizing the financial spend down consequences? Research suggests they do not. Most people believe mistakenly that Medicare or their health insurance will cover long-term care (AP-NORC, 2017, p. 2⁶⁶). They remain blissfully ignorant of long-term care risk despite being inundated with claims like those cited above insisting the government will not help with long-term care costs except after one’s personal resources are exhausted. What seems to happen is that consumers ignore the alarmist information about catastrophic spend down risk until they need expensive long-term care. At that point, they become quickly aware of information on how to avoid serious spend down liability and they use it, with or without the help of professional advisors.

⁶⁶ “Americans are confused about how they might pay for any needed care. The source that most Americans age 40 and older expect to rely heavily on to pay for ongoing living assistance is Medicare, which 57 percent say they will rely on quite a bit or completely. However, Medicare does not cover many expenses associated with long-term care, including most care in nursing homes, assisted living facilities, or from home health care aides.”

Such consumer behavior is rational and complies precisely with the real, though unintentional incentives in Medicaid eligibility policy. Eventual easy access to Medicaid long-term care benefits enables consumers to ignore warnings of long-term care risk with impunity. Then, if and when they need high-cost long-term care, they focus on how to pay and quickly discover the many ways to qualify for Medicaid. By then, however, the damage is done. It is too late, after someone already needs care, for him or her to save, invest, insure or otherwise prepare to pay privately for care. At that stage, Medicaid is the path of least resistance.

How Do People Qualify for Medicaid Long-Term Care Benefits While Preserving Most Wealth?

Once people are stricken by chronic illness that requires expensive long-term care, they and their families quickly become sensitive to the question of who pays and who does not. At first it sounds like they are on their own and the consequences could be devastating. But then they begin to learn how the system really works. After receiving no help from their Social Security, Medicare, or health insurance, they hear about Medicaid. When they—or more likely their adult children, as the parents themselves are disabled and often demented—go to the local welfare office, they receive a long, complicated Medicaid application form with many items of financial verification to complete, such as bank balances, home ownership and equity, asset transfers and why they made them, and so on. But they will also learn from the local Medicaid eligibility worker that income is not usually an obstacle, that many assets are totally exempt, and that they can and should use countable assets such as cash and liquid investments to purchase non-countable resources, such as prepaid burial plans or home improvements, in order to hasten the process of spend down and quicken eligibility. Some eligibility workers are more forthcoming

than others with information on how to facilitate eligibility for benefits, but most are caring people eager to help families negotiate an emotionally and financially difficult transition.

By this point, people discover information everywhere on how to navigate the crisis. Consumer information on painlessly qualifying for Medicaid is universally available. How-to and self-help books abound. An internet search for “Medicaid planning” reveals thousands of articles on how to qualify without spending down significantly. Anyone can search “Medicaid planning in [your state]” to find websites of law firms that specialize in the practice. Many such firms offer online articles explaining in general how Medicaid planning works, but also warning, to attract clients, why it is too complicated for laypersons to attempt without their professional guidance. Such firms routinely obtain, fully document, fill out, and submit the Medicaid application, often inches thick with verifying documents, to the state agency on behalf of their affluent clients’ families. MedicaidPlanning.org encourages advisors “of any kind (e.g., attorney, financial planner, CPA, care planner, etc.)” to provide the service and offers a book and training on how to impoverish people artificially to qualify them for Medicaid. The American Council on Aging, not to be confused with AARP’s National Council on the Aging (NCOA), offers these [Asset Planning Strategies](#) covering “Irrevocable Funeral Trusts, Spousal Asset Transfers, Annuities, Spend Down Excess Assets, Lady Bird Deeds, Medicaid Divorces, Medicaid Asset Protection Trusts, ‘Half a Loaf’ Strategies, Income Planning Strategies, Spousal Income Transfers, Qualified Income Trusts/Miller Trusts, and Income Spend Down.”

Access to a Medicaid planner anywhere in the country is facilitated by the National Academy of Elder Law Attorneys (NAELA), the professional association of lawyers who specialize in the practice of Medicaid planning. NAELA has a national membership of 4,500 and an annual budget of \$2 million (NAELA, 2019). Although elder law attorneys perform a wide range of

beneficial services for their mostly affluent clients, their primary source of billable hours is Medicaid planning. The fee to qualify someone for Medicaid ranges “from \$2500 for individuals with relatively simple estates to \$10,000 for individuals with significant assets” (Markovic, 2016, footnote 88).

Medicaid planners’ services are most often sought by the adult children of declining elders for the purpose of preserving their inheritances by avoiding private long-term care expenses for the parents. As Medicaid dependency often involves impaired access to and quality of long-term care (Ameriks, 2007, p. 22), Medicaid planners are vulnerable to and sensitive about accusations of financial abuse of the elderly. This self-description and justification is typical:

It is not uncommon for couples and individuals to engage in a practice often referred to as “Medicaid Planning,” which one commentary defines as “the legal fiction of ‘rearranging assets’ to make someone poor on paper so that he or she may qualify for Medicaid.” It is well established that such “Medicaid Planning” is legal and that it is professionally ethical, or acceptable, for attorneys and financial planners to assist clients in such planning. Nonetheless, the Medicaid planning and spend down processes are quite complex, potentially highly financially disruptive, and may lead to inequitable results. Moreover, although legal, Medicaid planning is often perceived as “gaming the system” (Hyer, Hannah, Burkhart, and Toevs, 2012, p. 359).

Clearly, information on how to qualify for Medicaid long-term care benefits while avoiding the seemingly restrictive financial eligibility rules is widely available. The financial incentive to use such information is great. There is every reason to believe families use this information (and

no evidence they do not) to minimize personal asset spend down and to hasten access to care financed by Medicaid.

The Legal Literature on Medicaid Planning

Beyond the ubiquitous consumer information on Medicaid planning, there is a large and always expanding professional legal literature on the topic. The first such article appeared within months of President Jimmy Carter's signing the Omnibus Budget Reconciliation Act of 1980 (OBRA '80), which imposed the first ever restriction on asset transfers done to qualify for Medicaid. OBRA '80 became law in December 1980; "Medicaid as an Estate Planning Tool," by William G. Talis, appeared in the *Massachusetts Law Review's* Spring 1981 issue. It stated "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, 1980, p. 94).

The article also describes ways clients might reduce exposure to health costs through (1) creation of various trust devices, (2) conveyance of remainder interests in property, (3) conversion of property into assets exempted from eligibility tests for Medicaid, and (4) outright transfers of property. If a client can be rendered eligible for Medicaid, medical expenses will be paid in full and estate assets will be conserved. Moreover, while the Department of Public Welfare may seek recovery for payments made on behalf of elderly recipients from their estates, careful planning can lawfully defeat the Department's ability to obtain indemnification (*Ibid.*, p. 90).

Although some of the methods described in this early article have since been proscribed or delimited by federal law, most of them remain viable and widely used. Quotes on how to do Medicaid planning from this first article and a selection of 86 others spanning the next 35 years

are compiled in “Appendix I: Supplemental Bibliography” of *How to Fix Long-Term Care Financing* (Moses, 2017). These include:

After President Ronald Reagan signed the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82) authorizing states voluntarily to (1) restrict asset transfers done within two years of applying for Medicaid, (2) place liens on real property, and (3) recover benefits correctly paid from recipients' estates, Medicaid planners concluded they could circumvent the new rules and explained how: “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).

After President Reagan signed the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85) restricting the use of Medicaid Qualifying Trusts, lawyers reassured their colleagues and clients: “Many people assume that a family's resources must be virtually exhausted before any help will be available through the Medicaid program. In fact, people in Washington [state] who need nursing home care can benefit from Medicaid without devastating their families” (Greenfield and Isenhour, 1986, p. 29).

After President Reagan signed the Medicare Catastrophic Coverage Act of 1988 (MCCA '88) making asset transfer penalties mandatory nationwide and expanding the look-back period to 30 months, one especially aggressive Medicaid planner wrote this in his best-selling book *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing-Home Care*:

So is there any practical way to juggle assets to qualify for Medicaid before losing everything? The answer is yes! By following the tips on these pages, an older person or couple can save most or all of their savings, despite our lawmakers' best efforts...Here are the best options: Hide money in exempt

assets...Transfer assets directly to children tax-free...Pay children for their help...Juggle assets between spouses...Pass assets to children through a spouse...Transfer a home while retaining a life estate...Change wills and title to property...Write a durable power of attorney...Set up a Medicaid Trust... Get a divorce.... (Budish, 1989, p. 34)

After President Bill Clinton signed the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) making estate recovery mandatory, expanding the asset transfer look back period to three years, eliminating the cap on asset transfer penalties, and prohibiting “pyramid divestment,” two experts reassured their colleagues: “Most of the basic planning options that seem to exist today will survive; but many of the more unique, aggressive tactics may or may not survive [p. 1] WE STILL BELIEVE THAT ALMOST ANYONE CAN BECOME MEDICAID ELIGIBLE FOR LONG-TERM CARE BENEFITS EVEN IN CRISIS.... [p. 11]” (Brown and Fleming, 1993, emphasis in original).

