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Working Paper

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AEI Economics Working Paper, No. 2022-01

Provided in Cooperation with:

American Enterprise Institute (AEI), Washington, DC

Suggested Citation: Warshawsky, Mark J. (2022) : Specific steps to improve the fairness and sustainability of Medicaid's financing of long-term services and supports for older Americans, AEI Economics Working Paper, No. 2022-01, American Enterprise Institute (AEI), Washington, DC

This Version is available at:

<https://hdl.handle.net/10419/280648>

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Specific Steps to Improve the Fairness and Sustainability of Medicaid's Financing of Long-Term Services and Supports for Older Americans

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AEI Economics Working Paper 2022-01
January 2022

Specific Steps to Improve the Fairness and Sustainability of Medicaid's Financing of Long-Term Services and Supports for Older Americans

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March 9, 2022

Abstract

In a prior article (Warshawsky and Marchand, 2017), a colleague and I put forward some broad proposals to improve the system of financing long-term services and supports (LTSS) for older Americans, to make it fairer, more sustainable, and more consistent with the value of self-reliance. In this report, I update the basis for those proposals and make them more specific, so that legislation could be written to implement them. Based on newly available unpublished data, I calculate a new lower bound estimate of how much additional resources would be available to states and the federal government from more effective enforcement of the estate recovery rules in Medicaid for LTSS — \$3 billion instead of the current \$700 million collected nationally. This estimate is based on the superior but not remarkable efforts of a few states, compared to the mediocre activity of many states and the nearly non-existent efforts of a few. I also explain how the state Medicaid LTSS eligibility and recovery rules could be better designed and administered, in particular by including retirement accounts as countable assets and outlawing various transfer techniques used by the well-to-do to qualify. These recommendations are in strong contrast to those contained in a recent report from the Medicaid and CHIP Payment and Access Commission (MACPAC), which recommended that estate recovery should be made optional for states and passed on addressing other fairness issues. In light of the falling birth rate in the US, which will increase the demand for paid LTSS care in the future even beyond the aging of the baby boom generation already increasing the Medicaid funding burden on governments, and the continued failure of California to follow federal Medicaid laws and its proposal to waive all asset tests, the reforms I recommend here for federal Medicaid matching to encourage state efforts and changes and to encourage individuals' insurance and asset accumulation are essential.

¹ Senior Fellow, American Enterprise Institute. Also Vice-Chair of the 2013 Federal Long-term Care Commission. My thanks to Kieran Allsop for excellent research assistance, to Brian Burwell, James Capretta and Robert Doar for helpful conversations, and to Mary Pat Farkas of CMS for providing unpublished data.

A Brief Review of the Issues and the Recent Literature

LTSS refers to a broad range of health and health-related services and assistance needed for an extended period of time by individuals of all ages. It is generally measured by limitations in an individual's ability to perform daily personal care activities such as bathing and dressing, or the need for personal supervision owing to severe cognitive problems. This care can be provided in an institutional setting, like a nursing home, or at the individual's residence, through home care provided by personal aides. According to Colello (2021), national spending on LTSS in 2019 totaled \$426 billion, or about 13 percent of the \$3.2 trillion spent on personal health care. Total Medicaid LTSS spending was \$183 billion, comprising 43 percent of all LTSS spending and 33 percent of all Medicaid spending. In terms of population, about 5.5 percent (4.7 million) of the Medicaid enrolled population gets Medicaid-paid LTSS care.

Because LTSS is not a universal need, but an uncertain risk, even at older ages, insurance may be thought to be the best mechanism for financing it. But the need for formal paid care as opposed to family and other informal care is also elastic and situation dependent. Therefore, the triggering events for insurance payment must be defined precisely and somewhat limited or the insurance model breaks down. According to careful calculations by Favreault and Johnson (2021) based on survey and other data, focusing on the expected LTSS need of those age 65 and older at a relatively severe level, the average duration of LTSS need is now 3.2 years for women and 2.3 years for men, although there is substantial variation. Severe in this context is defined, consistent with federal health law, as a need for assistance with at least two activities of daily living that is expected to last at least 90 days or need substantial supervision due to severe cognitive impairment. A large share (44 percent) of the older population will have no LTSS needs, and for 10 percent, needs will last less than a year. However, 22 percent of the older population will have LTSS needs for at least five years. These needs may be met by unpaid (usually family) care (more than half of such needs were met by unpaid care in 2020), or paid care, including service types such as nursing homes, residential care (like assisted living), and formal home care. Home care is currently more common at "younger" old ages, residential care is more common in "middle" older ages, and nursing home care is more common for "middle" and "old" older ages.

The lifetime need for any LTSS care and for paid care is somewhat higher for the lowest income groups and the unmarried, but, surprisingly, is not much different across groups with different health statuses at age 65. The skewness in the distribution for spending is even stronger than that for need, according to Favreault and Johnson (2021) – 52 percent will spend nothing, 8 percent will spend less than \$10,000 in present discounted value, but 12 percent will spend more than \$250,000. The average sum in 2020 dollars of lifetime LTSS expenditures for individuals above age 65 with severe needs, paid by Medicaid, is estimated to be \$101,000.

Insurance can be private or public, including universal social insurance programs. Private long-term care insurance (LTCI) grew during the 1980s and 1990s, both in extent of service coverage and in the number of people insured. According to the 2013 federal Long-Term Care Commission, about 13 percent of older Americans had purchased LTCI. More recently,

however, its growth has stalled, as favorable federal tax treatment, available for health insurance and retirement saving, has not been forthcoming. Exploiting variation in the adoption and generosity of state tax subsidies for LTCI, Goda (2011) finds that the average modest state tax subsidy increases private coverage rates by 2.7 percentage points, or 28 percent, and that each dollar of state tax expenditure produces about \$0.84 in Medicaid savings, split between state and federal governments. Because this effect is concentrated among high income and asset households, for reasons explained below, a larger federal tax subsidy combined with Medicaid reforms would likely produce a bigger impact and more savings.

Also, private premiums have unexpectedly increased, and several insurance companies have withdrawn from the market with unprofitable books of business and large investment and underwriting losses. In particular, unrealistic expectations of significant policy lapses used to lower product prices were not realized, and interest rates fell. “Partnership” policies were introduced in most states; with certain requirements on plan provisions, coverage by these policies gives asset protection from estate recovery up to the amount paid from the policy for LTSS care, and then eligibility for Medicaid. As explained by Lin and Prince (2013), if an individual purchases a partnership policy, he will qualify for Medicaid after the same amount of loss as if he didn’t have LTCI. So savings to Medicaid come mainly from reductions in asset transfers and use of other techniques to qualify for Medicaid. Indeed these researchers found that partnership programs increase LTCI take-up by 2.5 percentage points, which represents about a 15 percent increase of a baseline coverage rate of 17 percent for individuals above the 80th wealth percentile. As will become clear below, the incentive to purchase these policies is strongly enhanced by effective, well-advertised and vigorous eligibility determination and estate recovery efforts by states.

Private product innovation has largely stopped. The insurance industry never moved from a “modified whole life” insurance model, that is, continuous lifetime payments of fixed premiums set at the initial purchase age (“issue age rated”), unless the costs of the insured class unexpectedly increased. This approach necessitates strict underwriting in order to remove those who will claim early in the policy’s life cycle; this underwriting is estimated to eliminate a third or more of the older population from potential coverage because of health and life-style issues (American Association for Long-term Care Insurance, 2020). A paid-up or life care (combination) annuity approach would have solved this problem caused by adverse selection and largely eliminating the need for underwriting (see Brown and Warshawsky (2013)), but was not tried. So public insurance advocates entered the breach.

