Long-term Care, Medicaid, and Impoverishment of the Elderly

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MEDICAID IS THE DOMINANT THIRD-PARTY PAYER of long-term care (U.S. Congress 1991). The prevailing belief is that, as the program is structured, elderly persons with functional impairments ("disabled elderly") must impoverish themselves by incurring large out-of-pocket expenditures on nursing-home care before becoming eligible for Medicaid benefits. A common perception is that, to protect themselves against being impoverished by admission to a nursing home, the middle-class elderly are shielding their assets through various financial transactions in advance of admission in order to qualify for Medicaid (Budish 1989; Quinn 1989). The view that many elderly people become Medicaid recipients after staying in a nursing home is inconsistent with the empirical evidence that comparatively few persons switch to Medicaid after being admitted (Spence and Wiener 1990; Liu, Doty, and Manton 1990). A common misperception is that Medicaid provides nursing-home care at no out-of-pocket cost to recipients. In fact, the law requires substantial copayments. Although many observers emphasize the elderly's impoverishment as a result of high nursing-home charges, the rising cost of Medicaid has led others to search for new revenue sources. One possible untapped source is the housing wealth of the elderly themselves.

This study examines the following questions: First, to what extent does entry into nursing homes result in impoverishment before the disabled elderly become Medicaid eligible ("spenddown")? Second, how do states' eligibility rules affect spenddown? Third, are there substantial incentives for the disabled elderly to shield assets to facilitate becoming Medicaid eligible? Fourth, what out-of-pocket prices can the disabled elderly expect to pay for nursing-home care? Fifth, does the housing wealth that the disabled elderly or their heirs now retain constitute a major untapped Medicaid revenue source?

To date, many studies of Medicaid spenddown that address the first question have relied solely on information about nursing-home residents (Burwell, Adams, and Meiners 1989; Spence and Wiener 1990). Other research on this issue has focused on the dynamics of actual Medicaid enrollment in the noninstitutionalized population (Branch et al. 1988; Short et al. 1992). One study used the 1984 National Long Term Care Survey (NLTCS) to estimate conversions to Medicaid among community residents and compared rates of conversion between persons entering nursing homes and those remaining in the community (Liu, Doty, and Manton 1990).

These types of studies can answer the first question that our study addresses, but not the others. A more definitive answer to the question of the impoverishment of the disabled elderly requires a comparison of states' standards for Medicaid eligibility with the disabled elderly's income and wealth and marital status. To address the combination of issues embodied in the first four questions, we conducted policy simulations.

The simulations performed three functions: First, this method provided estimates of the number of disabled elderly in the community who would be financially eligible for Medicaid if they were to enter a nursing home and remain there until death. The effect of states' major decisions about eligibility policy on this eventuality was also considered. We identified persons eligible for Medicaid if they entered a nursing home by applying eligibility rules to persons living in the community. We used data from nursing-home residents to provide consistency checks on results from our policy simulations. Second, no survey provides information on amounts of public subsidies and the price of the nursing-home net of such subsidies. By combining data on income, assets, and marital status from the NLTCS with information on prices and state policies

from various sources, the simulations provided values of subsidies and net prices of nursing-home care. Third, we assessed effects of a major recent policy change that was designed to address the impoverishment issue—the spousal impoverishment provision of the Medicare Catastrophic Coverage Act of 1988 (MCCA)—on Medicaid eligibility and on the prices families could expect to pay for nursing-home care.

   A related theme is the impoverishment of the Medicaid program itself as a consequence of the high expense of nursing-home care. Potentially, a source of funds could be found in the assets of the elderly who are institutionalized at Medicaid's expense. With data on housing wealth of the disabled elderly from the NLTCS, we gauged the potential of such assets as a revenue source for Medicaid.

Evolution of Medicaid Policy regarding
Assets of the Elderly in Nursing Homes

Each state designs and manages its own Medicaid program within broad federal guidelines. States' considerable discretion in establishing eligibility criteria provides a source of variation in the price of nursing-home services faced by patients net of Medicaid's subsidy (Buchanan, Madel, and Persons 1991; Carpenter 1988; Neuschler 1987; U.S. General Accounting Office 1990). Unlike most services, for which Medicaid imposes at most minimal patient cost sharing, Medicaid requires that recipients contribute all but a small amount of their income to the cost of nursing-home care.

   Until recently, the answer, at first glance, to the question of whether the disabled elderly must impoverish themselves before becoming eligible for Medicaid may have seemed obvious. States were almost uniform in the wealth standards set to determine an elderly person's eligibility for Medicaid. Persons had to have virtually no nonhousing assets to qualify, although treatment of housing wealth was more liberal. However, the "spousal impoverishment" provision of the Medicare Catastrophic Coverage Act of 1988 (MCCA), a feature of the act that remains in force, changed the eligibility picture somewhat, at least for married persons entering nursing homes. The spousal impoverishment provision required states to permit spouses at home to retain a much larger amount of nonhousing assets (between $13,296 and $64,480 per month at each state's

discretion in 1991) and established higher national standards for the amount of income that the outside spouse could have available for his or her use, ranging from $856 to $1,662 in 1991 (National Governors' Association 1991). The majority of persons entering nursing homes are unmarried, and thus unaffected by the spousal impoverishment provision (Kemper and Murtaugh 1991). For such persons the resource standard was around $2,000 in 1991–92 (Sloan and Shayne 1992).