After President Clinton signed the Health Insurance Portability and Accountability Act of 1996 (HIPAA '96) making it a crime to transfer assets for less than fair market value for the purpose of qualifying for Medicaid, planners sought ways around the new rules:

By using a LCC [Life Care Contract], the applicant is outside the purview of the disqualifying transfer section of Title 42 because the contract anticipates a transfer for value and not a gift. Therefore, to the extent that the elder's assets are transferred pursuant to this contract, the elder will incur no period of ineligibility ... Using this one payment method, an elder can transfer a large number of assets and shortly thereafter qualify for Medicaid if the caregiver can prove that the medical condition causing the disability was totally unanticipated ... a one lump

sum payment of \$540,000 is a transfer for value and outside of the Medicaid rule
**... IT DOESN'T MATTER IF MOM HAS A MASSIVE STROKE AND IS A
CANDIDATE FOR LONG TERM CARE SIX MONTHS LATER...."**

(NAELA Conference Proceedings, 1996, pps. 1-2, 4, 11, double emphasis in the original).

After President Clinton signed the Balanced Budget Act of 1997 (BBA '97) repealing the criminalization of asset transfers to qualify for Medicaid, but making it a crime to recommend asset transfers for the purpose of qualifying for Medicaid in exchange for a fee, mortified planners encouraged community spouses of institutionalized Medicaid recipients simply to dodge their spousal support responsibility.

The law, therefore, allows an institutionalized spouse to qualify for Medicaid benefits even though he or she may have a spouse that chooses to keep assets over the CSRA [Community Spouse Resource Allowance]. The spouse retains the assets, in any amount, and then refuses to make them available for the institutionalized spouse's costs of long-term care. In turn, the state seeks an assignment of the institutionalized spouse's support rights (Solkoff, 2001, p. 26).

After President George W. Bush signed the Deficit Reduction Act of 2005 (DRA '05) placing the first cap ever on Medicaid's home equity exemption, limiting the half-a-loaf loophole, amending the annuity rules, and unencumbering the Long-Term Care Partnership Program, Medicaid planners reassured their colleagues and clients that artificial self-improvement to qualify for Medicaid remained feasible and no less ethical than tax planning:

Due to the high cost of nursing home care, elderly people and their families have increasingly turned to Medicaid-planning strategies to qualify for Medicaid

benefits and ease their financial burden. Medicaid planning involves taking measures to preserve one's assets in order to gain Medicaid eligibility by meeting the program's financial criteria (Wone, 2006, p. 487).

Many commentators, as well as taxpayers generally, have criticized the practice of 'Medicaid estate planning, [when] individuals shelter or divest their assets to qualify for Medicaid without first depleting their life savings. ... However, Medicaid estate planning is not only rational, but it is also consistent with notions of morality and fairness. Akin to tax planning, Medicaid estate planning is as justifiable as any other legal advice an attorney may give to a client to obtain favorable governmental treatment, despite recent measures taken by Congress that might suggest otherwise. The public perception seems to be that tax planning is perfectly acceptable, whereas Medicaid estate planning is morally questionable (Bothe, 2009-10, pp. 815-6).⁶⁷

No further government action has occurred since 2006 to target Medicaid long-term care benefits to the needy or to discourage their overuse by the affluent. These recent law journal articles show that most methods to qualify for Medicaid without spending down for care have survived and thrived:

Thus, for example, if a person gives away one million dollars six years before applying for Medicaid, that gift will not be considered in determining eligibility. (Miller, 2015-2016, p. 8)

In our earlier work on this topic, my co-authors and I described many Medicaid planning strategies. These include gifts beyond the five-year look-back

⁶⁷ The ethical difference between tax planning and Medicaid planning is that configuring one's income and assets to pay the minimum taxes owed does not result in the taxpayer's becoming dependent on a welfare program for long-term care with dubious access and quality. Medicaid planning does.

period, disinheritance of the institutionalized person; the use of special needs trusts for the institutional spouse; annuitization of retirement accounts and savings (often for the benefit of the community spouse); spend down on the home or other exempt assets (called asset repositioning); caregiver agreements with family members; certain transfers of the home to a spouse, child or sibling; use of exempt assets (i.e., the home) to pay for the nursing home during a penalty period arising from gratuitous transfers; and, finally, divorce or marriage avoidance. Some of these are only designed to obtain Medicaid eligibility while preserving wealth during the recipient's lifetime. Others, most prominently gifts and annuities, are designed to avoid estate recovery as well. The liberal income rules and the restrictive resource rules make the purchase of an annuity for the community spouse with excess resources an important planning tool for middle class couples. Indeed, the annuity purchase option is the chief planning alternative to divorce in many cases (*Ibid.*, p. 14).

Countable assets which are attributable to the institutionalized spouse can be reduced by spending or consuming them for the benefit of either spouse. The applicant or their spouse could pay off a mortgage or other debt, pay attorney's fees or other professional fees, pay for travel for themselves, or pay for home care services. ... Countable assets can be transformed into exempt assets, for example, by purchasing an irrevocable burial plan for each spouse and by paying for exempt assets which enhance the quality of life of either spouse, such as clothing, electronics, and repairs or improvements to the residence. ... Countable assets may also be transformed into a stream of income by the purchase of an approved

annuity, with the community spouse as annuitant (immediate payee) (Gilsinan, 2018, p. 19).

If a married couple who owns no primary residence but has substantial liquid assets engages in Medicaid planning, they could create an irrevocable trust and transfer all of their assets to that trust. ... As long as there are no circumstances in which the trustee could pay them any amount of trust principal, and as long as the married couple complies with the five-year look-back rule, the applicant would be eligible for Medicaid benefits because the assets would not be countable as his or her assets. ... The inclusion of the primary residence among the assets transferred to the irrevocable trust allows the grantor to avoid the estate recovery claim against his or her primary residence that would occur had the grantor obtained Medicaid long-term care benefits and continued to own the home until it was transferred to his or her heirs as part of the probate estate (Tunney, 2018, p. 23).

There are two main alternatives to the CSRA for protecting assets for the community spouse: spousal refusal and divorce. *a. Spousal Refusal.* A community spouse can simply refuse to allow his or her assets to be made available for use by the institutionalized spouse and refuse to cooperate in the application for Medicaid. ... *b. Divorce* ... Following the divorce, the institutionalized spouse could quickly qualify for Medicaid, and the couple's assets would be preserved for the community spouse (Beckett, 2016, p. 31).⁶⁸

⁶⁸ The Community Spouse Resource Allowance (CSRA) was created by the Medicare Catastrophic Coverage Act of 1988 to protect healthy spouses in the community from impoverishment due to an institutionalized wife's or husband's Medicaid status. But the CSRA only protects a portion of a couple's joint assets creating the incentive to find other means to protect the rest.

Clearly the practice of Medicaid planning remains vibrant and very well documented in the popular and professional literature on aging and estate planning.

Why Do Analysts Ignore this Vast Literature on Medicaid Eligibility Planning?

Long-term care researchers rarely mention, and never delve deeply into, the Medicaid planning literature. They pretend these easier pathways to eligibility are not widely used. Analysts might argue that widely available consumer information and the formal legal literature on Medicaid planning are irrelevant because the fact that people *can* qualify for Medicaid while preserving most of their wealth does not mean they *do it*. All that matters is the evidence showing whether people do or do not spend down. Yet, when analysts ignore the evidence of easy financial eligibility and widespread Medicaid planning, they are predisposed to expect more rather than less genuine spend down. If they knew and understood the methods, techniques, and incentives to use them described in this literature, they would be more likely to look for, find and understand evidence that disproves the presumption of widespread asset spend down for care.

Analysts know the official laws and regulations governing Medicaid long-term care eligibility are complicated and pliant. Yet they frequently apply only the ostensibly severe standards to data on seniors' wealth and then conclude people must be spending down millions before they qualify. If Medicaid denies access to applicants with more than \$723 per month of income and \$2,000 in assets, then surely, they reason, the vast majority of people on Medicaid have spent down, often catastrophically before qualifying. With that mistaken assumption firmly fixed in their minds, analysts conduct studies and search giant data bases looking for evidence to support it. This confirmation bias skews what they find.

Analysts could avoid such bias by reviewing and taking into account the legal literature on how to qualify for Medicaid without spending down for care. But they do not, which is a peculiar

oversight as the evidence adduced and referenced above is inescapable. How and why do scholars discuss Medicaid long-term care financial eligibility while avoiding the facts of easy access to Medicaid?