For some time, advocates pushed for a new social insurance program to be created to finance LTSS for the working age and, especially, the older (above ages 55 or 65) disabled populations. A version of that public insurance approach was part of the 2010 Affordable Care Act (ACA), called Community Living Assistance Services and Supports (CLASS). Its inclusion in the ACA was motivated largely by the forecasted front-end collection of significant insurance premiums for voluntary federal CLASS coverage, in order to help establish the political claim that the ACA

was fully funded. In fact, as Warshawsky (2010) had already shown, CLASS was a poorly designed program that would have been subject to severe adverse selection of risks, low take-up, and inadequate coverage. The Congressional Budget Office was mistaken to forecast so much revenue (\$70 billion) in the ten-year budget window from CLASS, a program that was never viable. It was never implemented, and Congress repealed it in 2013.

More broadly, universal mandatory LTSS social insurance faces the severe headwinds of competing political priorities for spending on other social welfare issues, the current and projected inadequate finances of existing massive social insurance programs (Social Security and Medicare), and the poor precedents of those programs for unfunded expansions, mistaken actuarial projections and exploding costs. So instead, advocates have more recently focused on changes to the existing main social welfare program for LTSS: Medicaid.

Washington State nevertheless passed legislation in 2019 to set up a state LTSS social insurance program by 2022; the program was mandatory for all current and future workers unless, on a one-time, initial and permanent basis, the individual claimed that he had current private long-term care insurance coverage. In mid-December 2021, Governor Inslee announced that the program would be delayed until at least 2023. Also, lawsuits against the program were filed, an opposition public referendum measure introduced, complaints made about a relatively modest benefit accrued just for those who paid payroll taxes and reside in the state, and severe doubts expressed about its long-run financial and structural viability. Interestingly, among the claimed advantages of the program are significant savings to Medicaid and Medicare. See Warshawsky (2022) for details about the program and its problems.

One rationale for social insurance is that there are gaps in coverage and serious unmet needs without government intervention. There is ambiguous evidence on whether there are significant unmet needs for LTSS arising from the current patchwork of Medicaid, Medicare, other government programs, private insurance, and private spending. Freedman and Spillman (2014), consistent with LaPlante et al. (2004) found quite modest unmet physical needs, e.g. 4 percent unmet needs with adverse consequences for toileting, 3 percent managing medications, and so on. Therefore, the social desirability of expansion of formal LTSS coverage is not established. The researchers did find a larger scope of unmet needs by expanding the definition to include indicators of social isolation, accounting for 15 percent of the older population. Despite this evidence and a general rising concern about social isolation, many advocates have recently turned their policy efforts to move the Medicaid program from focusing on group living, like nursing homes, to home care for isolated individuals. In the American Rescue Plan, and as proposed in Build Back Better legislation, additional federal Medicaid funding goes to states if they change program rules and plan to increase the share of LTSS Medicaid spending for home care and the pay of those workers providing the direct care, rather than care provided in nursing homes or pay for workers in this group setting.

Also, while ignoring the current porous eligibility rules for even wealthy households, some have proposed to remove the current requirements for states to recover Medicaid spending from estates of beneficiaries; see the recommendations of the federal Medicaid advisory and review panel, MACPAC (2021). This policy approach would, in essence, make Medicaid more of a social insurance program, albeit indirectly, through a policy back door. Government costs would rise, both because of the drop in state recovery collections directly and from the woodwork effect of increased Medicaid enrollment of higher income and greater asset-holding households. The MACPAC commissioners justify such a change by making an equity claim that the estate recovery activities of states concentrate on capturing the assets of lower middle-class beneficiaries, including those of color, as opposed to those of wealthy households. MACPAC, however, provides no evidence of such a bias. Indeed, elementary economic logic would indicate the opposite – surely it is more efficient for states, with limited enforcement resources, to target large estates, and many states have cost-effectiveness thresholds below which they do not collect. Further, many states also give hardship waivers. MACPAC (2021) itself reports on the results of a survey of ten states which found that the average recovery amount was in the tens of thousands of dollars and the maximum was in the hundreds of thousands and even millions of dollars.

Others, more conservative in orientation, also basing their proposals on the current LTSS financing system, want to go in the opposite direction, to encourage private saving and insurance, and reduce rapidly rising government costs. In particular, they are persuaded by the strong logical and empirical evidence found in Brown and Finkelstein (2007, 2008) that the current Medicaid program has largely crowded out private LTCI, except at the higher income and wealth registers. In particular, because Medicaid's benefits are free, even if partially means tested, they calculate that it is rational for all but those in the highest 10 to 35 percentiles of the wealth distribution to forgo the purchase of private insurance. Stated another way, Medicaid acts as an implicit tax – an amount exceeding 50 and approaching 100 percent of the expected present value of payments from a LTCI policy provide no net benefits for policyholders. While it is not expected that poor households would purchase private LTCI, it is reasonable to think that prudent middle-class households would at least buy partnership policies, as part of their retirement planning, if not for the Medicaid “tax.”

There is a strong strand in the economics literature that ascribes a significant share of the motivation for retirement savings to the need to finance LTSS. Hence, according to these findings, any increase in public insurance for LTSS would reduce retirement savings of households, and vice versa. The most sophisticated model of life cycle savings is by Ameriks, et al. (2020) which introduces health-dependent utility with preferences for bequests, LTSS spending, and ordinary consumption during retirement, with health and longevity uncertainty and incomplete private and public LTC insurance. Using strategic survey questions to sharply identify motives, they find that the desire to self-insure against LTSS risk explains a substantial fraction of the wealth holding of the half of the older American population which has significant

assets. For many older Americans, the desire to finance LTSS is roughly equal with the bequest motive in explaining savings behavior in terms of levels (higher overall) and postretirement patterns of decumulation (relatively slow). Other studies find more support for the bequest motive by noting the weak demand for LTCI, but they ignore the significant toll of underwriting on such demand.

Conservative analysts are also concerned about the current large and projected increasing government costs for LTSS, especially for the older population, and the concomitant need to raise taxes, as the baby boom generation ages, given that rates of severe disability increase rapidly with age. According to Favreault and Johnson (2021), Figure 2, using revised data provided by the authors, the disability rate at ages 65 to 69 is 4.8 percent, but by ages 90 and older, it is 47.1 percent. Further, based on Favreault and Johnson's elaborate projection model, matched to the assumptions of the 2019 Social Security and Medicare Trustees' Reports, and based on data from various surveys and further modeling assumptions, the number of aged people with severe disabilities is projected to double from 7.2 million to almost 14.3 million by 2065, a faster rate of growth than that for the rest of the aged population. For paid service users, the number will also double from 5.5 million to 11.1 million.

Favreault and Johnson (2021) model Medicaid and out-of-pocket payments as the main sources for LTSS expenditures. They produce a lower Medicaid and higher out-of-pocket payment share than other analysts, estimating that 39 percent of LTSS spending is covered by Medicaid and 57 percent by out-of-pocket payments, 2 percent other public, and 3 percent by LTCI. By contrast, Colello (2021) finds that 43 percent is paid by Medicaid, 21 percent by Medicare, 6 percent by other public programs, 15 percent out-of-pocket, 9 percent private insurance and 7 percent other private sources, mainly charity. Among the reasons for the differences are that Favreault and Johnson include just the elderly (generally having higher income and assets than the working-age disabled so less likely to be covered by Medicaid) and exclude shorter-term LTSS episodes which are often covered by Medicare and private health insurance. Still other reasons are that Favreault and Johnson include private pay, non-agency transactions, which by definition are out-of-pocket but typically are not included by other analysts, because they are considered to be too speculative given data issues. Favreault and Johnson also include the room and board component of residential care, which strictly is not LTSS but simple housing and food consumption.

