

Medicaid Enrollment and Intergenerational Transfers of Wealth Among Older Adults

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Abstract

Background and Objectives: Medicaid look-back periods are meant to prevent Medicaid applicants from gifting assets to meet eligibility requirements. These policies have the potential to affect families across generations given their ability to restrict the transfer of assets between parent and child.

Research Design and Methods: Using 2008–2018 data from the Health and Retirement Study, this study analyzed the estate planning and familial wealth transfer behaviors of a cohort of older adults aged 65 and older who became Medicaid recipients during a 10-year period.

Results: There were 8,347 respondents aged 65 and older in 2008 and 11.96% of respondents who were not Medicaid recipients at baseline became recipients over the study period. A little more than one third (36.47%) of Medicaid recipients participated in estate planning and asset transfer prior to becoming a recipient, with significant differences among select demographic characteristics. Married recipients were more likely to transfer money compared to their widowed counterparts (51.69% compared to 36.44%; $p < .001$) and transferred larger amounts compared to those unmarried (\$16,286.94 compared to 5,379.13). White, well-educated, married, men participated in higher rates of estate planning, likely a reflection of who has access to resources to make necessary arrangements early.

Discussion and Implications: This analysis concludes that more structurally advantaged groups are more likely to engage in estate planning prior to Medicaid enrollment. This analysis demonstrates that some individuals may circumvent Medicaid policies like look-back periods and estate recovery, while others cannot. Policymakers should consider policies that promote the financial health of low-income families.

Keywords: Estate planning, Medicaid, Wealth accumulation

Background

Medicaid, a means-tested public health insurance program, provides comprehensive healthcare coverage for low-income and disabled adults in the United States. As the largest payer of institutional and community-based long-term services and supports (LTSS), Medicaid also fills in when Medicare and other private payers have coverage gaps (Reaves & Musumeci, 2015), extending beyond the scope of low-income adults to cover an increasing number of middle-class Americans as they age (Bin Abdul Baten & Wehby, 2022; Grogan, 2006). The program's LTSS benefits cover nursing home care as well as home care for those who meet both financial and functional eligibility requirements. Long-term care facilities are costly (Norton, 2016) and not covered by Medicare, and while some long-term care insurance covers them, many do not opt into these policies (Brown & Finkelstein, 2009). As a result, individuals who would not otherwise qualify for a means-tested program end up as Medicaid recipients by spending-down their savings on medical expenses while still maintaining ownership of their largest assets, their homes (Pearson et al., 2019; The Medicaid Medically Needy Program, 2012). Despite restrictive eligibility requirements, Medicaid excludes a recipient's primary vehicle and owner-occupied housing assets from means-tested requirements as a way for policymakers

to ensure recipients do not become impoverished by illness (Grogan, 2006).

Medicaid and Spend-Down Behavior

To meet Medicaid's eligibility, individuals with income over the level determined by their state must spend-down their assets prior to receiving coverage (Medicaid Spenddown & Extra Help, 2022). Spending-down often involves a combination of medical expenditures and gifting, where a parent might choose to transfer wealth to their children (Ershow-Levenberg, 2005; Keohane et al., 2017). This enables parents to ensure an inheritance for their children while protecting assets from Medicaid's purview. Older adults frequently seek the guidance of attorneys for estate planning and may put money and other assets into exempt holdings to qualify for Medicaid (Ershow-Levenberg, 2005).

Medicaid's look-back period is meant to prevent applicants from gifting assets to become eligible. The look-back period refers to the period before the date someone applies for Medicaid that subjects all financial transactions—including transfers made by a spouse—to review by Medicaid prior to determining eligibility (Transfer of Assets in the Medicaid Program, 2008). If the look-back rule has been violated, an applicant is deemed ineligible for a specified period (see

Supplementary Table S1 for how the period is calculated). A total of 48 states and the District of Columbia have a 60-month (i.e., 5-year) look-back period, while California and New York are more lenient depending on the type of Medicaid coverage (see Supplementary Table S1 for more information). Despite the intentions of the look-back period, applicants may still transfer assets outside of the 60-month window. Early and proactive estate planning can secure assets for those who wish to cement an inheritance for surviving relatives. While many participate in early estate planning to protect familial wealth, not all have access to these resources, which may contribute to disparities in intergenerational wealth (Koss & Baker, 2018).

