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MEDICAID ELIGIBILITY: PLANNING FOR THE ELDERLY CLIENT

Cynthia M. Brubaker

Planning for long-term care for elderly individuals is becoming increasingly important in our society. Statistics show that Americans are living longer because of advances in medical technology. In 1993, there were about 3,304,000 people over age eighty-four in the United States.¹ The U.S. Census Bureau projects that this number will increase to 5,127,000 by the year 2020.² While our bodies are living longer, many people become unable physically and mentally to carry on necessary day-to-day activities. When this happens, there is an increased burden on families to care for their elders. Sometimes, even full-time residential care becomes needed. In reality, it is often impossible for family members to care for their elderly loved ones. The children of ailing parents have careers, children, and lives of their own. Spouses are often too feeble to care for each other and may themselves be suffering from ill health. All too often nursing homes are the only alternative.

Nursing homes cost an average of \$3,000 to \$4,000 per month and many people over age sixty-five do not have the income or resources to meet these costs. Those with the resources to pay nursing home costs face the possibility of losing a lifetime of assets and savings. Still others wish to preserve their assets, in order to pass something on to their children.

Whatever the motivation, Americans are turning to Medicaid for assistance in meeting the high costs of nursing home care. In most cases, other than Medicare and long-term care insurance, Medicaid is the only source of assistance for nursing home patients.

While all people age sixty-five and over are eligible for Medicare, this program only covers the cost of nursing home care in limited circumstances. First, for Medicare to pick up the cost, the individual must meet several threshold requirements. The patient must be in need of skilled nursing care that has been ordered by a physician.³ Further, the patient must also need nursing care or need a speech or physical therapist.⁴ In addition,

the patient must need daily services in a nursing home setting. Finally, the patient must be admitted to the nursing home after a minimum stay of three days in a hospital and within thirty days after release from the hospital.⁵

Even if the patient meets the medical need requirements, Medicare only pays in full for the first twenty days in the nursing home.⁶ For the next eighty days, Medicare pays only \$89.50 per day, and it pays nothing thereafter.⁷

As an alternative to Medicare, long-term care insurance is an excellent way of planning for long-term health care. However, due to its relative novelty, many elderly people are unaware of its existence and therefore do not use it as a tool to plan in advance for nursing home costs. By the time an individual becomes concerned about the issue, he or she is often already in ill health and ineligible for coverage. Furthermore, long-term care insurance has age requirements that may disqualify some individuals. Long-term care insurance also can be very expensive and, as such, is often just as unavailable as the underlying nursing care.

Since Medicare and long-term care insurance are not helpful to many elderly people, many are turning to Medicaid. However, Medicaid is meant to be a welfare program, not an insurance program. Accordingly, it is reserved only for those people who are indigent or impoverished. In order to qualify, an individual must meet strict rules regarding the income and assets that are available to him or her at the time of application.⁸

Eligibility Requirements

The Medicaid statute, codified at 42 U.S.C. § 1396,⁹ sets forth several criteria for determining whether a person is eligible for benefits and gives individual states the discretion to set further criteria. There are three tests to determine financial eligibility for an institutionalized individual. The institutionalized applicant must meet income and resource requirements, and will be scruti-

nized for any transfers of assets he or she has made. In addition, the applicant must meet strict medical need requirements.

Income Requirements

States are responsible for setting limitations on the amount of income a person can have and still be eligible for Medicaid.¹⁰ While some states only require that a nursing home patient have less income than the cost of nursing home care, other states set a maximum income that is often lower than the average nursing home bill.¹¹ These states, called “income cap” states, often leave patients trapped between a proverbial “rock and a hard place.” Such patients have too much income to qualify for Medicaid and too little income to afford proper care. However, Maryland is not an “income cap” state.