Medicaid spending on LTSS for the aged will increase from 0.37 percent of GDP in 2020 to 0.53 percent of GDP by 2047, a rate of cost growth faster than the unsustainable projected growth of Social Security, albeit at a lower level (Favreault and Johnson, 2021). According to the projections of national health expenditures as of March 2020 from a research team at the Center for Medicare and Medicaid Services, the combined components of Medicaid LTSS spending will increase 62 percent from 2019 through 2028, while GDP will only increase 46 percent. According to one state, Washington, Medicaid LTSS spending will increase from six to 12 percent of the state budget over the next twenty years.

There are several reasons for the Favreault and Johnson cost estimate to be considered on the low side of expectations. It assumes that governments do not fully index the parameters of the Medicaid program for inflation thereby eroding coverage in the long-run in a way which does not seem politically plausible. Similarly, it assumes that the rate of growth in wages of home care workers will lag that of other workers. Although it is true that home care workers are more likely to be immigrants, many undocumented, over the long run it is not a sustainable equilibrium to see this labor sector fall so far behind others. The model follows the assumptions of the Trustees' Reports. Although this is probably reasonable in general, the high fertility rate assumption of those Reports has been called into question, given recent trends and new survey evidence (see Warshawsky (2022)). Given that children are often unpaid caregivers, their future relative absence would imply higher Medicaid (and out-of-pocket) costs for paid care. This will also mean a lower GDP in the long run than currently projected.

Many analysts are also concerned with the unfairness of the current design and administration of the Medicaid LTSS program. Although the program is supposed to be devoted to poor households and is commonly asserted by advocates to require strict low-income and asset eligibility tests, that is, restricted to those with very limited resources, the reality is different. For a myriad of reasons, as I will explain briefly in the next section, the eligibility, continuing coverage, and estate recovery rules are porous and incomplete, allowing middle-class and even wealthy households complete Medicaid access and payment, with no payback demanded by states.

This distributional unfairness is confirmed empirically in numerous studies. Using survey data, Borella, et al. (2018) find that while 30 percent of the 70-year-old singles in the bottom third of the permanent income distribution are on Medicaid, nearly 10 percent of those in their late 90s with high permanent income are on Medicaid. People in couples are less likely to be on Medicaid than singles, but the increases in Medicaid reciprocity by income and age follow similar patterns for couples and singles. Although the result for older high income individuals might be explained by the longer longevity, lower morbidity, and a spend-down of assets for the high income group, the researchers find that there is little decumulation of assets for both couples and singles in the top permanent income tercile. So a different, more institutional and cultural, explanation is likely apposite. Using a multivariate analysis, controlling for variables related to Medicaid eligibility rules, they find that white people have a lower probability of receiving Medicaid than non-white people, but surprisingly this effect is zero for income percentiles below the 30th and increases with permanent income and reaches five percentage points difference at higher income levels. Education reduces the probability of Medicaid receipt at lower incomes while being a single woman increases it.

De Nardi, et al. (2016) similarly find that the reciprocity rate of higher-income retirees reaches 20 percent by age 95, and that, conditional on receiving Medicaid benefits, high-income individuals receive larger transfers (nearly double) than low-income individuals. In addition, Johnson and Favreault (2021), using their model, find that 25 percent of older adults in the middle quintile of

lifetime earnings, 16 percent of those in the fourth quintile and nine percent of those in the top quintile enroll in Medicaid. MACPAC (2021), using survey data, found considerable wealth remaining in the estates of deceased elderly Medicaid recipients from 2012 to 2016 – the overall average net worth was \$44,393 and in the upper wealth quartile, decedents had an average of \$173,436 in net worth, including \$98,694 in home equity, in 2016 dollars. Finally, microscopically reviewing 294 approved Medicaid nursing home applications in two counties each in three states, the Government Accountability Office (2014) found that 14 percent had total resources over \$100,000 and five percent transferred assets for less than fair market value.

Current Medicaid LTSS Rules and Practices

What accounts for the observed distributional unfairness in Medicaid LTSS? The answer is actually fairly simple – it owes to the program rules and administrative practices. Although the described broad federal legal framework for Medicaid LTSS is to limit coverage to the poor, defined in terms of set low income and asset levels, the actual detailed rules, called pathways in the government literature, and administration, which vary considerably by state, are loose. As a result, they allow Medicaid coverage to individuals and households with significant or even large asset holdings, give them the opportunity to transfer assets to others (often relatives), and fail to recover assets from decedent estates.

In general, all who are eligible for Supplemental Security Income (SSI), the cash welfare program for the disabled and elderly which has strict income and asset limits, are eligible for Medicaid. But, in most states, people can also be eligible for Medicaid if their spending on LTSS is in excess of a set income amount, averaging 45 percent of the federal poverty level across states. Income, with minor offsets, should be taken by the state when long-term care expenses are paid by Medicaid. Most states also give Medicaid LTSS institutional care access to those with income below 300 percent of the SSI monthly income test amount and many states give eligibility to all LTSS services for those with incomes below 100 percent of the poverty level. Asset holdings are also restricted, again varying by pathway and state. Rules protect some income and assets for community-resident spouses. See MACPAC (2021), Warshawsky and Marchand (2017), and Government Accountability Office (2014) for more specifics on all these pathways and conditions.

Significantly, some important asset classes are excluded from the “countable” asset limits, enabling Medicaid LTSS recipients to retain high net worth. Non-countable assets include the primary residence, household goods and personal effects, burial funds and spaces, some life insurance, and an automobile. If an individual’s home equity is above the state’s limit (in 2021, the federal minimum was \$603,000 and the maximum was \$906,000, although California, ignoring federal law, has set no maximum), the individual is ineligible for Medicaid LTSS, but if below that value the home equity is not a countable resource. The home limit also does not apply if the individual has a spouse, a child under 21, or a resident child with a disability of any age. As carefully documented by Warshawsky and Marchand (2017) and also shown by the American

Council on Aging (2020), qualified retirement assets, like IRAs, 401(k) and 403(b)s, cash balance plans, and so on, are also often non-countable, although the rules vary considerably by state, including whether spousal retirement assets or assets in pay-out status (including those getting minimum distributions after age 72) are counted or not. Among states with large older populations, California, Florida, New York, Illinois, Louisiana, North Carolina, Iowa, Kentucky, and Georgia exempt retirement assets in whole or in part. In its otherwise extensive review of Medicaid eligibility and recovery rules and survey of the literature, including Warshawsky and Marchand (2017), it is surprising that MACPAC did not mention the significant issue of countability of retirement assets. About 30 states exempt retirement assets fully or partially. This exclusion is significant because retirement assets now represent the largest source of income for older Americans, more than Social Security (see Dushi and Trenkamp (2021)), and are underreported in surveys of household income and wealth. More recently, California has proposed in its budget to waive all asset tests for Medicaid eligibility. It is unclear how CMS can approve such a waiver given the cost to taxpayer and the opposite direction taken in legislation and the equity concerns of the Biden Administration.