Estate Planning and Implications for Intergenerational Transfer of Wealth

Estate planning describes the process of making arrangements for a person's estate who is still living, in preparation for their eventual death or incapacity. It can include drafting a will or a trust as well as designating decision makers through advanced care directives. Completing a will or trust may protect assets from policies like look-back periods and Medicaid estate recovery (MER), both policies that may have implications for intergenerational transfers of wealth. MER was established in 1993 as a part of the Omnibus Budget Reconciliation Act, in an effort to rein in costs associated with Medicaid and shift the burden from states to Medicaid recipients and their families (H.R.2264—103rd Congress (1993–1994), 1993). MER allows states to recover costs associated with providing LTSS by seizing the assets of deceased Medicaid recipients (Greenhalgh-Stanley, 2012; Zieger, 1997). MER policies are structured such that “the cost of medical assistance covered by Medicaid becomes a debt of the recipient's estate or the estate of the recipient's spouse” (Zieger, 1997). Similar to look-back periods, awareness and understanding of MER remains low among recipients (March 2021 Report to Congress on Medicaid and CHIP, 2021), indicating a disconnect between the policy and recipients of LTSS benefits. However, recovery attempts have increased dramatically in recent years. According to an AARP survey, 42 states and the District of Columbia attempted recovery from 3,242 estates in 2004 (Karp et al., 2005). Within a 15-year period, this number increased sixfold; a Medicaid and CHIP Payment and Access Commission report found that 19,697 estates were recovered by just 10 states in 2019 (March 2021 Report to Congress on Medicaid and CHIP, 2021).

Evidence suggests that a number of sociodemographic factors including race/ethnicity and homeownership are associated with estate planning (Carr, 2012; Kelly et al., 2013; Koss & Baker, 2018; Yung-Ting, 2008). For example, White older adults are four times more likely to engage in estate planning than their Black counterparts (Koss & Baker, 2018). In addition, homeownership is associated with an increased likelihood of estate planning—regardless of property value (Koss & Baker, 2018). For low-income families, homeownership is the primary source of wealth (Shapiro et al., 2013; Wainer & Zabel, 2020) and inheriting a home from a parent can improve the long-term wealth accumulation of a young adult (Modi & Sewell, 2022; Pfeffer et al., 2013). Wealth provides families with a safety net in the event of a change in income or health emergency. Disparities in wealth have been well-documented (Gale & Scholz, 1994; McIntosh et al., 2020; McKernan et al., 2013, 2014; Wainer & Zabel, 2020).

In 2016, the net worth of a typical White family, \$171,000 on average, was nearly 10 times greater than that of a Black family (\$17,150). Gittleman and Wolff (2004) found that the wealth gap could shrink by an additional five percentage points if Black and White households received equal inheritances overall (Gittleman & Wolff, 2004). Considering existing Medicaid policies, without proactive estate planning, older adults may leave their assets vulnerable, having to sell their home to pay for care or forfeiting it to Medicaid upon their death.

Prior Literature

Research investigating the relationship between asset transfers and Medicaid enrollment is limited and dated. Lee et al. (2006) used data from the Health and Retirement Study (HRS) to analyze the relationship between asset transfers and Medicaid in the AHEAD sample (e.g., those aged 70 or older in 1993), controlling for marital status. The authors found a small number of familial wealth transfers occurred prior to Medicaid enrollment; when wealth transfers occurred, they were modest in size and more frequent among married couples (Lee et al., 2006). Furthermore, a report by the U.S. Government Accountability Office found that 22% of older adults in the 2002 HRS transferred cash resources and that amounts varied by income and assets (Medicaid, 2005). In the two decades since these studies, Medicaid look-back periods have been extended and MER policies have been implemented in every state.

Liu & Mukherjee (2020) used difference-in-difference models and 1998–2014 HRS data to measure the impact of the 2005 Deficit Reduction Act (DRA), which extended look-back periods from 30 to 60 months, on wealth transmission from parent to child (Liu & Mukherjee, 2020). Their study compared individuals with low risk to enter a nursing home compared to those deemed high risk, restricting analysis to married couples and controlling for demographic, health, and economic factors. They found that the DRA reduced wealth transfers by 11% among married individuals deemed likely to enter a nursing home (Liu & Mukherjee, 2020).

Twenty years after Lee's descriptive analysis, the landscape of long-term care and Medicaid financing has meaningfully changed. Specifically, this descriptive study builds upon the existing literature by examining Medicaid enrollment and intergenerational wealth, adding a focus on differences by race/ethnicity and look-back periods to investigate the prevalence of estate planning and wealth transfers among older adults newly enrolled in Medicaid, evaluating whether select characteristics influence new Medicaid recipient behavior.

Method

Data and Sample

This study utilized data from the HRS, a nationally representative, longitudinal panel study of individuals aged 51 and older that surveys households every 2 years. HRS includes information on family structure, health insurance, health status, caregiving decisions, estate planning, and financial transfers (Health and Retirement Study, 2023). The 2008–2018 period was selected to minimize bias, as the most recent 10-year period available prior to the coronavirus disease 2019 pandemic. The sample was restricted to individuals aged 65 or older for the entirety of 2008 (i.e., people who turned 65 in 2007).

Measures

There were three primary measures used for this analysis. First, I created a binary variable of whether a respondent was covered by Medicaid at the time of each interview wave, which occurred every 2 years. While Medicaid eligibility is granted at the individual level, the means-tested criteria for determining eligibility is applied at the individual or couple level. Thus, analysis was conducted at either the individual or couple level, examining whether any individual in a household was a Medicaid recipient.

Next, I created a binary variable of whether a respondent reported transferring \$500 or more in the last 2 years. I also used the follow-up question that asked how much money was transferred to a respondent's child or grandchild to understand the average dollar amounts of wealth that respondents were transferring to family members.

