# Improving the System of Financing Long-Term Services and Supports for Older Americans

Mark J. Warshawsky and
Ross A. Marchand

*January 2017*

MERCATUS WORKING PAPER

MERCATUS CENTER
George Mason University

3434 Washington Blvd., 4th Floor, Arlington, Virginia 22201
www.mercatus.org

*Mark J. Warshawsky and Ross A. Marchand. "Improving the System of Financing Long-Term Services and Supports for Older Americans." Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, January 2017.*

**Abstract**

Medicaid currently pays for most of the long-term services and supports (LTSS) given to older Americans. With the aging of the population, these costs to state and federal governments will increase rapidly. We summarize the current Medicaid eligibility rules, which are commonly portrayed as allowing access only to low-income and low-asset populations, but in reality they allow covered households to own significant housing and retirement assets. Furthermore, we present new empirical information about the weak efforts of states in enforcing even the current porous rules. We then report on the extensive asset holdings, especially in housing and retirement assets, across the distribution of retired households. We find that liberal eligibility rules and uneven enforcement increase the costs of governments and discourage the retired households that can afford it from covering LTSS exposure through private insurance and assets. We conclude with targeted recommendations to reform Medicaid and improve the LTSS financing system, following up on some of the proposals made by members of the 2013 federal Commission on Long-Term Care.

*JEL* codes: H510, H750, I130, I380

Keywords: Medicaid, long-term care, government spending

**Author Affiliation and Contact Information**

Mark J. Warshawsky
Senior Research Fellow
Mercatus Center at George Mason University
mwarshawsky@mercatus.gmu.edu

Ross A. Marchand
Associate Fellow
R Street Institute
rmarcha2@masonlive.gmu.edu

# Improving the System of Financing Long-Term Services and Supports for Older Americans

Mark J. Warshawsky and Ross A. Marchand

## Introduction

In this report, we put forward steps to improve the system of financing long-term services and supports (LTSS) for older Americans. We first describe the problems with our current system of financing LTSS—the prospect of a financially unsustainable Medicaid program and poorly designed and administered Medicaid policies that discourage retired households from self-reliance through private insurance and assets. We review the recommendations of one group on the 2013 federal Commission on Long-Term Care to remedy these faults. As background, we summarize the current Medicaid eligibility rules, with their perverse incentives, for private LTSS insurance and funding for and by households. We then present new empirical information about states' weak efforts to enforce current rules—in particular, to recover from estates of deceased Medicaid beneficiaries the value of assets, especially housing and retirement accounts, shielded from the spend-down rules. We document carefully—for the first time, to our knowledge—the wide variation in state rules concerning whether and how household retirement assets are counted in spend-down assets, showing that most states in fact exclude some or all retirement assets. We then report on the extensive asset holdings, especially in housing and retirement assets, of average retired households. Data are from the Health and Retirement Study (HRS 2012), the gold standard of data on the finances of older households, which is sponsored by the National Institute on Aging and is conducted by the University of Michigan, Ann Arbor. We then conclude with our own simple and targeted recommendations to reform Medicaid, being

more specific about a couple of the proposals put forward by a group on the commission, in order to lead to an overall improvement in the system of financing LTSS for older Americans.

**Problems with Current LTSS Financing, According to the Commission on Long-Term Care**

For some time now, some analysts, advocates, and policymakers have recommended that a new social insurance program be created to finance LTSS for the working-age disabled population and, in particular, the older (above age 65) disabled population. This recommendation came close to fruition when the Community Living Assistance Services and Supports (CLASS) program was included in the Patient Protection and Affordable Care Act (ACA) and used in the scoring to help fund that legislation. CLASS would have been a national, voluntary insurance program sponsored and administered by the federal government. The program would sell insurance to most workers, with no underwriting, to cover a portion of their LTSS needs. Inherent flaws in the design and financing of CLASS were evident to some even before its passage (Warshawsky 2009). These flaws were further demonstrated through several congressional hearings after its passage. The Obama administration never implemented the CLASS program, and Congress repealed it (Gleckman 2013). Aside from the automatic enrollment requirement on employers for health insurance, CLASS has been the only major piece of the ACA repealed thus far.

As part of the political compromise that formed the budget and tax legislation passed at the end of 2012, which included the repeal of CLASS, the Commission on Long-Term Care was set up in June 2013 to create a plan for addressing the nation's challenges with delivering and financing LTSS. The commission met the law's due date of September 30, 2013 to submit its report. With Bruce Chernof, head of the SCAN Foundation, as chair and Mark Warshawsky,

director of retirement research at Towers Watson, as vice chair, the committee comprised 15 accomplished members drawn from both political parties and from various walks of life. The commission did not find that the current provision of care services was inadequate; indeed, studies showed that unmet needs were quite modest (see LaPlante and others 2004). Rather, the commission stated that the real problem lies in the projections of a financially unsustainable system: The need for care will grow rapidly with the aging of the population, and the finances of the federal and state governments that currently pay for 62 percent of paid LTSS (mainly through Medicaid but also through other programs) will be increasingly burdened. The commission was also concerned about the declining availability of uncompensated family caregivers, given demographic trends.

Moreover, the commission recognized that the primary current form of government LTSS financing—the welfare Medicaid model—was not a true insurance program. Therefore, it was not well designed for dealing with most individuals' risks of needing long-term care. A person's need for LTSS is not certain; one-third to one-half of the older population will not need long-term care at any point in their remaining lifetimes. Even for those who will need care, the extent and duration of needed care is highly variable. For example, some older Americans might need just a few months and less than $30,000 for home health care, while others might need several years and hundreds of thousands of dollars for nursing home care. Hence, for many, the best protection against LTSS risk is a true insurance program. Several members on the commission thought that with sufficient data and experience and with regulatory flexibility and innovation, insurance companies should be able to shoulder the risk through the operation of the law of large numbers. But, as the best economic research on the subject concludes, Medicaid is filling the space instead and discouraging the purchase of private long-term care insurance (LTCI).

In particular, research by Brown and Finkelstein (2007, 2008) was presented to the commission and suggested that Medicaid coverage, because it was free even if its benefits were somewhat restrictive, substantially crowded out the purchase of LTCI. As a result, the research stated that it was rational for all but those in the highest 10–35 percent of the wealth distribution to forgo the purchase of private LTCI. Stated another way, for all but the upper deciles of the wealth distribution, Medicaid acts as an implicit tax. That is, a figure exceeding 50 percent and approaching 100 percent of the expected present value of payments from a private LTCI policy provides no net benefit for policyholders because the costs would have otherwise been paid by Medicaid. The commission also heard that medical underwriting limits the ability of some older people to purchase LTCI at typical retirement ages regardless of their wealth—up to 25 percent of those age 65, according to Murtaugh, Spillman, and Warshawsky (2001).

Consistent with the aforementioned theory and with the data, the current purchasers of private LTCI (about 13 percent of older Americans, according to the commission) are concentrated among the upper-income group. But the commission was also presented with evidence contradicting the oft-made claim that Medicaid is available only to those who meet strict low-income and asset eligibility requirements. On the basis of the study by De Nardi, French, and Jones (2013), the commission heard that many older individuals in the upper-income quintiles (about 5 percent of the top two-fifths of the income distribution, compared with 15 percent in the middle one-fifth and about 55 percent in the lowest two-fifths) were Medicaid recipients for LTSS. Moreover, those upper-income recipients got larger average payments than the lower-income recipients (about $15,000 versus $9,500 in 2005 dollars). This discrepancy was a puzzling, even disturbing, finding that the commission did not have time to analyze.

The commission coalesced around many recommendations to improve service delivery and the LTSS workforce. Commission members agreed on the need for a comprehensive financing solution that emphasized insurance with public and private sources of funds as well as assistance to the poor. However, the commission split on the extent of the role of the government. Some commission members wanted to create a full Medicare-like social insurance program for LTSS, with a small optional carve-out for private LTCI; others favored a federal catastrophic insurance program to cover the back end of the LTSS risk. And still others (the self-identified conservative group including Warshawsky) wanted to rely mainly on private resources and insurance, with some federal support for the LTSS needs of the poor.

Whereas some on the commission emphasized the lack of retirement savings, the conservative group thought that the availability of private resources was fairly widespread or could be forthcoming. This group wanted to further encourage—through both incentives and strict enforcement of Medicaid eligibility and repayment rules—private insurance solutions and private funding sources for LTSS, as outlined in the appendix. They thought that the Medicaid incentive to avoid the purchase of LTCI could be cut back by (1) stricter enforcement of the current eligibility requirements, (2) more diligent asset recovery from estates of deceased beneficiaries, and (3) stricter rules that would increase the amount and types of assets that are counted and considered in determining Medicaid eligibility—especially retirement accounts. Despite somewhat poor current conditions, they also thought that the market for LTCI and the nature of LTCI products could be greatly improved through more regulatory flexibility and product innovation. In the resulting report (Commission on Long-Term Care 2013), the aforementioned problems in LTSS provision and financing are described in detail with corresponding proposed solutions. The relevant portion of the report is provided in the appendix.

## This Paper's Contribution

The remit of the commission was large, and the group's time and resources were relatively small. Furthermore, the topics and data the commission analyzed were a result of political compromise. Therefore, the commission was not able to look into many of the issues relevant to the recommendations made by the various groups. In particular, the commission did not assess the extent of state efforts to recover assets (housing and other assets) from the estates of Medicaid recipients of LTSS. It did not estimate the asset holdings of older Americans from which financing of LTSS could be found. It also did not look carefully into the variability in state rules regarding the exclusion of retirement assets, such as individual retirement accounts (IRAs)and 401(k) accounts, from assets that count for Medicaid eligibility—the "millionaires on Medicaid" problem. Owing to the recent availability of federal data on estate recovery efforts by states, and through our own careful collection of information on state rules for countable assets and asset holdings of older Americans, we are able to examine all these issues in greater detail here. We then offer our specific recommendations for Medicaid policy.

## A Brief Summary of the Medicaid Eligibility Rules and Relevant Studies

When individuals and families have exhausted a certain percentage of their personal resources, they come to depend on Medicaid for help to finance LTSS expenses.[1] Individuals become eligible for Medicaid if they are eligible for Supplemental Security Income (SSI) because of low incomes and assets or as a result of spending down their incomes and assets on medical and LTSS expenses. Eligibility for Medicaid and the array of benefits provided vary substantially by state. As we will see, despite its reputation, Medicaid for LTSS is not just a program for the poor.

[1] With a few changes, a portion of this section summarizing the Medicaid eligibility rules is drawn from Commission on Long-Term Care (2013, 29–30).

According to the US Government Accountability Office (GAO), Medicaid paid for nearly half of the $263 billion in LTSS expenditures in 2010, representing about a quarter of total Medicaid spending (GAO 2012). State Medicaid programs pay for the specific LTSS services specified by each state plan for people who meet the income and assets tests particular to that state. Nursing home services must be offered, but other LTSS services are optional. Depending on state thresholds, older adults with low income and assets are likely to be eligible for Medicaid before they experience LTSS needs. But some people become eligible for Medicaid because of their spending on LTSS: They "spend down" to Medicaid eligibility by spending nearly all their income and some of their assets on services. Because nearly all income must be spent before Medicaid begins to pay, rules protect some income and assets for community-resident spouses. In addition, some assets are excluded, thus enabling a Medicaid recipient to retain assets of substantial value. For example, the value of the family home is protected during the lifetime of the Medicaid recipient and spouse.

Medicaid eligibility is complicated and varies substantially from state to state. For states that base eligibility on the federal SSI coverage requirements, in 2013 recipients had to have a monthly income below $710 for an individual ($1,066 for a couple), about 75 percent of the federal poverty level (FPL). States may extend Medicaid coverage to individuals in a nursing home or other institution with incomes up to 300 percent of FPL. Under SSI program rules, Medicaid recipients may also have countable assets of no more than $2,000 for an individual (no more than $3,000 for a couple). Medicaid allows the recipient to exclude from countable assets the value of the primary residence—up to $536,000 (indexed) in 2013, although states can allow up to $802,000 (indexed) in 2013—as well as a car, personal and household items, burial funds, term life insurance, and some or all qualified retirement assets in most states.