A complicating factor is that income and wealth may be shielded by the individual to facilitate becoming Medicaid eligible. One way to avoid using one's own assets for nursing-home care ("spenddown") is to transfer wealth to relatives. Although, to date, transfers for this purpose are thought to occur infrequently, anecdotal evidence suggests that the practice is increasing (Kosterlitz 1991). Recent publications that provide financial advice to the elderly and newspaper reports suggest that, with asset transfers, Medicaid trusts, or annuities, a large number of elderly could become Medicaid eligible without impoverishment (Bove 1982; Budish 1989; Quinn 1989; Asinof 1991; Schultz 1992).

In order to limit individuals' attempts to circumvent Medicaid's resource limits by transferring assets, Congress enacted two statutory changes in the early 1980s. The Boren–Long Amendment of 1980 permitted states to restrict transfers of Medicaid-excluded assets from assets counted in determining financial eligibility. Home equity, which represents most elderly persons' largest asset, remained exempt from restrictions on transfers. In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Congress enacted a more comprehensive approach by authorizing state Medicaid programs to place further restrictions on asset transfers, impose liens on real property owned by living Medicaid recipients, and recover the costs of services from the estates of deceased recipients (U.S. General Accounting Office 1989). Recent reports suggest that few states have implemented the TEFRA provisions that permit them to tap these resources (Kusserow 1988; U.S. General Accounting Office 1989).

The original transfer-of-assets provisions of TEFRA permitted states to deny Medicaid coverage to individuals who otherwise became eligible because they disposed of assets for less than fair market value within 24 months of applying for Medicaid or at any time after this period. MCCA subsequently extended the time period ("lookback period") to 30 months and made the period uniform among states.

Methods

Data

Data on elderly individuals came from the National Long Term Care Surveys (NLTCS) conducted by the U.S. Census Bureau in 1982, 1984, and 1989. For most purposes we limited our analysis to 1989. During May–June 1989, NLTCS surveyed 6,120 persons, of whom 1,520 resided in institutions, mainly nursing homes. The sample was derived by screening persons from the Medicare Health Insurance Skeleton Eligibility Write-off file. Criteria for inclusion in the NLTCS were that respondents be at least age 65 and "disabled," that is, needing help in one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) for at least three months prior to the survey. About 15 percent of the Medicare-eligible population had conditions that qualified them for inclusion in the NLTCS. Although NLTCS is unrepresentative of all elderly, having ADLs and IADLs appreciably increases the probable use either of nursing-home care or of help at home (Headen 1993; Kemper 1992). Thus, from the standpoint of long-term-care services, this is a relatively vulnerable population. At the time of the survey, respondents were subject to pre-MCCA Medicaid eligibility rules, although some may have been influenced by awareness of the new rules that were to become effective later in the year.

Compared with the general population of persons over age 65, data from the Current Population Survey (CPS) showed that NLTCS respondents were older and more likely to be female and unmarried, less well educated, and less affluent. Respondents to the NLTCS had many more ADLs than did respondents to the Longitudinal Study on Aging, which surveyed persons over age 70 without regard to functional status. (See table 1.)

A strength of the NLTCS is that it obtained information on income by source and on wealth of various types as well as data on demographic variables, health, and functional status. However, respondents appeared to have more difficulty answering questions on income and wealth than on most other topics, or they were sometimes reluctant to provide personal financial information. When information on nonhousing wealth and income were missing in NLTCS, we used Tobit regression to develop imputations for the missing values. Predictors included were housing wealth; number of automobiles owned by the household; educational

TABLE 1

Mean comparisons between 1989 National Long Term Care Survey
of Disabled Elderly and Other Elderly[a]

Variable	NLTCS–1989	CPS–1989[a]	LSOA–1984[b]
Age	79.7	73.6	–
Female (%)	69.0	59.9	–
Married (%)	34.2	54.0	–
Black (%)	10.8	8.1	–
Education < 10 years (%)	52.2	34.7	–
Education ≥ 16 years (%)	6.8	10.2	–
Household income (1991 '000 $)	16.4	27.3	–
Received SSI (%)	12.9	4.7	–
Got assistance for ≥ one ADL (%)	70.2	–	12.0
≥ two ADLs (%)	66.0	–	7.0
≥ three ADLs (%)	55.2	–	4.9

[a] We limited the 1989 CPS sample to persons over age 65.
[b] The LSOA surveyed persons over age 70. We used LSOA data from 1984.
Abbreviations: NLTCS, National Long Term Care Survey; CPS, Current Population
Survey; LSOA, Longitudinal Study on Aging; SSI, Supplemental Security Income; ADL,
Activity of Daily Living.

attainment; receipt of public subsidies like food stamps; age; marital status; and gender.