Finally, I created a binary variable for estate planning that was 1 if a respondent had either a will or trust, and 0 if they did not have a will or a trust. Respondents could report (1) having a will only, (2) have a will and trust, (3) not having a will, but having a trust, or (4) having neither a will nor a trust. [Supplementary Table S2](#) contains the verbatim of the primary measures from the HRS questionnaire.

Subgroup analyses were conducted using a measure of whether a respondent was living in a nursing home at the time of the interview. I created an additional variable of the year the respondent moved to the nursing home to distinguish newly institutionalized older adults from those who lived in a nursing home at the start of the study period.

While most states have a 60-month look-back period, two states have shorter look-back periods, which could affect estate planning and wealth transfers ([Supplementary Table S1](#)). I created a binary variable that records a respondent's state of residence and whether that state had a more generous (e.g., California and New York) look-back period.

Demographic characteristics included a continuous measure of age, gender (male, female), race/ethnicity (non-Hispanic [NH] White, NH Black, Hispanic/Latino, Other), educational attainment (more than a high school degree, high school degree or less), marital status (married, unmarried, widowed), a continuous measure for number of children, health condition (fair or poor, good or very good or excellent), homeownership (did not own a home, owned a home), a continuous measure of home value, income (above 100% Federal Poverty Level [FPL], below 100% FPL), a continuous measure of total existing wealth, and a binary measure for state look-back period (living in a state with a 60-month look-back period, living in a state with less than a 60-month look-back period). Categories were created to handle missing data for all demographic variables, following the single imputation strategy for missing values conducted as standard methodology ([Roda et al., 2014](#)). Because the HRS is a multistage probability sample of households, the data were weighted using HRS household weights, accounting for clustering and stratification.

Empirical Strategy

Main analysis

In order to understand the relationship between becoming a new Medicaid recipient and wealth transfers, I identified those who did not report having Medicaid at the baseline interview in 2008, but became Medicaid recipients before subsequent

interviews. Then, I traced back their wealth transfer behaviors before Medicaid enrollment. Because of its potential relationship with wealth and estate planning, analyses were stratified by marital status. I report the descriptive statistics for changes in Medicaid status across waves and the frequency and amount of wealth transfers overall and by marital status.

I analyzed the demographic characteristics of respondents who became new Medicaid recipients after the baseline interview. Then, I examined the demographics of respondents who became new Medicaid recipients and transferred wealth, compared to the characteristics of those who did not transfer wealth, before enrolling in Medicaid. I also examined the demographics of respondents who became new Medicaid recipients and participated in estate planning prior to Medicaid enrollment, and compared characteristics against those who did not estate plan prior to Medicaid enrollment. Wald tests were used to identify significant differences between groups.

Additional analyses

While many rely on Medicaid for home- and community-based services, Medicaid is also the largest funding source for custodial nursing home care ([Reaves & Musumeci, 2015](#)). The need for nursing home care may motivate wealth transfers that differ from those who remain in the community. I conducted a subgroup analysis that tracked those who became institutionalized at some point during the 10-year study period, but were not living in a nursing home at the baseline interview. After identifying those who became new nursing home residents, I traced back their Medicaid benefits and wealth transfer behaviors. Given small sample sizes, this analysis could not be stratified by marital status as in the main analysis.

To ensure no sample selection bias based on age, I conducted an additional sensitivity analysis of the main analyses with a sample restricted to a cohort of adults aged 60 and older.

Results

I identified 8,347 respondents who were aged 65 and older in 2008, representing a weighted total of 27,542,639 individuals. By 2018, there were 3,209 respondents remaining, representing 11,043,941 individuals weighted, and a 61.56% exit rate. [Table 1](#) shows the frequency of Medicaid receipt over a 10-year period overall and by marital status. Just 4.07% (379) of respondents who were not beneficiaries at the baseline interview in 2008 became Medicaid recipients in 2010. A majority of new 2010 Medicaid recipients were unmarried (265 vs 114 married). More than 10% (11.96%; 998) of respondents who were not beneficiaries in the baseline interview became Medicaid recipients over the 10-year period. Trends in marital status and Medicaid receipt continued with 13.65% (650) of respondents who became Medicaid recipients during the 10-year period being unmarried compared to 9.65% (346) married. Just over a quarter (27.61%; 104) of the 379 new Medicaid recipients in 2010 transferred wealth prior to becoming a recipient and 61.54% (64) respondents reported the dollar amount of that transfer. During the 10-year period, 36.47% (364) of new Medicaid recipients reported transferring wealth prior to becoming a recipient. The average dollar amount transferred prior to becoming a 2010 Medicaid recipient was \$5,215.15 (95% confidence

