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Asset Transfer and Nursing Home Use: Empirical Evidence and Policy Significance

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The perception that many "well-to-do" elderly Americans transfer assets to gain Medicaid coverage for nursing home care is an issue that has consumed considerable policy interest in recent years. The concern is that the individual's assets should be used to pay privately for nursing home care, instead of being transferred to relatives. Because Medicaid was designed to be a safety net only for the poor, asset transfer practices are thought to distort the intent of the Medicaid program and unnecessarily inflate public spending. In response to these concerns and as an attempt to reduce spending, the Deficit Reduction Act of 2005 (DRA) included provisions tightening the Medicaid eligibility rules related to asset transfers and nursing home use.

The claim that asset transfers are utilized to gain Medicaid eligibility is mainly supported by anecdotal evidence about elder law attorneys' assistance to elders in estate planning and nursing home care. Prior empirical studies also provide little indication of asset transfers and expected future nursing home use (See O'Brien, 2005, for a recent review of the literature). Little is known, however, about the frequency of such asset transfers occurring for the purpose of obtaining Medicaid coverage and the amounts of money involved.

We used multiple waves of the Health and Retirement Study (HRS) to relate nursing home use, asset transfers, and Medicaid coverage. We examined the timing of these events to provide insight on the likelihood that asset transfers might have been utilized for the purpose of gaining Medicaid covered nursing home care. Our findings indicate that relatively few people who become Medicaid nursing home residents have transferred a substantial number of dollars. Asset transfer patterns were most common among nursing home residents who were "always private pay" meaning they did not receive Medicaid assistance to cover the cost of their nursing home care. Our analysis also estimated the maximum number of dollars that could possibly be recovered by Medicaid if all cases of transferred assets were deemed inappropriate and were collected as program savings and found that even the most aggressive pursuit of transferred assets would recover only about 1 percent of total Medicaid spending for long-term care.

Background

Elderly persons who are disabled or have chronic conditions that will shortly lead to disability presumably begin to think about how they will receive and pay for long-term care services. Because Medicare does not cover long-term nursing home care, Medicaid is the only source of public financing for this type of service. The Medicaid program was designed for the poor, however, and financial eligibility standards are very restrictive. In most states, Medicaid eligibility requires low levels of income and financial assets of $3000 or less. Thus, to gain Medicaid coverage for nursing home care, people with substantial assets have to exhaust them on nursing care or find ways to shelter any assets above the Medicaid qualifying levels. Even after qualifying for Medicaid an individual must put all their income except for a small personal needs allowance toward the cost of care.

The general strategy that has been the concern of policy makers is that elderly persons with substantial financial resources transfer "excess" assets to other family members in order to become Medicaid eligible for nursing home care. Left untransferred, those assets might otherwise be used for privately paid nursing home care, thereby reducing the amount of time that Medicaid would be expected to pay for that care. Existing Medicaid rules designed to discourage such practices include a "look-back period," in which asset transfers occurring within five years of application for Medicaid eligibility trigger a "penalty period" over which Medicaid will not pay for the nursing home care. The duration of the penalty period is based roughly on the amount of assets transferred divided by the average cost of private nursing home care. For example, if a nursing home resident who was otherwise eligible for Medicaid had transferred $10,000, and private nursing home care averaged $5,000 per month, that person would be subject to a penalty period of 2 months during which time Medicaid would not pay for the care.

Despite such Medicaid rules, it is widely believed that strategies have been developed and applied to "game" them. One strategy, for example, is known as the "half-a-loaf" solution in which persons seeking Medicaid nursing home coverage transfer only half of their assets during the look-back period. Because the penalty period is a function of the amount of assets transferred, and because the penalty period prior to DRA started on the date the transfer was made, the remaining half of assets that was not transferred would exactly cover the amount of time imposed under the penalty period rule. The DRA changes are in part intended to curtail these practices.

In an earlier analysis (Liu & Waidmann, 2005), we found that only a small proportion of persons, who entered nursing homes and concurrently (in the same wave of the HRS) became Medicaid eligible, had transferred assets, and that the amount of assets transferred was small. In this analysis, we expanded the observation period to include persons who become Medicaid eligible only after a substantial period of private nursing home coverage. In this way, we provide insight on the practitioners of the "half-a-loaf" and other such strategies as well as separately tracking those who were Medicaid eligible at admission.