Data on state Medicaid policies came from several sources. The National Governors Association (NGA) conducted a survey of state Medicaid programs on eligibility of the elderly for Medicaid-subsidized, long-term-care services in 1987 (Neuschler 1987). We revised the NGA questionnaire to reflect federally mandated changes required by the MCCA, added some additional topics, and resurveyed the states in 1991–92. The NGA conducted a brief survey of Medicaid programs in 1991 (National Governors' Association 1991). We did not reask the questions, but have included the information obtained in the NGA's 1991 survey in our analysis. For items used in this study, the response rate was 100 percent. Information on cash transfers was obtained from U.S. government sources (U.S. Department of Health and Human Services 1987, 1991). We converted dollar values of standards for 1987 to 1991 dollars, using the Consumer Price Index (CPI)—all items.

We used state-specific estimates of the mean private-pay nursing-home price from the 1985 National Nursing Home Survey, updated to

1991 dollars, using the medical service component of the CPI. No na-
tional survey sufficiently large to permit computation of nursing-home
prices at a level as disaggregated as a state has been conducted since
1985.

Policy Simulations

We used data from the NLTCS community sample to conduct policy
simulations of spenddown. First, we determined whether a person would
be eligible for Medicaid nursing-home coverage in a particular month.
We then computed the net price each person would pay. A person who
was not on Medicaid was assumed to be paying the nursing home's
charge.

Financial eligibility for Medicaid was determined in each month fol-
lowing hypothetical entry into the nursing home by comparing a per-
son's wealth and income with the state's eligibility criteria in 1987, and,
alternatively, in 1991. We computed annual net prices of nursing-home
care faced by the recipient's household during the first three years fol-
lowing entry to the nursing-home, assuming the person would stay this
long. The net price was defined as the price charged by the nursing
home *minus* the following: the discount obtained by Medicaid; the Med-
icaid subsidy on behalf of the recipient; any cash payment the individual
received by virtue of living in the nursing home, *plus* any public transfer
payments the individual lost by entering the nursing home.

Medicaid makes an important distinction between nonhousing and
housing wealth in determining eligibility. Therefore, we assessed these
two types of wealth separately. Before MCCA, assets were attributed to
individual spouses. After MCCA, Medicaid considers all wealth to be
jointly held. Thus, for our simulation of eligibility before MCCA, we
needed information about asset ownership on a person-specific basis. The
NLTCS did not obtain information on ownership of assets by particular
household members, but it did obtain information on property income
that each household member received. We apportioned nonhousing
wealth (which, in our analysis, included all financial assets, rental prop-
erty, and owned businesses, but excluded automobiles and household
goods) based on the property income each spouse received.

When the spouse or a dependent relative lives in the home of the per-
son in the nursing home, Medicaid treats the home as a protected asset.
Most states allowed unmarried, institutionalized recipients to keep their

homes indefinitely. In the minority of states that did not, we assumed that an unoccupied home would, in fact, be sold in the month when, according to the state's Medicaid law, it would no longer be excluded as a countable resource. (The extent to which such provisions have been enforced is unknown.) Until the expenditure of the proceeds from the house on private nursing-home charges reduced the person's wealth to the state's resource threshold, we considered the person to be off Medicaid.

Although, at least before MCCA, there was comparatively little variation among states in the maximum nonhousing wealth permitted for a person to qualify for Medicaid, there has always been considerable variation in the income standards. The variation depends on which of three income eligibility rules the state adopts:

1. The income limit for nursing-home residents is set at the federally allowed maximum of 300 percent of the Supplemental Security Income (SSI) standard for persons living alone in the community (for nursing-home residents, this was $1,020 per month in 1987 and $1,221 in 1991), hereafter termed "high-income threshold."

2. The income limit is set at an amount lower than this, or a "low income threshold."

3. There is no fixed upper limit on income, but eligibility instead is determined by subtracting medical expense (including nursing-home expense) from income, and the subsidy is provided to persons whose income, net of such expense, is below a threshold, called the "variable income threshold."

In all states, a nominal amount of income ("disregard") is subtracted from income that is considered in eligibility determination.

In states with a fixed income standard, we used this standard to determine a person's eligibility. In the other states, we determined a person's eligibility by subtracting the mean price the state Medicaid program paid nursing homes (intermediate-care facility rate) from the individual's income. If he or she entered a nursing home, the person would be eligible for Medicaid in a given month if the difference was less than a net income standard. Coverage plausibly extended to the greatest proportion of disabled elderly in states using the variable income threshold (i.e., states in which Medicaid eligibility for coverage of nursing homes applies to "medically needy" elderly), whereas it extended to the lowest

proportion in states with a low income threshold (i.e., those adopting the Section 209[b] option of the Social Security Amendments of 1972, which permitted states to retain tighter eligibility screens). For states employing more than one standard, we used the one that extended coverage to the greater number of individuals.

Some persons would have been ineligible during a given month either because they had too much nonhousing wealth or because the state Medicaid program would no longer have been willing to exclude the house from eligibility determination. For these persons, we had to make an assumption about how the month's care would have been financed because information on how private patients finance their stays was unavailable from any source. The individual plausibly would use some combination of income and wealth. We assumed that individuals would use their income up to $100 per month if unmarried and up to $200 if married. We assumed that they would take the rest from nonhousing wealth if the house were a protected asset during that month; otherwise they would take from total wealth. Our results were not sensitive to alternative plausible spending rules.