Table 1. Medicaid Estate Planning Among 65+ Households by Wave, HRS 2008–2018

Variable	Wave 9 (2008)	Wave 10 (2010)	Wave 11 (2012)	Wave 12 (2014)	Wave 13 (2016)	Wave 14 (2018)	Cumulative over 10 years
No. of households who participated in the interview							
Overall	8,347	6,954	6,131	5,232	4,212	3,209	
Unmarried, % (no.)	54.86 (4,761)	54.98 (3,995)	55.36 (3,564)	56.56 (3,135)	56.64 (2,565)	57.08 (1,971)	
Married, % (no.)	45.14 (3,585)	45.02 (2,959)	44.57 (2,560)	43.27 (2,088)	43.10 (1,639)	42.87 (1,236)	
% of those who did not participate in the interview among those who participated in the prior interview	—	16.69 (1,393)	11.83 (823)	14.66 (899)	19.50 (1,020)	23.81 (1,003)	61.56 (5,138)
% of new Medicaid recipients among those who were not Medicaid beneficiaries in the previous wave							
Overall, % (no.)	—	4.07 (379)	2.71 (244)	1.87 (168)	1.50 (133)	0.81 (74)	11.96 (998)
Unmarried, % (no.)	—	6.14 (265)	4.15 (156)	3.02 (98)	2.98 (82)	2.14 (49)	13.65 (650)
Married, % (no.)	—	3.20 (114)	2.93 (88)	2.72 (70)	2.58 (49)	1.87 (25)	9.65 (346)
% of new Medicaid recipients who transferred wealth							
Overall, % (no.)	—	27.61 (104)	38.07 (87)	40.13 (71)	46.88 (61)	60.55 (41)	36.47 (364)
Unmarried, % (no.)	—	24.81 (58)	39.42 (49)	40.13 (36)	44.86 (32)	54.21 (22)	30.31 (197)
Married, % (no.)	—	44.54 (46)	48.82 (38)	53.80 (35)	75.82 (28)	86.86 (19)	47.98 (166)
Dollar amount of transferred wealth, \$							
Overall							
N	64	64	64	51	42	34	255
Mean	—	5,215.15	5,670.63	6,846.39	31,858.61	7,091.22	10,557.49
CI	—	(3,996.43–6,433.88)	(3,737.49–7,603.76)	(6,069.46–7,623.33)	(28,947.20–34,770.01)	(6,174.90–8,007.54)	(2,091.17–19,023.82)
Median	—	2,000.00	2,000.00	1,000.00	3,300.00	2,000.00	2,000.00
Minimum	—	400.00	300.00	300.00	250.00	400.00	250.00
Maximum	—	70,000.00	57,000.00	60,000.00	631,000.00	82,000.00	631,000.00
Unmarried							
N	40	36	36	27	22	17	142
Mean	—	6,175.26	3,527.34	8,587.34	4,331.79	3,625.56	5,379.13
CI	—	(4,517.28–7,833.25)	(2,926.89–4,127.79)	(7,563.54–9,611.14)	(1,175.62–7,487.96)	(1,201.72–6,049.40)	(3,036.11–7,722.16)
Median	—	2,000.00	1,900.00	1,200.00	1,750.00	1,500.00	2,000.00
Minimum	—	400.00	400.00	300.00	250.00	500.00	250.00
Maximum	—	70,000.00	57,000.00	60,000.00	12,320.00	13,550.00	70,000.00
Married							
N	24	24	28	24	19	17	112
Mean	—	3,691.97	8,062.63	4,896.75	58,782.23	9,379.18	16,286.94
CI	—	(2,592.72–4,791.22)	(2,838.38–13,286.89)	(4,672.65–5,120.85)	(51,589.56–65,974.90)	(7,710.39–11,047.96)	(13,844.33–18,729.55)
Median	—	2,000.00	3,850.00	1,000.00	9,000.00	3,500.00	2,500.00
Minimum	—	500.00	300.00	300.00	500.00	400.00	300.00

Table 1. Continued

Variable	Wave 9 (2008)	Wave 10 (2010)	Wave 11 (2012)	Wave 12 (2014)	Wave 13 (2016)	Wave 14 (2018)	Cumulative over 10 years
Maximum	—	22,000.00	35,000.00	22,500.00	631,000.00	82,000.00	631,000.00

Notes: CI = confidence interval. Authors' analysis of 2008–2018 Health and Retirement Study (HRS) data of a cohort of adults aged 65+. Numbers presented are weighted using HRS household weights and N values are presented in parentheses. Estimates based on fewer than 10 respondents are suppressed. Cumulative marital status is determined by the marital status reported from the wave a respondent enrolled in Medicaid.

interval [CI]: 3,996.43–6,433.88). However, there was variation in amounts transferred ranging from a minimum of \$400.00 to a maximum of \$70,000.00. Across all waves, unmarried respondents reported transferring less wealth on average compared to married respondents. Unmarried respondents transferred an average of \$5,379.13 (95% CI: 3,036.11–7,722.16), while married respondents transferred an average of \$16,286.94 (95% CI: 13,844.33–18,729.55).

Demographic characteristics of the 1,101 new Medicaid recipients, representing a weighted total of 3,294,968 individuals, are displayed in Table 2. A majority of the sample were NH White women (69.23% NH White; 58.67% female) with a high school degree or less (75.47%), living above 100% of the FPL (77.44%), and almost half (44.69%) were widowed. The new Medicaid recipients were almost exactly split between those in fair or poor health (49.40%) and those in good health or better (50.49%) and the average age was 81 years. Just over half of the sample owned their home (51.19%) and reported an average home value of \$79,117.32. Most of the new Medicaid recipients resided in a state with a 60-month look-back period (83.90%) and the average amount of total existing wealth was \$189,450.20.

