Strategic Spend Down and Long Term Care

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13 November 2019
CRESUS Final conference, Antwerpen

Introduction

- People live longer but with age-related disabilities
- Changes in family values lead to outsourced help activities
- Expensive because they are labor intensive: end of life totally impoverished & no bequests
- Private and/or public insurance could cover their dependence costs in the future
  - Medicaid: "needs-based" program for the poorest (US)
  - From 1.2% of GDP in 1999 to 3.7% in 2040 (CBO, 2004)

Introduction

- Middle class can be tempted to apply for Medicaid in case of dependency
- To qualify for LTC Medicaid benefits → insufficient assets to pay for one's own care
- Process of reducing the value of assets is referred to "spending down"
  - By paying for LTC until a level low enough
  - By transferring the assets to children

→ Focus on the process of spending down triggered by bequests motives (with the assumption of preference for late bequests)

Introduction

- Voluntary Impoverishment defeats Medicaid's purpose and preserving peoples' inheritances does not justify diversion of government resources (Miller, 2003)

- When a senior is applying $\rightarrow$ asset threshold limited by a so-called look-back period

- All assets transfers within this timeframe are reviewed $\rightarrow$ if rules are violated, a penalty is applied

$\rightarrow$ Research question: do we observe a strategic behavior to benefit from the public aid?

Introduction

- Use of 2006 Reform (increase of the look-back period from 3 to 5 years) to work in a Difference-in-Differences framework
  - Treated group: 60-64 & Control group: 50-54
  - True data (no hidden transfers) and parents want to keep money as long as possible (precautionary and/or strategic reasons)
- Idea: average increase in transfers for people concerned by the reform ⇒ strategic spend down
- Empirical evidence of strategic behavior (robust results) but ambiguous signals from government

Medicaid Planning and 2006 Reform

- Cost differences among states: annual median of $85,000 for semi-private room
- Medicaid can help because it covers costs in excess of the amount that a Medicaid-eligible is capable of paying (Pargoff, 2012) BUT eligibility criteria:
  - Health and Age: 2 ADLs or more for at least 30 days and 65 years old or more
  - Financial: asset and income (diverse thresholds) tests
    - $2,000 in non-exempt resources (special status for the "community spouse" and HH goods)
    - $3,000 if both spouses apply and live together in the same room at the NH (for at least six months)
    - Examples of non-exempt resources: vacation property, boats, stocks, bonds, insurance policies, funds in retirement accounts

Medicaid Planning and 2006 Reform

- ▶ Three possibilities to "reach" this threshold
  - ▶ They were poor to begin with
  - ▶ They spend down their assets in LTC without any strategy
  - ▶ They voluntary impoverished themselves
    - ▶ To supplement Medicaid ⇒ maintain quality of life until the very end
    - ▶ To assure savings are passed on to loved ones rather than consumed by LTC costs
  - ▶ Several techniques of voluntary impoverishment: creation of trusts (Stone, 2002; Miller, 2003), purchase or improvement of a home, paying off a mortgage, buying a cemetery lot, pre-paying for funeral services (Fliegelman et al., 1997), divorce (Miller, 2015) and outright gifts to children (Miller, 2003)

⇒ Focus only on transfers to children behavior in empirical part

Medicaid Planning and 2006 Reform

- Medicaid Planning exists (specialized lawyers, Markovic (2016)) and so...
- In 2006, government wanted to tighten the conditions of access to Medicaid by increasing the look-back period from 3 to 5 years
- Transfers within the look-back period are subject to transfer penalty.
  - Penalties are calculated according to this rule (Miller, 2015): *"to divid[e] the fair market value of the transferred asset by the statewide monthly average lowest semiprivate room rate for Medicaid certified nursing facilities calculated annually"*.
  - $100,000 during the look-back period ($7,396 for private room in NH in the state) $\Rightarrow$ 13 months and 15 days of ineligibility

Medicaid Planning and 2006 Reform

- Scientific literature about Medicaid Planning in law journals
- Limited empirical evidence of this strategic spend-down behaviour (Norton, 1995; Costa-Font, 2010)
  - Lee et al. (2006) show existence of this phenomenon but in a small number of cases (4 waves of HRS and before the 2006 reform)

Data & Econometric Analyses

- ▶ HRS data from 1998 to 2012 (self-assessment)
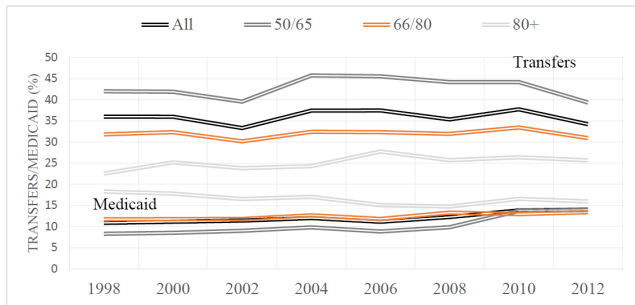- ▶ 4 periods before and 4 periods after the 2006 reform

Figure: Evolution of Medicaid beneficiaries and inter-vivos transfers to children (%)

- ▶ Sample: 50+ with at least one child and answering at least one time before and one time after the reform

Data & Econometric Analyses

Is Medicaid only available to eligible people?