Evasion of and Equivocation on Critical Concepts and Facts

Long-term care scholarship does include several excellent explanations of the complicated federal and state Medicaid long-term care financial eligibility rules such as Musumeci, Chidambaram and O'Malley Watts, 2019. But these treatments rarely draw out the ramifications of allowing relatively high-income people with substantial wealth to qualify for public benefits. Nor do they discuss how the superficially strict but fundamentally generous income and asset rules can be stretched to expand eligibility to include even the very well-to-do. When analysts do acknowledge that Medicaid long-term care benefits reach more than the poor, they nearly always equivocate on key concepts such as impoverishment, spend down, decumulation, median wealth, Medicaid planning and out-of-pocket expenses. Moreover, they use highly dubious data sources to substantiate their conclusions. These examples will clarify this point.

Impoverishment

Medicaid long-term care eligibility requires inadequate cash flow, i.e. insufficient income, to cover all of an individual's medical and long-term care costs. But it does not require low income, low assets, or financial destitution. Yet a typical analysis claims "Medicaid only covers the long-term care costs of the indigent" (Friedberg, Hou, Sun, and Webb, 2014, p. 1). Synonyms for the term "indigent" include "poor, impecunious, destitute, penniless, impoverished, poverty-stricken, down and out, pauperized, without a penny to one's name," and many more ([Dictionary definition of indigent](#)). Clearly, if people with substantial income and assets can qualify for Medicaid long-term care benefits, then eligibility does not require impoverishment, much less

indigence. The right conclusion to reach about Medicaid's role in long-term care financing is that it substantially ameliorates the risk and cost of long-term care, not that it impoverishes people.

Spend Down

Medicaid financial eligibility rules allow people to spend down their private income and assets to reach eligibility limits. *Income* spend down must be done to purchase medical or long-term care services (Medicaid.gov, 2019⁶⁹). But *asset* spend down does not have the same requirement (ElderLawAnswers, 2018⁷⁰). Excess assets may be spent on or converted to exempt resources. There is no requirement to spend down assets on medical or long-term care expenses (Schneider and Huber, 1989, p. 142⁷¹). An expensive birthday party or "one last tour of Reno's

⁶⁹ "States have the option to establish a 'medically needy program' for individuals with significant health needs whose income is too high to otherwise qualify for Medicaid under other eligibility groups. Medically needy individuals can still become eligible by 'spending down' the amount of income that is above a state's medically needy income standard. Individuals spend down by incurring expenses for medical and remedial care for which they do not have health insurance. Once an individual's incurred expenses exceed the difference between the individual's income and the state's medically needy income level (the 'spenddown' amount), the person can be eligible for Medicaid. The Medicaid program then pays the cost of services that exceeds the expenses the individual had to incur to become eligible."

⁷⁰ "A Medicaid applicant can spend down money on anything that would benefit the applicant. Following are examples of what a Medicaid applicant may be able to spend money on:

- **Prepay funeral expenses.** A prepaid or pre-need funeral contract allows you to purchase funeral goods and services before you die.
 - **Pay off a mortgage, car loan, or credit card debts.** You can pay off the debt fully or make partial payment.
 - **Make repairs to a home.** Fix the roof, make the house handicapped accessible, buy new carpet, etc.
 - **Replace an old automobile.** This can be useful for the healthy spouse.
 - **Update your personal effects.** Buy household goods or personal comfort objects. Buy a new wardrobe, electronics, or furniture.
 - **Medical care and equipment.** Purchase items that aren't covered by Medicare or Medicaid. See a dentist or get your eyes checked if those items aren't covered by your insurance.
 - **Pay for more care at home.** Make sure you get any caregiving agreements in writing, especially if family members are providing the care.
 - **Buy a new home.** A home can be an exempt asset, so it may be possible to purchase a new home."
- (Emphasis in the original) Last Modified: 08/01/2018. Cited January 8, 2020.

⁷¹ "...[A] common misconception among [Medicaid] applicants is that excess resources must be spent only on doctors, hospitals, nurses, medication, and nursing homes. Nowhere in the law is this indicated. Quite literally, an applicant could spend all of his or her assets on something 'frivolous,' such as a 90th birthday celebration of Ziegfield Follies proportion and this should not be cause for denial of Medicaid, because the applicant received 'value' for his or her money."

finest establishments” (Gilfix and Woolpert, p. 42⁷²) are viable asset spend down options. Yet the presumption that wide swaths of the American public are forced to spend down their life’s savings on long-term care has prevailed in the research literature for decades.

When several “spend down” studies in the late 1980s and early 1990s set out to prove widespread asset spend down, they found it was far less common than previously believed. A 1992 analysis concluded: “Based on the studies conducted to date, it appears that somewhere between one in four and one in five persons who originally enter nursing homes as private payers convert to Medicaid before final discharge (Spend-Down I)” (Adams, Meiners and Burwell, 1992). Moreover, neither these early studies nor more recent ones distinguished between real spend down, paying privately for care until eligible, and artificial spend down, qualifying by purchasing exempt assets or otherwise sheltering or divesting wealth. Hence:

Very little is known about what has actually taken place for the individuals whom the foregoing studies have identified as asset spend-downers. Indeed, we cannot actually be sure these individuals have depleted assets; most of the studies can only identify that a change in payor source has taken place (*Ibid.*).

A well-known, more recent report further exemplifies the point. “Medicaid Spend Down: Implications for Long-Term Services and Supports and Aging Policy” confidently states: “The high cost of long-term services and supports (LTSS) results in catastrophic out-of-pocket costs for many people needing services, some of whom spend down to Medicaid eligibility” (Wiener, *et al.*, 2013, p. 1). Yet what this report calls “spend down” is nothing more than the “transition”

⁷² “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.”

from non-Medicaid status to Medicaid eligibility, which as explained above, is achievable without catastrophic financial consequences.

Asset Decumulation

Recent research on asset decumulation in retirement belies the conventional wisdom that widespread long-term-care spend down occurs. In a study sponsored by the Employee Benefits Research Institute, Sudipto Banerjee observed: “One of the assumptions underlying many models used to measure retirement income adequacy is that retirees will spend down their accumulated assets to fund their retirement needs.” Then he asked “While this may make sense in theory, do people actually behave like this?” (Banerjee, 2018, p. 4) What he found was stunning. People with relatively low savings, under \$200,000 in non-housing assets, dropped in wealth only 24.4 percent in the first 18 years of retirement, a rate of asset decumulation “definitely much lower than what has been traditionally assumed by most retirement models” (*Ibid.*, p. 5). Those with \$200,000 to \$500,000 dropped only 27.2 percent (*Ibid.*, p. 7). “So, in this group as well, retirees did not spend down their assets as quickly as retirement models would generally predict” (*Ibid.*). Finally, the group with over \$500,000 dropped only 11.2 percent. “So, the group with the highest level of assets had the lowest rate of asset spend down” (*Ibid.*).

Banerjee then asks “Why are retirees not spending down their assets?” (*Ibid.*) He speculates that people are reluctant to expend their savings because they do not know how long they will live or how large their medical or long-term care expenses may be. They may wish to leave a bequest or they are just being cautious or saving is a habit for them. But there could be a much simpler explanation. Once in retirement, consumers who safely ignored the risk and cost of long-term care during their work lives finally become concerned after their employment income has ended. Decades of academic studies and media reports convince them they will lose everything if

they succumb to the high risk of needing long-term care. So, as best they can, people preserve their assets and spend only income. But catastrophic spend down for long-term care is a myth because Medicaid pays for most expensive long-term care, exempts most assets, is easy to get after care is needed without spending down wealth significantly and only requires income as the patient's contribution to the cost of care. Consequently, after decades living in retirement, most people at most levels of wealth spend down very little.

Other research does show that people do spend down very rapidly at the very end of life, especially in the last year. But, again, no one knows for sure how much of this depletion of measurable wealth represents real or artificial spend down. French, *et al.*, found that medical spending before death, combined with burial expenses explained only “about 24 percent of the decline in assets of the soon-to-be deceased and about 37 percent of the decline in assets in the last year of life” (French, De Nardi, Jones, Baker, and Doctor, 2006, p. 2). The bottom line question, however, is how much Medicaid actually helps affluent people defray the cost of late-life chronic illness and the answer is striking. For households at the top of the income distribution, Jones, *et al.*, found

Medicaid covers 21 percent of lifetime costs at age 70, with the fraction rising to nearly 30 percent at age 100. While most high-income households do not receive Medicaid, those that do qualify under the Medically Needy provision, which assists households whose financial resources have been exhausted by medical expenses [N.B.: Or by Medicaid planning, a key point unmentioned in this article]. Such households tend to have high medical expenses and tend to receive large Medicaid benefits (Jones, Bailey, De Nardi, French, McGee, and Kirschner, 2018, p. 24).

The fact that Medicaid offsets upwards of one quarter of the lifetime medical and long-term care expenses of high income households is staggering and belies the common presumption that people must and do spend down into impoverishment to obtain benefits.