Federal law discourages individuals from employing methods in order to establish Medicaid eligibility for LTSS such as transferring countable assets to relatives. Those who transfer assets during a look-back period of five years (only 30 months in California) before applying for Medicaid (before transferring assets in California) will be ineligible for a period of time called a penalty period. Although this law represents an important equity improvement over prior laws, there are still legal loopholes that allow transfers of assets to relatives while gaining Medicaid eligibility. As explained by the Government Accountability Office (2014) and Miller and Stroud (2015), these legal transfer mechanisms include:

- purchases of non-countable goods and services (including care agreements with children and home improvements or even upgrades);
- purchasing income annuities or promissory notes whose payouts must be used for the expenses of LTSS care at the lower Medicaid rate, enabling some savings compared to private pay rates;
- so-called “reverse half-a-loaf” transfers, shortening the penalty period, involving the post-eligibility return of a gift to the Medicaid user;
- transferring assets to a community spouse who then refuses to provide support;
- special needs trusts;
- “gift-stacking” or non-countable asset transfers to non-spouses in California;
- and purchases of short-term income annuities for the community spouse (because the community spouse’s resources are deemed non-countable post-eligibility).

Apparently unique to California, there are no transfer penalties for home care paid by Medicaid.

These mechanisms can be complicated and are often implemented with the help of lawyers and financial planners. However, this assistance is readily available. Indeed, by typing “avoid

Medicaid estate recovery” in a Google search on November 23, 2021, I found 216 results. Half were from law firms; the rest were news items, educational, governmental, legal aid, and so on. About a fifth of the results were national in scope. For the rest, the rules of 47 states were specifically mentioned with Texas, New York, Georgia, Ohio, and Pennsylvania most frequent.

Another source of unfairness is the lack of rigor in the states’ administration of these eligibility rules. The Government Accountability Office (2012) found lax standards for documentation of assets from applicants, obtaining information from third parties to verify assets, or retrospective investigations to determine the application of the look-back period. In 2011, no states had yet implemented the electronic asset verification system, despite a federal law requirement. By 2018, a dozen states still had not implemented the system and so in 2019, Congress passed a law whereby the federal medical assistance percentage (FMAP) would be reduced for further non-compliance. According to MACPAC (2020), four states have still not implemented the system and five states have done so only partially. Moreover, these asset verification systems involve only some banks and no other financial institutions such as retirement plan record keepers or mutual fund providers, so the effectiveness and scope of asset searches using the system can be quite incomplete. More broadly, the HHS Inspector General has found numerous state errors in eligibility determination for Medicaid generally (see, for example, its 2018 report on California).

Most of these inadequacies in both eligibility rules and administration could be remedied, at least in part, by effective recovery of assets from the Medicaid beneficiary’s estate. A strong recovery program, well publicized, would incentivize private insurance coverage, asset accumulation, and avoidance of Medicaid LTSS application among the middle- and higher-income and larger asset-holding households, thereby reducing government costs and the need to raise taxes. The Medicaid law since 1993 requires states to recoup private assets of institutionalized individuals and those who were older than 55 when they received benefits, through probate when a beneficiary dies, in order to recover Medicaid expenditures on her behalf. Some states use liens imposed on property even before the death of the beneficiary and some go beyond probate in collecting from the estate. These efforts include non-countable assets like the home, or assets missed at, or accumulated after, the eligibility determination. The use of probate, however, is limiting as it excludes assets that do not go through probate, importantly including retirement assets which are nearly always assigned to designated beneficiaries. Probate is also limiting to the state if other higher priority creditors collect first. It also misses asset transfers and, in most states, it misses when the Medicaid beneficiary dies before a community spouse who subsequently never uses Medicaid. Hardship waivers are also required, generally, for income-producing assets, if the home is of modest value, or if it is not cost effective to pursue recovery. States are required to provide notice to Medicaid applicants explaining estate recovery and some give subsequent reminders. See MACPAC (2021) for more details on estate recovery processes, by state.

New Estimates of Estate Recoveries by States and the Extent of Effort

Warshawsky and Marchand (2017) was the first comprehensive study collecting data from various sources and conducting an analysis of estate recovery efforts by state, from 2002 through 2011. They found that in the latter years of that period, after all states had begun recovery programs, states collected about \$500 million in aggregate annually. Using various assumptions, the researchers estimated that, in aggregate, states collected about 6 percent of the net worth of older Medicaid beneficiaries, and around 0.4 percent of the annual Medicaid LTSS expenditures, with some apparent impact from the economic cycle. The researchers described these results as significant but modest because they also found that there was wide variability in effort by state and instability over time. In particular, they found that in later years Idaho and Iowa collected nearly five times as much as the average state, using the metric of the ratio of collections to expenditures. If all states had been as diligent as Idaho in 2011, \$3.1 billion would have been collected nationally rather than \$0.5 billion. MACPAC (2021) calculated that in 2019, states collected about \$730 million from beneficiary estates. As a portion of Medicaid LTSS spending, excluding managed care, recoveries were about 0.6 percent annually over the period 2015 to 2019, with Iowa having the most effective program, and Delaware and Vermont reporting no collections.

Table 1 shows data on Medicaid estate recoveries for the 50 states and DC, from 2012 to 2020. The data for 2015 to 2019 is reproduced from MACPAC (2021), while the data for 2012 to 2014 and 2020 was provided by CMS, based on their Form CMS-64. We see that nationally, estate recovery collections increased substantially from \$474 million in 2012 to \$754 million in 2017, a peak, moving sideways to \$733 million in 2019 before dropping to \$656 million in 2020. The latter data point perhaps reflects a drop in asset values during the COVID recession, and, perhaps, an increase in hardship waivers. Looking across states, in dollar terms, Massachusetts, New York, Pennsylvania, Ohio, Wisconsin, Minnesota, and until 2019, California collected the most money, while Arizona, Delaware, Hawaii, Louisiana, Mississippi, New Mexico, and Vermont were making little or no effort at estate recoveries, according to their annual reports to the federal government. The federal government shares in the fruits of each state's recoveries, according to the state-specific FMAP, so there may be some incentive for states to underreport. The substantial drop in recoveries in California is notable and bears further investigation.

Although the dollar values of estate recoveries are insightful, it is more relevant to see the efforts made by states relative to the total net worth of their deceased Medicaid LTSS beneficiaries, as the maximum possible base of recovery. The latter can be estimated, and is likely related to the number of beneficiaries and the relative prosperity of the state residents, which I infer from home values. Indeed the net value, after deduction for mortgages, of homes are often the major asset of deceased Medicaid households, as cited above.

I estimate the annual by-state net worth of deceased Medicaid beneficiaries as follows. First I calculate the average national Medicaid LTSS expenditure per beneficiary by dividing annual national Medicaid LTSS expenditures, as found in Medicaid LTSS expenditure reports for 2012 to 2018 (Medicaid.gov, 2021), by the number of national Medicaid LTSS enrollees, as found in

MACStats (MACPAC, 2021). Missing expenditure data for California, Illinois, New York, and Virginia for 2017 and 2018 is estimated, and enrollee numbers for 2012, 2014, 2015, 2016, and 2017 are based on an interpolation. I then adjust the national per beneficiary spending to account for state differences in the cost of care by multiplying by a state price level factor to get per beneficiary spending for each state. This price level factor is the ratio of the median house value in the state to the national median house value in a given year, as found in the American Community Survey. Then to estimate the number of state Medicaid LTSS beneficiaries, I divide annual total state Medicaid LTSS expenditures, as found in the Medicaid LTSS expenditure reports mentioned above, by the estimates of state per beneficiary spending for 2012 to 2018.