The Medicaid estate recovery program requires states to recoup private assets when a beneficiary dies in order to recover Medicaid expenditures on that person's behalf. The amount of recovery through this program has been quite small, but it varies among states, as we describe below.

Federal law discourages individuals from transferring countable assets to relatives in order to establish eligibility. In particular, those who transfer assets during a look-back period of five years before applying for Medicaid will be ineligible for a period of time.[2] States are responsible for assessing eligibility according to their varied rules, under broad federal guidelines.

GAO (2012) reported the results of a survey in late 2011 to gather information on states' requirements and practices for assessing Medicaid financial eligibility. In particular, the GAO (1) examined the extent to which states required documentation of assets from applicants, (2) obtained information from third parties to verify applicants' assets, and (3) obtained information about applicants' assets to enforce the rules for the look-back period. The GAO found that almost all states did ask applicants for information about income and some assets, but only 37 states asked for information about the primary residence (with some of the remainder looking at county property records). Fewer than half the states asked for information going back five years. All states matched reported Social Security income with Social Security Administration records, but matching with other government agencies, such as the IRS and state unemployment insurance, was spottier. Most states did not contact financial institutions, whether listed or not listed on the application. Despite a federal law requiring most states to have implemented an

[2] So-called spousal refusal and the use of certain types of trust and insurance reportedly are employed by some well-to-do households to qualify for Medicaid, even inside the look-back period. The extent of this activity is unknown and should be studied more carefully using case reviews.

electronic asset verification system by 2011 to obtain information from financial institutions, none had done so. Eighteen states, however, said they had begun such implementation.

Nadia Greenhalgh-Stanley (2012) conducted another study relevant to an examination of the nexus of housing and long-term care financing decisions of older Americans. Greenhalgh-Stanley posits that Medicaid coverage of LTSS and its detailed eligibility and financing rules are a major influence on the overall decision by the retired household to keep housing equity as a significant part of the retirement asset portfolio, so as to leave it as a bequest. In particular, she emphasizes that housing (up to more than $800,000) is exempt from the asset spend-down requirement for Medicaid eligibility for LTSS payments. At the same time, states have gradually implemented a 1993 federal requirement to set up Medicaid estate recovery programs. Such programs grant states the right to reclaim the value of Medicaid expenditures on LTSS after the death of an unmarried individual who is a Medicaid beneficiary by placing a lien on his or her home. Some states have gone further in complying with federal law and impose a lien while the owner is living.

Greenhalgh-Stanley (2012) conducts an empirical investigation of the effect of Medicaid means testing on asset and portfolio behavior by using, at the state-by-calendar-year level, variation in the adoption of estate recovery and lien programs from 1993 through 2004. The study uses Health and Retirement Study panel data on older Americans' housing, portfolio, and bequest decisions. Greenhalgh-Stanley finds that in states that adopt recovery programs, older Americans are induced to decrease their home ownership rate by 4.6 percent. These program changes also cause a 15 percent decrease in home equity and a decrease in the proportion of the total wealth portfolio that is made up of primary housing assets. That decrease is by 7.8 percentage points; on a base housing share of 54.9 percent, the decrease is 14.2 percent.

Greenhalgh-Stanley also finds that adoption of the recovery programs results in a decrease in home ownership at death by 33 percent. Furthermore, she finds that trusts are used as a substitute method to protect assets and carry out bequest motives. These results are robust to including proxies for local housing market conditions, Medicaid generosity, and state-by-time trends.

Although one might be skeptical of those empirical results because the decision to keep one's housing assets is influenced by so many different economic, social, and policy factors, some detailed aspects of Greenhalgh-Stanley's (2012) findings make her case more persuasive. The effect she finds is stronger for lien programs, which makes sense because liens placed during the beneficiary's lifetime are highly visible and salient to the affected individuals and to others. Furthermore, she finds a differential effect by marital status—stronger on singles—which is also sensible because liens are not placed on a house when there is a surviving spouse and, for purposes of estate recovery, states do not track the home for the duration of the community spouse's stay in the house. She also finds that most of the decrease in home equity is driven by activity in the upper end of the income and wealth distribution.

**Measures of Resource Recovery from Estates by the States**

Despite varied efforts by the states to recover resources from estates of deceased Medicaid beneficiaries since Medicaid's creation in 1965, there are no systematic data sources on these collections over the subsequent five-decade period. The US Department of Health and Human Services (HHS) published state-by-state estimates of estate collections for fiscal years 1985 and 1993, but these data preceded the Omnibus Reconciliation Act of 1993, which required states to attempt to recover resources from estates. In these early HHS studies, more than 20 states did not report recovering any assets from the estates of former Medicaid recipients (HHS Office of

Inspector General 1995). The 2005 HHS study contains the first federally reported data since the mandate, and it covers collections from 2002 to 2005. Subsequently, at the request of Congress, the HHS Office of the Inspector General (2014) published state-by-state estimates in the 2006–2011 period.[3] Table 1 is the combined data from these reports, tracking collections from 2002 to 2011.

**Table 1. Medicaid Estate Recovery Efforts by States, 2002–2011**

| State | 2002 ($) | 2003 ($) | 2004 ($) | 2005 ($) | 2006 ($) |
|---|---|---|---|---|---|
| Alabama | 5,607,357.50 | 5,151,796.48 | 7,383,754.84 | 6,657,776.65 | 6,141,367.68 |
| Alaska | 0.00 | 0.00 | 0.00 | 5,750.00 | 499,047.36 |
| Arizona | 2,238,443.75 | 2,623,317.20 | 2,859,934.14 | 2,804,713.15 | 5,063,484.16 |
| Arkansas | 1,932,413.75 | 2,110,722.00 | 2,503,821.88 | 1,837,445.85 | 2,278,933.44 |
| California | 45,418,951.25 | 53,709,373.94 | 53,155,927.93 | 78,243,320.50 | 87,927,510.72 |
| Colorado | 5,022,661.25 | 5,672,902.40 | 7,427,971.67 | 8,487,113.85 | 9,067,864.96 |
| Connecticut | 12,804,235.00 | 13,279,480.40 | 9,763,096.77 | 10,869,429.70 | 12,442,655.68 |
| Delaware | 819,795.00 | 1,352,424.90 | 519,280.30 | 1,558,608.80 | 1,393,892.64 |
| District of Columbia | 9,436,061.25 | 7,095,749.36 | 12,817,341.25 | 2,761,023.50 | 3,017,374.08 |
| Florida | 12,103,858.75 | 13,998,871.70 | 16,039,066.33 | 19,821,233.25 | 14,477,859.20 |
| Georgia | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Hawaii | 1,630,781.25 | 2,751,190.28 | 2,004,293.20 | 2,896,958.10 | 4,640,885.76 |
| Idaho | 5,043,486.25 | 6,536,042.64 | 6,778,062.69 | 7,723,337.90 | 9,858,093.28 |
| Illinois | 21,254,775.00 | 20,732,614.12 | 25,293,142.98 | 22,620,258.50 | 21,633,171.84 |
| Indiana | 7,957,841.25 | 8,987,431.34 | 9,102,796.71 | 8,919,160.80 | 8,899,759.68 |
| Iowa | 11,431,920.00 | 13,392,944.06 | 14,511,593.04 | 11,876,757.25 | 16,899,535.52 |
| Kansas | 5,952,875.00 | 7,555,656.42 | 5,791,140.95 | 6,969,552.00 | 5,163,329.92 |
| Kentucky | 2,367,267.50 | 3,613,396.00 | 6,415,343.55 | 9,596,624.65 | 10,080,014.56 |
| Louisiana | 0.00 | 127,801.10 | 123,585.07 | 194,852.55 | 201,418.56 |
| Maine | 5,951,042.50 | 7,240,335.22 | 7,352,825.55 | 5,222,910.15 | 4,972,698.08 |
| Maryland | 7,972,077.50 | 8,442,296.30 | 6,493,290.93 | 435,908.65 | 8,478,238.72 |
| Massachusetts | 36,046,820.00 | 34,799,661.86 | 38,766,988.19 | 43,607,098.40 | 45,212,473.60 |
| Michigan | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Minnesota | 23,336,148.75 | 15,737,695.00 | 29,749,518.05 | 30,059,970.75 | 26,656,940.80 |
| Mississippi | 1,150,452.50 | 205,856.70 | 466,400.27 | 680,039.85 | 520,513.28 |
| Missouri | 9,210,190.00 | 9,126,268.56 | 10,230,813.18 | 11,911,165.25 | 14,580,814.08 |
| Montana | 2,079,961.25 | 2,418,391.36 | 2,812,353.18 | 1,924,682.55 | 1,987,416.48 |
| Nebraska | 1,098,083.75 | 1,719,317.94 | 1,339,904.30 | 1,042,892.45 | 1,753,671.36 |

[3] We thank Brian Blase, a senior research fellow at the Mercatus Center at George Mason University, for bringing this study to our attention.

| | | | | | |
|---|---|---|---|---|---|
| Nevada | 1,473,767.50 | 1,666,957.98 | 500,310.51 | 2,214,339.95 | 1,844,104.64 |
| New Hampshire | 6,205,527.50 | 4,336,448.52 | 5,191,542.79 | 6,775,012.25 | 6,193,156.48 |
| New Jersey | 6,639,476.25 | 7,358,425.12 | 9,912,559.58 | 14,939,078.45 | 6,733,354.88 |
| New Mexico | 0.00 | 0.00 | 92,864.03 | 1,155,989.20 | 1,579,289.60 |
| New York | 33,598,570.00 | 33,238,547.42 | 35,644,467.46 | 39,504,785.05 | 39,715,621.12 |
| North Carolina | 5,250,000.00 | 4,944,807.62 | 6,580,285.88 | 8,530,498.75 | 8,592,093.44 |
| North Dakota | 2,033,767.50 | 2,055,292.52 | 2,380,911.54 | 1,870,041.45 | 2,219,033.60 |
| Ohio | 13,518,071.25 | 15,106,862.28 | 16,645,677.16 | 17,067,915.90 | 17,553,332.16 |
| Oklahoma | 1,595,923.75 | 2,285,430.88 | 1,872,956.47 | 2,743,060.50 | 2,770,034.40 |
| Oregon | 17,173,412.50 | 17,075,561.64 | 16,473,874.48 | 1,335,362.75 | 14,716,284.80 |
| Pennsylvania | 29,110,055.00 | 28,241,811.72 | 7,007,384.02 | 31,387,320.30 | 30,406,070.24 |
| Rhode Island | 5,484,972.50 | 4,342,072.72 | 3,323,060.72 | 4,825,819.75 | 7,172,882.08 |
| South Carolina | 4,354,043.75 | 6,283,522.16 | 7,386,115.80 | 6,309,784.35 | 7,408,294.88 |
| South Dakota | 1,371,165.00 | 1,578,451.86 | 1,455,004.67 | 1,450,361.60 | 1,380,986.88 |
| Tennessee | 6,007,471.25 | 3,360,194.76 | 10,586,161.46 | 17,331,479.80 | 15,651,553.12 |
| Texas | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Utah | 2,559,265.00 | 560,468.00 | 56,457.17 | 480,174.45 | 279,156.64 |
| Vermont | 796,123.75 | 594,175.38 | 478,565.64 | 1,003,245.05 | 625,298.24 |
| Virginia | 1,013,166.25 | 1,163,155.32 | 924,470.54 | 1,650,975.65 | 1,120,729.12 |
| Washington | 1,217,735.00 | 2,023,499.32 | 2,129,588.30 | 12,857,034.50 | 19,074,485.92 |
| West Virginia | 758,432.50 | 1,444,179.88 | 255,440.64 | 218,615.00 | 111,403.04 |
| Wisconsin | 19,309,860.00 | 15,631,694.08 | 19,959,547.51 | 20,036,910.00 | 23,856,756.00 |
| Wyoming | 1,069,185.00 | 1,338,632.80 | 1,942,517.92 | 1,491,808.75 | 1,904,741.44 |
| United States | 398,407,491.25 | 403,011,729.26 | 430,502,011.24 | 493,908,198.50 | 534,757,628.16 |