Table 2 also shows the demographics of the 391 new Medicaid recipients who reported transferring wealth before becoming a recipient. There were statistically significant differences between recipients who transferred wealth and those who did not by gender, race/ethnicity, education, marital status, homeownership, and housing value. More men reported transferring wealth prior to becoming a Medicaid recipient compared to women, 51.80% of men compared to 36.72% of women ($p < .001$). Compared to 45.77% NH White Medicaid recipients who transferred wealth, just 25.24% of Hispanic/Latino recipients transferred wealth prior to becoming a Medicaid recipient ($p < .001$). Almost 40% (38.23%) of new recipients with a high school education or less transferred wealth compared to 56.43% of those with more than a high school degree ($p < .001$). Married recipients were more likely to transfer money compared to their widowed counterparts (51.69% compared to 36.44%; $p < .001$). Similar proportions were present for homeowners compared to non-homeowners, with just 34.59% of non-homeowners reporting a transfer prior to becoming a Medicaid recipient compared to 50.04% of homeowners ($p < .001$). There were statistically significant differences in home value between those who transferred wealth reporting an average of \$121,276.80 in housing wealth compared to an average of \$53,755.84 in housing wealth for those who did not transfer ($p < .001$). In other words, those who transferred wealth reported more than double the amount of housing wealth compared to those who did not transfer wealth. Approximately two thirds (65.00%) of residents living in a state with a shorter look-back period transferred wealth prior to becoming a Medicaid recipient compared to 44.29% of those living in a state with a 60-month look-back period; however, differences were not statistically significant. Similarly, there were no statistically significant differences by age, number of children, or existing wealth.

The demographics of the 520 new Medicaid recipients who reported estate planning prior to becoming a recipient are also reported in Table 2. There were statistically significant differences between those who participated in estate planning and those who did not by age, gender, race/ethnicity, education, marital status, health condition, income, homeownership,

Table 2. Demographic Characteristics of New Medicaid Recipients by Wealth Transfer and Estate Planning, HRS 2008–2018

Demographic characteristics	All new Medicaid recipients		Transferred wealth before becoming a Medicaid recipient		Participated in estate planning before becoming a Medicaid recipient	
	Yes	No	Yes	No	Yes	No
Observations	Unweighted = 1,101 (weighted = 3,294,968)	Unweighted = 391 (weighted = 1,200,230)	Unweighted = 555 (weighted = 1,607,224)	Unweighted = 520 (weighted = 1,655,388)	Unweighted = 227 (weighted = 589,034)	
Age (years)						
Mean	80.98	81.06	81.29	81.29	83.44	79.59***
CI	(80.38–81.58)	(80.24–81.87)	(80.36–82.22)	(80.36–82.22)	(82.60–84.28)	(78.60–80.57)
Gender						
% Male	41.33 (37.97–44.76)	51.80 (46.72–56.85)	48.20 (43.15–53.28)	48.20 (43.15–53.28)	82.58 (77.31–86.84)	17.42 (13.16–22.69)
% Female	58.67 (55.24–62.03)	36.72 (33.39–40.17)	63.28 (59.83–66.61)***	63.28 (59.83–66.61)***	69.49 (65.59–73.13)	30.51 (26.87–34.41)***
Race/Ethnicity						
% Non-Hispanic White	69.23 (64.80–73.34)	45.77 (41.55–50.05)	54.23 (49.95–58.45)	54.23 (49.95–58.45)	84.22 (80.77–87.14)	15.78 (12.86–19.23)
% Non-Hispanic Black	16.47 (13.38–20.12)	40.59 (31.61–50.24)	59.41 (49.76–68.39)	59.41 (49.76–68.39)	45.31 (40.04–50.68)	54.69 (49.32–59.96)***
% Hispanic/Latino	11.81 (8.91–15.50)	25.24 (18.11–34.01)	74.76 (65.99–81.89)***	74.76 (65.99–81.89)***	41.27 (33.01–50.06)	58.73 (49.94–66.99)***
% Other	2.48 (1.69–3.62)	54.63 (34.05–73.73)	45.37 (26.27–65.95)	45.37 (26.27–65.95)	71.41 (14.71–97.31)	28.59 (2.69–85.29)
Education						
% High school education or less	75.47 (72.10–78.47)	38.23 (34.64–41.95)	61.77 (58.05–65.36)	61.77 (58.05–65.36)	70.16 (66.79–73.33)	29.84 (26.67–33.21)
% More than high school	24.53 (21.47–27.86)	56.43 (48.61–63.93)	43.57 (36.07–51.39)***	43.57 (36.07–51.39)***	86.13 (80.10–90.56)	13.87 (9.44–19.90)***
Marital status						
% Married	33.45 (29.94–37.15)	51.69 (46.05–57.28)	48.31 (42.72–53.95)	48.31 (42.72–53.95)	97.75 (93.74–99.21)	2.25 (0.79–6.26)
% Unmarried	21.59 (18.89–24.56)	40.48 (31.21–50.48)	59.52 (49.52–68.79)	59.52 (49.52–68.79)	60.40 (53.15–67.23)	39.60 (32.77–46.85)***
% Widowed	44.69 (41.45–47.99)	36.44 (31.79–41.36)	63.56 (58.64–68.21)***	63.56 (58.64–68.21)***	72.55 (69.17–75.70)	27.45 (24.30–30.83)***
Number of children						
Mean	3.59	3.87	3.78	3.78	3.33	3.31
CI	(3.42–3.77)	(3.66–4.07)	(3.54–4.02)	(3.54–4.02)	(3.10–3.55)	(2.95–3.67)
Health condition						
% Fair or poor	49.40 (46.42–52.39)	38.20 (33.57–43.05)	61.80 (56.95–66.43)	61.80 (56.95–66.43)	72.52 (68.73–76.00)	27.48 (24.00–31.27)
% Good, very good, or excellent	50.49 (47.51–53.46)	46.91 (42.50–51.38)	53.09 (48.62–57.50)**	53.09 (48.62–57.50)**	74.98 (69.73–79.58)	25.02 (20.42–30.27)***
Homeownership status						
% Does not own a home	48.81 (44.69–52.95)	34.59 (29.62–39.92)	65.41 (60.08–70.38)	65.41 (60.08–70.38)	67.10 (61.93–71.89)	32.90 (28.11–38.07)
% Owns home	51.19 (47.05–55.31)	50.04 (46.02–54.07)	49.96 (45.93–53.98)***	49.96 (45.93–53.98)***	81.56 (76.03–86.05)	18.44 (13.95–23.97)***
Housing wealth						
Mean	79,117.32	121,276.80	53,755.84***	53,755.84***	83,449.70	28,787.95***
CI	(65,699.30–92,535.33)	(93,226.08–149,327.60)	(42,408.54–65,103.14)	(42,408.54–65,103.14)	(64,500.84–102,398.60)	(15,825.23–41,750.67)
Total existing wealth						
Mean	189,450.20	353,648.00	92,138.00	92,138.00	197,662.90	30,253.73
CI	(129,778.50–249,122.00)	(206,621.10–500,675.00)	(65,528.13–118,749.70)	(65,528.13–118,749.70)	(108,814.20–286,511.60)	(14,697.79–45,809.68)
Income						
% Above 100% FPL	77.44 (74.46–80.16)	47.14 (43.14–51.19)	52.86 (48.81–56.86)	52.86 (48.81–56.86)	79.90 (75.55–83.64)	20.10 (16.36–24.45)