In Maryland, a Medicaid applicant must have an income, minus several allowable deductions, that is less than the average cost of nursing home care.¹² Medicaid will pay the difference between the amount of income the applicant can apply to the cost of his or her care and the amount that Medicaid allows for nursing home care.¹³

In determining this difference, the applicant’s total monthly income is reduced to allow for expenses which the patient incurs outside the nursing home. A personal needs allowance of \$40 per month is permitted for institutionalized individuals.¹⁴ In addition, a single person may be given an allowance to maintain his or her residence during institutionalization if he or she is expected to return home.¹⁵ In order to receive this allowance, the patient must establish, based on a medical review process, that he or she will be able to resume living in the community and that he or she intends to do so.¹⁶ The residential maintenance allowance will be deducted from income for a period of six months, beginning with the person’s first full month of institutionalization.¹⁷ In addition, the applicant’s monthly income will be reduced by the amount he or she spends on Medicare and other health insurance premiums, as well as amounts spent on medical care and other remedial services not covered by Medicaid.¹⁸

When an institutionalized individual has a spouse or family that remains in the community (community spouse), regulations allow for a spousal or family allowance, or both.¹⁹ In addition, income of the community spouse may not be counted as income available

to the institutionalized spouse.²⁰

Resource Requirements

The second test to determine eligibility for Medicaid is the Available Resources Test. An applicant must have assets below an amount established by state law available as a source to pay for nursing home costs. For individuals in Maryland, the amount of available resources may not exceed \$2,500.²¹ The computation of available assets is generally made at the time of application for Medicaid. Maryland law establishes which assets held by the applicant at that time may be excluded from the computation.

The largest asset held by most applicants is the home. Unless he or she has a life estate interest with full powers in the home, the home is excluded from available resources.²² However, this exclusion applies only if the patient is expected to return home.²³ If the patient does not intend to return to the home, the home may still be excluded if it is occupied by the patient’s spouse or a dependent relative.²⁴

In addition, household goods and personal effects that remain in the possession of the patient at the nursing home may be excluded.²⁵ This provision allows nursing home patients to have some of the amenities of home: a television, personal clothing, wedding and engagement rings, and other items for comfort and accommodation.

Further, unlimited amounts of term life insurance are also excluded as long as they have no surrender value.²⁶ Whole life insurance with a maximum face value of \$1,500 for each person is excluded,²⁷ as is the applicant’s burial space.²⁸ In addition, the applicant may have up to \$1,500 in burial funds set aside in an account,²⁹ and he or she may prepay funeral expenses in an unlimited amount.³⁰

When a patient has a community spouse, the total non-exempt resources that either spouse has an interest in at the time of institutionalization are pooled together to determine the total joint resources.³¹ All resources jointly or severally held by both spouses are considered to be available to the institutionalized spouse.³² However, the regulations provide a community spouse resource allowance, consisting of \$14,964 or one half of the total joint assets up to \$74,820, whichever is greater.³³ If the community spouse does not hold title to the amount of assets excluded from the available

resources, the institutionalized spouse may transfer assets in that amount to the community spouse. However, the assets must be transferred to or for the sole benefit of the community spouse.³⁴

A community spouse may also have one automobile that will not be considered an available resource.³⁵ The excludable value of the automobile is unlimited if it is necessary for employment or for medical treatment of a specific or regular medical problem.³⁶ The excludable value is also unlimited if the automobile has been modified for use by, or for the transportation of, a handicapped person who is a member of the household.³⁷ In all other cases, the automobile may only be excluded up to \$4,500 of its value.³⁸

Transfers

In order to qualify for Medicaid under the income and resource tests, an applicant must disclose any asset transfers made within a thirty-six month "look-back period."³⁹ If an applicant has made any transfers within the thirty-six month period prior to application, he or she will be ineligible for Medicaid for the period of time that he or she could have paid for nursing home care with the assets transferred.⁴⁰ Prior federal law established a maximum period of disqualification of thirty months.⁴¹ However, changes made by the Omnibus Budget and Reconciliation Act of 1993 ("OBRA")⁴² created new rules that put no limits upon the time of disqualification for transfers of assets.

Under the new rules, an institutionalized applicant must disclose any transfers made to individuals within the period that began thirty-six months before both the first date that the individual is institutionalized and the date the individual had applied for assistance.⁴³ The applicant must also disclose any payments made to certain trusts within a sixty month look-back period.⁴⁴

There is no limit on the length of ineligibility caused by transfers of assets made within the "look back period."⁴⁵ The applicant will be ineligible for the period of time that he or she could have paid for nursing home care with the funds transferred. The number of months of ineligibility is determined by dividing the value of assets transferred by the applicant (or community spouse) on or after the look-back date by the average monthly cost of nursing home care for private patients at the time of application.⁴⁶ For example, assume that an applicant transferred \$300,000 worth of assets within the look-

back period and that the average monthly nursing home cost is \$3,000. His or her period of ineligibility will be \$300,000 divided by \$3,000, or 100 months. This results in a much longer period of ineligibility than if the applicant had waited until after the thirty-six or sixty month look-back period to apply for benefits.