Next, to get the number of decedents annually from these state beneficiary numbers, I multiply by a mortality rate. The mortality rate is that found in De Nardi, et al. (2017), table 2, for nursing home residents, weighted by gender, and divided by two to approximately account for the lower mortality of home care recipients. The resulting mortality rate is 22 percent. The gender weighting is 68:32 for women:men based off of the 2015 nursing home population (NCHS, 2019).

Finally, to get the annual by-state net worth of deceased beneficiaries, I multiply the above estimate of deaths by the average net worth of Medicaid beneficiaries in the state. We saw earlier that the national average in 2018 of the net worth of deceased older Medicaid beneficiaries was \$44,000. That is roughly equivalent to the 40th percentile in the Panel Study of Income Dynamics (PSID) data for the distribution of the same measure. The PSID has the advantages that it is a representative survey widely used, long-running, and relatively easy to code, that gives the needed statistic every two years, so I can get annual measures extrapolated from the observations. The annual national net worth averages are then adjusted for state differences by using the state price level factors described above. Then, for each state, I calculate the annual ratio of their actual Medicaid estate recoveries to the estimated total net worth of deceased Medicaid LTSS beneficiaries. These ratios can be used to compare states' efforts and effectiveness, to observe trends, and to estimate what the national total could be if all states were as effective as the state with the highest ratio.

As shown in Figures 1 A through E, there is a wide range in states' efforts in Medicaid estate recovery, during the period 2012 to 2018. As in the past, Idaho and Iowa lead other states by a substantial margin, collecting around 10 percent of estimated net worth of deceased beneficiaries; Kansas, Wyoming, Oregon, South Dakota, Massachusetts, New Hampshire, Wisconsin, Minnesota, Maine, and Utah are often above six percent. Most other states collect only about two to three percent of the net worth of deceased beneficiaries, including the large states of California, Illinois, and New York, and many states never even crack one percent, including Michigan, Texas, and Virginia. In addition to Delaware and Vermont, already mentioned, West Virginia, Louisiana, Arizona, and Hawaii essentially make no effort to recover from estates, as evidenced by their consistently very low collection ratios. Most states are fairly consistent in their efforts over time, but there is sometimes variability within a state over time. I

remove from further analysis the unusual and unexplained very high collections of Delaware in 2014 and Oklahoma in 2017. Figure 2 shows the time series of the weighted average for the nation as a whole over this period of the Medicaid estate recovery as a percent of the estimated net worth of deceased beneficiaries. That national average was about three percent in 2014 but declined to less than 2.5 percent of total net worth by 2018, as the increase in collections failed to keep up with the increase in net worth. Although no doubt estate collection is difficult work, it is usually contracted out to third parties (MACPAC, 2021), so policy and other administrative decisions by states likely play a major role in the extent of recoveries.

Table 2 shows the two states with the highest collection ratios in each year, 2012 to 2018. If we apply the highest probate collection rate for each year to the estimated net worth of deceased Medicaid beneficiaries in each state, we get an estimate of the potential amount that states could reasonably collect, using the administrative and policy choices made by these states, usually Iowa or Idaho. According to MACPAC (2021), however, there were no apparently unusual policy choices by these states. Given that these are small states, presumably economics of scale or scope are not a consideration in their efforts. As seen in Figure 3, by 2018, the improved effort would recover \$3 billion annually instead of the about \$700 million actually collected, that is, the potential is about four and a quarter as large as the actual. Most of this additional collection would come from the estates of high income and large asset-holding households, given the known distribution. Given that the 10 to 12 percent represents considerably less than the entire estimated estate, it is certainly possible that these estimates are low for the true amount that could be collected.

Summary of Results and Policy Recommendations

The evidence clearly shows that eligibility for Medicaid LTSS crowds out private insurance and asset accumulation that substantial portions of the population could manage to purchase or save to cover the risk of LTSS in old age. The current rules and administration of Medicaid by states exempt the major assets of retired households – housing and qualified retirement assets – and the enforcement of spend-down and asset transfer rules is incomplete and inadequate. This is apparent from direct review of state rules and administration and from observations in numerous studies on the extent of Medicaid use by middle- and upper-income and asset older households. Indeed, despite past legal improvements in targeting Medicaid LTSS eligibility away from well-to-do households and to keep it focused, as a matter of fairness and economy, on the poor and lower-middle-class, mechanisms and strategies still exist and are actively marketed to avoid the federal safeguards. California, after fifteen years, still has not implemented the existing federal rules and is proposing further deviations from federal standards. Medicaid LTSS expenditures are already large for state and federal governments and will grow considerably with the aging of the baby boom generation, increasing longevity, and declining birth rates. These weaknesses can be, at least partially, remedied after the fact by effective administration of estate recovery programs, to collect remaining assets, both countable and non-countable, from Medicaid beneficiaries with net worth, which indeed the survey evidence shows is significant and

widespread. But most states make no, little, or modest efforts at estate recovery compared to conservative estimates of the net worth pool which is available to be collected. Much more can be done – instead of the current \$700 million collected by states, at least \$3 billion could be recaptured annually.

Some advocates have nonetheless recommended increasing federal spending on new social insurance programs or on Medicaid LTSS, or weakening Medicaid program rules such as making state efforts for estate recovery optional. Given the political unlikelihood, to say nothing of the policy inadvisability, of these proposals, a different direction is needed, which will result in an overall more robust system and would encourage insurance and financial sector innovation, as well as self-reliance, and reduce projected government costs and avoid tax increases. Building on the current system, there are several straightforward steps that can be taken, by legislation, rule-making, and administration to more tightly focus Medicaid LTSS eligibility and administration on the core population who needs its paid services, and improve estate recovery.

As recommended in Warshawsky and Marchand (2017), qualified retirement assets should be made, by federal law, universally and completely countable assets. These assets have been granted significant tax benefits precisely to support spending in retirement, including LTSS, and not to leave as bequests or to avoid other federal program safeguards, like in Medicaid. The inclusion of retirement assets at the beginning of the eligibility process also avoids the obvious problem of recovery in probate. Similarly, state *dum vivit* liens on housing, even for couples, should be allowed and encouraged. Warshawsky and Marchand also recommended lowering the allowable limit on housing equity, given the increase in liquidity of that asset class, given reserve mortgages and home lines of credit. In the current inflationary environment, indeed a housing bubble, this suggestion is not likely to be legislated, for political reasons. Existing federal rules for the state Medicaid programs must be enforced by the Centers for Medicare and Medicaid Services (CMS), backed up by penalties. States that still do not have fully functional electronic asset verification systems must be penalized by a one percent annual reduction in their FMAP, as indeed is required by current law. And some experimentation by the states, partially subsidized by CMS, at expanding asset tracking beyond banking assets should be started. Similarly, California must be even more severely penalized for not implementing the many rules of the Deficit Reduction Act of 2005, by a reduction of its FMAP from the statutory 50 percent by 2 percentage points per year until it comes into compliance. Federal law should be changed to disallow the many complex and obscure transfer and avoidance mechanisms and products that enable the well-to-do to gain eligibility to Medicaid LTSS.