Table 2. Continued

Demographic characteristics	All new Medicaid recipients		Transferred wealth before becoming a Medicaid recipient		Participated in estate planning before becoming a Medicaid recipient	
		Yes	No	Yes	No	Yes
% Below 100% FPL	22.56 (19.84–25.54)	26.81 (21.50–32.89)	73.19 (67.11–78.50)***	55.49 (47.66–63.05)	44.51 (36.95–52.34)***	
State of residence						
% States with a 60-month look-back period	83.90 (76.27–89.42)	44.29 (40.88–47.75)	55.71 (52.25–59.12)	74.85 (71.79–77.68)	25.15 (22.32–28.21)	
% States with 0- to 30-month look-back period	15.85 (10.36–23.48)	65.00 (58.06–71.35)	35.00 (28.65–41.94)	67.85 (57.96–76.36)	32.15 (23.64–42.04)	

Notes: Authors' analysis of 2008–2018 Health and Retirement Study (HRS) data of a cohort of adults aged 65+ who newly enrolled in Medicaid after 2008. HRS household-level weights are used. Estimates based on fewer than 10 respondents are suppressed. There are 155 missing observations in the transfer variable. There are 354 missing from the estate planning variable. Estate planning is defined as having a will and/or a trust completed prior to enrolling in Medicaid. Number of children is treated as a continuous variable. Total existing wealth represents the cumulative total of a respondent's wealth (e.g., savings, stocks, bonds, investments, etc.) minus any outstanding debt. Income is defined using household size and income as a percentage of the Federal Poverty Level (FPL). California and New York are the two states included in the less than 60-month look-back period category. 95% confidence intervals (CIs) are in parentheses. Wald tests were conducted to assess the *p* value. The *p* value represents the difference in the percentages. ****p* < .01. ***p* < .001.

and home value. The average age of Medicaid recipients who estate planned was almost 4 years older than those who did not plan (*p* < .001). Similar to wealth transfers, men were significantly more likely to participate in estate planning compared to women (*p* < .001). NH Black and Hispanic/Latino Medicaid recipients were significantly less likely to participate in estate planning compared to their NH White counterparts (*p* < .001). There were significant differences by education, where 70.16% of respondents with a high school education or less estate planned compared to 86.13% of those with more than a high school degree (*p* < .001). Almost all (97.75%) married Medicaid recipients participated in estate planning compared to 60.40% unmarried recipients and 72.55% widowed (*p* < .001). Medicaid recipients who lived above 100% FPL estate planned at a rate of 79.90% compared to 55.49% of those living below 100% FPL (*p* < .001). Significantly more homeowners were likely to estate plan compared to non-homeowners (*p* < 0.001). Among homeowners, those who planned had almost three times the amount of housing wealth as those who did not (\$83,449.70 compared to \$28,787.95; *p* < .001). Approximately one third (67.85%) of residents living in a shorter look-back period state, estate planned prior to becoming a Medicaid recipient compared to 74.85% of those living in a 60-month look-back period state; however, differences were not statistically significant. There were no statistically significant differences between the total existing wealth of those who did and did not estate plan.