The 1993 OBRA amendments also made an important change in the definition of "assets." The definition now includes all income and resources of the individual and his or her spouse.⁴⁷ It includes any income that either person is entitled to, but does not receive because of the action of another, including any action of the individual or his or her spouse.⁴⁸ It also may include the action of any person, including a court or administrative body, acting in place of or on behalf of the applicant or the spouse, or any person acting at the direction of, or upon the request of the applicant or spouse.⁴⁹ This definition removes the distinction between income and resources, and will heighten the effect of trust distributions on ineligibility.

Medical Need

In addition to being in financial need, a Medicaid applicant must also meet medical need requirements. In Maryland, the applicant must require "nursing facility services" as defined by the Maryland Department of Health and Mental Hygiene.⁵⁰ In order to qualify, the applicant's need must meet all of the following elements. The applicant must require skilled nursing care and related services, rehabilitation services, or health related services above the level of room and board. The services must be needed on a daily and inpatient basis. In addition, the needed services must be provided by a facility that is certified for participation in Medicaid and must be ordered by and provided under the direction of a physician.⁵¹

The "skilled nursing care" element requires that the patient need some type of care that must be administered by a health professional, such as a nurse or a physical therapist. The inclusion of "health related services" makes this element slightly flexible. For example, an applicant may be eligible if he or she needs "services to maintain, improve, or protect [his or her] health."⁵² This may include the administration of medication "when [the] patient's medical condition or cognitive deficits require the skilled observation and judgment of a licensed health professional."⁵³ There-

fore, it is possible that a patient who has lost only mental faculties may in fact qualify if he or she needs to take medication on a frequent and regular basis. Unfortunately, most patients who are physically healthy, but who require constant supervision, will not qualify.

Planning for Eligibility

Many elderly clients fear that the day will come when their families can no longer take care of them. They fear that either they will need nursing home care and will not be able to afford it or that they will have to spend all of their assets to pay the cost. To prevent this from happening, they seek advice on planning techniques that will permit them to keep their assets and still qualify for Medicaid.

The primary goal of Medicaid planning is to prevent the impoverishment of the client. The available resources of the client must be reduced to the maximum amount allowable under the eligibility laws. This goal can be accomplished through a variety of approaches, including the use of "spending down" the family assets, giving assets to family members, or creating trusts.

Spending Down Family Assets

An elderly person who is anticipating a need for nursing home care may spend some money without the expenditures being considered transfers of assets. Money may be spent on goods or services that are for the benefit of the applicant or his or her spouse. For example, a client may consider spending extra money on entertainment, rather than saving it to eventually spend on long-term care or pass on to his or her beneficiaries as an inheritance. Thus, the client could take an expensive vacation that he or she has always dreamed of, eat in nice restaurants, or attend theater, athletic events, or other social gatherings. The problem with this approach is that, once spent on entertainment, the money is gone and the client has nothing to show for it. If the client does continue to live independently, he or she may need some of this money for other expenses.

Another alternative is to spend some money on concrete items. The client may buy items that will make life more comfortable. For example, he or she might purchase some modern home appliances such as a

microwave oven or a cordless telephone. The client may also make improvements to his or her home that once seemed unaffordable. An electric garage door opener may make the client's life easier, or a home alarm system may make him or her feel more secure. In addition, the client may want to catch up on necessary home repairs such as a new roof, replacement windows, or a professional painting of the exterior of the home. These expenditures are particularly beneficial if a spouse or other family member will remain in the community home after the client is institutionalized.

If the client is single and has no dependents, he or she may not want to invest a lot of money into a home that will eventually be sold to cover nursing home costs. The single client may, however, make expenditures on personal and household items that can be taken to the nursing home with him or her. A television, an electric blanket, or extra items of clothing may be beneficial for this purpose.