Median Wealth

Analysts focus on people with median or less income and assets, but they routinely evade the more interesting questions of whether and how people with much higher wealth qualify for Medicaid. For example, in testimony before the Commission on Long-Term Care, Richard W. Johnson of the Urban Institute summarized his research findings that people who end up in nursing homes on Medicaid tend to have relatively low incomes and assets. Then he concluded

Most older adults who end up on the program would never have been able to earn enough income or accumulate enough wealth to cover their nursing home costs. It seems likely that Medicaid will continue to play an important role in long-term care financing as long as those with long-term care needs are disproportionately those with limited financial resources (Johnson, 2013, p. 12).

It should not evoke surprise that poor people qualify for Medicaid or that most people who qualify for Medicaid are, and many always were, poor. Helping the poor is the program's statutory purpose. But, what about people who do have income and assets well above the median? Take Medicare beneficiaries for example. The Kaiser Family Foundation states

While a small share of the Medicare population lives on relatively high incomes, most are of modest means, with half of people on Medicare living on less than \$26,200 and one quarter living on less than \$15,250 in 2016. The typical beneficiary has some savings and home equity, but the range of asset values among beneficiaries is wide and varies greatly across demographic characteristics.

. . . As policymakers consider options for decreasing federal Medicare spending and addressing the federal debt and deficit, these findings raise questions about the extent to which the next generation of Medicare beneficiaries will be able to bear a larger share of costs (Jacobson, Griffin, Neuman, and Smith, 2017, pp. 6-7).

In essence, Kaiser says Medicare beneficiaries are so poor that it behooves policymakers not to consider “decreasing federal Medicare spending” when they are “addressing the federal debt and deficit.” But, what about Medicare beneficiaries who are not so poor? Would they still qualify for Medicaid long-term care benefits?

According to the Kaiser issue brief, half of all Medicare beneficiaries have incomes of \$26,200 or less (*Ibid.*). That is more than double the \$12,490 poverty guideline for a single person as of 2017, but poor enough to be sure. These are the people we might hope the Medicaid long-term care safety net protects. In fact, it does. Anyone needing formal long-term care with that level of income would qualify easily anywhere in the United States.

But what about the other half of Medicare beneficiaries? Forty-five percent of them had incomes between \$26,200 and \$103,450. That is hardly impoverished. Could someone with an annual income of up to \$103,450, at the 95th percentile of all Medicare beneficiaries, qualify for Medicaid LTC benefits? Yes. All it would take is paying the cost of a nursing home out of pocket at a little more than the median national annual rate for a semi-private bed (\$89,292), hardly uncommon in high-cost states like California, New York or Massachusetts. Anyone in the \$26,200 to \$103,450 range would qualify in most states as long as their total uncompensated medical and long-term care expenses exceeded their income, as they likely would for people who need expensive long-term services and supports.

Turning to the *savings* of Medicare beneficiaries, we find the same upside down policy incentives as for *income*. The one-half of beneficiaries with the least savings qualify easily for Medicaid LTC benefits, but *so do most of the upper half*.

Half of Medicare beneficiaries have savings of \$74,450 or less, including “retirement account holdings (such as IRAs or 401Ks) and other financial assets, including savings accounts, bonds and stocks” (*Ibid.*, p. 3). Although their savings exceed the usual Medicaid limit of \$2,000 in countable assets, these people can easily purchase extra home equity and other exempt assets, in any amount, such as personal belongings, home furnishings, prepaid burial plans, term life insurance, an automobile, *etc.*, in order to reduce their countable resources and reach the asset eligibility limit.

But, what about the 45 percent of Medicare beneficiaries who have savings between \$74,450 and \$1.4 million? These higher-savings seniors generally have greater access to professional financial advice on how to protect their wealth from long-term care expenditures. They can avail themselves of Medicaid’s \$595,000 to \$893,000 home equity exemption and purchase other exempt assets as well; they can take advantage of loopholes favoring the affluent such as Medicaid-friendly annuities, irrevocable income-only trusts, spousal refusal and reverse half-a-loaf strategies; or they can simply divest their savings five years or more before applying for Medicaid as most Medicaid planning attorneys recommend.

Because it is easy and financially beneficial to qualify for Medicaid long-term care benefits while sheltering or divesting up to \$1.4 million (the 95th percentile of Medicare beneficiaries’ savings) or more, Medicaid planners do a land-office business often in practices with multiple geographic locations.⁷³

⁷³ Four examples: (1) [Gilfix and La Poll Associates LLP](#) in California; (2) [Littman Krooks LLP](#) in New York; (3) [Marshall, Parker & Weber LLC](#) in Pennsylvania; and [Russo Law Group, P.C.](#) in New York.

Medicaid Planning

Medicaid planning is the practice of reconfiguring income and assets, with or without professional legal advice, to achieve financial eligibility for Medicaid long-term care benefits while minimizing financial consequences. Analysts seldom cite the extensive legal literature on Medicaid planning nor do they acknowledge the omnipresent information on its many methods and techniques available online and in the popular media. Instead, when they write about decumulating wealth to qualify for Medicaid, they assume and imply that savings are used to purchase long-term care rather than being divested, diverted, or sheltered to achieve eligibility.

In the rare instances when analysts consider the possibility that people might qualify for Medicaid without spending down wealth, they write only about “asset transfers” without considering other far more common and effective Medicaid planning techniques. For example: “[C]ritics contend 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’—transfer their assets to qualify for public subsidies intended for the poor” (O’Brien, 2005, p. 2). First, no one contends that “most nursing home residents” transferred assets. Asset transfers *are* very expensive for taxpayers, having increased Medicaid spending by as much as “1 percent of total Medicaid spending for long-term care” (Waidmann and Liu, 2006, p. 1) or \$1.7 billion as of 2016. But asset transfers are only the tip of the Medicaid planning iceberg, a minor factor compared to the more common methods of artificial self-impoverishment. Yet the O’Brien article makes only this passing reference to “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)”

(O'Brien, 2005, p. 2). By focusing exclusively on asset transfers while ignoring the abundant evidence for the more important Medicaid planning techniques, this article and most of its type violate the Strawman logical fallacy.⁷⁴

Furthermore, formal Medicaid planning itself pales in significance compared to the simple reality explained above that most income and assets do not impede access to Medicaid long-term care benefits. Average middle class people qualify fairly easily without using asset transfers or other Medicaid planning techniques that, when employed, enable even the wealthy to qualify by following sophisticated legal advice.

Long-term care researchers sometimes debunk the idea that Medicaid planning is common among the well-to-do by suggesting that Medicaid's reputation for poor access and quality would discourage people with financial means from seeking eligibility. Two points rebut that argument. First, the principal drivers behind Medicaid planning are not the ailing parents, but rather the adult children who want to protect their inheritances and therefore have a financial conflict of interest. Second, Medicaid planners routinely advise clients and their families not to worry about Medicaid's poor reputation. By holding back enough "key money" for the parent to pay privately for a few months, they can buy their way into the best facilities which have relatively few Medicaid beds. Nursing homes routinely give admission preference to higher-paying private payers (Gandhi, 2019, p.1⁷⁵). Then when the last of the cash runs out, the attorney files the Medicaid application and the client remains in the preferred facility because state and federal laws prevent expelling residents simply because their source of payment changes from private to

⁷⁴ [Strawman Fallacy](#). Description: Substituting a person's actual position or argument with a distorted, exaggerated, or misrepresented version of the position of the argument.

⁷⁵ "A number of factors incentivize selective admission practices in the nursing home industry. First, reimbursement rates can vary substantially depending on the payment source. For example, while facilities are legally obligated to offer the same type and quality of care to their Medicaid and private-pay residents, private-pay rates are nearly 30% higher than Medicaid rates on average."

Medicaid. Ironically, poor people for whom Medicaid is supposed to be a safety net, lack the key money to ensure access to the best care. They go to the Medicaid facilities with the bad reputations.

Out-of-Pocket Expenditures

Some analysts wrongly insist Medicaid requires impoverishment by claiming out-of-pocket expenditures are higher than they really are. For example, Melissa Favreault and Judith Dey conclude “Families will pay about half of the costs themselves out-of-pocket . . .” (Favreault and Dey, 2016, p. 1). They arrive at that figure by including room and board expenses in residential care settings—costs that people would incur whether they need long-term care or not—and by excluding Medicare post-acute care expenditures, which as explained above, are critical to sustain Medicaid’s viability as the dominant long-term care financing source. The truth is that out-of-pocket long-term care costs have been declining for half a century. In 1970, five years after Medicaid began picking up the long-term care tab, nearly half of nursing home expenditures still came from private resources. That share has dropped to almost one quarter as of 2017, including the spend-through of Social Security income, as explained earlier. Bottom line, over 90 percent of the cost of nursing home care in the United States is explained without counting out-of-pocket *asset*, as opposed to *income*, spend down (Colello, 2018, p. 1⁷⁶).