| **State** | **2007 ($)** | **2008 ($)** | **2009 ($)** | **2010 ($)** | **2011 ($)** |
|---|---|---|---|---|---|
| Alabama | 6,140,054.88 | 6,396,053.04 | 7,290,598.35 | 5,512,378.72 | 6,564,264.00 |
| Alaska | 194,114.88 | 134,079.92 | 122,353.35 | 946,328.98 | 455,766.00 |
| Arizona | 5,339,777.04 | 2,937,308.40 | 2,515,436.70 | 3,285,847.29 | 2,234,513.00 |
| Arkansas | 1,459,488.24 | 1,897,001.60 | 1,460,542.65 | 853,407.53 | 1,634,504.00 |
| California | 85,087,452.24 | 70,432,234.08 | 61,931,471.70 | 63,878,554.42 | 61,652,429.00 |
| Colorado | 6,790,914.72 | 6,031,143.04 | 6,299,165.25 | 6,803,226.22 | 6,942,415.00 |
| Connecticut | 12,223,999.44 | 9,404,271.76 | 10,210,986.45 | 7,818,161.44 | 7,139,525.00 |
| Delaware | 894,940.92 | 1,489,510.88 | 1,713,123.30 | 1,805,201.69 | 2,988,378.00 |
| District of Columbia | 2,605,856.40 | 1,246,698.96 | 1,212,898.05 | 321,145.76 | 735,790.00 |
| Florida | 16,395,113.88 | 12,682,673.12 | 10,382,029.35 | 11,414,579.48 | 13,465,339.00 |
| Georgia | 1,536,858.36 | 4,044,622.40 | 5,177,044.95 | 4,933,241.65 | 4,347,901.00 |
| Hawaii | 3,489,377.40 | 1,396,808.40 | 2,860,526.55 | 531,910.54 | 2,071,524.00 |
| Idaho | 10,312,846.56 | 8,969,512.24 | 8,092,389.90 | 4,400,523.59 | 10,371,418.00 |
| Illinois | 22,507,284.24 | 19,448,052.00 | 20,868,360.45 | 26,490,196.11 | 21,011,820.00 |
| Indiana | 10,294,932.60 | 10,986,700.40 | 15,447,267.15 | 11,765,508.72 | 12,460,792.00 |
| Iowa | 16,389,222.48 | 17,966,264.16 | 18,949,817.25 | 19,399,587.53 | 19,041,568.00 |
| Kansas | 5,676,796.44 | 8,064,099.68 | 8,122,645.65 | 9,989,215.01 | 8,245,416.00 |
| Kentucky | 7,246,040.76 | 6,213,647.44 | 6,287,508.15 | 5,867,903.82 | 5,609,746.00 |

| | | | | | |
|---|---|---|---|---|---|
| Louisiana | 120,164.04 | 404,597.44 | 343,465.50 | 333,502.67 | 608,924.00 |
| Maine | 6,371,293.68 | 5,185,232.00 | 6,683,658.45 | 8,094,077.84 | 6,039,744.00 |
| Maryland | 9,101,128.68 | 7,984,047.76 | 6,293,987.70 | 7,118,232.15 | 7,301,871.00 |
| Massachusetts | 43,452,238.32 | 36,863,992.88 | 35,161,587.30 | 36,402,416.56 | 33,961,351.00 |
| Michigan | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Minnesota | 21,575,840.40 | 20,922,260.32 | 22,559,859.00 | 22,548,066.81 | 20,128,159.00 |
| Mississippi | 1,759,722.84 | 1,755,241.28 | 1,372,975.80 | 1,296,100.50 | 1,795,534.00 |
| Missouri | 14,546,869.92 | 12,904,352.24 | 12,979,352.40 | 12,827,328.51 | 10,784,440.00 |
| Montana | 2,645,958.96 | 2,269,099.04 | 2,943,237.15 | 2,050,397.31 | 2,100,299.00 |
| Nebraska | 2,088,848.52 | 1,342,086.72 | 1,979,210.10 | 1,895,937.48 | 1,528,142.00 |
| Nevada | 2,157,609.96 | 2,074,795.84 | 1,554,808.50 | 1,797,558.06 | 1,870,037.00 |
| New Hampshire | 4,673,504.52 | 4,829,810.96 | 5,737,477.20 | 4,574,343.30 | 4,933,904.00 |
| New Jersey | 12,683,934.72 | 15,606,691.36 | 9,301,748.40 | 15,302,274.31 | 12,140,609.00 |
| New Mexico | 1,173,006.36 | 2,381,427.36 | 1,275,651.30 | 1,518,726.76 | 1,738,452.00 |
| New York | 42,113,473.56 | 36,834,904.08 | 47,036,016.30 | 46,384,053.86 | 46,429,235.00 |
| North Carolina | 12,934,111.32 | 10,645,992.24 | 10,008,878.25 | 9,381,662.30 | 9,937,605.00 |
| North Dakota | 1,763,952.12 | 1,951,851.20 | 2,184,590.10 | 2,957,289.65 | 3,165,516.00 |
| Ohio | 17,314,566.48 | 20,269,100.80 | 22,704,184.65 | 23,888,832.23 | 24,642,062.00 |
| Oklahoma | 2,647,105.92 | 2,168,381.28 | 2,854,219.20 | 3,794,144.05 | 2,478,909.00 |
| Oregon | 12,674,646.72 | 15,993,857.36 | 14,129,013.15 | 11,094,139.27 | 12,454,190.00 |
| Pennsylvania | 36,461,544.12 | 36,767,252.08 | 33,819,228.45 | 35,790,624.37 | 35,004,237.00 |
| Rhode Island | 3,408,438.96 | 2,977,487.76 | 2,886,565.50 | 2,979,295.60 | 3,469,600.00 |
| South Carolina | 6,123,252.24 | 4,694,675.44 | 3,786,164.55 | 4,604,654.14 | 3,839,379.00 |
| South Dakota | 1,302,777.00 | 971,664.72 | 1,837,177.65 | 1,863,399.78 | 1,981,471.00 |
| Tennessee | 18,462,976.92 | 17,168,842.08 | 13,489,861.35 | 14,374,510.05 | 15,124,120.00 |
| Texas | 1,116,448.92 | 4,093,438.96 | 5,574,605.40 | 5,007,513.92 | 4,784,423.00 |
| Utah | 122,192.28 | 163,764.64 | 130,722.90 | 164,926.69 | 1,902,532.00 |
| Vermont | 642,264.12 | 750,324.64 | 665,728.35 | 1,828,940.10 | 597,066.00 |
| Virginia | 2,766,883.32 | 1,209,126.88 | 1,351,820.40 | 1,409,098.71 | 2,009,293.00 |
| Washington | 18,420,268.32 | 18,988,386.56 | 15,204,781.20 | 13,770,465.52 | 12,665,058.00 |
| West Virginia | 133,741.80 | 152,181.12 | 136,522.05 | 153,966.46 | 104,209.00 |
| Wisconsin | 14,057,566.20 | 20,446,912.72 | 20,042,859.90 | 20,366,617.45 | 23,751,651.00 |
| Wyoming | 2,015,849.16 | 1,763,803.60 | 1,317,267.00 | 1,450,106.10 | 1,660,252.00 |
| United States | 531,417,251.88 | 502,276,264.88 | 496,291,390.35 | 503,040,121.01 | 497,905,382.00 |

Sources: HHS Office of the Assistant Secretary for Planning and Evaluation and Office of Disability, Aging, and Long-Term Care Policy (2005); HHS Office of Inspector General (2014).

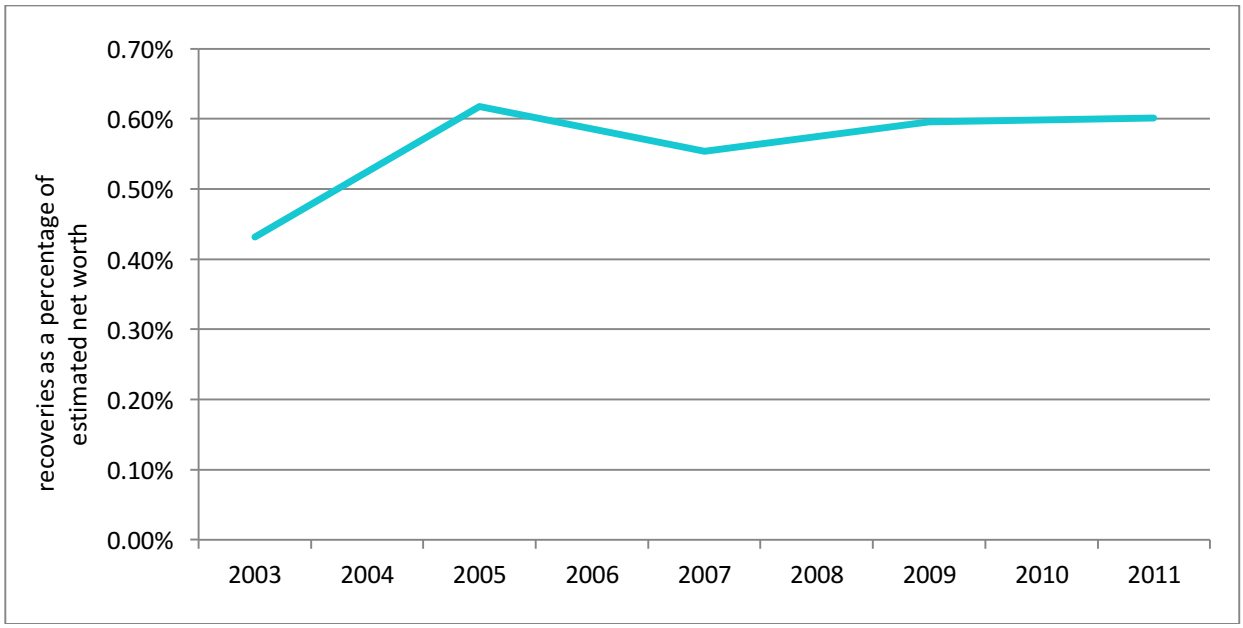
In recent years, states have recovered about $500 million annually, in national aggregate, from estates of deceased Medicaid beneficiaries. Despite the 1993 federal mandate for states to recover Medicaid benefits from estates, several states did not implement estate recovery

programs until the early to mid-2000s. These states include Georgia, Texas, New Mexico, and Michigan. In 2007, Michigan was the last state to implement a recovery program; no collections data have been reported from Michigan in the period since implementation.

To get a sense of whether $500 million across the states represents much effort or success relative to the assets that might be available for recovery or to the LTSS expenditures, we calculate two ratios over time for the nation as whole. In the first ratio, we calculate recoveries over time as a percentage of a rough estimate of the net worth of individuals who are more likely presumed to use Medicaid-paid LTSS benefits—that is, those in the middle of the lower half of the wealth distribution or the 25th percentile of net worth of older Americans. Data on net worth are obtained from the 2011, 2009, 2007, 2005, and 2003 waves of the Panel Study on Income Dynamics (PSID), a biennial survey that tracks a representative sample of US households (Institute for Social Research 2016). In calculating net worth, the PSID takes the sum of financial wealth, housing wealth, real assets, and retirement wealth and subtracts liabilities such as mortgages. This dataset cannot produce a direct estimate of the net worth of seniors on Medicaid, because household members are not asked if they are receiving Medicaid benefits. We therefore take the net worth of the 25th percentile in the net worth distribution of senior households for each year collected by the PSID. This statistic is then multiplied by the number of older Americans' households in the United States containing Medicaid enrollees, using data from the Medicaid and CHIP (Children Health Insurance Program) Payment and Access Commission (MACPAC 2015). The result is the presumed aggregate net worth of seniors on Medicaid. Data for the relevant year on estate recoveries, shown in table 1, are divided by these aggregate net worth amounts to arrive at the rate of estate recoveries nationally. For the second ratio, we divide national recoveries every year by national Medicaid expenditures on LTSS.