It is also a good idea for the client to pre-pay funeral expenses. The client can spend an unlimited amount for a funeral, and it will not be considered an available resource as long as the money is irrevocable.⁵⁴ Additional amounts may be spent on the burial space or put in a burial fund. Paying funeral expenses in advance not only lowers the client's available resources, but it relieves the client's family of having to make funeral arrangements during the very difficult time that follows the death of a loved one. On the other hand, the client may feel uneasy about making plans for his or her own death.

Finally, the client may consider using some of his or her resources to pay off outstanding debt. The client may want to pay off a car loan, mortgage, or credit card debt. This is a good way to reduce resources, since debt is not deducted from the amount of assets the client owns.

Transfers to Individuals

A client may want to make gifts to family members or friends so that the assets cannot be considered available resources for purposes of Medicaid eligibility. Federal law provides that certain transfers will not cause an applicant to be ineligible even if they are made within the look-back period.

First, an individual may transfer his or her home to various family members. Transfers of the home to a spouse are exempt under any circumstances.⁵⁵ Home

transfers may also be made to a child of the individual without causing ineligibility if the child is under age twenty-one, blind, or otherwise disabled.⁵⁶ In addition, a parent may transfer the home to a son or daughter who lived in the home with the parent for at least two years immediately before the parent's admission to the nursing home and provided care that permitted the parent to live in the community.⁵⁷ Finally, a home transfer to a sibling does not cause ineligibility if the sibling has an equity interest in the home and was residing there for at least one year immediately before the date that the individual enters the nursing home.⁵⁸

Second, an applicant will not be declared ineligible because of transfers of assets made to his or her spouse or other person for the sole benefit of the applicant's spouse.⁵⁹ Of course, any assets that are not otherwise exempt will be included in the available resources of the individual if they exceed the spousal resource allowance.

Transferring assets to a spouse may not always be a good idea. If the community spouse dies before the institutionalized spouse, the estate may be subject to recovery by Medicaid. For example, in Maryland a person has a right to a statutory share of his or her spouse's estate.⁶⁰ Many people are concerned that Medicaid may deem a patient ineligible if he or she does not elect the spousal share. In the alternative, Medicaid may institute procedures to recover the spousal share for the institutionalized individual and use the estate to pay for nursing home care.⁶¹ In addition, there is always a possibility that the community spouse will need long-term care. If this happens, all assets held by him or her will be considered available resources, and he or she may have to spend the money or be ineligible for Medicaid.

Third, the rules provide that a client will not be ineligible if he or she intended to transfer the assets at fair market value or for other valuable consideration, if the assets were transferred for a purpose other than to qualify for Medicaid. Also, the client will not be eligible if *all* of the transferred assets have been returned to the client for less than the fair market value.⁶² Finally, a transfer may be exempt if an applicant can show that denial of eligibility would create an undue hardship.⁶³ These last two exceptions place a heavy burden on the client and, in practice, are almost never effective.

As an alternative, a client may decide to transfer assets that cause a period of ineligibility. A client

planning in advance for nursing home care may decide to transfer all of his or her assets. However, when a client decides to make such a transfer, it is important that he or she give the assets to someone who is trustworthy and will look out for his or her best interests. The transferee must be willing to use the funds to pay for the needs of the client, including nursing home care if the need arises during the look-back period. This method is advantageous to clients whose children take itemized deductions on their tax returns, because the transferee can deduct the nursing home payments as a medical expense.⁶⁴ Transferring all of the client's assets is useful when a client is not in immediate need of nursing home care, and may not be in need of such care for many months. However, in the interim, the transferee must be someone who will allow the client to use the funds when necessary.

In the alternative, a client who is entering a nursing home soon, or is already institutionalized, will most likely have to pay for care during the period of ineligibility caused by a transfer. In this case, it is best for the client to transfer only part of his or her assets and reserve enough funds to pay for the nursing home during the period of ineligibility. When the period of ineligibility is over, the funds will be depleted, and there will be insufficient available assets to cause ineligibility. Paying for the nursing home with private funds is advantageous to the client who is seeking a room in a nursing facility. Nursing homes often limit the number of beds that can be occupied by Medicaid patients, making it more difficult for them to be accommodated.