As nonhousing wealth is depleted, income from nonhousing wealth declines as well. By contrast, income from Social Security and pensions should be unaffected. Such income therefore was assumed to be unaffected by entry into the nursing home. In our simulations, we assumed that reductions in income from nonhousing wealth at entry to the nursing home would occur in the same proportion as reductions in the corpus as the stay progressed. If the person received cash assistance in the community, usually SSI payments, virtually all of this subsidy would be lost if the person were to enter a nursing home because Medicaid allows recipients residing in nursing homes to keep only a very modest "personal needs allowance" of $25 to $40 monthly. A loss of a cash subsidy at entry to the nursing home increases the net price of nursing-home care.

The amount of the subsidy in all states depended on the person's income relative to a number of variables:

1. the personal needs allowance
2. cash assistance to eligible persons in a nursing home with little or no income, the maximum amount of which was generally less than the personal needs allowance

3. the home maintenance allowance for unmarried persons who owned a home
4. set-asides for maintenance of the outside spouse when the institutionalized spouse's income was more than enough to cover the personal needs allowance
5. the outside spouse's contribution to the inside spouse's nursing-home care

The contributions were required by a few states prior to MCCA. Thus, for example, if an unmarried person had a monthly income of $1,000 and the applicable allowances for personal needs and home maintenance were $40 and $400, respectively, the person would be required to contribute $560 to his or her own care. A person having no income would pay nothing for the nursing home and might receive a cash assistance payment less than, or equal to, the personal needs allowance.

We also took into account the policies before and after MCCA concerning the treatment of married couples' income and assets and requirements concerning the outside spouse's contribution to the cost of the nursing home. Since MCCA, the protected income amounts for couples have been increased and the minimum level has been tied to a percentage of the federal poverty income level for couples (National Governors' Association 1991). This change was reflected in the estimated net price of nursing-home care to the institutionalized individual in 1991. MCCA required that assets of the couple be pooled and divided in half. The resources allocated to the outside spouse were protected up to much higher amounts than previously. Immediately before MCCA was enacted, 36 states did not require an outside spouse to contribute to the cost of the inside spouse's nursing-home care. However, the other states at least nominally required the spouse to devote income above a threshold for this purpose (Neuschler 1987). In our simulations, we assumed that this contribution was in fact made. MCCA eliminated any required contribution from the outside spouse.

We also determined the proportion of disabled elderly who were not receiving Medicaid benefits in the community, but who satisfied financial eligibility criteria for such benefits. This proportion was compared with the proportion who would satisfy Medicaid's criteria for financial eligibility if they were in a nursing home.

To assess the difference in Medicaid eligibility for nursing-home care and for services in the community, we calculated community residents'

eligibility using data from the NLTCS community sample. As a consistency check of the simulations, we studied actual patterns of spenddown to Medicaid using data from the NLTCS nursing-home sample. To assess the disabled elderly's housing wealth as a potential source of revenue for the Medicaid program, we relied on the NLTCS community sample because the NLTCS did not collect information on housing wealth from nursing-home residents.

Findings

Simulated Spenddown to Medicaid

Our computation of the time to spenddown to Medicaid in a nursing home, using the sample of disabled elderly residing in the community from the NLTCS (table 2), revealed that the majority were either already financially eligible or would have been so immediately, had they been institutionalized. About 19 percent were actually on Medicaid in the community and hence presumably would have qualified financially for

TABLE 2
Time to Medicaid Spenddown in a Nursing Home by Marital Status:
Simulations Based on the Community Sample[a]

When eligible for Medicaid	Before MCCA			After MCCA		
	Single	Married	All	Single	Married	All
Already on	24.0	10.1	18.7	24.0	10.1	18.7
Immediately eligible	48.5	43.3	46.4	48.9	75.3	59.0
Eligible in 1 to less than 6 months	7.8	11.3	9.2	7.8	1.3	5.3
Eligible in 6–30 months	7.2	13.4	9.6	7.5	3.1	5.8
Eligible in over 30 months but less than 10 years	4.7	9.1	6.4	4.6	1.6	3.8
Not eligible within 10 years	7.8	12.8	9.7	7.2	7.7	7.4
	100.0	100.0	100.0	100.0	100.0	100.0

[a] Percent distribution. These computations are based on data from the 1989 NLTCS sample of community residents.
Abbreviations: MCCA, Medicare Catastrophic Coverage Act of 1988; NLTCS, National Long Term Care Survey.

Medicaid on entry to the nursing home as well. Almost half (46 percent) of the disabled elderly not on Medicaid in the community would have qualified for Medicaid immediately on entry to the nursing home, according to pre-MCCA eligibility rules. After MCCA, nearly three-fifths (59 percent) of such persons would have qualified for Medicaid immediately on entry. Almost everyone would qualify if they survived in the nursing home for 10 years or more. Slightly less than 10 percent of the disabled elderly would not have satisfied Medicaid's income and wealth standards within 10 years of entry by pre-MCCA rules. Following MCCA, this group fell to 7 percent.