Those two ratios—or rates of estate recovery over time—are shown in figures 1 and 2. According to either measure, state efforts are modest at best. Both measures indicate that states collect considerably below 1 percent of either available estimated Medicaid-using household net worth or actual Medicaid LTSS spending.

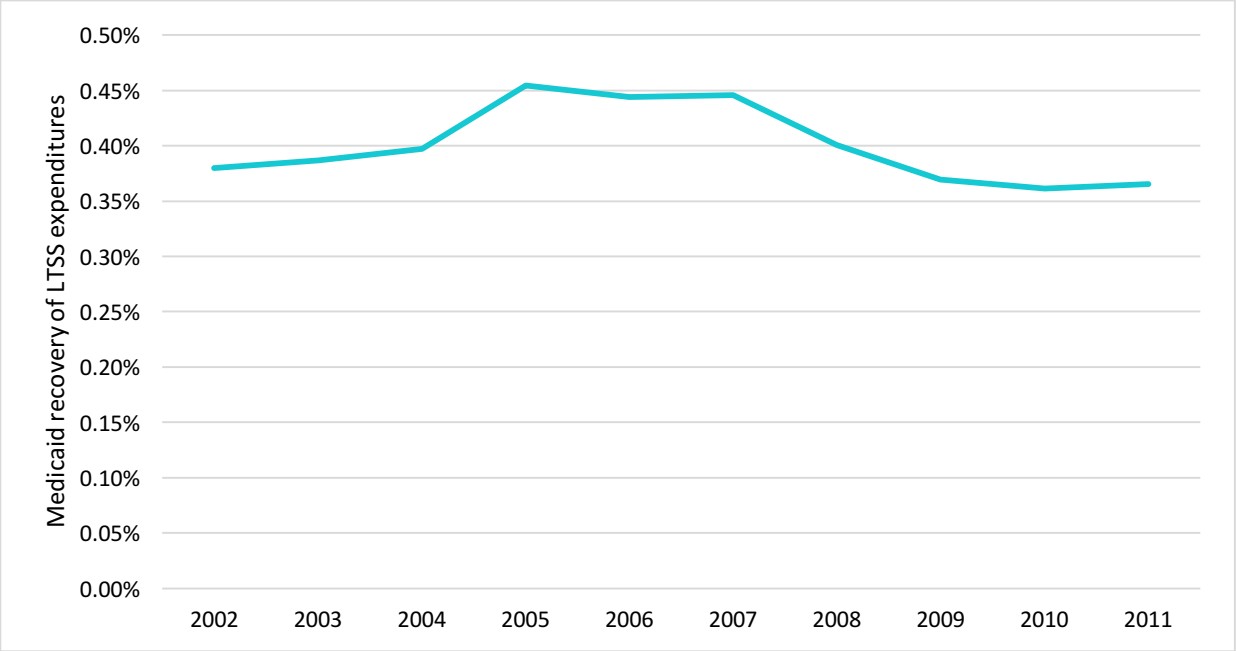
**Figure 1. LTSS Medicaid Estate Recovery Amounts as a Percentage of Estimated Net Worth of Senior Medicaid Beneficiaries, 2003–2011**




Note: LTSS = long-term services and supports.

Sources: Authors' calculations, based on data from the PSID (Institute for Social Research 2016) on net worth and HHS Department of Human Services (2005) and HHS Office of Inspector General (2014) on estate recoveries.

**Figure 2. Medicaid Estate Recovery Amounts as a Percentage of LTSS Expenditures, US Aggregates, 2002–2011**




Note: LTSS = long-term services and supports.

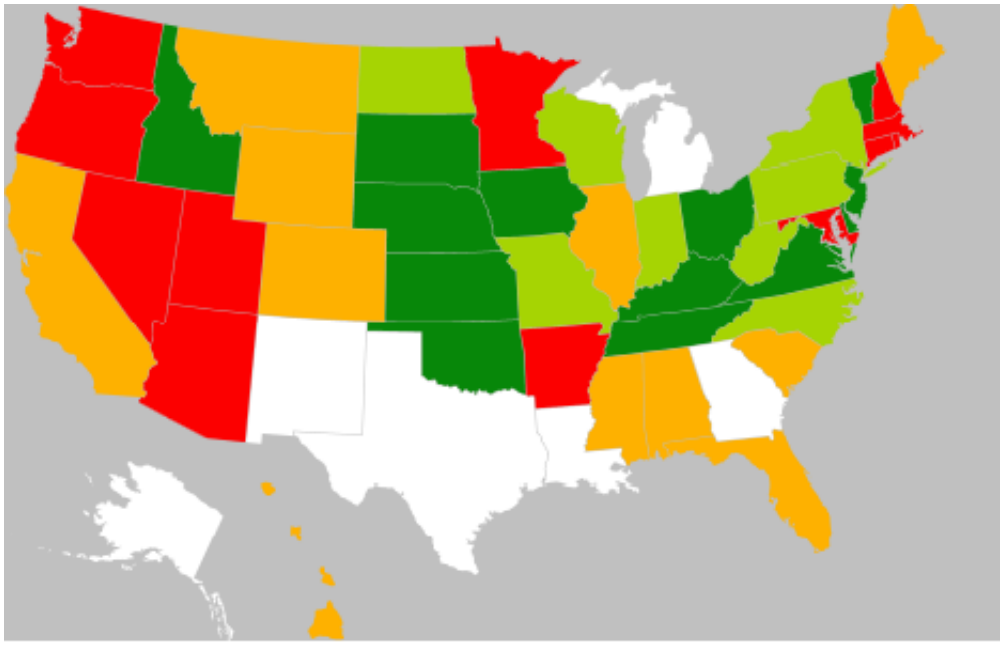
Sources: Authors' calculations, based on data in Burwell, Sredl, and Eiken (2009) and Eiken et al. (2013) on LTSS expenditures and HHS Office of the Assistant Secretary for Planning and Evaluation (2005) and HHS Office of Inspector General (2014) on estate recoveries.

Figures 1 and 2 show an increase in recovery rates in the first two or three years of the period examined; this increase corresponds to the aforementioned increase in the number of states actively pursuing collections from former LTSS households. The second ratio indicates a permanent decline in the recovery rate after 2007, but the corresponding drop in the first ratio is temporary. The decline and drop are probably caused by the recession at the end of the previous decade. The recession likely had an adverse effect on recoveries; states have "hardship waivers" built into their estate recovery programs that allow individuals to exempt their assets from seizure if they can show that said assets are a "necessity" to survival (O'Brien 2015). During the Great Recession, the value of housing and the stock market dropped significantly, which would

have had an adverse effect on asset levels and net worth, but subsequently there was some rebound in values. By contrast, LTSS expenditures kept rising.

Using the HHS statistics by state and year, we are also able to compute changes in estate recovery rates (second ratio) by year by state from 2002 to 2011. Figure 3 shows states by their change in Medicaid estate recovery as a percentage of LTSS expenditures from 2002 to 2011. There is a considerable heterogeneity in recovery rate changes over this period, with 13 states experiencing drops in recovery efficiency greater than 30 percent and 13 states experiencing rate increases exceeding 30 percent. Overall, recovery rate gains and losses were fairly evenly distributed; slightly more states experienced losses (24) than gains (21).

**Figure 3. Percentage Changes in Medicaid State Recovery Efficiency, 2002–2011**

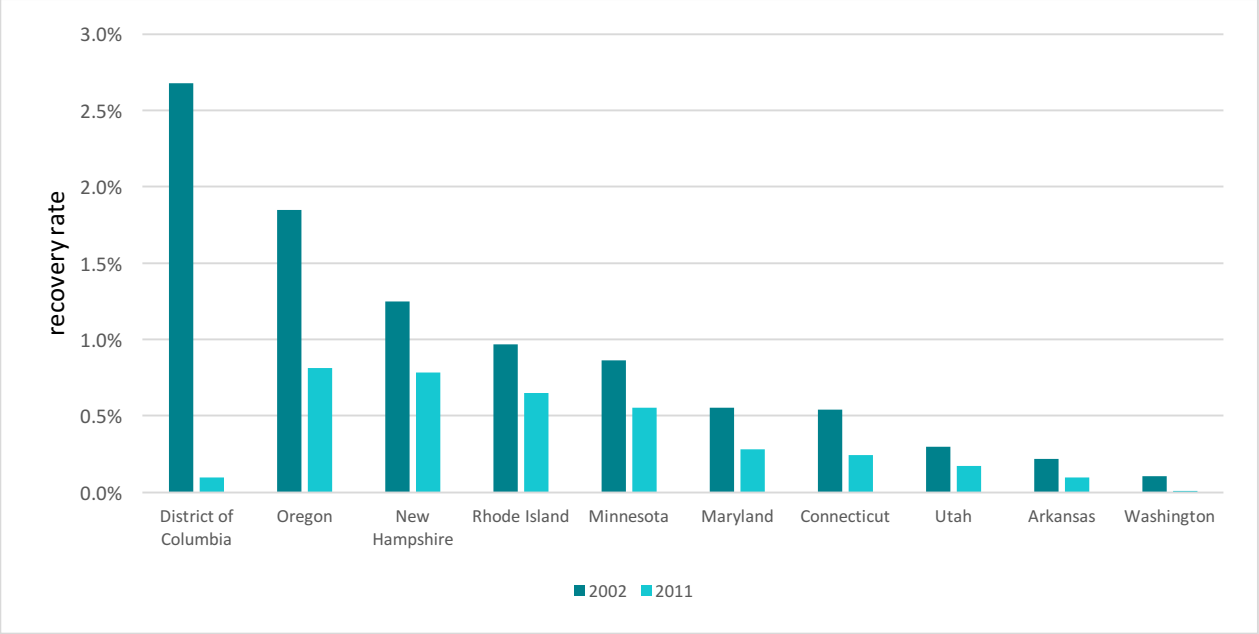



Notes: N/A = not available. States designated by N/A did not report estate recoveries to HHS in 2002. Arizona's sharp decrease reflects incomplete data reported to HHS by the Arizona government in the beginning of the period studied. The expenditures were underreported by roughly a factor of 10, giving the appearance of a far higher recovery rate in 2002 than in 2011.

Sources: Authors' calculations based on data in Burwell, Sredl, and Eiken (2009) and Eiken et al. (2013) on LTSS expenditures and HHS Office of the Assistant Secretary for Planning and Evaluation (2005) and HHS Office of Inspector General (2014) on estate recoveries.

Figure 4 shows the states with the largest losses in recovery efficiency during the 10-year period studied. The largest decrease of all the states was observed for the District of Columbia, which saw a 163 percent increase in LTSS expenditures from 2002 to 2011 and a 90 percent drop in estate collections over the same period. States such as Rhode Island and Oregon saw a similar pattern, despite milder decreases in collections and increases in LTSS expenditures. Washington and Oregon were able to increase their estate collections, but large corresponding increases in expenditures meant overall drops in recovery rates.