Table 3 presents descriptive statistics of a subgroup analysis of the 767 older adults who moved into a nursing home during the 10-year study period. Among newly institutionalized respondents, 23.47% (180) became new Medicaid recipients prior to moving. Of the 180 who newly enrolled, 27.78% (50) transferred wealth prior to Medicaid enrollment and they transferred an average of \$5,827.78.

Supplementary Tables S3 and S4 present results from a subgroup analysis of a cohort of adults aged 60 and older. Rates of Medicaid enrollment and planning and wealth transfer behaviors are consistent and similar to the primary cohort of those aged 65 and older.

Limitations

The primary limitation of this study is the measurement of wealth transfers and estate planning. Respondents are likely to underreport the prevalence or amounts of transferred wealth. Medicaid look-back periods and recall bias may contribute to respondents' reticence to adequately report transfers that took place before Medicaid enrollment. Outright gifts and cash were the only form of asset transfer considered, which may also contribute to the underreporting of wealth transfers. Further, the wording of the question used to measure wealth transfers could result in wide variation in responses that may not necessarily capture wealth transfers. Respondents could interpret the phrase, "financial help" in vastly different ways that may not consider help as intergenerational transfers of wealth, which is what this study is trying to measure. Additionally, the HRS item used to capture familial wealth transfers may not capture family structures outside of traditional definitions of "children or grandchildren," such as LGBTQ+ families where intergenerational wealth might look different. This limits our analysis of demographic differences in wealth transfer behaviors.

HRS does not contain a variable that measures whether a respondent has worked with an elder law attorney or other

Table 3. Older Adults Living in a Nursing Home, Medicaid Status, and Their Wealth Transfers

Variable	Wave 9 (2008)	Wave 10 (2010)	Wave 11 (2012)	Wave 12 (2014)	Wave 13 (2016)	Wave 14 (2018)	Cumulative over 10 years
All households	8,347	6,954	6,131	5,232	4,212	3,209	
% of nursing home residents	4.34 (387)	4.97 (356)	5.62 (344)	5.96 (308)	6.77 (275)	6.21 (190)	
No. of respondents, newly institutionalized since the last interview	—	200	164	149	158	96	767
% of new Medicaid recipients among newly institutionalized adults in nursing homes	—	22.50 (45)	23.17 (38)	26.17 (39)	19.62 (31)	28.13 (27)	23.47 (180)
% who transferred wealth before becoming Medicaid recipients	—	11.11 (5)	13.16 (5)	41.03 (16)	25.81 (8)	59.26 (16)	27.78 (50)
Mean (maximum) dollar amount of transferred wealth, \$	—	18,235.19 (25,000.00)	7,238.57 (19,080.00)	4,101.64 (12,000.00)	5,092.60 (12,000.00)	8,088.02 (35,000.00)	5,827.78 (35,000.00)

Notes: Authors' analysis of 2008–2018 Health and Retirement Study (HRS) data of a cohort of adults aged 65+ who moved into a nursing home during the study period. Numbers presented are weighted using HRS household weights and N values are presented in parentheses.

estate planning expert. While the will or trust variable used offers some insight into whether a respondent has engaged in estate planning, I cannot differentiate between those who have independently planned and those who presumably have more access to resources and are able to rely on experts in the field. Elder law attorneys have devised a variety of ways to safeguard assets outside the purview of state Medicaid administrators through mechanisms like irrevocable annuities, Medicaid Asset Protection Trusts, and life estates. This is particularly salient when considering a trust often requires outside expertise compared to the process of completing a will. However, insufficient sample sizes preclude this analysis from distinguishing those who have only completed a will from those who have completed both a will and a trust. This additional information would provide more nuance into the analysis of how people estate plan differently based on privilege, education, and access to resources.

Over the 10-year period, 61.56% of the sample dropped out. Respondents who dropped out were likely deceased and may have been the oldest in the sample at the start of the study period. The remaining sample may skew younger and healthier, which could show the asset transfer and estate planning decisions of a more advantaged group of older adults with censoring from the data of those who died younger.

This study is only able to capture a snapshot of a cohort of adults aged 65 and older, those with access to more resources who value an inheritance for their children may be estate planning much earlier, which would not be reflected in this cohort and/or by this period of time. In addition, small sample sizes, especially among the nursing home subgroup, may limit the generalizability of this analysis. However, the HRS provides the largest representative sample of older adults in the United States, which allows this study to understand the estate planning and wealth transfer behaviors of older adults newly enrolled in Medicaid. Future research should consider if there are data sets with larger samples of nursing home residents to better understand their decision making. Lastly, this is a descriptive analysis, and findings cannot be used to draw causal conclusions or identify pathways about the direct effects of Medicaid policies on estate planning and wealth transfer behaviors of older adults.