Conceptual Framework

We employed the HRS to estimate the incidences of asset transfers and amount of assets transferred by elderly Medicaid nursing home residents.[1] Many residents were already Medicaid eligible in their community prior to entering nursing homes, while others became Medicaid eligible with nursing home admission.[2] A third group of Medicaid eligible residents were those who entered nursing homes during one wave of the HRS and only became Medicaid eligible in subsequent waves. Because the HRS waves generally cover a two-year period, this last group of people was private pay residents for approximately two years before spending down their assets and gaining Medicaid eligibility. Our analysis, therefore, captures the transitions of nearly all nursing home residents who eventually became covered by Medicaid.

[1] The HRS questionnaire asks, "Including help with education, but **not** shared housing or food, in the last two years did you give financial help totaling $500 or more to any of your children or grandchildren?" Interviewers prompted respondents to include a broad range of potential transfers.

[2] Because exact dates of Medicaid eligibility are unavailable from the HRS, we refer to persons who became Medicaid eligible and entered nursing homes in the same wave (2-year period) of the HRS as "concurrent" Medicaid nursing home admissions. In this analysis, we excluded individuals with nursing home stays of less than 90 days.

Although our focus was on the portion of the nursing home population that became Medicaid eligible, we also included for comparison those persons who were "always private pay." While people in this group also transferred assets, they did not become Medicaid eligible even after four years of nursing home care. Although it is possible that some persons in this group could become eligible for Medicaid in the future, it seems implausible, since they were private pay nursing home residents for, on average, four years. In addition, their greater wealth made them more likely to afford professional estate planning help in the first place.

We summed cumulative assets transferred from the HRS waves up to six years before individuals entered nursing homes. Both liquid assets and the value of deeded homes were included in the estimation of amounts of transferred assets up to and including the HRS wave in which they became Medicaid eligible. When there was an indication of a "deed transfer" we assigned the total value of the primary residence to the transfer, even though a deed transfer might simply have been an enactment of deed sharing between elderly persons and their children or grandchildren. Thus our estimates of the value of deeds passed on to relatives are very likely to be overestimates of actual amounts of assets transfers. It is important to note, however, that only a very small proportion (4.6%) of Medicaid nursing home residents actually made a deed transfer.

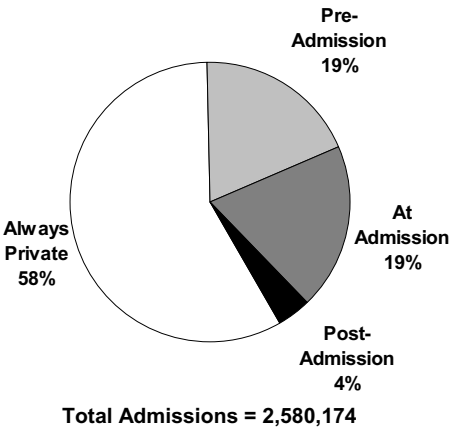
Findings

Many nursing home residents were already Medicaid eligible in the community

Figure 1 presents the distribution of all nursing home entrants by whether they became Medicaid eligible, before, concurrent with, or after they entered nursing homes, or whether they were "always private pay." About 19% of all nursing home residents are eligible for Medicaid benefits for about one year before entering nursing homes, and presumably received full Medicaid benefits (e.g., drugs, Medicare cost sharing) in the community. Almost all of these elderly persons qualified for Medicaid because they were eligible for Supplemental Security Income (SSI) or were medically needy under traditional Medicare eligibility rules. By definition, this group was poor and did not possess substantial assets. Another 19% become Medicaid eligible concurrent with (or within about one year of) nursing home admission, while 4% become Medicaid eligible after a year or more of entering nursing homes. Thus approximately 43% of all nursing home residents eventually become Medicaid eligible, while the balance remains "always private pay." These findings are consistent with other research, which finds that 35-45% of nursing home residents are covered by Medicaid around the time of admission.[3] Since only 4% of nursing home residents have delayed Medicaid coverage, our findings indicate that few Medicaid nursing home residents become eligible after a long period of asset spend down.