**Figure 4. States with the Sharpest Declines in Medicaid Estate Recovery Rates, 2002–2011**

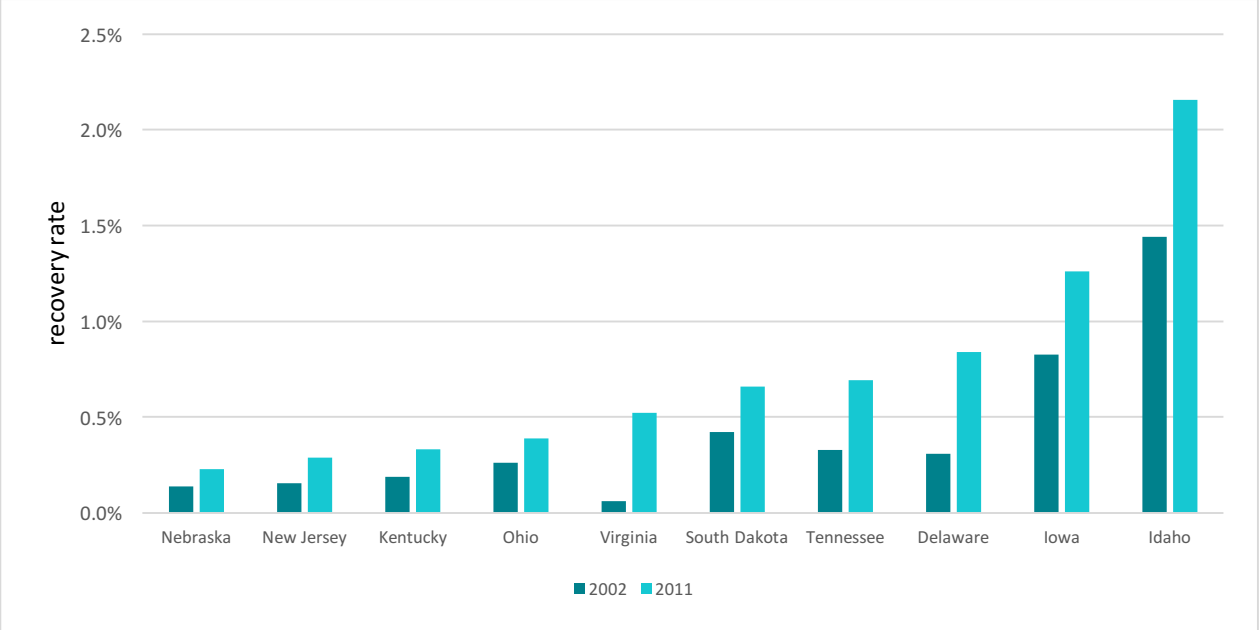



Sources: Author's calculations based on data from Burwell, Sredl, and Eiken (2009) and Eiken and others (2013) on LTSS expenditures and HHS Office of the Assistant Secretary for Planning and Evaluation (2005) and HHS Office of Inspector General (2014) on estate recoveries.

Figure 5 illustrates the 10 states with the largest increases in recovery rates from 2002 to 2011. Both Idaho and Iowa were able to double their recovery collections while keeping LTSS

cost growth under 75 percent. All the states shown in figure 5 had collection growths exceeding 70 percent, and all but two states (Virginia and Idaho) kept LTSS growth below 70 percent.

**Figure 5. States with the Sharpest Increases in Medicaid Estate Recovery Rates, 2002–2011**




Sources: Author's calculations based on data from Burwell, Sredl, and Eiken (2009) and Eiken et al. (2013) on LTSS expenditures and HHS Office of the Assistant Secretary for Planning and Evaluation (2005) and HHS Office of Inspector General (2014) on estate recoveries.

To get another sense of the possible recoveries that could occur if all states employed their best efforts, with the state with the highest recovery rate in any year as the standard, we apply that diligent state's recovery rate to national LTSS expenditures for the relevant year. The result is an estimate of the upper boundary of potential recoveries for all states for the given year. Table 2 shows these potential and actual recoveries for the 2002–2011 period. For the early years, the highest recovery rates were achieved by the District of Columbia; this later changed as the District's rate decreased and Idaho's and Iowa's rates surpassed it. Had all states met these "best efforts" rates, which were in the range of 1 percent to 4 percent (hardly strenuous), nearly $20

billion more—$24 billion instead of $4.4 billion—could have been recovered for governments nationally from estates of deceased Medicaid LTSS beneficiaries in the 2002–2011 period.

**Table 2. Actual and Potential Estate Recovery Amounts Assuming Replication of Highest State Recovery Rates, 2002–2011**

| Year | State with highest recovery rate | Millions of dollars, 2016 | | |
|---|---|---|---|---|
| | | Potential national recovery | Actual national recovery | Difference |
| 2002 | District of Columbia (2.7%) | 2,990.24 | 420.72 | 2,569.52 |
| 2003 | District of Columbia (1.9%) | 2,094.52 | 426.14 | 1,668.38 |
| 2004 | District of Columbia (3.5%) | 3,983.90 | 452.21 | 3,531.69 |
| 2005 | Idaho (2.1%) | 2,401.24 | 519.68 | 1,881.56 |
| 2006 | Idaho (2.4%) | 3,045.41 | 563.41 | 2,482.00 |
| 2007 | Idaho (2.5%) | 3,147.63 | 560.94 | 2,586.69 |
| 2008 | Idaho (2.1%) | 2,784.67 | 531.25 | 2,253.41 |
| 2009 | Idaho (1.8%) | 2,534.51 | 519.92 | 2,014.59 |
| 2010 | Iowa (1.3%) | 1,914.87 | 532.34 | 1,382.53 |
| 2011 | Idaho (2.2%) | 3,146.15 | 522.80 | 2,623.35 |
| 2002–2011 | | 23,991.25 | 4,351.74 | 19,639.51 |

Sources: Authors' calculations based on data from Burwell, Sredl, and Eiken (2009) and Eiken and others (2013) on LTSS expenditures and HHS Office of the Assistant Secretary for Planning and Evaluation (2005) and HHS Office of Inspector General (2014) on estate recoveries.

## State Spend-Down Variations for Medicaid LTSS

State rules on Medicaid LTSS eligibility vary considerably, including a wide array of rules on which assets owned by the applicant and the applicant's spouse are considered countable toward the asset limits. Using state legislative codes and interviews with state health departments, we determined and classified each state's rules concerning retirement assets. In the first instance, these rules differ in how the retirement assets of the applicant's spouse are treated; most states hold that the spouse's assets are countable toward the asset limit of the applicant, but many do not. Rules also differ in their treatment of retirement resources that have already been accessed by the applicant and his or her spouse. Some states count retirement assets only if they are

accessed, but others will exempt the assets if periodic distributions are being taken from accounts, including legally required minimum distributions after age 70.5.

In our examination of these rules, we found nine groupings of state rules about retirement assets. To estimate how these rules affect Medicaid eligibility for senior residents of different states, we used the 2011 PSID data on retirement account holdings from each state to calculate an approximate percentage of residents' retirement assets deemed countable for Medicaid eligibility purposes. Because of the thinness of the PSID dataset, not all states had sufficient observations to determine the percentage of countable assets. For those states with insufficient PSID observations, data are used from comparable states with a sufficiently large number of PSID observations.

States in the retirement resource category 1, or grouping 1, count all the retirement assets of both the Medicaid applicant and the applicant's spouse. The asset percentage for these states is 100 percent. States in grouping 2 do not count the retirement assets of the applicant or the spouse; the corresponding percentage is 0 percent.

Connecticut, the sole member of grouping 3, counts assets in individual retirement accounts and Keogh plans with no contractual obligations to non–household members (meaning everyone except the spouse who is listed as the inheritor). Assets in 401(k) accounts and Keogh plans with contractual obligations to non–household members are exempted. In addition, the spouse's assets are countable. Previous estimations suggest that roughly 30 percent of retirement wealth is held in 401(k) accounts (Investment Company Institute 2015); breakdowns of Keogh plan ownership by contractual obligation status are not available. We assume that 70 percent of Connecticut's retirement assets are countable.

States in grouping 4 count the assets of the applicant but exempt the spouse's assets. In determining the percentage of countable assets, we add the assets of single households and one-half of the combined assets of dual households. We divide this total by aggregate retirement assets in the state.

Grouping 5 consists solely of Maine, which counts applicants' assets in excess of $8,000 if they are not married. If the applicant has a spouse, the spouse's assets are entirely countable toward the applicant's asset limit. We add the retirement assets of single households in excess of the $8,000 limit, as well as the combined assets of dual households. The total is then divided by the aggregate assets in the state.

States in grouping 6 count applicants' assets when retirement accounts are currently being accessed; the same rule is applied to the applicants' spouses' assets. If individuals are under age 70.5, they are not required by the tax rules to take distributions from their retirement plans. Applicants and spouses under this age can choose to delay their distribution so they may qualify for Medicaid. Because individuals over this age cannot engage in this strategic behavior without incurring a significant penalty from the IRS, we add the assets of (1) single householders over age 70.5, (2) dual households in which both members are over age 70.5, and (3) half the combined assets of dual households in which one member is over age 70.5 and the other member is under age 70.5. Those assets are then divided by aggregate assets in the state to produce the asset percentage figure.

States in grouping 7 also count the applicant's assets when they are accessed, but the spouse's assets are not counted. For these states, we add the assets of single householders over age 70.5 and half of the combined assets of dual households in which (1) both members are over

age 70.5 or (2) one member is over age 70.5 and the other member is under age 70.5. This figure is divided by the aggregate asset amounts for the state.

Groupings 8 and 9 cover states with periodic payment rules. In these states, retirement account balances are not counted as assets as long as regular distributions are being taken from said account. These distributions are then counted as income in determining Medicaid eligibility. Grouping 8 applies this rule to applicants' and their spouses' assets. We add the assets of (1) single householders under age 70.5, (2) dual households if both members are under age 70.5, and (3) half of the combined assets of dual households in which one member is over age 70.5 and the other member is under age 70.5. This total is divided by aggregate assets for the state.

States in grouping 9 exempt the applicant's assets as long as regular distributions are being taken, but the spouse's assets are unconditionally exempted. We add (1) the assets of single householders below the age of 70.5; and (2) half of the combined assets of dual households in which both members are under age 70.5 and (3) half of the combined assets of dual households in which one member is over age 70.5 and the other member is under age 70.5. The total is divided by aggregate asset value in the state.

The resulting state-by-state percentages, shown in table 3, are then multiplied by each state's senior population to provide weighting. These products are then added together to derive a weighted average of countable retirement assets in the United States.

**Table 3. Percentage of Retirement Assets Deemed Countable toward Medicaid Asset Limit in 2011, by State and Rules Grouping**

| State | Retirement resource grouping | Senior population (2014) | Countable assets (%) |
|---|---|---|---|
| Alabama | 1 | 746,512 | 100.0 |
| Arizona | 1 | 1,070,757 | 100.0 |
| Arkansas | 1 | 465,012 | 100.0 |
| Colorado | 1 | 679,572 | 100.0 |
| Delaware | 1 | 153,759 | 100.0 |
| Hawaii | 1 | 228,061 | 100.0 |
| Maryland | 1 | 822,171 | 100.0 |
| Massachusetts | 1 | 1,015,577 | 100.0 |
| Michigan | 1 | 1,531,067 | 100.0 |
| Missouri | 1 | 931,890 | 100.0 |
| Nebraska | 1 | 270,677 | 100.0 |
| Nevada | 1 | 400,514 | 100.0 |
| New Hampshire | 1 | 209,447 | 100.0 |
| New Jersey | 1 | 1,312,125 | 100.0 |
| New Mexico | 1 | 318,086 | 100.0 |
| Ohio | 1 | 1,796,868 | 100.0 |
| Oklahoma | 1 | 561,568 | 100.0 |
| Oregon | 1 | 634,226 | 100.0 |
| Texas | 1 | 3,096,013 | 100.0 |
| Utah | 1 | 294,979 | 100.0 |
| Virginia | 1 | 1,146,846 | 100.0 |
| Washington | 1 | 992,516 | 100.0 |
| Alaska | 2 | 69,899 | 0.0 |
| District of Columbia | 2 | 74,465 | 0.0 |
| Louisiana | 2 | 631,170 | 0.0 |
| North Dakota | 2 | 104,679 | 0.0 |
| Vermont | 2 | 106,655 | 0.0 |
| Connecticut | 3 | 555,528 | 70.0 |
| Indiana | 4 | 941,494 | 77.1 |
| North Carolina | 4 | 1,461,149 | 62.8 |
| Pennsylvania | 4 | 2,134,099 | 58.1 |
| South Carolina | 4 | 761,583 | 56.5 |
| South Dakota | 4 | 129,354 | 50.0 |
| West Virginia | 4 | 329,055 | 56.4 |
| Wisconsin | 4 | 875,720 | 66.9 |
| Wyoming | 4 | 80,332 | 50.0 |
| Maine | 5 | 242,564 | 99.5 |
| Iowa | 6 | 490,628 | 14.4 |
| Kentucky | 6 | 653,022 | 17.2 |
| Montana | 7 | 170,153 | 9.1 |
| Georgia | 8 | 1,248,870 | 63.5 |
| Idaho | 8 | 234,979 | 84.5 |
| Kansas | 8 | 417,533 | 78.8 |
| Minnesota | 8 | 777,833 | 83.9 |
| Rhode Island | 8 | 167,180 | 54.6 |
| Tennessee | 8 | 986,813 | 92.0 |
| California | 9 | 4,990,092 | 48.5 |

| | | | |
|---|---|---|---|
| Florida | 9 | 3,790,954 | 40.2 |
| Illinois | 9 | 1,787,854 | 46.1 |
| Mississippi | 9 | 427,313 | 46.5 |
| New York | 9 | 2,895,680 | 46.0 |
| United States | N/A | 46,214,893 | 71.3 |

| Designation | Description |
|---|---|
| Grouping 1 | Retirement assets countable; spouse's assets countable. |
| Grouping 2 | Retirement assets exempt; spouse's assets exempt. |
| Grouping 3 | 401(k)s, some Keoghs exempt; IRAs, other Keoghs, and spouse's assets countable. |
| Grouping 4 | Retirement assets countable; spouse's assets exempt. |
| Grouping 5 | Retirement assets start being counted when balance exceeds $8,000 for the applicant; spouse's assets countable. |
| Grouping 6 | Retirement assets countable when accessed; spouse's assets countable when accessed. |
| Grouping 7 | Retirement assets countable when accessed; spouse's assets exempt. |
| Grouping 8 | Retirement assets subject to periodic payments rule; spouse's assets exempt. |
| Grouping 9 | Retirement assets subject to periodic payments rule; spouse's assets subject to periodic payment rule. |

Note: IRA = individual retirement account.