These results explain why relatively few persons actually switch to Medicaid during even an extended nursing-home stay (table 3). Of the patients who, at the interview date, had been in a nursing home for 30 months or more, 61 percent were on Medicaid; 46 percent had been on Medicaid since they were admitted. Even fewer among those in nursing homes for less than 30 months switched to Medicaid. Not many disabled elderly persons switch because, as our simulations show, most such per-

TABLE 3
Dependence on Medicaid as Primary Source of Payment
for Nursing-home Care[a]

	Patients in nursing homes		
	30+ months at date of interview	6–30 months at date of interview	Within 6 months at date of interview
On Medicaid at admission	45.8	40.8	37.7
Switched to Medicaid from:			
Self-pay	+11.6	+7.5	+4.5
Payment by friends/relatives	+0.9	+3.9	+0.5
Private insurance	+0.5	+0.3	+0.0
Medicare	+2.9	+3.6	+3.6
Other	+0.4	+0.0	+0.5
Switched from Medicaid	−1.2	−1.2	−0.5
On Medicaid at interview	60.9	54.9	46.3

[a] Rate per 100 institutionalized persons. Totals may not add exactly due to rounding. These computations are based on data from the NLTCS sample of institutionalized persons. We limited the sample to institutionalized disabled elderly residing in skilled nursing- or intermediate-care facilities at the 1989 survey date.

sons satisfy income and resource standards for Medicaid-subsidized nursing-home care at entry.

Based on state Medicaid programs' financial conditions for eligibility (table 2), the percentage of persons who were potential Medicaid recipients was far greater than the actual percentage covered by Medicaid in nursing homes (table 3). According to our simulations, before MCCA, 84 percent would have been on Medicaid after 30 months in the nursing home (computed from table 2). By contrast, of those actually in nursing homes for 30 months or more, 61 percent were on Medicaid (table 3). Given the low rate of Medicaid reimbursement of nursing homes in many states, many potentially Medicaid-eligible persons are simply not admitted by these facilities (U.S. General Accounting Office 1990).

Although there is widespread concern about assets transfers, our results suggest that only a small percentage of persons at relatively high risk of becoming institutionalized — the disabled elderly — would have an incentive to transfer assets. Those financially eligible within six months of entry have, for practical purposes, too little wealth to warrant hiring an attorney to arrange an asset transfer. After 30 months, a wealth transfer can no longer be contested. Thus, an individual could transfer assets at the time of admission and apply for Medicaid 30 months later without the transfer being questioned by Medicaid. Before MCCA less than a tenth (9.6 percent) of the sample would have potentially spent down to Medicaid after six months and before 30 months in a nursing home. Only about 6 percent would have spent down within this time period after MCCA (table 2).

The provision of MCCA aimed at reducing spousal impoverishment had a dramatic effect on the proportion of married elderly immediately eligible for Medicaid. Although Congress sought to make it more difficult to transfer assets for the purpose of establishing eligibility for Medicaid in a nursing home, in fact, it virtually eliminated any incentive for the vast majority of married disabled elderly to transfer assets *if* they believed their spouses would survive them and remain in the community. Before MCCA, 13 percent of couples — those spending down after six months but before 30 months — might have benefited from an asset transfer, assuming a 30-month lookback period. States' actual lookback periods before MCCA were less than this, implying that even fewer married couples would have benefited. After MCCA, the pool of married persons potentially benefiting from assets transfer shrank to 3 percent.

A question remains whether the results on time to spenddown ob-

served for disabled elderly nationally generalize to states with different financial eligibility criteria for Medicaid. One might expect that the proportion of institutionalized disabled elderly who are financially eligible for Medicaid would be higher in states that use a variable income eligibility standard, which makes Medicaid accessible to persons with higher incomes. This was not the case before MCCA (table 4), nor is there a reason to expect a change after MCCA was implemented. (Pre-MCCA estimates are presented because these rules applied when the 1989 NLTCS was conducted.)

Judging from NLTCS data, the disabled elderly in states with a variable standard had slightly more wealth on average. This greater wealth and the higher nursing-home charges, not the existence of a medically needy program, are factors that explain the somewhat higher proportion of disabled elderly persons likely to spend down to Medicaid in such states.

Compared with nursing-home residents, few disabled elderly in the community qualify for Medicaid. Only 23 percent of the disabled elderly living in the community were either Medicaid recipients or would have passed the wealth and income screens for Medicaid as community residents had they applied for Medicaid (table 5). Unmarried individuals were almost three times more likely than married persons to be Medicaid eligible. Medicaid's more stringent eligibility policies for coverage in the

TABLE 4

Time to Medicaid Spenddown in a Nursing Home by Income Eligibility Rules before MCCA: Simulations Based on the Community Sample[a]

When eligible for Medicaid	High income threshold	Low income threshold	Variable income threshold
Already on	22.9	21.3	16.5
Immediately eligible	47.7	45.9	46.2
Eligible in 1 to less than 6 months	7.5	6.0	10.4
Eligible in 6–30 months	8.0	6.2	11.2
Eligible in over 30 months, but less than 10 years	4.2	4.7	7.7
Not eligible within 10 years	9.7	15.9	8.0
	100.0	100.0	100.0

[a] Percent distribution. These computations are based on data from the 1989 NLTCS sample of community residents.

TABLE 5
The Disabled Elderly's Eligibility for Medicaid in the Community in 1989[a]

When eligible for Medicaid	Single	Married	All
Already on (%)	24.3	10.3	18.9[a]
Immediately financially eligible (%)	6.2	1.3	4.3
	30.5	11.6	23.2

[a] The percentages differ slightly from table 2 because our screening criteria were slightly different. These computations are based on data from the 1989 NLTCS sample of community residents.

community, compared with coverage in a nursing home, create an important bias toward institutionalization.