[3] Liu, Doty, and Manton, 1990; Jones, 2002

Figure 1



SOURCE: Authors' tabulation based on the Health and Retirement Study, 1995-2004

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Asset Transfer amounts are small among Medicaid nursing home residents

Table 1 presents statistics on the rates of asset transfers, and mean and median amounts transferred, for all nursing home entrants by their Medicaid eligibility status relative to nursing home admission (e.g., Medicaid eligible before they entered nursing homes). The Table presents findings for transfers involving only cash assets and for transfers involving both cash and house deed values. Transferred assets were included from up to six years before nursing home entry and up to two years after entry.

The first panel of Table 1 shows that the rate of asset transfer, 17.5%, and amount of cash transferred, $11,101, were lowest among persons already Medicaid eligible in the community. Persons becoming Medicaid eligible concurrently with nursing home admission or within two years thereof had higher rates of asset transfer, with those who became Medicaid eligible after a period of private payment having the higher amounts transferred. Finally, nursing home residents who were "always private pay" had the highest rate of asset transfer, 49%, and transferred the largest amounts of monies, $135,218. The second panel of Table 1 presents the pattern for transfers involving cash and house deeds. Although the rate of transfer and amounts are higher than when only cash transfers are measured, the overall patterns, by Medicaid eligibility groups, are essentially the same as in the first panel.

The patterns in Table 1 seem consistent with expected wealth of the different groups of nursing home residents. When we measured the net worth of nursing home residents' households approximately four years prior to admission, we found that those who were Medicaid eligible in advance of admission had the least liquid and housing assets. On average this group had household assets of $36,561 in equity in their principal residences and $23,551 in non-housing wealth. The median person in the group had $430 in non-housing assets and $6,800 in

housing equity. The two groups that became Medicaid-eligible because of their nursing home use had substantially more assets measured at either the mean or median levels of assets. Those who were always private pay nursing home residents, not surprisingly, had the highest asset holding four years before admission. Average equity in the principal residence was $82,501, and average non-housing assets were $283,291. The median person in this group had $62,000 in home equity and $61,900 in non-housing wealth.

Table 1: Transfers Made Up to 6 Years Prior to Nursing Home Admission

		Cash Only			Cash or Deed		
Medicaid Eligibility (relative to NH admission[1])	Population Size	Percent with Any Transfers	Mean Positive Transfer	Median Positive Transfer	Percent with Any Transfers	Mean Positive Transfer	Median Positive Transfer
Pre Admission (prior wave)	615,326	17.5	11,101	2,800	18.5	50,578	7,200
At Admission (same wave)	668,124	38.7	18,773	4,000	43.6	37,637	5,000
Post Admission[2] (subsequent wave)	180,586	31.7	39,479	5,000	34.0	130,801	7,500
Always Private-Pay	1,891,713	49.0	135,218	10,000	51.2	187,797	15,500

[1] Sequential HRS waves (each covering a 2-year period) are used to determine transitions in nursing home admission and Medicaid eligibility. Transitions can occur at any time during a wave.

[2] Transfers are cumulative over a six year period (three HRS interview waves). For the "Post-Admission" group, the six year period ends with the first wave of Medicaid participation. For the other groups, the six year period ends with the first wave of nursing home use.

Source: Authors' tabulations based on Health and Retirement Study, 1995-2004

Few Medicaid nursing home residents transferred substantial assets to their offspring

Table 2 presents the distributions of amounts of assets transferred by the groups of nursing home residents in the period beginning about six years prior to admission and ending at Medicaid eligibility. Among those with Medicaid eligibility predating their nursing home use, about two-thirds of persons giving any assets to their children transferred less than $5,000 over six years. The median transfer was $2,800, roughly the cost of two weeks of nursing home care. Only 5% of all positive transfers by this group (representing less than 1% of the persons in this eligibility cohort) were larger than $50,000. If we include estimated values of deed transfers, still only a fifth of all transfers were larger than $50,000. Transfer amounts by the concurrently Medicaid eligible and nursing home admission group were also modest. Nearly 60% of persons making any financial gifts to their children gave less than $5,000. When value of deeds is included, half of transfers were less than $5,000. Among persons making transfers who became Medicaid eligible after a period of private payment, approximately 5% had transfer amounts above $50,000 (32% when deeds are included).