Sources: Authors' calculations from state legislative codes; interviews with state Medicaid offices; data from HRS (2012) and US Census Bureau (2016).

With these percentages and state senior population totals, we derive a weighted average of the percentage of retirement assets counted toward Medicaid eligibility in the United States. Because a plurality of states counts both the applicant's retirement assets and the spouse's assets, and other states count at least some of the retirement assets of the relevant populations, the resulting weighted average is more than half (71.3 percent). However, stated another way, almost one-third of retirement assets are not counted toward Medicaid eligibility despite the policy intent that these tax-qualified assets be used not for bequest but for all types of spending in retirement. Moreover, most states have exemptions that allow seniors with access to well-funded retirement accounts to exclude said assets. These states appear to share little in common; state government ideologies and population sizes are heterogeneous. States with unique rules tend to be small states with consistently left-of-center state governments and small, homogeneous populations. Moreover, as Medicaid is largely funded with federal dollars, lax eligibility requirements in one state unfairly burden other states and impair their ability to get needed

resources to fund their programs. Vermont seniors with sizeable retirement assets can qualify for LTSS Medicaid at the expense of New Hampshire seniors a few miles away, who are barred from having those same retirement assets if they enroll in Medicaid.

**Asset Holdings by Older Americans**

The Medicaid asset rules vary by state and the enforcement of those rules varies—in particular, the extent of asset recovery efforts from the estates of deceased Medicaid beneficiaries. Thus, it is worthwhile to examine in more detail the asset holdings of older Americans at the point in their life cycle when they begin to enter the high-disability years. Instead of the PSID, which does have state identifiers for household observations, here we use 2012 data from the Health and Retirement Study (HRS 2012). The Health and Retirement Study is generally regarded as a superior data source to the PSID for asset holdings of older Americans, but it is more complex and does not have state identifiers. Therefore, we report data on the averages and the distribution of asset holdings for the retired population age 65–67 from the year 2012 on a national basis. Some imputations were needed for assets in defined contribution plans and income flows from defined benefit pension plans; see Warshawsky and Zohrabyan (2016) for methodological details.

As shown in table 4, more than 80 percent of retired households age 65–67 in 2012 owned their own homes. Therefore, the exclusion of the home from countable assets in determining Medicaid eligibility, as well as the level of effort by states to recover the home from estates to pay back Medicaid spending, affects most older Americans for LTSS financing; homes owned by retired households are a major potential source of funds. Moreover, the extensive development and use in the past 20 years of various financial products—such as home equity

lines of credit, reverse mortgages (a federal program), cash-out mortgage refinancing, and so on—make the home a liquid asset, when it was considered an illiquid asset in past decades.

**Table 4. Percentage of All Retired Households Age 65–67 by Home Ownership Status**

| Ownership status | Percentage (%) |
|---|---|
| Rent | 16.32 |
| Own | 80.59 |
| Other | 3.09 |

Source: Warshawsky and Zohrabyan (2016), based on HRS (2012).

Table 5 gives a strong indication of the extensive holdings of assets (both financial and real, retirement and nonretirement) and various sources of income among older Americans. Among all such households owning a home, the median value of the home, net of any mortgages, was more than $100,000; 52 percent had retirement assets, whose median value was $90,000. These amounts, plus financial assets and other assets (including secondary housing and other real estate and business assets) produced a median net worth of $213,000 for the 87 percent of retired households that have a positive net worth even without considering the value of their annuity income ("nonannuity net worth"). Therefore, at the median, substantial assets exist to pay for retirement expenses, including LTSS. Furthermore, the significant regular annuity income from Social Security and defined benefit pension plans—$27,000 annually at the median (not shown)—should be considered. Across all households, median nonannuity net worth was almost $140,000. Also evident from table 5 is how much better off married households are than single households.

## Table 5. Balance Sheets and Annuity Income Amounts for Households Age 65–67, 2012

| Variables | Household wish asset (%) | Mean holding ($) | Median holding ($) | Nonannuity wealth (%) | Conditional on positive values | |
|---|---|---|---|---|---|---|
| | | | | | Mean ($) | Median ($) |
| All households | | | | | | |
| Financial assets | 81.01 | 100,391 | 9,700 | 23.49 | 123,920 | 20,000 |
| Non-mortgage debt | 34.88 | −2,916 | 0 | −0.68 | −8,359 | −5,000 |
| Primary residence (net) | 80.59 | 119,309 | 80,000 | 27.91 | 156,381 | 103,500 |
| Mortgages and other debt | 37.55 | −39,547 | 0 | −9.25 | −105,311 | −74,500 |
| Secondary residence (net) | 17.58 | 24,391 | 0 | 5.71 | 145,493 | 60,000 |
| Other real estate | 13.64 | 30,708 | 0 | 7.18 | 225,087 | 100,000 |
| Business asset | 6.33 | 30,147 | 0 | 7.05 | 476,322 | 140,000 |
| Personal retirement accounts | 52.04 | 125,397 | 3,500 | 29.34 | 240,966 | 90,000 |
| IRAs and Keoghs | 37.27 | 96,255 | 0 | 22.52 | 258,253 | 120,000 |
| 401(k)s and similar plans | 32.49 | 29,143 | 0 | 6.82 | 89,699 | 30,885 |
| Social Security income (annual) | 88.05 | 17,245 | 16,027 | N/A | 19,586 | 17,819 |
| Defined benefit pension (annual) | 39.24 | 8,505 | 0 | N/A | 21,674 | 14,400 |
| Nonannuity net worth | 87.20 | 427,428 | 138,600 | 100.00 | 491,570 | 212,750 |
| Single-person households | | | | | | |
| Financial assets | 72.44 | 44,110 | 1,000 | 22.62 | 60,888 | 10,000 |
| Non-mortgage debt | 30.67 | −1,506 | 0 | −0.77 | −4,912 | −3,000 |
| Primary residence (net) | 61.33 | 64,097 | 22,000 | 32.87 | 112,537 | 80,000 |
| Mortgages and other debt | 24.44 | −27,430 | 0 | −14.07 | −112,216 | −78,000 |
| Secondary residence (net) | 7.56 | 9,167 | 0 | 4.70 | 154,502 | 60,000 |
| Other real estate | 6.67 | 15,120 | 0 | 7.75 | 226,800 | 150,000 |
| Business asset | 4.00 | 9,898 | 0 | 5.08 | 247,444 | 140,000 |
| Personal retirement accounts | 33.78 | 54,095 | 0 | 27.74 | 160,150 | 37,000 |
| IRAs and Keoghs | 22.22 | 43,010 | 0 | 22.06 | 193,545 | 50,850 |
| 401(k)s and similar plans | 15.56 | 11,085 | 0 | 5.69 | 71,262 | 14,361 |
| Social Security income (annual) | 76.00 | 9,366 | 9,852 | N/A | 12,324 | 11,900 |
| Defined benefit pension (annual) | 24.00 | 4,962 | 0 | N/A | 20,673 | 13,218 |
| Nonannuity net worth | 76.44 | 194,980 | 42,000 | 100.00 | 257,022 | 85,000 |
| Married couples | | | | | | |
| Financial assets | 84.98 | 126,447 | 12,000 | 23.63 | 148,797 | 26,000 |
| Non-mortgage debt | 36.83 | −3,568 | 0 | −0.67 | −9,687 | −5,000 |
| Primary residence (net) | 89.51 | 144,871 | 100,000 | 27.08 | 170,088 | 120,000 |
| Mortgages and other debt | 43.62 | −45,157 | 0 | −8.44 | −103,520 | −70,000 |
| Secondary residence (net) | 22.22 | 31,439 | 0 | 5.88 | 144,218 | 60,000 |
| Other real estate | 16.87 | 37,925 | 0 | 7.09 | 224,773 | 100,000 |
| Business asset | 7.41 | 39,522 | 0 | 7.39 | 533,542 | 160,000 |
| Personal retirement accounts | 60.49 | 158,408 | 25,000 | 29.61 | 261,858 | 104,947 |
| IRAs and Keoghs | 44.24 | 120,905 | 0 | 22.60 | 273,302 | 131,000 |
| 401(k)s and similar plans | 40.33 | 37,503 | 0 | 7.01 | 92,991 | 32,994 |
| Social Security income (annual) | 93.62 | 20,892 | 21,600 | N/A | 22,316 | 22,880 |
| Defined benefit pension (annual) | 46.30 | 10,145 | 0 | N/A | 21,914 | 14,460 |
| Nonannuity net worth | 92.18 | 535,043 | 228,500 | 100.00 | 581,619 | 264,838 |

Note: IRA = individual retirement account.

Source: Warshawsky and Zohrabyan (2016), based on HRS (2012).

Table 6 gives the distribution of each of the major components of wealth and income in households age 65–67. PRAs—personal retirement accounts—include individual retirement accounts, Keoghs, and 401(k) accounts. As shown, significant housing assets extend deeply into the lower realms of the distribution—the median at the 30th percentile of this wealth category is $55,000. Similarly, retirement assets are large for those who have them—$160,000 median value at the 80th percentile. Again, married households are much better off than single households. As low as the 40th percentile of the distribution of nonannuity net worth, the average net worth was $88,000—a significant amount of resources, even without considering income. At the 50th percentile, net worth was $138,600.