Simulated Prices of Nursing-home Care Paid by Disabled Elderly Persons

Unlike other forms of care, Medicaid requires recipients to make a sizable contribution to the cost of their own nursing-home care. Based on our simulations, we found that, before MCCA, the disabled elderly living in the community would have paid $10,980 (1991 dollars) out of pocket for nursing-home care on average in the first year following entry into a nursing home, an amount equivalent to 48 percent of the usual nursing-home charge (fig. 1). This mean amount reflects out-of-pocket prices paid by elderly persons both on and not on Medicaid. Such elderly would have paid $10,217 in the second and $9,544 in the third year on average.

Virtually all disabled elderly persons in the community eligible for Medicaid in the nursing home (98.1 percent) would have paid something to the nursing home for their care. Only part of the price reduction to Medicaid recipients reflects a direct subsidy by Medicaid. The rest results from the substantial discount Medicaid obtains from nursing homes in most states. The net prices are charges less discounts Medicaid obtained and subsidies provided by Medicaid. At the margin, a dollar increase in income above the very modest personal needs allowance is taxed at a 100 percent rate up to the discounted nursing-home price that Medicaid pays.
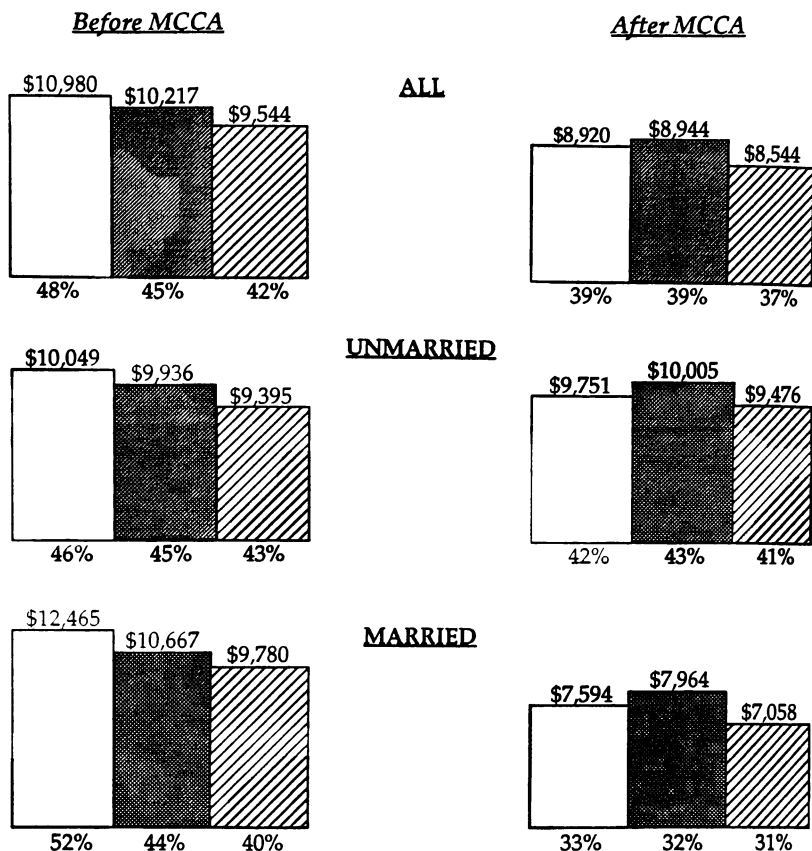
FIG. 1. Mean net price, in 1991 dollars, of nursing-home net of Medicaid subsidy before and after MCCA. Percentages are the proportions of the price paid by Medicaid recipients of the private-pay nursing-home charge in the person's state. These computations are based on data from the 1989 NLTCS sample community residents and other sources (see text). □, year 1; ■, year 2; ⊿, year 3.

There are several reasons for the decline in net price over time in a nursing home. Most important, as duration of stay increases, a higher proportion of elderly become Medicaid eligible. Also, however, as some elderly on Medicaid spend their assets, income decreases correspondingly. As a recipient's income falls, the amount of income "taxed" by Medicaid declines.

On the other hand, there are reasons for net price, as we computed it, to rise for a while as the stay lengthens. The home maintenance allow-

ance protected recipients' incomes for only a limited period. Also, Medicaid in some states required institutionalized individuals who were not expected to return home to sell their houses to pay for the cost of the nursing home. Income from the sale of the house would make them temporarily ineligible, during which time they would have to pay the higher private rate and assume the entire cost.

Our simulations suggest that MCCA's spousal impoverishment provision reduced the net price of nursing-home care. The net price of care paid by married persons fell by one-third on average. Whereas before MCCA Medicaid's subsidy was greater for unmarried than for married elderly, the reverse was true after MCCA. Net prices tended to be higher in states with variable income thresholds for Medicaid eligibility (not shown). The subsidies in such states were roughly comparable to other states; the difference in net price was due primarily to the higher wealth of disabled elderly persons and higher nursing-home charges in such states.