Related to the main focus of this paper, the federal requirement for estate recovery program by states must be stiffened and specifically enforced. Although the implementation details (more effective administration, policy changes, and so on) can be left to the states, the requirement, three years after passage, must be that estate recoveries reach five percent of available net worth, as we have estimated it, in each state, increasing one percentage point each year, over five years, to 10 percent of net worth. Estates with less than \$2,000 for individuals and \$3,000 for couples,

the current Medicaid limits (or higher if those limits were to be raised), could be excluded from the requirement for state efforts, in order to focus on the most productive and fair collection activities. If the state does not reach these goals, then its FMAP will be reduced by one percent per year until compliance is achieved. Enough states are already in range of these targets to make this legislative proposal a reasonable and plausible fix to the current overall lack of state effort at estate recovery, to complete the package of reforms to ensure the fairness of the Medicaid LTSS program, and to improve the incentives and provisions of the current system of financing LTSS for older Americans.

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Tables and Figures

Table 1: Medicaid Estate Recoveries by States, 2012-2020 (\$ thousands)

State	2012	2013	2014	2015	2016	2017	2018	2019	2020
Alabama	6,655	9,067	4,516	4,847	5,277	5,686	6,749	7,259	7,638
Alaska	2,551	1,469	1,546	2,890	2,092	3,222	2,245	2,679	1,978
Arizona	101	28	346	449	393	583	354	216	198
Arkansas	3,029	2,467	1,938	2,240	2,632	3,094	2,779	3,796	2,732
California	52,722	52,318	59,865	71,786	69,613	68,411	41,127	28,987	16,881
Colorado	3,094	4,771	4,951	7,250	5,599	6,432	8,377	6,409	8,193
Connecticut	8,277	7,766	8,982	6,460	7,728	8,424	12,078	15,405	13,183
Delaware	12	0	11,551	25	0	0	0	0	0
District of Columbia	275	520	445	3,485	2,072	2,283	1,357	1,461	1,866
Florida	11,574	12,861	14,514	14,537	16,003	16,468	21,327	22,411	25,745
Georgia	4,133	4,455	4,005	5,903	6,134	5,331	4,939	4,481	4,422
Hawaii	68	45	32	12	55	21	55	31	25
Idaho	8,034	7,322	8,571	9,561	10,573	10,202	11,699	11,934	14,574
Illinois	21,444	24,609	23,950	18,948	19,829	19,731	22,354	25,949	22,821
Indiana	10,168	10,790	13,511	16,398	17,005	19,077	17,493	13,198	16,790
Iowa	19,839	21,149	22,163	24,174	24,746	27,664	27,426	26,485	26,172
Kansas	10,677	9,915	14,016	13,114	9,722	12,776	18,199	13,240	16,402
Kentucky	6,545	8,305	8,165	12,397	8,122	6,254	7,142	7,351	5,321
Louisiana	376	467	374	381	230	313	534	430	248
Maine	6,475	7,126	9,107	9,195	10,481	11,203	9,847	10,248	9,442
Maryland	7,432	14,035	6,778	14,972	10,128	14,450	13,734	13,701	2,521
Massachusetts	33,794	47,680	53,892	55,974	59,877	63,813	73,712	83,071	70,438
Michigan	0	1,286	3,792	4,201	2,114	0	5,118	6,478	5,639
Minnesota	28,389	30,396	32,269	33,078	32,031	35,127	36,561	39,905	39,558
Mississippi	980	812	463	559	691	947	684	399	235
Missouri	14,274	12,173	18,215	11,394	13,796	15,221	17,382	13,695	16,851
Montana	2,614	2,189	2,868	3,580	2,963	3,614	4,135	4,037	4,777
Nebraska	2,375	2,350	2,955	3,842	3,753	6,681	5,532	4,742	6,616
Nevada	1,996	1,695	1,923	2,351	3,950	1,954	2,545	3,154	3,255
New Hampshire	4,866	5,998	6,534	5,280	5,612	6,248	7,420	7,713	6,385
New Jersey	7,930	11,270	7,110	12,173	18,596	13,898	18,261	13,840	19,888
New Mexico	39	172	55	301	349	67	1,005	157	143
New York	23,715	52,817	53,331	52,365	67,625	70,036	62,882	59,760	44,678
North Carolina	13,667	13,688	14,643	12,827	16,118	14,245	17,405	19,842	15,245
North Dakota	3,719	2,108	3,937	3,596	3,020	2,491	4,663	4,490	2,533
Ohio	28,547	32,509	32,313	35,634	29,357	31,224	40,575	43,795	44,743
Oklahoma	3,914	4,124	3,492	3,652	4,830	81,875	5,076	5,264	5,063
Oregon	17,063	14,542	12,274	20,566	25,684	28,225	30,704	31,434	20,850
Pennsylvania	36,110	41,195	40,026	38,106	43,891	54,047	52,133	54,093	44,599
Rhode Island	3,274	2,438	2,573	3,103	3,270	3,785	2,753	5,381	4,660
South Carolina	4,113	3,953	5,003	4,689	4,093	1,565	5,560	3,844	3,575
South Dakota	2,257	3,123	2,856	3,058	3,229	3,355	3,732	2,714	3,948
Tennessee	14,492	11,780	14,739	20,101	21,017	21,553	24,381	29,437	23,386
Texas	7,632	5,570	5,675	5,960	4,377	6,178	6,244	4,996	6,144
Utah	2,615	2,639	3,938	4,853	3,944	5,132	4,306	5,488	4,980
Vermont	707	521	738	453	0	0	0	0	0
Virginia	952	648	729	1,173	4,312	3,593	3,999	6,130	2,992
Washington	6,023	29,013	16,026	14,302	15,887	16,196	20,374	16,989	17,227
West Virginia	441	503	545	717	498	537	477	210	2,006
Wisconsin	22,138	22,476	25,146	22,931	21,563	17,793	33,059	41,400	32,862
Wyoming	1,958	1,838	2,383	2,450	1,607	3,454	3,379	5,307	5,146
United States	474,075	560,991	589,769	622,293	646,488	754,479	723,872	733,436	655,574