## Table 6. Distribution of Nonannuity Wealth Components for Households Age 65–67, 2012

| Percentile | Financial assets | PRA assets | Financial + PRA | Primary housing (G) | Secondary housing (G) | Social Security income | DB pension (income) | Nonannuity net worth |
|---|---|---|---|---|---|---|---|---|
| All households | | | | | | | | |
| 10 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 20 | $8 | N/A | $100 | $3,000 | N/A | $6,840 | N/A | $11,500 |
| 30 | $500 | N/A | $2,000 | $55,000 | N/A | $9,960 | N/A | $44,662 |
| 40 | $2,800 | N/A | $14,000 | $82,000 | N/A | $12,900 | N/A | $88,000 |
| 50 | $9,700 | $3,500 | $35,000 | $120,000 | N/A | $16,027 | N/A | $138,600 |
| 60 | $21,400 | $25,000 | $71,000 | $150,000 | N/A | $19,680 | N/A | $240,256 |
| 70 | $45,000 | $51,700 | $160,422 | $190,000 | N/A | $23,952 | $5,148 | $394,000 |
| 80 | $100,000 | $160,000 | $327,000 | $250,000 | N/A | $27,600 | $14,400 | $632,000 |
| 90 | $250,000 | $360,000 | $629,349 | $350,000 | $50,000 | $32,400 | $29,100 | $1,124,349 |
| 95 | $431,000 | $648,842 | $999,731 | $500,000 | $169,000 | $36,084 | $46,200 | $1,785,000 |
| 99 | $1,178,000 | $1,742,801 | $2,265,000 | $800,000 | $600,000 | $50,400 | $82,536 | $3,654,111 |
| Single-person households | | | | | | | | |
| 10 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | −$500 |
| 20 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 30 | $36 | N/A | $75 | N/A | N/A | $5,400 | N/A | $500 |
| 40 | $200 | N/A | $425 | $6,500 | N/A | $8,400 | N/A | $19,170 |
| 50 | $1,000 | N/A | $2,600 | $40,000 | N/A | $9,852 | N/A | $42,000 |
| 60 | $6,000 | N/A | $15,000 | $79,500 | N/A | $11,550 | N/A | $79,425 |
| 70 | $20,000 | $3,662 | $40,000 | $120,000 | N/A | $13,200 | N/A | $119,700 |
| 80 | $43,500 | $20,000 | $117,500 | $160,000 | N/A | $15,560 | $3,720 | $296,925 |
| 90 | $124,000 | $110,000 | $315,000 | $230,000 | N/A | $18,000 | $15,600 | $587,033 |
| 95 | $255,361 | $209,998 | $421,129 | $300,000 | $30,000 | $21,000 | $29,100 | $930,000 |
| 99 | $506,400 | $935,000 | $1,035,558 | $552,256 | $400,000 | $25,371 | $76,800 | $2,190,080 |
| Married couples | | | | | | | | |
| 10 | N/A | N/A | N/A | N/A | N/A | $4,100 | N/A | $2,000 |
| 20 | $200 | N/A | $1,000 | $55,000 | N/A | $9,760 | N/A | $47,085 |
| 30 | $2,000 | N/A | $11,000 | $85,000 | N/A | $14,400 | N/A | $90,000 |
| 40 | $6,500 | $1,500 | $30,422 | $110,000 | N/A | $17,616 | N/A | $137,300 |
| 50 | $12,000 | $25,000 | $58,000 | $150,000 | N/A | $21,600 | N/A | $228,500 |
| 60 | $30,000 | $40,702 | $124,913 | $180,000 | N/A | $24,684 | $2,664 | $338,697 |
| 70 | $60,000 | $107,645 | $232,000 | $225,000 | N/A | $27,324 | $8,400 | $530,000 |
| 80 | $130,000 | $225,000 | $413,256 | $300,000 | $5,000 | $30,600 | $18,000 | $813,000 |
| 90 | $300,000 | $450,000 | $798,000 | $400,000 | $100,000 | $34,248 | $37,320 | $1,362,000 |
| 95 | $520,000 | $757,427 | $1,150,000 | $537,249 | $200,000 | $38,524 | $50,200 | $2,013,187 |
| 99 | $1,802,000 | $1,820,000 | $2,518,200 | $900,000 | $700,000 | $53,412 | $82,560 | $4,855,000 |

Note: DB = defined benefit; G = gross value; PRA = personal retirement account.

Source: Warshawsky and Zohrabyan (2016), based on HRS (2012).

Table 7 gives selected measures of retirement resources by income quintile, and table 8 gives them by whether the household has any retirement savings. Evident again are the widespread holdings of assets even by lower-income households and those with no retirement savings. Also evident is the significance of housing and retirement assets—those asset categories that are excluded either always or mostly from countable assets in the Medicaid eligibility standards and where state efforts on estate recovery would and should be expanded. In the second quintile of retired households by income, 45 percent own their homes clear, with a median value of $110,000. For the half of retired households that have at least some retirement savings, nearly half have paid off their mortgage, and the median home value is $177,500. Again, these statistics give the impression of a fairly widespread holding of significant and valuable assets, especially housing and retirement accounts, except at the lower end of the distribution.

**Table 7. Select Retirement Resources for All Retired Households Age 65–67, by Income Quintile**

| | Quintile | | | | |
|---|---|---|---|---|---|
| **Retirement resources** | **1 (bottom)** | **2** | **3** | **4** | **5 (top)** |
| Percentage of households with retirement savings | 27.5 | 36.1 | 53.8 | 62.5 | 78.3 |
| Among those who have them, median retirement savings | $40,000 | $36,702 | $98,000 | $121,414 | $159,214 |
| Percentage of households with a defined benefit plan | 5.6 | 21.5 | 36.4 | 62.5 | 68.5 |
| Among those who have it, median defined benefit income | $4,644 | $3,600 | $7,573 | $16,200 | $36,660 |
| Percentage of households who own a primary home that is paid off | 40.1 | 45.1 | 47.6 | 34.0 | 46.9 |
| Among those who own a home, median primary home value | $80,000 | $110,000 | $142,500 | $170,000 | $200,000 |
| Percentage of households with debt greater than twice annual income | 32.3 | 19.4 | 28.0 | 29.9 | 12.6 |
| Percentage with Social Security income | 56.9 | 96.5 | 98.6 | 95.1 | 89.5 |
| Among those who receive Social Security, median Social Security income | $8,220 | $14,304 | $23,820 | $25,116 | $25,200 |

Source: Warshawsky and Zohrabyan (2016), based on HRS (2012).

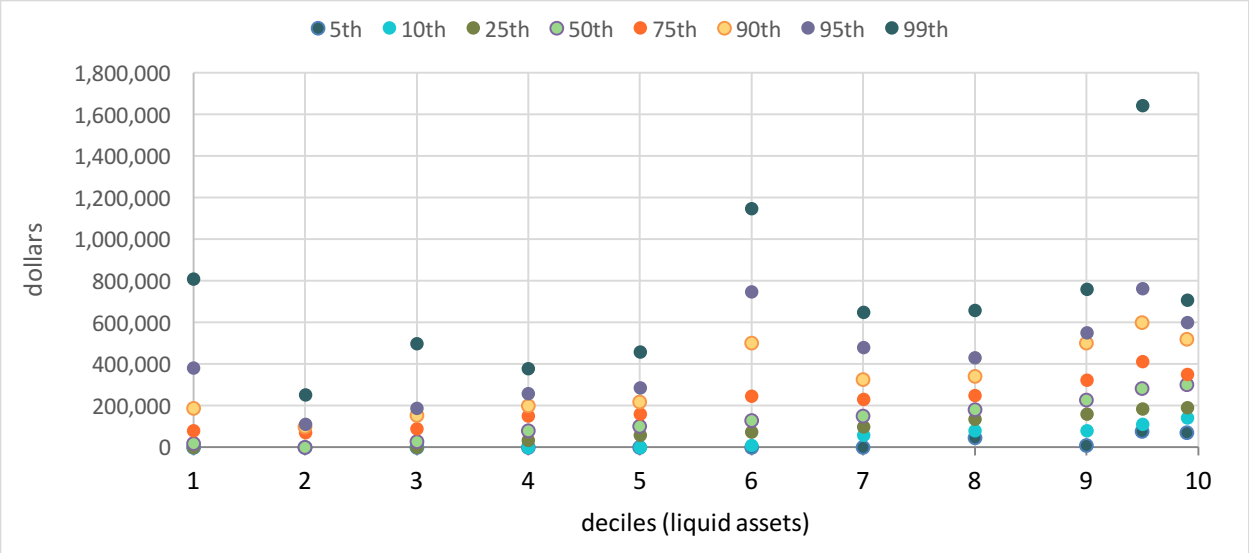
**Table 8. Select Resources for Retired Households Age 65–67, by Ownership of Retirement Savings**

| Category | Households age 65–67 with no retirement savings | Households age 65–67 with some retirement savings |
|---|---|---|
| Percentage of households | 48.0 | 52.0 |
| Median net worth | $40,000 | $386,000 |
| Median nonretirement financial resources | $450 | $33,500 |
| Median income | $19,680 | $36,288 |
| Median primary house value | $60,000 | $177,500 |
| Primary home ownership rates (%) | 66.6 | 93.5 |
| Percentage of households who own a home that is paid off | 37.0 | 48.6 |
| Percentage of households with a defined benefit plan | 22.6 | 54.6 |

Source: Warshawsky and Zohrabyan (2016), based on HRS (2012).

Finally, in figure 6, we show the distribution of housing assets by potentially annuitizable wealth deciles for this age group in 2012. Potentially annuitizable wealth includes financial and retirement assets and hence represents just the most liquid components of household net worth. As is evident, some households, even with little in the way of liquid assets, have very significant housing assets. For example, in the first (bottom) decile of liquid assets, in the 90th percentile of households, housing assets are worth about $200,000. In the sixth decile of liquid assets, in the 75th percentile, the value of housing assets exceeds $200,000. In summary, significant housing assets exist across all groups of older Americans.

**Figure 6. Percentiles of Primary Housing Assets by Potentially Annuitizable Wealth Deciles, Retired Households Age 65–67**




Source: Warshawsky and Zohrabyan (2016), based on HRS (2012).

**Summary of Results and Policy Recommendations**

To advocates of the federal provision of social insurance for LTSS, the current Medicaid program is inadequate. Furthermore, these advocates claim that failures in private insurance provision, coupled with the lack of retirement savings, make market solutions for the provision of LTSS untenable. As we have seen, such claims are not supported by the data. The best science available indicates that private LTCI is crowded out by the current Medicaid provision. As this paper has discussed, empirical evidence on the net worth of retired households clearly indicates widespread and significant holdings of housing and retirement assets. Those holdings are in precisely the asset classes that Medicaid rules and state administrations either always or sometimes exempt from consideration in determining eligibility (Warshawsky and Zohrabyan 2016). Lax eligibility criteria and administration, and weak estate recovery procedures and efforts, have led middle- and upper-income older Americans to seek Medicaid enrollment.

Whereas giving states discretion in how they recover costs may be an admirable goal, state efforts to do so have not been sufficient for what is largely a federally financed welfare program. Tightening the rules and administration around Medicaid eligibility and estate recovery should not be considered a tax increase; the purpose of this action is to lessen the federal government's encouragement of reliance on public resources. This tightening will likely lead to less dependence on taxpayer dollars and greater use of private assets and insurance. In particular, state rules exempting retirement assets from being counted toward the Medicaid asset limit when determining eligibility lead older Americans with well-funded PRAs to seek public assistance rather than rely on their savings. If states continue to ignore retirement assets such as individual retirement accounts and Keoghs when they examine applicants, the problem of upper quintiles accessing Medicaid services will likely grow worse. As public and private employers transition from defined benefit to defined contribution plans, the percentage of wealth held in personal retirement savings accounts will increase over time. As a result, older Americans applying for Medicaid in states with looser eligibility rules will see a diminishing percentage of their wealth subjected to counting by examiners.

To ensure that the Medicaid resources are allocated to individuals with insufficient financial means to pay for their long-term care, eligibility rules regarding retirement assets must be tightened across the country. A federal mandate requiring that the retirement assets of applicants and applicants' spouses be subject to counting would mean that roughly 30 states with various exemptions would need to revise their procedures to determine eligibility. The federal government should also expand its earlier mandate to verify assets electronically during the application process. Additionally, it should require states to ask applicants to produce financial information on all available resources for the five-year period preceding the application.

Additionally, the federal government should require states to narrow the "primary residence" exclusion in examining applicants. Currently, the federal government requires states to reject applicants if their equity interest in their primary residence exceeds $816,000. States can adapt more stringent limits than this, but they are not allowed to set the equity interest limit lower than $545,000. This federally set minimum, however, is roughly two-and-a-half times the median US housing value. As we have seen in one study, older Americans vary home ownership depending on the rigidity of Medicaid policies. New federal rules requiring states to reject applicants with home equity interest exceeding $100,000 would diminish this strategic behavior and would ensure that program enrollees are those with legitimate financial need. Housing is no longer the illiquid asset it once was; new financial products are available to enable older Americans to draw equity from their homes while still living in them. The minimum limit that states are allowed to impose should also be set at $100,000, as a safeguard against states enacting restrictive policies that keep older Americans with demonstrable need from accessing the program.