The situation with home health care financing is very similar. According to CMS, of the \$102.2 billion America spent on home health care in 2018, Medicare covered 39.4 percent and Medicaid 35.1 percent, totaling 74.5 percent. Private insurance paid 11.9 percent. Only 9.9 percent of home health care costs were paid out of pocket, roughly one dollar out of every \$10,

⁷⁶ Medicaid (42.2 percent) plus Medicare (21.8 percent) plus other public sources (6.3 percent) plus private insurance (7.5 percent) plus other private sources (6.5 percent) totals 84.3 percent leaving only 15.7 percent that could possibly come from asset spend down, half of which has been shown already to have been income spend down, mostly Social Security income Medicaid recipients are required to contribute to offset the cost of their care.

and some portion of that amount was income spend down that Medicaid requires from recipients. The remainder came from several small public and private financing sources (CMS, 2020, Table 14).

Faulty Data

When economists and health policy analysts claim that older people approaching the need for long-term care retain few assets and spend down rapidly, they generally draw their evidence from survey data provided by the Health and Retirement Study (HRS) and its auxiliary, the Asset and Health Dynamics among the Oldest Old (AHEAD) study. These longitudinal surveys contain information on home values, automobile ownership, liquid assets, farms and other businesses, retirement accounts, and other assets (De Nardi, French and Jones, 2016). Noteworthy is the fact that each of these financial holdings, as explained above, is either expressly exempt under federal law or easily converted into an exempt asset for purposes of achieving Medicaid long-term care eligibility. In other words, it would not matter for purposes of determining Medicaid long-term care eligibility whether such assets were retained or spent down.

Furthermore, the HRS and AHEAD data are highly dubious regarding amounts held in each of these asset classes. One expert describes “measurement errors in the data, particularly those arising from item nonresponse and from inaccurate respondent reports of the ownership and level of assets” (Venti, 2011, p. 3). Another identifies several other problems with the data including

The Health and Retirement Study contains no information on health and long-term services and supports expenditures, including out-of-pocket expenditures.

Thus, it is not possible to directly link transition to Medicaid with out-of-pocket expenditures for health and long-term services and supports. ... Finally,

information on people who are cognitively impaired and who die is derived from proxy respondents, often relatives, who may not know about specific long-term services and supports use or Medicaid eligibility (Wiener, *et al.*, 2013, p. 50).

There are many reasons why survey respondents and their representatives might fail to report income and assets to surveyors or even purposefully misrepresent the facts. People who have hidden or reconfigured their wealth to qualify for public welfare benefits may be ashamed of having done so or simply unaware that their heirs did this on their behalf. Seniors reporting on themselves may be cognitively impaired or intimidated by self-interested family members. Heirs who benefit from preserving parents' estates by putting them on Medicaid may prefer to conceal the facts. Lawyers who do Medicaid planning are protected from disclosure by attorney/client privilege, while long-term care providers and Medicaid eligibility staff, who often know which affluent locals are taking advantage of Medicaid, cannot disclose the information because of legally enforced confidentiality. Getting to the truth in such matters is extremely difficult. Yet analysts routinely accept the HRS/AHEAD data as though it were unchallengeable. They often treat such data as incontrovertible proof of widespread catastrophic long-term care spend down.

What is the Evidence that People Dodge Medicaid Asset Spend Down Requirements?

Anecdotal Evidence Abounds

Ask any Medicaid eligibility worker if he or she sees wealthy people taking advantage of Medicaid long-term care benefits and you are likely to hear a rant in reply. Workers are often frustrated by the difficulty they have qualifying really needy people for the program, while the well-to-do provide sanitized applications completed by their lawyers that are indisputable.

New York Medicaid eligibility supervisor Janice Eulau testified before Congress in 2011 that during her 36-year career in the field, she witnessed many individuals diverting significant

resources in order to obtain Medicaid. She stated that about 60 percent of applicants do some form of Medicaid planning and added

It is not at all unusual to encounter individuals and couples with resources exceeding a half million dollars, some with over one million. There is no attempt to hide that this money exists; there is no need. There are various legal means to prevent those funds from being used to pay for the applicant's nursing home care. Wealthy applicants for Medicaid's nursing home coverage consider that benefit to be their right, regardless of their ability to pay themselves (Eulau, 2011).

In response to a Congressional inquiry,⁷⁷ states provided numerous examples of Medicaid planning practices.⁷⁸ For example:

North Dakota

A couple with \$700,000 in liquid assets qualified for Medicaid long-term care benefits by purchasing a more expensive house, car, and an additional annuity while receiving \$8,000 per month of income from pensions, Social Security, annuity payments and oil lease money. Another couple had more than \$528,000 in assets, but qualified when the community spouse bought a new home, a new car, and two annuities worth \$240,000, and then applied for Medicaid to pay the institutionalized spouse's nursing home costs.

Wisconsin

⁷⁷ A copy of the letter from four Congressmen to all state governors is included in the Appendix of this paper.

⁷⁸ The four questions asked of Governors were: (1) "Should the federal government give states greater flexibility to consider assets, including substantial home equity, when determining eligibility for long-term care coverage through the Medicaid program? Why or why not?" (2) "Please provide examples of barriers to effective Medicaid estate recovery programs and tools that might help states in this area." (3) "Should state and federal governments encourage middle-income Americans to anticipate and plan for their future long-term care needs, instead of relying on Medicaid, a safety net for the poor? Why or why not?" (4) "Do you consider Medicaid estate planning to be a significant problem that takes resources from the truly needy in your state? Please explain and provide examples." For their answers, see S. Moses, "[LTC Bullet: States Decry Medicaid LTC Loopholes](http://www.centerltc.com/bullets/archives2013/984.htm)," January 11, 2013; <http://www.centerltc.com/bullets/archives2013/984.htm>.

An ill spouse transferred \$600,000 to the community spouse who refused to sign the Medicaid application, making the ill spouse eligible for Medicaid because “interspousal transfers are not considered divestment.”

New York

Using promissory notes, immediate annuities and spousal refusal, affluent long-term care Medicaid applicants qualify while retaining unlimited assets. This occurs even when the state has legal recourse, because “Medicaid does not have sufficient resources to pursue all these cases in court.”

Rhode Island

A couple with \$400,000 in a bond account became eligible in one month by purchasing “a large single premium immediate annuity.” A single man transferred \$100,000 to his son but dodged half of the penalty for transferring assets by using a promissory note to carry out a reverse half-a-loaf strategy.

Virginia

A man bought a \$900,000 annuity in his wife’s name, which paid her \$89,000 per month, but “the Virginia Medicaid program could not count this income for purposes of determining the husband’s Medicaid LTC eligibility.”

“Spending down” assets to qualify for Medicaid without expending those funds for long-term care or any other health-related expense is far easier and more commonplace than most economists and long-term care policy analysts willingly acknowledge.

But Hard Evidence is Scarce

Unfortunately, hard empirical evidence of Medicaid long-term care asset spend down avoidance is sparse. Most researchers have preferred to scan big data bases looking for evidence

to the contrary instead of examining actual Medicaid long-term care cases. In May 2014, however, the Government Accountability Office published results of the only study to date of a sample of such cases for this purpose. They found dramatic results, but for some reason downplayed their own findings.

GAO identified four main methods used by applicants to reduce their countable assets—income or resources—and qualify for Medicaid coverage: 1. spending countable resources on goods and services that are not countable towards financial eligibility, such as prepaid funeral arrangements; 2. converting countable resources into noncountable resources that generate an income stream for the applicant, such as an annuity or promissory note; 3. giving away countable assets as a gift to another individual—such gifts could lead to a penalty period that delays Medicaid nursing home coverage [N.B.: but only if discovered]; and 4. for married applicants, increasing the amount of assets a spouse remaining in the community can retain, such as through the purchase of an annuity (GAO, 2014, unnumbered “GAO Highlights” page).

Those methods of qualifying for Medicaid without spending down resources for care are exactly in line with the techniques and procedures recommended by the popular and professional literature on the topic discussed above.

GAO analyzed a random, but non-generalizable, sample of 294 Medicaid nursing home applications in two counties in each of three states: Florida, New York, and South Carolina. They found “Nearly 75 percent of applicants owned some non-countable resources, such as burial contracts; the median amount of non-countable resources was \$12,530” (*Ibid.*). That seems significant, but GAO does not draw out the implications in its report. A back-of-the-envelope

estimate finds that if those results could be projected to the total of all Medicaid nursing home residents nationally—which they cannot, suggesting a study that could provide generalizable results is needed—665,700 Medicaid nursing home residents sheltered over \$8.3 billion in non-countable resources or 42.4 percent of the \$19.7 billion Medicaid paid for their nursing home care in 2009, the most recent data available at the time of the GAO study’s publication (Houser, Fox-Grage and Ujvari, 2012⁷⁹). That is a lot of money to divert from private long-term care financing liability.