Thousands of dollars

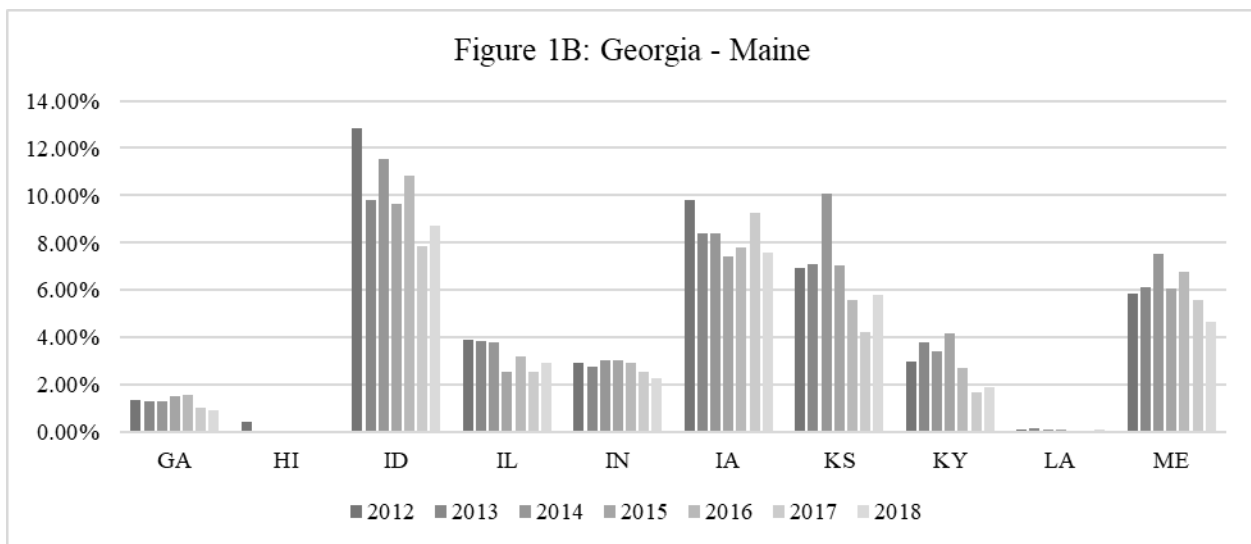
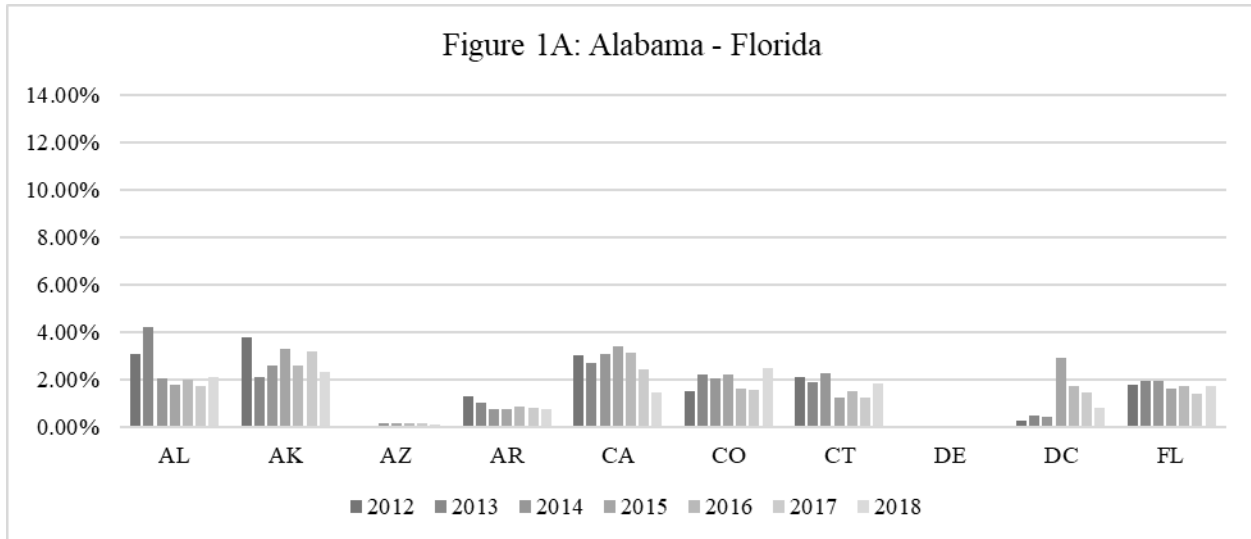
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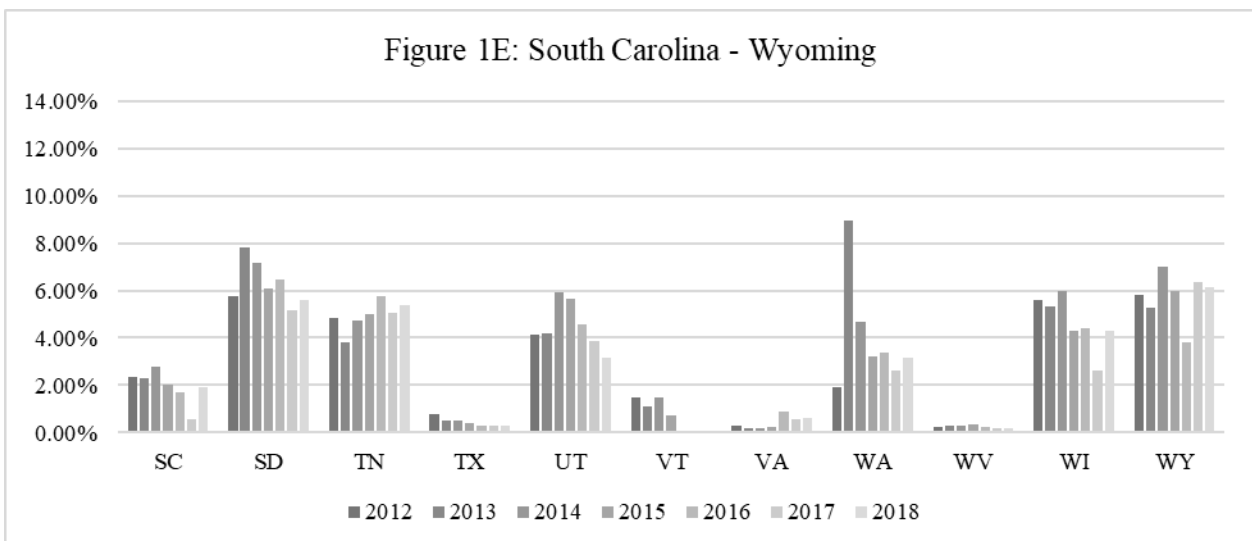
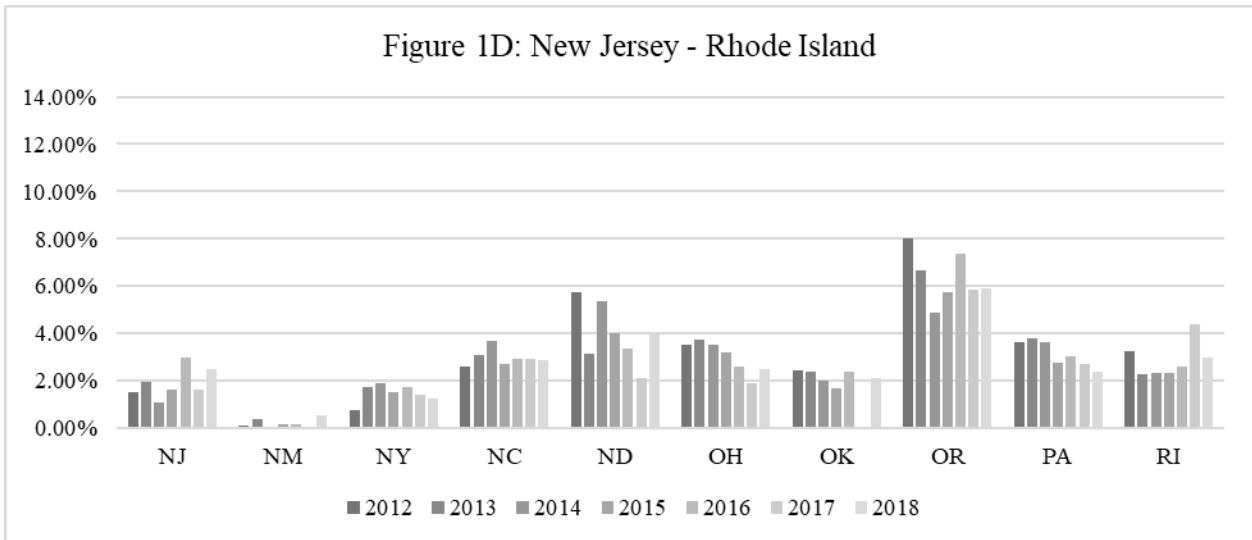
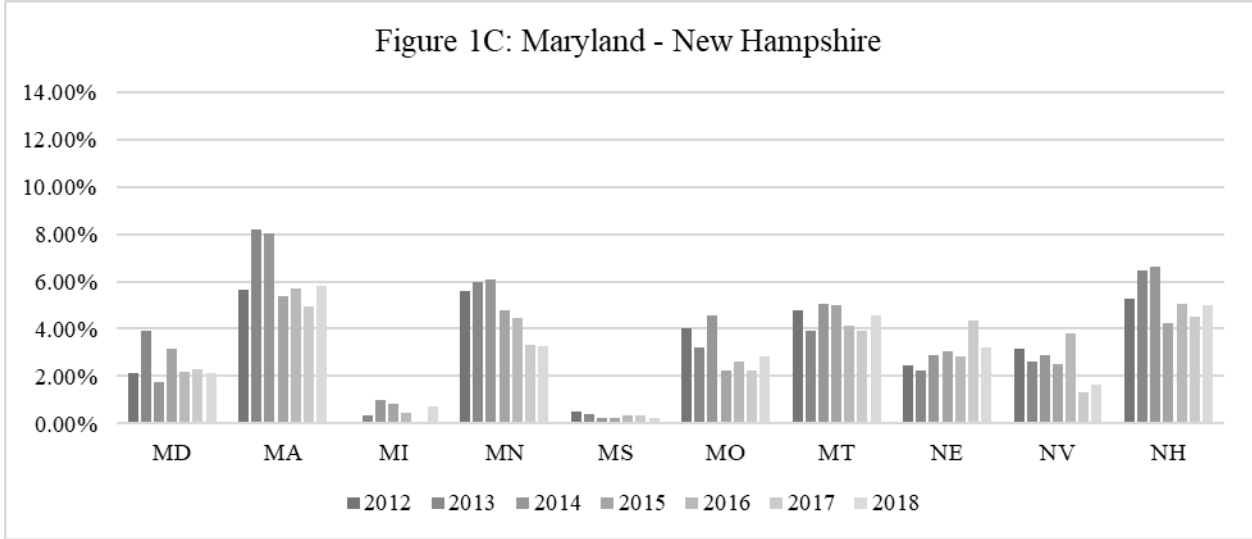
Table 2: Highest State Estate Recovery Rates, 2012 – 2018