Table 2: Distribution of Positive Transfer Amounts

Timing of Medicaid Eligibility[1]	Median	Percent Under $5000	Percent $5,000 to $50,000	Percent Over $50,000
	Cash Transfers Only			
Pre Admission	2,800	66%	29%	5%
At Admission	4,000	59%	37%	5%
Post Admission[2]	5,000	50%	36%	14%
Always Private-Pay	10,000	37%	50%	13%
	Cash or Deed Transfers			
Pre Admission	7,200	50%	30%	20%
At Admission	5,000	50%	36%	13%
Post Admission[2]	7,500	34%	33%	32%
Always Private-Pay	15,500	32%	46%	22%

[1] Sequential HRS waves (each covering a 2-year period) are used to determine transitions in nursing home admission and Medicaid eligibility. Transitions can occur at any time during a wave.

[2] Transfers are cumulative over a six year period (three HRS interview waves). For the "Post-Admission" group, the six year period ends with the first wave of Medicaid participation. For the other groups, the six year period ends with the first wave of nursing home use.

Source: Authors' tabulations based on Health and Retirement Study, 1995-2004

As shown in Table 3, only a small fraction of persons account for nearly all assets transferred by Medicaid nursing home residents. Approximately 16% of Medicaid nursing home residents who transferred more than $5,000 accounted for 90% of cash transfers, and 2.4% of beneficiaries who transferred more than $50,000 accounted for 43% of assets transferred. When the estimated value of deed transfers is included, 22% of beneficiaries accounted for more than 95% of transferred assets, and 7% accounted for two thirds of transfers.

Asset transfer is most common among "always private pay" nursing home residents

Table 2 also presents the distribution of amount of assets transferred by nursing home residents who **never** become Medicaid covered. This group is the most likely to make transfers of any size, and are also the most likely to make significant transfers, with about half making a transfer in the six years prior to nursing home admission. Approximately two- thirds of transfers made were larger than $5,000, and the median transfer made was $10,000, or $15,500 if the value of deed transfers is included. Given their wealth, people in the "always private pay" group

would also be most likely to make use of legal assistance in planning their estates, which includes accounting for personal acute and long-term health care expenses and monetary gifts to their children and grandchildren.

Table 3: Distribution of Transfers Among Nursing Home Residents Qualifying for Medicaid At or Post Nursing Home Admission

	Cash Only			Cash and Deeds		
Medicaid Admissions over 5 years	713,593			713,593		
Transfer per capita	$ 4,598			$ 9,372		
Total Transfers ($Billion)	3.28			6.69		
By Persons transferring	Amount in billions	Percent of total transfers	Percent of Medicaid Nursing Patients	Amount in billions	Percent of total transfers	Percent of Medicaid Nursing Patients
More than $50,000	1.41	*42.9*	*2.4*	4.45	*66.5*	*7.0*
$5,001-$50,000	1.54	*46.9*	*13.6*	1.94	*29.0*	*14.8*
Less than $5,000	0.33	*10.2*	*21.2*	0.30	*4.5*	*19.6*

Note: Transfers examined over a six-year look-back period.
Source: Authors' tabulations based on Health and Retirement Study, 1995-2004

Maximum Amount of Assets Transferred and Potential Budgetary Impact

Table 3 shows the total amount of transfers among nursing home residents who qualify for Medicaid at or post admission over a five year period. The total amount of transferred assets in the six years prior to qualifying for Medicaid was $3.28 billion, when considering only liquid resources and approximately twice that amount if value of deeds are included. These estimates represent the absolute upper bound of dollars that are subject to current or future Medicaid recovery rules, regardless of the intent of the transfers. Thus, they provide a reference for assessing budgetary impact of proposed changes in Medicaid asset recovery rules.