GAO found “Eligibility workers in 10 of the 12 counties interviewed stated that purchasing burial contracts and prepaid funeral arrangements, which are generally noncountable resources, was a common way applicants reduced their countable assets; and eligibility workers from one state said they recommend making such purchases to applicants” (GAO, 2014, 25). In fact, 39 percent of GAO’s sample owned “Burial contracts and prepaid funeral arrangements” with a median value of \$9,311. If that proportion holds for the country as a whole, \$3.2 billion or 6.3 percent of total Medicaid nursing home expenditures are diverted from funding long-term care to relieving families of the final expenses for their loved ones. This matters because funeral and burial pre-planning to expedite Medicaid eligibility is big business in the United States. Heavy use by Medicaid families of prepaid burial plans to shelter otherwise countable assets has the effect of shifting scarce program resources from purchasing long-term care services for the poor to subsidizing the funeral industry and indemnifying often affluent adult children from the cost of burying their parents.

GAO found “. . . 44 percent of approved applicants—129 applicants—had between \$2,501 and \$100,000 in total resources, and 14 percent of approved applicants—42 applicants—had

⁷⁹ Calculations in this section are based on figures for Medicaid nursing home expenditures, number of Medicaid nursing home residents, etc., as reported in AARP’s *Across the States*, 2012 publication. Detailed computations by the author are available upon request.

over \$100,000 in total resources” (*Ibid.*, p. 14). Pretending again that GAO’s findings are representative of all Medicaid nursing facility recipients, how much wealth would that mean Medicaid is sheltering from private long-term care financial liability nationwide? 887,598 nursing home residents receive Medicaid. If 14 percent of them, or 124,264 recipients, possessed \$100,000 or more in non-countable resources, that is at least \$12.4 billion or 3.4 times the \$3.7 billion Medicaid spent for their nursing facility care. Yet, again, GAO does not draw out the implications.

GAO found: “For the 51 applicants for whom we were able to determine the equity interest in the home, the median home equity was \$50,000, and ranged from \$0 to \$700,000” (*Ibid.*, p. 20). Most home equity (equity, not value) is non-countable, up to as much as \$893,000 in some states as of 2020. GAO found median home equity to be \$50,000 among the 51 applicants (out of 91 total homeowners or 31 percent of the sample) for whom they were able to determine it. Thus 100 percent of their sample’s home equity was non-countable. Keep in mind that \$50,000 is a median home equity value, meaning as many exempt homes were higher in home equity value as were lower, and meaning that the average or mean home equity value could be significantly higher. If 31 percent of 887,598 Medicaid nursing home recipients nationwide or 275,155 recipients own homes with a median equity value of \$50,000, then at least \$13.8 billion worth of their home equity is non-countable, a figure that is 1.7 times the annual \$8.1 billion cost of their care. Did it not behoove GAO to dig a little deeper? How much money could Medicaid save by making nursing facility care available only after home equity is spent down by means of private or commercial home equity conversion methods?

GAO found: “Among the Medicaid application files that we reviewed in selected states, 16 of the 294 approved applicants (5 percent) had a personal service contract—all of which were

determined to be for FMV [fair market value]. The median value of the personal service contracts was \$37,000; the value of the contracts ranged from \$4,460 to \$250,004” (*Ibid.*, p. 26). What if GAO’s findings were valid nationwide? If 5 percent of Medicaid nursing home recipients (44,380 recipients) sheltered a median value of \$37,000 each in personal service contracts, the total diverted away from private long-term care financial liability would be \$1.6 billion or 3.4 percent of total Medicaid nursing home expenditures nationally in the same year. That’s a very large subsidy to family members for taking care of their loved ones. Personal service contracts are a technique that is available mostly to savvier, more affluent families who seek legal advice on how to shelter assets. Commonly, the poor lose what little wealth they have to long-term care expenses without learning the often technical and complicated legal methods of artificial self-improvement.

GAO found: “Of the 70 married approved applicants whose files we reviewed, 13 had applications that contained a claim of spousal refusal. . . . These 13 applicants resided in two states and the community spouse retained a median value of \$291,888 in non-housing resources; two of the community spouses were able to retain over \$1 million in non-housing resources” (*Ibid.*, p. 31). Spousal refusal is based on a bizarre interpretation of federal law commonplace in only two states (New York and Florida, both of which were included in GAO’s three-state sample for this study) by which spouses of institutionalized Medicaid recipients are allowed to refuse to contribute financially toward the cost of their spouse’s Medicaid-financed care—with impunity and in direct contradiction of the federal statute. The GAO report does not challenge this practice, nor has CMS taken action to curtail or end it. The spousal refusal cases GAO identified had a median value of nearly \$292,000 in non-housing resources, but as they also found, some spousal refusal cases involve a million dollars or more. Why exactly is this

allowed? Why doesn't GAO question the practice? Where is CMS? The report makes no comment.

GAO found: "State Medicaid officials, county eligibility workers, and attorneys who provided information on the value of annuities for the community spouse reported average values ranging from \$50,000 to \$300,000. Officials from one state reported seeing annuities for the community spouse worth more than \$1 million. Medicaid officials from one state indicated that they have seen annuities that disbursed all of the payments to the community spouse shortly after the annuity was purchased, while officials from another state said that annuities can have large monthly payments for the community spouse, such as \$10,000 per month" (*Ibid.*, p. 32). Spousal annuities are a huge loophole that allows many millions of dollars to be diverted from private long-term care financing into the pockets of affluent Medicaid nursing home recipients' spouses. Yet GAO does not call for closing the annuity loophole nor has CMS done anything about it.

GAO found: "Among the 294 approved applicants whose files we reviewed, we identified 5 applicants (2 percent) who appeared to have used one of the 'reverse half-a-loaf' mechanisms; 4 of the applicants appeared to use the mechanism that involved creating an income stream through a promissory note to pay for nursing home care during the penalty period. These 4 applicants gifted between \$20,150 and \$227,250 worth of resources, and had penalty periods of between 2 months and 22 months" (*Ibid.*, p. 29). Again, GAO gives only glancing attention to the reverse half-a-loaf technique often employed by Medicaid planners to reduce their affluent clients' Medicaid spend down liability by half. The incidence of this technique's use as identified by GAO—only 2 percent—seems small, but keep in mind that it is only used for people with substantial assets. Otherwise, it would hardly be worth the cost in attorneys' fees to set up the

complicated procedure. Public officials should ask about this and all the other techniques downplayed in the GAO report “how much public spending is being wasted?” and “why are such abuses allowed to continue?”

One final point about this study: GAO says “Our analysis was limited to information included in the application files, which states used to make their eligibility determinations. We did not independently verify the accuracy of this information (*Ibid.*, pp. 4-5).” That single admission obviates any value or credibility this report might otherwise have. Federal quality control audits have found that state welfare eligibility determinations are wrong in a third to a half of all cases even after state quality control reviews have confirmed the original determinations by state or county workers. We will never know the true extent of Medicaid asset shelters, transfers and other artificial self-improvement techniques until someone reviews a valid random sample of long-term care cases that is generalizable statewide and nationwide and goes beyond the extremely limited information available in case records for purposes of verification.

The Government Accountability Office or the DHHS Inspector General or any serious researcher or organization should review a generalizable sample of Medicaid long-term care cases to establish once and for all how much money is being lost to Medicaid financial eligibility rules that divert the programs scarce resources from the needy to the affluent.

Ramifications

If Medicaid is not the catastrophic poverty-maker it is commonly made out to be, what is it? Simply put, Medicaid has become a long-term care entitlement for middle-class and affluent families. Individuals can ignore the risk of future long-term care expenses, avoid premiums for private insurance, and then protect home equity and other wealth for heirs if such care is ever

needed, shifting the cost of long-term care to taxpayers. The consequences of this reality affect every aspect of the long-term care market.

By making nursing home care virtually free in the mid-1960s, Medicaid locked institutional bias into the long-term care system, crowded out a privately financed market for the home care seniors prefer, and trapped the World War II generation in welfare-financed nursing facilities.

By reimbursing nursing homes less than the cost of providing the care, Medicaid guaranteed that America's long-term care service delivery system would suffer from serious access and quality problems.

By underfunding most long-term care providers—leading to doubtful quality—Medicaid incentivized plaintiffs' lawyers to launch giant tort liability lawsuits, extract massive financial penalties, and further undercut providers' ability to offer quality care.

By making public financing of expensive long-term care available after the insurable event occurred, Medicaid discouraged early and responsible long-term care planning and crowded out the market for private long-term care insurance.

By compelling impoverished citizens to spend down what little income and savings they possessed in order to qualify for long-term care benefits, Medicaid discouraged accumulation and growth of savings among the poor, reducing their incentives to improve their stations in life (De Nardi, French and Jones, 2009, pp. 4-5⁸⁰).