One technique used by practitioners to determine the amount of money a client should transfer is the "50/50 strategy."⁶⁵ Under this strategy, a client would transfer half of his or her available assets and retain the other half to pay for medical costs. For example, a client with \$150,000 would transfer \$75,000 to his or her son. This would cause ineligibility for twenty-five months in a state that has an average nursing home cost of \$3,000 per month. The \$75,000 retained by the client will pay for care for twenty-five months at the average rate. The client can then apply for Medicaid when the funds are depleted, which happens to be the end of the period of ineligibility.

However, this method has several flaws. It fails to consider inflation and the fact that the cost of nursing home care may go up over the twenty-five month period. Further, it fails to consider the difference

between the state average cost for long-term care and the amount the client will actually pay for care. The client will almost always pay more than the state average. Finally, this method does not factor in the client's monthly income. Almost everyone has some form of income, whether it is a pension, social security, supplemental security income, or some other benefit. This income will be spent on care during the period of ineligibility and will decrease the amount that the client must reserve to pay for care.

As an alternative to the "50/50 strategy," some practitioners use a simple formula to determine the amount the client should transfer to his or her child:

Amount of transfer = $E \times [A/(A+C)]$, where

E = Excess resources

A = Average cost of care

C = Cost of care in excess of retirement income.⁶⁶

For example, if the cost of nursing home care for a private individual is \$4,000 per month, the average cost of nursing home care is \$3,000 per month, the client has \$2,000 per month retirement income, and he or she has \$100,000 in excess resources, he or she should transfer \$60,000.⁶⁷ The remaining \$40,000 should be used to pay for nursing home care during the period of ineligibility. A transfer of \$60,000 will result in a period of ineligibility of 20 months ($60,000 / 3,000$). The remaining \$40,000 will pay for the nursing home for twenty months at a rate of \$2,000 per month, which is the amount of private funds available from the client's income. At the end of the twenty months, the applicant will be eligible for Medicaid.

When using the formula above, it is important to remember that the look-back period is only thirty-six months. Therefore, proper planning can lead to unlimited amounts of transfers for a client with large amounts of excess resources, while he or she is only disqualified for thirty-six months. For example, assume the client in the above example has \$180,000 in excess resources. According to the formula, he or she should transfer \$108,000. This transfer results in a thirty-six month period of ineligibility ($108,000 / 3,000$). Since thirty-six months is the length of the look-back period, it is the maximum amount of time any client should wait to apply.⁶⁸

Therefore, a client who has greater than \$180,000 in excess resources in the above example should only reserve enough assets to pay for thirty-six months of

nursing home care. The remainder of the assets should be transferred to a family member. The client then will apply for Medicaid after the thirty-six month look-back period ends. The transfer will not be considered and the client's available resources will have been depleted by paying for long-term care.

Transferring assets may be a simple way of qualifying for Medicaid without spending all of the resources that the client owns. However, the client should be very cautious in making this decision because there are several disadvantages to transferring one's assets, even to a family member.

First, the donee of the assets must be very trustworthy. This person must be willing to give the client money when he or she wants or needs it. If the donee is greedy, he or she may withhold funds from the client to preserve them for his or her own benefit. The donee may be a controlling family member who does not approve of the expenditure the client wants to make. In addition, the funds will be subject to the donee's creditors. If he or she is unable to pay debts, creditors can attach the donated funds because they become the property of the donee.

Even if the client has no problem getting money from the donee, he or she may still feel a loss of financial independence. The client can no longer make purchases without reporting to someone, and loses the freedom to spend money and the privacy of buying items without approval of a family member. Further, there will be various financial consequences when a client gives assets to a family member. The donee will be responsible for property taxes and maintenance costs of real property. In addition, there may be gift tax consequences depending on the value of the gift.

Second, income taxes are another important consideration. If the client transfers property that is subject to capital gains tax, the donee will receive the donor's basis in the property.⁶⁹ Therefore, when the property is eventually sold, the donee will have to pay income taxes on the appreciation that accrued during the time that the donor held the property. In contrast, if the donor had held onto the property until death and transferred it to the donee by will, the donee's basis would be the market value of the property at the time of death.⁷⁰ This valuation of basis results in a considerable tax savings for appreciated property.