The pattern of net prices by year changed for unmarried persons as well. Before MCCA, net prices declined monotonically. After MCCA, net price increased in the second year. This occurred not because of MCCA, but rather because several states switched their eligibility standard from a low-income threshold to other thresholds. As a result, some unmarried persons became Medicaid eligible earlier in the nursing-home stay and policies regarding retention of the house and home maintenance allowance took effect earlier.

The Disabled Elderly's Housing Wealth

One-third of disabled elderly community residents had no housing wealth in 1989, based on data from the 1989 NLTCS (table 6). The other two-thirds, however, had housing assets that, if tapped, might be sufficient to offset an appreciable share of Medicaid's outlays for nursing-home care if, in fact, they should receive such care and be covered by Medicaid. The community disabled elderly averaged $45,062 (in 1991 dollars) in housing wealth in 1989. However, considering only persons with some housing wealth, the mean of $45,062 increases to $67,865, which would cover about three years of nursing-home care at the prices Medicaid programs pay. Mean values for the disabled elderly population are comparable to those for persons over age 75 regardless of functional

TABLE 6
Housing Wealth of Disabled Elderly Persons in 1989[a]

	Fraction owning house	Mean	SD	Those owning a house	
				Mean	SD
All (n = 2,116)	0.66	$45,062	$56,314	$67,865	$56,820
Married, both 1984 and 1989 (n = 844)	0.77	55,496	58,447	72,394	56,700
Single, both 1984 and 1989 (n = 1,026)	0.58	37,379	54,003	64,403	57,294
Married 1984, single 1989 (n = 216)	0.66	42,383	53,816	64,469	54,609

[a] These computations, in 1991 dollars, are based on the 1984 and 1989 NLTCS samples of community residents. Only persons included in both surveys and reporting housing wealth were included in the computations.
Abbreviation: SD, standard deviation.

impairments, according to data obtained from the Survey of Income and Program Participation (Radbill and Short 1992).

If Medicaid took wealth from nursing-home recipients, it would presumably take such wealth from unmarried persons who constitute the vast majority of nursing-home residents. It is doubtful that Medicaid would change current rules excluding the home from countable resources as long as the spouse lives there. Although the fraction of disabled elderly persons with houses varies by marital status, the mean value of housing wealth for those with a house varies little.

The estimates in table 6 pertain to housing wealth of disabled persons in the community at the time of the survey. Another admission to a nursing home would plausibly cause some reduction in wealth, but it would less likely be housing than nonhousing wealth. The mean values in table 6 are elevated by the inclusion of persons who would not be eligible for Medicaid within 10 years or more after admission to a nursing home. However, as noted previously, these persons represent a very small share of the disabled elderly population.

Although housing assets held by the elderly appear to be sufficiently high to offset an appreciable portion of Medicaid expenditures for nursing-home care, a survey of Medicaid programs that we conducted from

late 1991 to early 1992 revealed that few state programs have recovered funds commensurate with the potential amounts that could have been tapped. Twenty-six states had estate recovery programs, of which only four (California, Minnesota, Oregon, and Wisconsin) reported annual recoveries of over six million dollars. Only nine states placed liens on the property of institutionalized Medicaid recipients; for those with data, the amounts of potential recoveries were very modest: about 0.5 million dollars per state per year.

Public Policy Implications

Impoverishment and Spenddown

There is widespread concern that the elderly become impoverished by expenditures on nursing-home care and that they must deplete their assets in order to qualify for Medicaid coverage. Our analysis suggests otherwise. Relatively few disabled elderly have assets sufficient to make them ineligible for Medicaid coverage of nursing-home care. If anything, we have overstated the incentive of the disabled elderly to transfer assets because the simulations do not consider the possibility of death or leaving the nursing home before spenddown could occur. In fact, mortality rates of the disabled elderly are high. By the time of the 1984 interviews, 22 percent of respondents to the 1982 NLTCS had died (Headen 1993).

For purposes of considering the lack of asset spenddown, it is useful to divide the life cycle of persons over age 65 into three stages:

1. before the onset of functional impairments
2. after the onset of such impairments
3. after entry into a long-term-care facility

Of course, many elderly never become functionally impaired for an appreciable length of time, and most never enter a long-term-care facility. However, persons who enter the first stage face appreciable risk of entering the second and third.

In our study, we measured the elderly's income and wealth in only the second and third stages. By the time many elderly persons reach the sec-

ond stage, they have little or no wealth other than a house, and therefore nonhousing wealth is no longer a barrier to receipt of Medicaid. Their income, which is largely derived from Social Security and private pensions, does not bar them from Medicaid if they enter a nursing home, but is much more frequently a barrier for receipt of Medicaid while they live in the community. This is the major factor accounting for the lack of spenddown in the nursing home that we and others (Burwell, Adams, and Meiners 1989; Spence and Wiener 1990; Liu, Doty, and Manton 1990) have observed. Lack of spenddown does not primarily result from some patients staying in the nursing home for short periods and/or elderly persons' reliance on relatives for contributions to the cost of their nursing-home care—possibilities suggested by others (Spence and Wiener 1990; Liu, Doty, and Manton 1990).