Eligibility criteria	Year	1998	2000	2002	2004	2006	2008	2010	2012
Annual Income (max)	Single or if one of the Couple is dependent	$17,784	$18,468	$19,620	$20,304	$21,708	$22,932	$24,264	$25,128
	If both of Couple are dependent	$26,676	$27,684	$29,412	$30,456	$32,544	$34,416	$36,396	$37,728
Assets (others than housing)	Single or if one of the couple is dependent	Less than $2,000 per person							
	If both of Couple are dependent	Less than $3,000 for the couple							
Dependence	All	2 ADL or more							
Eligible in the sample (%)	All	21.2	20.7	19.9	20.8	20.5	21.2	27.1	26.5
Access to Medicaid even if not eligible (%)	All	1.6	1.8	1.9	2.3	2.1	2.6	2.7	3.0
Access to Medicaid if dependent (%)	All	28.9	29.2	29.8	31.7	28.6	30.0	31.5	31.8
	% in Eligible	24.9	26.3	26.2	26.9	24.6	24.6	27.1	27.0

Figure: Eligibility to Medicaid and Access to Medicaid (%)

$\Rightarrow$ Minor fraud elements

Data & Econometric Analyses

Can we observe potential strategic spend down behavior in descriptive panel data?

	Eligible in t		Eligible in t if no eligible in period of transfer		Medicaid in t		Medicaid in t if no Medicaid in period of transfer	
	N	%	N	%	N	%	N	%
Unbalanced Panel								
Transfer in t	29,658	18.7	-	-	11,346	11.7	-	-
Transfer in t-2	22,711	20.8	7,048	30.4	9,092	12.7	3,244	18.9
Transfer in t-4	16,632	21.6	6,306	31.7	6,984	13.3	3,185	19.8
Transfer in t-6	12,638	23.0	5,378	32.7	5,450	15.1	2,894	21.3
Balanced Panel								
Transfer in t	11,291	18.1	-	-	4,407	10.7	-	-
Transfer in t-2	9,905	20.5	3,208	30.6	3,996	12.0	1,431	18.9
Transfer in t-4	8,523	21.8	3,280	32.2	3,546	13.4	1,581	20.1
Transfer in t-6	7,141	23.4	3,041	33.1	3,035	15.2	1,558	21.6

Figure: Eligibility and Medicaid in t according to current and previous transfers

$\Rightarrow$ Suspicion but not confirmed by classic panel econometric analysis (Negative and significant relationship between transfer in t, t-2, t-4 and t-6 and eligibility or medicaid access in t)

Data & Econometric Analyses

- ▶ Until now, no evidence of strategic impoverishment
- ▶ Indeed, if we had found a significant relationship between previous transfers and eligibility/access to Medicaid, we could have concluded that the economic agents were acting strategically
- ▶ Results show the opposite sign for the different models tried (except for access to Medicaid with FE where we do not find any effect of transfer but possibly driven by richest individuals)

$\Rightarrow$ We move to a difference-in-differences analysis using the 2006 reform as a buffer date and assume that if we see in average an increase in transfers for people concerned by the reform

$\Rightarrow$ strategic spend down

Data & Econometric Analyses

▶ Necessary assumption for DD method: treatment and control outcomes move in parallel in the absence of treatment
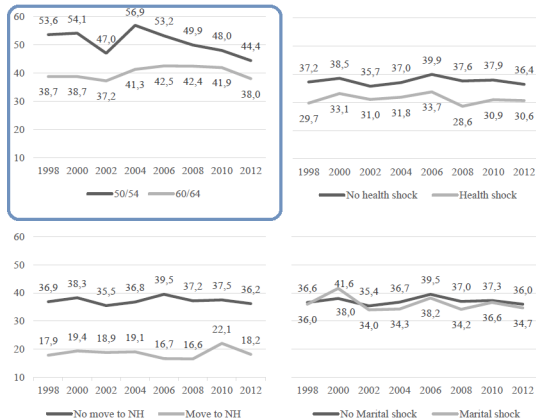
▶ Treated group: 60-64 & Control group: 50-54

Figure: Parallel trends of probability of transfers for control and treated groups

Data & Econometric Analyses

We can then estimate the following regression using OLS:

$$Y_{ist} = \alpha_s + \beta_t + \gamma\, I_{st} + c\, X_{ist} + \epsilon_{ist}$$

where α_s and β_t are fixed effects for states (age group) and years respectively, X_{ist} are relevant individual controls and ϵ_{ist} is an error term. The estimated impact of intervention is then the OLS estimate $\hat{\gamma}$.