	Rank 1		Rank 2	
	State	Collection Percentage	State	Collection Percentage
2012	Idaho	12.82%	Iowa	9.79%
2013	Idaho	9.82%	Washington	9.95%
2014	Idaho	11.52%	Kansas	10.08%
2015	Idaho	9.63%	Iowa	7.41%
2016	Idaho	10.84%	Iowa	7.81%
2017	Iowa	9.29%	Idaho	7.84%
2018	Idaho	8.73%	Iowa	7.58%

Source: Author's calculations.

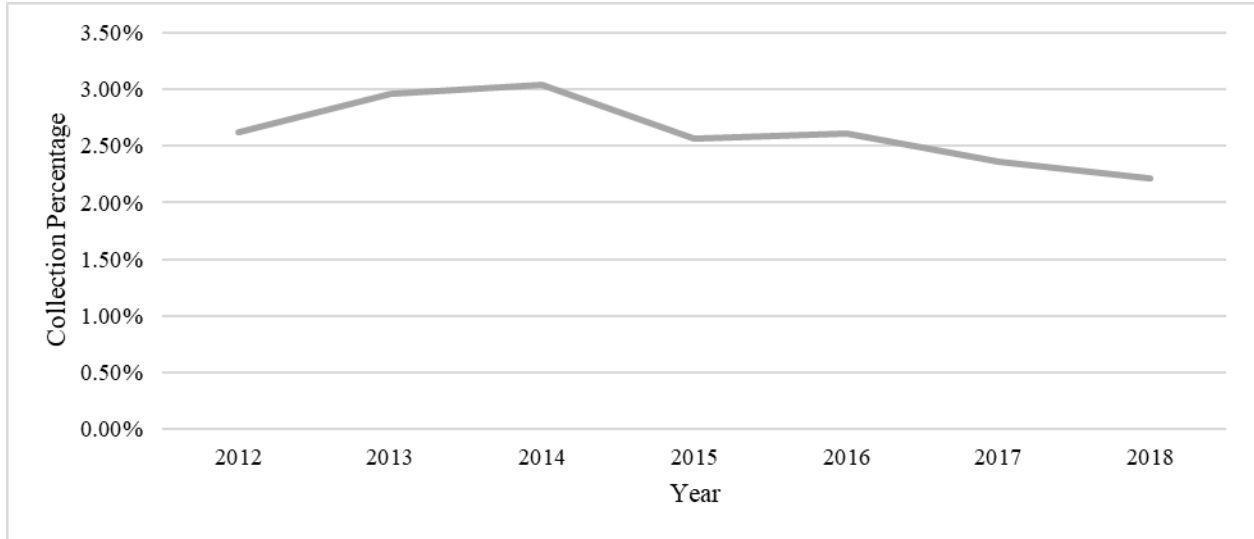
Figures 1A through E, Estimated Rate of Estate Recovery in States, 2012 – 2018





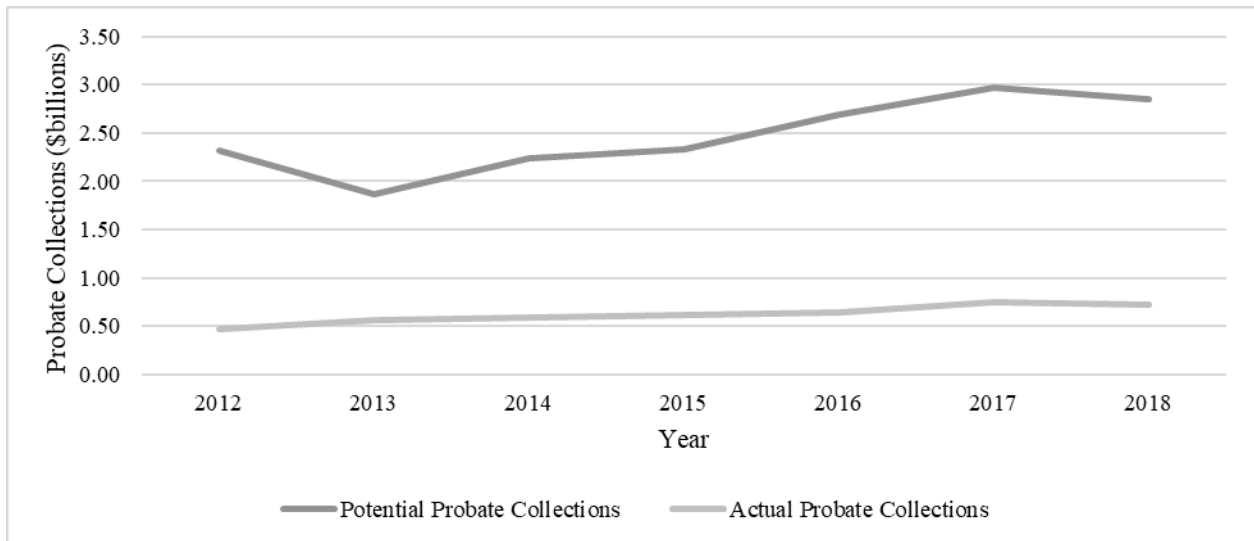
Source: Author's calculations.

Figure 2: National Average Medicaid Estate Recovery Rate, 2012 – 2018



Source: Author's calculations.

Figure 3: Potential vs. Actual Medicaid Estate Recoveries, National Totals, 2012 – 2018



Source: Author's calculations