Preventing Medicaid funds from being distributed to households with significant assets also requires a more robust estate recovery scheme. Despite the growth in recovery programs over the past 15 years, recoveries represent a negligible percentage of both LTSS expenditures and the estimated net worth of program enrollees. With the best efforts of the most vigorous state, almost six times the current estate recoveries could be collected in aggregate by states. On the basis of the best-case scenarios, the initial goal for estate recovery as a percentage of program expenditures should be 1 percent, gradually increasing to 2 percent. With a federal mandate requiring expanded estate recovery programs on the part of states, proceeds from well-to-do beneficiaries' estates can compensate for inappropriate program expenditures. Specifically, the federal government should enforce the existing requirement on states to automatically impose

liens on the housing properties of beneficiaries. Imposing these liens in all cases would significantly improve recovery rates.

Because the federal government generously matches state Medicaid spending, some states get only 25 cents on the dollar for their collection efforts. As a penalty for state noncompliance with the housing lien procedures and to counteract the weak state incentives to collect, the federal government should decrease Medicaid matching rates for LTSS expenditures for states performing inadequately. The Supreme Court ruled in *National Federation of Independent Business v. Sebelius*[4] that it was unconstitutional for the federal government to withhold Medicaid funds to pressure states into the Affordable Care Act's (ACA) Medicaid expansion scheme. However, the majority opinion held that the government action was not permissible because of the severity of the threat. Writing for the majority, Chief Justice Roberts argued that it was the "threatened loss of over 10 percent of a state's budget" that was considered unconstitutional; the withholding of funds constituted an "economic dragooning that leaves the states with no real option."[5] The majority opinion, however, contrasted this policy with the federal withholding of highway funds in response to states lowering their drinking age. Citing the precedent of *South Dakota v. Dole*[6], the majority in *NFIB* said withholding of highway funds was permissible because only a fraction of 1 percent of the average state budget was at stake.

Thus, decreasing the LTSS match by a few percentage points is constitutional under *Dole*, and it is likely sufficient incentive to encourage compliance with current and proposed mandates. In addition, LTSS-related programs in the ACA that offer enhanced federal matching rates in exchange for achieving federally specified goals should be made contingent on

[4] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 1, 132 S. Ct. 2566 (2012).
[5] 567 U.S. at 52.
[6] South Dakota v. Dole, 483 U.S. 203, 107 S. Ct. 2793 (1987).

participating states following the proposed mandates. Although programs such as the Community First Choice initiative are designed to improve long-term care outcomes by providing incentives to choose home-based care over institutional care, resources will be misallocated unless there are strict eligibility and estate recovery laws.

As Medicaid anticipates the arrival of a large wave of retirees, appropriate actions must be taken to ensure that program recipients are those genuinely in need of LTSS financing assistance. Data show that even at the median of the older population, substantial assets exist to pay for retirement expenses, including LTSS. With updated eligibility-determination rules and processes, systematic asset tracking, and enhanced estate recovery programs, the Medicaid LTSS program can achieve financial sustainability and simultaneously reduce the crowding out of private alternatives such as LTCI. Federal mandates requiring states to undertake these reforms can result in substantial future savings for taxpayers while strengthening a key part of the social safety net for those who truly need it.

**Appendix: Commission on Long-Term Care's *Report to the Congress***

The following text is taken verbatim from pages 63 through 65 of the Commission on Long-Term Care's *Report to the Congress* (2013).

Approach A: Strengthen LTSS financing through private options for financial protection.

Problem:

- Governments are facing serious budget constraints that threaten funding for existing health care, disability, and retirement programs. We cannot assure the safety net will hold for the most vulnerable who must rely on public programs if we also publicly finance care for millions of Americans who could prepare now for their needs in future years.
- Private long-term care insurance (LTCI) could play a more substantial role in LTSS financing, but changes are needed to boost participation, including new incentives, more flexibility so insurers can offer greater variety in the structure of policies and make coverage more affordable, and educational campaigns to explain future risks and options for financial planning.
- Creative solutions are needed to bring together new partnerships, new incentives, and innovative programs for those who can prepare now for their own long-term care needs to make sure the public safety net is there for those most in need. Private savings and a diverse choice of products are critical components of the LTSS financing solution.

Proposal:

- Provide new market incentives: Fewer people are purchasing long-term care insurance policies today, and fewer companies are offering the policies. The high cost of policies is a primary deterrent. A lack of understanding about the risks of not having financial protection and the lack of incentives to purchase coverage also contribute to limited uptake of LTCI.
    - Provide a tax preference for long-term care policies through retirement and health accounts: Allowing withdrawals from existing 401k, IRA, or Section 125 accounts to pay LTCI premiums or distributions would have minimal tax implications. The tax costs of incentivizing broader participation would be more than offset over time as those with private coverage draw on private rather than public resources to finance their care.
    - Support new forms of combination policies such as a "life care annuity," which combines a life annuity insurance policy with long-term care insurance: A change in tax law to allow investment and distribution in the LTCI portion through tax-advantaged retirement accounts would encourage creation and uptake of these policies. The combination policy reduces adverse selection in the immediate life annuity portion, resulting in lowers premiums, and allows for considerable relaxation in underwriting standards for the long-term care portion of the policy.
    - Support Long-Term Care Partnership Programs that currently operate in most states: These public-private partnerships allow residents to purchase long-term care

insurance and still qualify for Medicaid if and when their insurance is exhausted without depleting all of their assets. The program combines the benefits of private insurance with the backing and safety net of the government. This provides a net savings to the government because the purchase of LTCI is encouraged.

- Allow a Medicaid Carve Out: individuals would have the option (when claiming Social Security retirement benefits) of receiving a portion of the expected actuarial present value of Medicaid benefits, adjusted down by income, as a subsidy to purchase permanent long-term care insurance, including through combination policies. In exchange, they would give up the right to future Medicaid LTC services.
- Provide protection for catastrophic LTC costs: Create a financing mechanism for the catastrophic "tail" of costs (the small number of long-durational, high-cost LTSS) not now covered by private LTCI. This would combine a safety net for truly catastrophic costs, through private or public reinsurance, with private responsibility (savings, family care, and private LTCI).
- Remove regulatory burdens and barriers: regulatory inflexibility has hampered the ability of carriers to respond to rapid and large changes in the economy and to provide affordable and attractive products to consumers.
- Allow flexibility in pricing and product design: rapid and sustained drops in interest rates induced by unusual Federal Reserve monetary policies have challenged LTCI carriers expecting a more traditional return on investment. Private LTCI carriers need greater flexibility in structuring policies, including policies with varied benefit structures (e.g., longer elimination periods) and benefit time periods, to continue to meet consumer needs for affordable policies.
- Allow LTCI policy portability: allow policy portability through such mechanisms as multi-state compacts, possibly developed in consultation with the National Association of Insurance Commissioners.
- Minimize Medicaid Crowd-Out: The structure of federal health care programs, particularly Medicaid, discourages individuals from taking responsibility for their future long-term care needs. Medicaid resources need to be more carefully targeted to those individuals the program was intended to serve—the needy and the poor.
- Strengthen Medicaid eligibility requirements for middle-income Americans: Consider retirement assets and a larger portion of home values for those applying for Medicaid.
- Strengthen asset recovery: Ensure states meet their responsibility to oversee and enforce asset recovery to prevent middle- and upper-middle income seniors from hiding assets to gain eligibility for Medicaid.
- Use reverse mortgages: Use reverse mortgages to enable seniors to use the value of their home equity to fund long-term care services, including while remaining in their homes. Enable retirees to pre-qualify so funds would be available when needed.

- Education:
  - Establish an ongoing awareness campaign: Educate the public about the limitations of Medicare and Medicaid in funding LTSS and the options and incentives for private financial protection.

**References**


Brown, Jeffrey R., and Amy Finkelstein. 2007. "Why Is the Market for Long-Term Care Insurance So Small?" *Journal of Public Economics* 91 (10): 1967–91.

———. 2008. "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market." *American Economic Review* 98 (3): 1083–1102.

Burwell, Brian, Kate Sredl, and Steve Eiken. 2009. *Medicaid Long-Term Care Expenditures in FY 2008*. Research Paper, Thomson Reuters, Cambridge, MA.

Commission on Long-Term Care. 2013. *Report to the Congress.* Washington, DC: Government Printing Office.

De Nardi, Mariacristina, Eric French, and John B. Jones. 2013. "Medicaid Insurance in Old Age." NBER Working Paper No. 19151, National Bureau of Economic Research, Cambridge, MA.

Eiken, Steve, Kate Sredl, Lisa Gold, Jessica Kasten, Brian Burwell, and Paul Saucier. 2013. *Medicaid Expenditures for Long-Term Services and Supports in 2011* (report). Washington, DC: Truven Health Analytics for Mathematica Policy Research Inc. and the Centers for Medicare and Medicaid Services.

GAO (Government Accountability Office). 2012. *Medicaid Long-Term Care: Information Obtained by States about Applicants' Assets Varies and May Be Insufficient.* Washington, DC.

Gleckman, Howard. 2013. "Fiscal Cliff Deal Repeals CLASS Act, Creates Long-Term Care Commission," *Forbes*, January 1.

Greenhalgh-Stanley, Nadia. 2012. "Medicaid and the Housing and Asset Decisions of the Elderly: Evidence from Estate Recovery Programs." *Journal of Urban Economics* 72 (2): 210–24.

HHS (Department of Health and Human Services), Office of the Assistant Secretary for Planning and Evaluation and Office of Disability, Aging, and Long-Term Care Policy. 2005. *Medicaid Estate Recovery Collections*. Policy brief, Washington, DC.

HHS (Department of Health and Human Services), Office of Inspector General. 1995. *Medicaid Estate Recovery Programs*. Report OEI-07-92-00880, Washington, DC.

———. 2014. *States' Efforts in Implementing Asset Transfer and Estate Recovery Provisions of OBRA 93 and DRA 05* (A-O5-12-00027) (memorandum). Washington, DC: HHS Office of Inspector General. http://centerltc.com/OIG/IG_LetterReport.pdf.

HRS (Health and Retirement Study). 2012. Public use dataset. Produced and distributed by the University of Michigan with funding from the National Institute on Aging (grant number NIA U01AG009740), Ann Arbor, MI.

Institute for Social Research. 2016. Panel Study of Income Dynamics (PSID), public use dataset. Survey Research Center, Institute for Social Research, University of Michigan, Ann Arbor, MI.

Investment Company Institute. 2015. *Report: The US Retirement Market, Third Quarter 2015*.Washington, DC.

LaPlante, Mitchell P., H. Stephen Kaye, Taewoon Kang, and Charlene Harrington. 2004. "Unmet Need for Personal Assistance Services: Estimating the Shortfall in Hours of Help and Adverse Consequences." *Journals of Gerontology Series B Psychological Sciences and Social Sciences* 59 (2): S98–S108.

Murtaugh, Christopher M., Brenda C. Spillman, and Mark J. Warshawsky. 2001. "In Sickness and in Health: An Annuity Approach to Financing Long-Term Care and Retirement Income." *Journal of Risk and Insurance* 68 (2): 225–54.

MACPAC (Medicaid and CHIP Payment and Access Commission). 2015. *MACStats: Medicaid and CHIP Data Book.* Washington, DC.

O'Brien, Raymond C. 2015. "Selective Issues in Effective Medicaid Estate Recovery Statutes." *Catholic University Law Review* 65 (1): 27–185.

US Census Bureau. 2016. *American FactFinder.* Washington, DC: US Department of Commerce. http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.

Warshawsky, Mark J. 2009. "Will the 'CLASS' Program Succeed? Is It Sustainable?" *Watson Wyatt Insider* 19 (12).

Warshawsky, Mark J., and Tatevik Zohrabyan. 2016. "Retire on the House: The Use of Reverse Mortgages to Enhance Retirement Security." Working Paper, MIT Center on Finance and Policy.