- ▶ Coefficient $\hat{\gamma}$ expected to be positive if there is a strategic behaviour
- ▶ People would like to transfer quicker assets to children in order to qualify for Medicaid because of the increase of the look-back period which lengthens the duration of the observation of financial transfers by administration
- ▶ Parents would anticipate the risk (potentially with altruistic reasons)

Data & Econometric Analyses

	(1)		(2)		(3)		(4)	
Treat	-0.147***	(0.010)	-0.119***	(0.010)	-0.116***	(0.010)	-0.110***	(0.010)
Post	-0.038***	(0.014)	-0.039***	(0.013)	-0.039***	(0.014)	-0.005	(0.018)
Treat * Post	0.061***	(0.017)	0.038**	(0.016)	0.038**	(0.017)	0.042**	(0.017)
Man	ref.		ref.		ref.		ref.	
Woman			-0.093***	(0.017)	-0.090***	(0.017)	-0.090***	(0.017)
Couple			-0.012	(0.016)	-0.028*	(0.016)	-0.028*	(0.016)
Education			0.037***	(0.001)	0.036***	(0.001)	0.036***	(0.001)
Children (#)			-0.000	(0.002)	0.001	(0.002)	0.001	(0.002)
Environment & Health								
Help fr. children					-0.007	(0.018)	-0.006	(0.018)
Health Index					0.118***	(0.017)	0.121***	(0.018)
NH Living					-0.376***	(0.038)	-0.367***	(0.036)
Unem. Rate					-0.003	(0.002)	0.007	(0.005)
Year Dummies	No		No		No		Yes	
N	28281		27861		25627		25627	
R^2	0.014		0.073		0.076		0.077	

Robust standard errors in parentheses (clustered at HH level); $^*p < 0.1$, $^{**}p < 0.05$, $^{***}p < 0.01$

Figure: Reform impact on probability of financial transfers to children (50-54 vs. 60-64)

Data & Econometric Analyses

- Main results of Pooled LPM:
  - Negative and statistically significant signs of α_s and β_t
  - Positive and statistically significant sign of $\hat{\gamma}$: anticipation of the risk of assets spend down due to dependency
- Robustness tests:
  - Placebo (53-55 vs. 56-58): no effect
  - Broader age limits (50-57 vs. 60-67): effect
  - Balanced panel: effect
  - Trigger points? Health or HH shocks: no effect
- Intensive margin: no effect (but no parallel trends before the reform)

Extrapolations & Discussion

- Simple extrapolations with strong assumptions
- We multiply the average amount of transfers by the statistically significant increase of probability of transfers and by the number of inhabitants (by age group) $\Rightarrow$ $8 billion

Treated group (age)	Increase of probability of transfers (1)	Average amount of transfer if transfer (2)	USA inhabitants 2015 (by age group) (3)	Extrapolation (1)*(2)*(3)	Medicaid 2015	% of Medicaid 2015
60-64	4.2%	9840	18986357	7,846,681,621	552 billion	1.42%
60-67	3.0%	10040	28437080	8,565,248,496		1.55%

Figure: Extrapolations on increasing transfers

However, these figures do not say anything about the amount that could have been saved by Medicaid if any strategic behavior could be curbed

Extrapolations & Discussion

- Ambiguous signal from government:
  - Allowing this behavior...
  - But repressing it through the look-back period and the penalties

- Implicit tax (difficult access to Medicaid) to late transfers implies that government could seek in some way to accelerate these transfers in order to boost the economy by placing money in the hands of economic agents likely to spend it (and prevent wealth from sleeping in a bank account)
  - Matthew Effect appears (Merton, 1968)

- Two solutions (Cremer and Pestieau, 2017): audits or taxation of inter vivos gifts (but costs may outweigh benefits)

Conclusion

- Very little literature on the empirical evidence of strategic spend down

- By using the 2006 as a buffer date and the DD method $\Rightarrow$ empirical evidence of average increase of transfers for people concerned by the reform

- By assuming preferences for late transfers $\Rightarrow$ this increase = strategic spend down