The fact that these individuals were no more affluent on average in 1984 than in 1989 suggests that becoming poor from transferring assets in anticipation of being institutionalized was not widespread. Only infrequently would transfers for this purpose be likely to occur five or more years in advance of an anticipated nursing-home stay. Further, comparing nonhousing wealth of the NLTCS respondents in 1984 and 1989 (not shown), we found that about as many disabled elderly individuals accumulated such wealth as lost it during the five years between the surveys. This suggests that the lack of nonhousing wealth of the disabled elderly has its roots in stage one—that is, an appreciable share of persons who become elderly with functional impairments never accumulate much wealth beyond a house.

Admittedly, we know far less about the wealth of people in the first stage and changes in wealth associated with the transition from the first stage to the second. Impoverishment of the disabled elderly begins before a nursing-home stay, and therefore focus on impoverishment as a consequence of nursing-home use is misplaced. To the extent that impoverishment of the disabled elderly is a policy issue, emphasis should be placed on the elderly more generally.

The Elderly's "Fair" Share of the Cost of Long-term Care

Although the issue of impoverishment of the elderly is at one end of the policy spectrum, at the other end is the argument that the elderly and

their families should pay an even larger part of long-term-care expense. Our simulations suggest that relatively few disabled elderly have sufficient nonhousing wealth to make finding legal loopholes to shield wealth worth the cost to these individuals. Since implementation of MCCA's spousal impoverishment provisions, lack of an incentive to shield assets is particularly applicable to married individuals as long as they stay married. Thus, further tightening of Medicaid transfer-of-assets rules would not raise appreciable amounts of revenue for long-term care.

Traditionally, Medicaid has given preferential treatment to housing wealth in determining financial eligibility and, to a lesser extent, in assessing recipients for part of their nursing-home expense. Most wealth of the disabled elderly living in the community is in the home, according to data from the 1989 NLTCS (not shown). Unfortunately, we could not compute a similar percentage for nursing-home residents because the NLTCS did not obtain information on housing wealth from such persons. Thus, we cannot know for sure whether nursing-home residents are voluntarily liquidating their home equity to pay for their care. For many reasons, among them that Medicaid does not require depletion of housing assets as a condition of eligibility, at least at entry to a nursing home, many elderly may choose not to reduce such assets.

Requiring that housing assets be used to finance a nursing-home stay while a spouse or dependent relative lives in the home or when there is more than a negligible chance that the institutionalized individual will return home would violate social norms. A stronger case can be made for using such wealth when the home or its proceeds would otherwise become the property of nondependent relatives or friends. Proceeds from sale of the home after the surviving spouse or dependent has died could be used to finance an appreciable amount of nursing-home care that would otherwise be subsidized by Medicaid.

There are two arguments against requiring sale of a home. First, informal caregiving may be partly motivated by expectations of inheritance (Bernheim, Schleifer, and Summers 1985). Thus, aggressive pursuit of housing wealth may reduce informal caregiving, which is a much more important source of support of the disabled elderly in the community than is formal care. According to data from the 1989 NLTCS, the disabled elderly in the community received 17 hours of informal care from relatives and friends and four hours of formal, paid care per week, on average. Second, requiring a person to give up a home to finance a cata-

strophic acute illness such as cancer or AIDS would clearly violate social norms. There would be an inconsistency in requiring persons with diseases that frequently lead to long-term disability and are equally beyond the individual's control, such as stroke and Alzheimer's disease, to pay for the cost of their care with their homes. These concerns may explain, at least in part, states' inactivity to date in pursuing liens and estate recoveries in order to provide revenue for their Medicaid programs.

Options for Funding Long-term Care

A larger question concerns the appropriateness of current reliance on Medicaid, a program ostensibly designed to finance acute care for low-income persons, as the primary source of third-party funding for long-term care for a much larger segment of the population. With Medicaid's income and assets standards set where they are, a high percentage of disabled elderly persons, as our simulations indicate, would be financially eligible for Medicaid at entry to a nursing home. The spousal impoverishment provision of the Medicare Catastrophic Coverage Act of 1988 pushed the nation further in the direction of universal long-term-care financing, perhaps inadvertently.

The availability of Medicaid payment for nursing-home care for most disabled elderly helps to explain why a market for private long-term-care insurance has been slow to evolve (Pauly 1990; U.S. General Accounting Office 1987). Even so, many disabled elderly individuals may not regard Medicaid and private long-term-care insurance as perfect substitutes for each other. Much of the price reduction reported above is attributable to discounts Medicaid obtains rather than to the public subsidy per se. As a result, many nursing homes give subsequently lower priority to Medicaid recipients or persons likely to become Medicaid eligible (U.S. General Accounting Office 1990). This policy on the part of nursing homes is reflected in our finding that fewer disabled elderly in nursing homes actually receive Medicaid benefits than our calculations revealed to be eligible for such assistance. Also, persons covered by Medicaid may not gain access to homes of a quality comparable to facilities for private-pay patients.

As an alternative to the current Medicaid system of financing long-term care or to a private market, the nation could decide to implement more complete protection against the catastrophic costs of long-term care by adopting compulsory social insurance for long-term care. A social in-

surance system presumably would not require the substantial out-of-pocket payments that our calculations show Medicaid now imposes and would probably improve disabled elderly persons' access to nursing-home care. However, competition for health-care dollars to pay for hospital, physician, and other health services is a major impediment to social insurance for long-term care.

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