By allowing affluent people to access subsidized long-term care benefits late in life, Medicaid encouraged accumulation and growth of savings among the rich who could pass their estates to

⁸⁰ "Social insurance programs are important in explaining why low income individuals have few assets prior to retirement ... and why these people do not accumulate assets during retirement."

their heirs whether they were stricken by high long-term care expenditures or not, contributing to inequality (*Ibid.*, p. 2⁸¹).

These conditions have prevailed for Medicaid's 55-year history. They explain why America's long-term care service delivery and financing system is so dysfunctional. The widespread fallacy of impoverishment sustains this status quo because scholars fail to challenge it. This explains why long-term care dominates Medicaid expenditures but remains impervious to reform.

Policy Recommendations

Everyone agrees that America's long-term care services and financing system is broken and unsustainable. But most analysis of the problem fails to address its causes rooted in public financing. The usual result is ever more emphasis on expanding government's role even further. On that path lies more decline and dysfunction.

If the fundamental cause of long-term care problems is easy and elastic Medicaid financial eligibility combined with generous federal matching funds to induce Medicaid spending by states, then corrective action must address those causes if it is ever to effect improvements in the symptoms of exploding costs, dubious access and poor quality.

The best way to eliminate the incentive for states to maximize federal Medicaid matching funds is, for the first time ever, to cap those funds at some reasonable level based on past and anticipated future long-term care expenditures. Without unlimited access to federal funds and with fewer regulatory strings attached to the funds they do receive, states will have an incentive to make the best use of the federal revenue. They will experiment, succeed or fail, and learn from each other, taking full advantage of America's inimitable federal system.

⁸¹ "These government programs, however, also benefit the rich because they insure them against their worst nightmares about their very old age: either not being able to afford the medical care that they need, or being left destitute by huge medical bills."

On the consumer side, the obvious solution is to eliminate incentives in public policy that discourage early and responsible long-term care planning. One way to do that would be to end all pathways that enable people to qualify for Medicaid while protecting income and assets. If individuals and families truly did face impoverishment when catastrophic long-term care expenditures occur, that risk and cost would move to the top of their retirement and estate planning priorities much earlier. But such an approach would be disruptive, disorienting, and cruel, as well as politically infeasible.

A less drastic measure would be to eliminate or greatly reduce Medicaid's home equity exemption. Home equity is seniors' largest asset. As of the third quarter of 2019, 78.9 percent of people over the age of 65 own their homes (U.S Census Bureau, 2019), and of these 63.2 percent own free and clear of mortgage debt (Census Bureau, 2017). "Housing wealth for homeowners 62 and older continues to grow at a steady clip, reaching a record \$7.05 trillion in the fourth quarter of 2018" (Guerin, 2019). Ownership and transfers are easy to track through public records. Transfers of ownership within 20 years of applying for Medicaid could be deemed disqualifying as all transfers of any assets are now, though with only a five-year look-back. With home equity at risk, more people would save, invest or insure for long-term care. If they failed to do that, they would need to use reverse mortgages or some other method of public or private home equity conversion to pay for their care until they became legitimately eligible for public welfare assistance.

A less politically objectionable approach would be to allow people to receive long-term care help from Medicaid when they need it while retaining even more of their income and assets than is allowed now, but to lien that wealth effectively and recover it after the recipients' passing, from their estates. Instead of making families run the gauntlet of degrading artificial self-

impoverishment methods, let them keep and use what they have saved. As most of elders' wealth is in their home equity, securing that wealth with a publicly administered and enforced home equity conversion program could reduce the cost of Medicaid and empower far more people to obtain high quality private long-term care in the most appropriate venue. To avoid dependency on Medicaid and the eventual liability of estate recovery, elders and their heirs would have a much stronger incentive to plan early and responsibly for long-term care risk and cost.

Critics may say we tried that approach with OBRA '93, which discouraged divestment of wealth and required estate recovery. Unfortunately, that strategy did not work because the legislation left too many loopholes and exclusions enabling divestment and impeding estate recovery. The Medicaid planning bar creatively worked around the new restrictions finding ever more ingenious ways to defeat the policy. Furthermore, states failed to implement; the federal government did not enforce; and the media neglected to publicize the new rules that were intended to encourage people to plan ahead to avoid Medicaid dependency (USDHHS Inspector General, 2014⁸²). Consequently, consumer behavior did not change.

Policymakers should try again and this time eliminate the loopholes, enforce implementation, and publicize the methods and benefits of preparing to pay privately for long-term care. But first, we should all ...

Redefine the Problem

Albert Einstein said "[We can't solve problems by using the same kind of thinking we used when we created them.](#)" The kind of thinking that created the long-term care problem is that markets cannot provide the services people need without massive government regulation and

⁸² The Department of Health and Human Services Inspector General reported in July 2014 that many states failed to implement mandatory provisions in OBRA '93 and/or DRA '05 designed to discourage the overuse and abuse of Medicaid long-term care benefits. The IG report also showed that few states do Medicaid estate recoveries well resulting in a potential annual loss, inferred from the IG data, of \$2.5 billion.

financing. No other way of thinking about the problem has been seriously considered heretofore. But some recent research suggests how we might reconceptualize the quandary we are in so that it is not such a huge challenge and may in fact be amenable to a market-based solution.

Long-term care may not be the titanic crisis it has been assumed to be. For example, in February 2016, the Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE) reported:

Using microsimulation modeling, we estimate that about half (52%) of Americans turning 65 today will develop a disability serious enough to require LTSS, although most will need assistance for less than two years. About one in seven adults, however, will have a disability for more than five years. On average, an American turning 65 today will incur \$138,000 in future LTSS costs, which could be financed by setting aside \$70,000 today (Favreault and Dey, 2016, p. 1).

That does not sound so daunting, especially if you consider these authors believe half the cost of long-term care will be covered by other payers, including Medicaid. Where would the average person come up with \$70,000 today so that it would appreciate from that present discounted value to the \$138,000 he or she might need to cover long-term care costs in the future? The extractable home equity of 19.4 million senior households (age 65 plus) at a conservative Combined Loan to Value (CLTV) of 75 percent was \$3.1 trillion in 2015, averaging \$160,000 per household (Kaul and Goodman, 2017, pp. 2-3 and Tables 1 and 2). If Medicaid did not exempt a minimum of \$595,000, more than triple the average extractable home equity amount, a way could be found to earmark enough of it to cover the total cost of most older homeowners' long-term care. By

diverting people with sufficient home equity from Medicaid dependency to financing their own care privately, the fiscal burden on Medicaid could be substantially reduced.

There is more good news. In June 2019, Johnson and Wang “simulated the financial burden of paid home care for a nationally representative sample of non-Medicaid community-dwelling adults ages sixty-five and older.” They “found that 74 percent could fund at least two years of a moderate amount of paid home care if they liquidated all of their assets, and 58 percent could fund at least two years of an extensive amount of paid home care” (Johnson and Wang, 2019, p. 994). Furthermore: “Nearly nine in ten older adults have enough resources, including income and wealth, to cover assisted living expenses for two years” (*Ibid.*, p. 1000). So, the problem is much more manageable than we thought. All we have to do is persuade people to liquidate all their assets.

Obviously, there is no incentive for people to liquidate their wealth as long as Medicaid long-term care financial eligibility works the way it does. But if Medicaid’s perverse incentives were changed to encourage responsible long-term care planning and private payment, how would people respond? Home equity conversion could handle much of the financial burden for the majority of home-owning elders. Reverse mortgages would free up cash flow to cover home care expenses or, for people who plan ahead, the extra revenue could be used to fund long-term care insurance premiums.

Most analysts, however, have written off private long-term care insurance as unlikely ever to penetrate enough of the middle market to become a significant payment source. But they have always assumed that people would need much more coverage at too great a cost to attract enough buyers to make a big difference. That assumption may be wrong. The [National Investment Center](#) (NIC) recently reported that reducing the annual cost of

seniors housing by \$15,000, from \$60,000 to \$45,000 per year, would expand the middle market for seniors housing by 3.6 million individuals enabling 71 percent of middle-income seniors to afford the product (NIC, 2019, April⁸³).

Where could consumers find that extra \$15,000 to bring the cost of seniors housing into reach? The premium for an annual long-term care insurance benefit of \$15,000 would only cost a small fraction of the premium required for the full coverage that consumers find so financially daunting now. Unfortunately, insurance regulations forbid carriers from offering coverage with a benefit of less than \$18,000 per year. Once again, well-intentioned regulation stands in the way of sensible long-term care policy and planning.