Given a federal match of about 57%, our estimate of $3.28 billion of total assets transferred 6 years prior to qualifying for Medicaid, translates to potential Medicaid savings of approximately $1.87 billion if all transfers are recovered. Our estimate is roughly comparable to the CBO estimate of the asset transfer provisions enacted in the DRA. However, the expected Medicaid savings from the proposed rule changes relies on recovery of virtually all assets transferred by Medicaid nursing home residents for whatever purposes. These potential savings, moreover, do not necessarily include administrative costs of recovering transferred assets, which are not likely to be trivial.

Discussion

While there is general agreement that some people with substantial financial assets employ asset transfers to gain Medicaid coverage for nursing home care, the extent of this practice has not been adequately documented, notwithstanding considerable public policy debate over potential Medicaid savings. Using data from the HRS to address this question, we found that people who eventually become Medicaid nursing home residents do transfer assets, albeit at a rate slightly below the average of all elderly persons, with amounts of monies that are very small, on average. More important, only a small proportion of Medicaid nursing home residents transfer substantial assets over a five-year period leading up to Medicaid eligibility.[4] In fact, it is the subgroup of nursing home residents who never become Medicaid eligible that practices asset transfers extensively and transfers large amounts of monies. The *a priori* reasoning behind their asset transfers to their offspring was conceivably not to gain Medicaid eligibility for nursing home care.

Given the widely publicized consultation of estate planning lawyers, it is reasonable to ask why these reports seem to be at odds with our empirical findings. We think there are some very plausible reasons for these seemingly inconsistent results.

People expecting to enter nursing homes probably have multiple goals, such as (a) ensuring independence of spouse, (b) avoiding a lien on their home, (c) ensuring placement in a desirable nursing home, and finally (d) providing an inheritance or "repaying" children for the costs of providing assistance and care at home.

Simply learning the steps necessary to protect a non-disabled spouse from impoverishment, while allowing him/her to remain at home may well require the assistance of an attorney. Furthermore, being able to choose among desirable nursing homes often requires sufficient funds to pay privately for many months (or years) of care. Given the high cost of nursing home care, approximately $5,000 per month, a sizeable portion of assets might be used to meet this goal alone.

Available remaining assets to transfer to children or grandchildren may, therefore, be very limited by the time private nursing home costs and other goals are addressed. The associated expenses would result in the relatively small amounts of assets transferred, as recorded by the HRS, even if elderly law attorneys were retained to help with estate planning for Medicaid coverage. Hence, while the "half-a-loaf" strategy sounds logical, expenses to meet other goals may leave only a "slice" of assets left to transfer to children and grandchildren.

[4] These findings are consistent with another recent analysis using a portion of the HRS sample (Lee, Kim, & Tanenbaum, 2006).

Conclusions

Using the best available data on changes in asset profiles of the elderly population, we provide an estimate of all of the assets that were transferred by elderly persons who eventually became Medicaid nursing home residents. This estimate is essentially the maximum number of dollars that could possibly be recovered by Medicaid if all cases of transferred assets were deemed inappropriate and were collected as program savings.

Our estimate is of the potential amounts that were transferred, and do not include the "cost of recovery." Thus, it is an overestimate of the amount of Medicaid savings that could be achieved. It is not implausible that Medicaid nursing home residents with relatively small assets transfers (e.g., less than $5,000) may not be considered *policy significant,* particularly since recovery costs for them may exceed savings. In any case, persons transferring small and moderate amounts and qualifying for Medicaid certainly do not fit the profile of the "well-to-do," were probably not consulting attorneys, and were probably not engaged in planning for Medicaid eligibility when they made these transfers. The data distributions can hopefully help inform which parts of the Medicaid nursing home population are policy relevant for shaping asset transfer rules.

Even if the total amount of transferred assets that we estimated is hypothetically translated into Medicaid savings, this amount is dwarfed by total state and federal spending on long-term care by Medicaid programs, which amounted to $101 billion in FY2004 (http://www.statehealthfacts.org). Thus, even the most aggressive pursuit of transferred assets would recover only about 1% of total Medicaid spending for long-term care. It seems safe to infer that eliminating asset transfers for Medicaid nursing home coverage will not substantially alter the private market for long-term care and is not the panacea for controlling growth in Medicaid spending.

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