Discussion

Using longitudinal 2008–2018 HRS data, this study sought to understand the prevalence of estate planning and the frequency and size of wealth transfers among a cohort of older adults aged 65 and older who newly enrolled in Medicaid benefits. This analysis found almost 40% of Medicaid recipients participated in estate planning and asset transfer prior to enrolling in Medicaid, with significant differences among select demographic characteristics. There was notable variation in the size of wealth transfers and married respondents transferred larger amounts of wealth, on average.

A small, but nontrivial number of respondents became Medicaid recipients during the study period (almost 12%) and this study found a meaningful number of those new recipients transferred wealth and participated in estate planning prior to enrolling in Medicaid with significant differences by marital status. About half of married respondents transferred wealth compared to 30% of unmarried respondents who transferred wealth. Married respondents also tended to transfer larger amounts of wealth. Across the 10-year period, married

Medicaid recipients transferred an average of \$16,286 compared to an average of \$5,379 for unmarried recipients. Further, unmarried and widowed recipients were significantly less likely to participate in estate planning compared to their married counterparts.

These findings are consistent with the existing body of research on the gender and marital status wealth gap and can be explained, in part, by the marital resource model. The marital resource model is a conceptual framework to understand the health advantages and financial and emotional benefits that marriage confers on couples relative to unmarried individuals (Choi & Carr, 2023). Married couples may be more motivated to carry out estate planning to ensure the security and emotional stability of their partner. Moreover, married couples who have never experienced a marital disruption like divorce or widowhood have significantly higher incomes, net worth, and lower rates of poverty compared to those who have been widowed or divorced (Ruel & Hauser, 2012; Wilmoth & Koso, 2002; Yamokoski & Keister, 2006). In general, even if they experience a divorce, but remarry, married couples maintain higher median incomes and net worth (Wilmoth & Koso, 2002). While marriage may be a protective factor for wealth overall, impacts are larger for men than women and for White couples compared to Black couples (Wilmoth & Koso, 2002; Yamokoski & Keister, 2006). Wealth transfers and estate planning may also be explained by gendered differences in traditional familial roles and childbearing, especially when it comes to finances. Risks associated with childbirth can affect a woman's health in the long-term and in turn her wealth. Women with health limitations during any period in their life have been found to accumulate less household wealth in older adulthood compared to those with no health limitations (Wilkinson et al., 2019).

Additionally, this analysis concludes that more structurally advantaged groups are more likely to engage in estate planning to protect assets prior to Medicaid enrollment. I conclude that NH White men are more likely to transfer wealth prior to enrolling in Medicaid and have completed a will or trust, which lends itself as further evidence in support of cumulative disadvantage theory (O'Rand, 1996). The theory suggests that throughout the life course, differences in opportunities and barriers can lead to increasing inequities (Koss & Baker, 2018; O'Rand, 1996). In other words, the cumulative disadvantages that Black families experience from structural racism can lead to Black older adults having fewer assets to transfer to adult children later in life. Higher levels of educational attainment, income, and homeownership are also associated with the likelihood of engaging with estate planning and the transfer of assets prior to becoming a Medicaid recipient. These demographics, primarily White, well-educated, married, men participating in higher rates of estate planning reflect who has access to resources to make necessary arrangements early. More privileged families are able to take advantage of elder law attorneys who can explain common methods to secure assets for children and out of the purview of Medicaid's look-back period (Koss & Baker, 2018; March 2021 Report to Congress on Medicaid and CHIP, 2021).

Overall, more wealth transfers occurred among those living in the community compared to those who moved into a nursing home. Similar to prior research, this finding may reflect proactive arrangements by community-dwelling older adults who anticipate eventually transitioning to a higher level of care, but have not yet moved (Lee et al., 2006). It suggests

estate planning may be taking place, for most older adults, far earlier than just before moving into a nursing home.

Conclusion

Estate planning and familial asset transfers are common practices among older adults prior to enrolling in Medicaid and certain demographic characteristics may be associated with the size of and likelihood of intergenerational transfers of wealth. This analysis demonstrates that some individuals may be able to circumvent Medicaid policies like look-back periods and MER, while others are not. Policymakers should consider policies that promote the financial health of low-income families. Given the changing terrain of aging in America, where LTSS costs have risen exponentially and the Black-White wealth gap is widening, this analysis makes a timely and important addition to the literature by providing new evidence on the long-term planning decisions of older adults.

Supplementary Material

Supplementary data are available at *The Gerontologist* online.

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Conflict of Interest

None.

Data Availability

Data and analytic methods and materials are not publicly available because this analysis relies on restricted data through a restricted data agreement (RDA) with the Health and Retirement Study (HRS). However, those who wish to replicate this study using the same data and analytical methods may apply for an RDA through the HRS website. This study reported in this manuscript was not preregistered.

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Author Contributions

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