Then there is this. A Cato Institute Policy Analysis reports that “Improved estimates of poverty show that only about 2 percent of today’s population lives in poverty, well below the 11 percent to 15 percent that has been reported during the past five decades” (Early, 2018, p. 1). How can that be? “By design, the official estimates of income inequality and poverty omit significant government transfer payments to low-income households; they also ignore taxes paid by households” (*Ibid.*, p. 2). What is the bottom line? “The net effect is that pretax data overstate the true income of upper-income households by as much as 50 percent, and missing transfers understate the true income of lower-income households by a factor of two or more” (*Ibid.*, p. 4). The rich are poorer and the poor, richer than we thought. “More than 50 years after the United States declared the War on Poverty, poverty is almost entirely gone. ... Public policy debate should begin with the

⁸³ “By reducing annual seniors housing costs by \$15,000 per year—from \$60,000 to \$45,000—the potential market expands by 3.6 million individuals 75+. At the \$45,000 annual cost level, 10.2 (71 percent) million middle-income seniors have resources including housing equity above the annual cost.”

realization that only about 2 percent of the population—not 13.5 percent—live in poverty” (*Ibid.*, p. 21).

Former Democratic presidential candidate New York Mayor Bill de Blasio is correct when he says “[There's plenty of money in this country.](#)” He’s mistaken when he adds “[it's just in the wrong hands.](#)” It’s in exactly the right hands, those of the people with personal resources or home equity sufficient to fund their own long-term care and stay off Medicaid. All they need is positive public policy incentives to get them to use it. But, unfortunately, the kind of corrective action needed to achieve that outcome is highly unlikely in the current economic environment of profligate fiscal and monetary policy.

The Broken Rhythm of Reform

Historically, progress toward making Medicaid a better long-term care safety for the poor—by diverting the middle class and affluent from dependency on it—tends to occur after major economic downturns when state and federal governments face serious budgetary constraints. After most recessions since 1965, congresses and presidents of widely divergent ideological persuasions backed legislation closing Medicaid long-term care eligibility loopholes and encouraging early and responsible long-term care planning. But as each recession was followed by a rapid economic recovery in which budgetary pressure abated, Medicaid long-term care benefits always reverted to virtually universal availability for all economic classes.

This pattern has changed since the start of the new millennium. After the recession from March 2001 to November 2001 following the internet bubble’s implosion, economic recovery came more slowly than before. Likewise, it took much longer for legislation discouraging the excessive use of Medicaid long-term care benefits to be passed. The Deficit Reduction Act of 2005, which imposed the first cap on home equity and expanded the asset transfer look back

period, was not signed into law until February of 2006, nearly five years after the start of the previous recession. Economic recovery came and, true to form, enforcement of DRA 2005 declined.

The new boom ended when the housing bubble burst, causing the Great Recession of December 2007 to June 2009. Again, economic recovery came very slowly. To date, over ten years after the end of the last recession, we have seen no action to spend Medicaid's scarce resources more wisely by aiming them toward people most in need. In fact, public policy analysts and advocates are moving in the opposite direction, towards proposing yet another compulsory government program funded by taxpayers to expand public financing of long-term care for all.

What might explain slower economic recoveries in recent years and less attention to the cost of Medicaid long-term care benefits? The Federal Reserve forced interest rates to artificially low levels during and since the Great Recession. The consequences of this policy have ramified through the economy in many ways. One way is that government has been able to finance deficit spending and the rapidly increasing national debt at considerably lower carrying costs than before, when interest rates were much higher. By enabling politicians to spend more without facing the normal budgetary consequences, this new economic policy has attracted greater financial resources, including borrowed funds, into public financing of all kinds and simultaneously diverted private wealth into low-interest-rate-induced malinvestment. Consequently, political concern about burgeoning budgets and debt has subsided and no significant effort to preserve Medicaid funds by targeting them to the poor has occurred.

The danger is that just as excessive public spending and private malinvestment in the early 2000s led to the housing bubble and its consequent recession, so the current much larger credit

bubble driven by excessive government borrowing and spending could lead to an even greater economic collapse. With the current national debt exceeding \$23 trillion and total unfunded entitlement liabilities around \$128 trillion, a return to economically realistic market-based interest rates would render the federal government immediately insolvent (The National Debt Clock, 2019).

Further exacerbating the problem of long-term care financing is the fact that the long-anticipated age wave is finally cresting and will soon crash on the U.S. economy. Baby boomers began retiring and taking Social Security benefits at age 62 in 2008. At age 65 in 2011, they turned the Social Security program cash-flow negative (Burtless, 2011). Boomers began taking Required Minimum Distributions (RMDs) from their tax-deferred retirement accounts in 2016, depleting the supply of private investment capital. They will begin to reach the critical age (85 years plus) of rising long-term care needs in 2031, around the time Medicare (2026) and Social Security (2035) are expected to deplete their trust funds, forcing them to reduce benefits.

Of course, Medicaid is the main funder of long-term care, but according to the Centers for Medicare and Medicaid Services Chief Actuary in a statement of consummate denial: “. . . Medicaid outlays and revenues are automatically in financial balance, there is no need to maintain a contingency reserve, and, unlike Medicare, the ‘financial status’ of the program is not in question from an actuarial perspective” (Truffer, Wolfe, and Rennie, 2016, p. 3). In summary, conditions are coalescing for a potential economic cataclysm in or before the second-third of this century and public officials are almost entirely ignoring the risk.

Conclusion

America’s long-term care services and financing system is badly broken. An oncoming demographic age wave guarantees the symptoms of its dysfunctionality will get much worse if

something is not done. But to address the symptoms of high cost and low quality without reducing reliance on the public financing which caused them will only make matters worse. Unfortunately, that is the course most scholarship on this subject takes, resulting in ever more urgent calls for even more state and federal financial involvement, with citizens compelled to participate and pay. Ludvig von Mises warned: “The goal of their policies is to substitute ‘planning’ for the alleged planlessness of the market economy. The term ‘planning’ as they use it means, of course, central planning by the authorities, enforced by the police power. It implies the nullification of each citizen’s right to plan his own life” (Mises, 1953, p. 436). A better course is to reduce states’ dependency on federal funds, target scarce public resources to people who need them most, and let free market incentives and products take care of the rest.

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Appendix: Letter from four congressmen to all state governors

Congress of the United States
 Washington, DC 20515

September 14, 2012

The Honorable Chris Christie
 P.O. Box 001
 Trenton, New Jersey 8625

Dear Governor Christie:

We recently introduced the Medicaid Long-Term Care Reform Act (H.R. 6033). Part of this bill would require the Department of Health and Human Services to seek feedback from the governors of each of the 50 states on policies to strengthen program integrity and make Medicaid more sustainable for state and federal budgets. We're contacting you to request your written response to several related questions.

Background information:

The Government Accountability Office reports "State Medicaid programs have, by default, become the major form of insurance for long-term care." Since 1995, the cost of Medicaid long-term care has grown at an average annual rate of 6.5 percent. Medicaid spending has already put a strain on state budgets, surpassing outlays for K-12 education programs. Future costs will rise. More than six out of ten seniors will need long-term care services. Demographers project that the number of Americans who are 85 or older – the group most likely to need long-term care – will increase by more than 250 percent between 2000 and 2040.

With this challenge in mind, the National Governors' Association called for policy solutions that "encourage personal responsibility and discourage the reliance on Medicaid financed long-term care." Unfortunately, federal rules weaken Medicaid's program integrity by forcing states to exempt more than half-a-million dollars in home equity and the entire value of a Rolls Royce when determining an individual's eligibility for these welfare benefits. As you know, states often find it difficult to recover Medicaid spending from the estates of people with significant financial assets and home equity. In total, states recovered .78 percent of Medicaid spending for nursing homes in 2004.

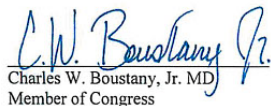
Questions:

As a governor who manages a Medicaid budget, we respectfully request your comments on the following questions.

1. Should the federal government give states greater flexibility to consider assets, including substantial home equity, when determining eligibility for long-term care coverage through the Medicaid program? Why or why not?
2. Please provide examples of barriers to effective Medicaid estate recovery programs and tools that might help states in this area.
3. Should state and federal governments encourage middle-income Americans to anticipate and plan for their future long-term care needs, instead of relying on Medicaid, a safety net for the poor? Why or why not?
4. Do you consider Medicaid estate planning to be a significant problem that takes resources from the truly needy in your state? Please explain and provide examples.

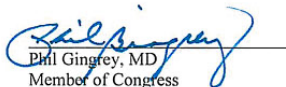
We appreciate your attention to this matter. Please provide a response to this letter by October 26, 2012. In the meantime, if you have any questions, please have a member of your staff contact Mike Thompson in Rep. Charles Boustany's office at 202-225-2031.

Sincerely,


 Charles W. Boustany, Jr. MD
 Member of Congress


 Pat Tiberi
 Member of Congress


 Marsha Blackburn
 Member of Congress


 Phil Gingrey, MD
 Member of Congress