Finally, the donee will be subject to tax on unearned income from the transfer of assets. If the client transfers

money or investments that earn interest or dividends, the donee will have to pay income tax on these amounts. If the donee is in a high tax bracket, the amount of tax will be higher than if the client had been charged with the income.

Trusts

The OBRA 1993 amendments⁷¹ make it considerably more difficult for an individual to create self-settled trusts without the trust disqualifying him or her from Medicaid eligibility. When an applicant has created a trust, Medicaid eligibility is based on three criteria: (1) whether the funding of the trust includes a transfer of assets; (2) if so, what the applicable period of ineligibility is as a result of the transfer; and (3) whether the principle and/or income of the trust is available for Medicaid purposes.⁷²

The trust rules established by 42 U.S.C. § 1396p(d) apply to trusts established by the individual applying for benefits.⁷³ However, the applicant is deemed to have established the trust if it is funded wholly or partially by assets of the applicant and is established by one of the following people: the applicant; the applicant's spouse; a person, including a court or administrative body, with legal authority to act on behalf of the applicant; or a person, including a court or administrative body, acting under the direction or upon the request of the applicant or the applicant's spouse.⁷⁴ As a result, the rules apply to virtually any trust that is established using the applicant's funds, regardless of who established the trust. The statute also applies to the trust regardless of the purposes for its creation, the degree of discretion given the trustees, the restrictions on when or whether distributions may be made, or restrictions on the use of the distributions.⁷⁵

Any assets that are deemed "not available" to the applicant because of their placement in a trust established by the applicant will be considered a transfer of assets.⁷⁶ These amounts are then subject to a sixty month look-back period.⁷⁷

For determining availability of trust assets, the rules vary depending upon whether the trust is revocable or irrevocable. If the trust is revocable, the entire corpus is considered to be a resource available to the applicant.⁷⁸ In addition, any payments from the trust that are to or for the benefit of the applicant are considered income.⁷⁹ Any other payments from the trust are

considered transfers of assets and will be subject to the penalties for transfers made within the look-back period.⁸⁰

If the trust is irrevocable, any portion of the principal or income that could be given to or used for the benefit of the applicant under any circumstances will be considered resources available to the individual.⁸¹ Any payments made from the income or principal to the applicant will also be considered income of the individual.⁸² If any payments are made from the "available" portion of the trust for any other purpose, they will be considered transfers of assets and will be subject to the transfer rules.⁸³ In addition, any portion of the trust that could not be paid to the applicant under any circumstances will be treated as a transfer of assets as of the date of its establishment.⁸⁴ The value of the trust will be determined by including the amount of any payments made from that portion of the trust after it was established.⁸⁵

It is important to note that the new definition of "assets" will affect the use of self-settled trusts. Any assignment of trust income is now considered a transfer of assets if made to anyone other than the applicant's spouse.

Exempt Trusts

Despite very strong efforts by Congress to have trusts included as available assets for Medicaid purposes, the Medicaid statute establishes three types of trusts to which the rules do not apply. Trusts established for certain disabled individuals and some trusts comprised solely of pension, Social Security, and other income to the individual are exempt.⁸⁶

A trust that contains the assets of a disabled person under age sixty-five, known as a "supplemental needs" trust, is exempt from Medicaid rules if established by a parent, grandparent, legal guardian, or a court.⁸⁷ The trust must provide that assets remaining in the trust upon the beneficiary's death, up to an amount equal to the total Medicaid paid on behalf of the individual, shall be paid to the State as reimbursement for Medicaid.⁸⁸

This exception allows a third party to create such a trust for a disabled individual using the individual's assets. The only disadvantage is that the remainder of the trust goes to the State. If the disabled individual wants the remainder of the trust to go to another beneficiary, this trust will not be a viable option. How-

ever, the typical reason a person sets up a supplemental needs trust for a family member is to provide for his comfort and to make certain that the disabled individual is provided for beyond the minimum level of support. The family often does not object to paying for the long-term care or living facility except that they fear that all of the money will be used to pay for support, leaving no extra money for entertainment or luxuries. Under the new law, the supplemental needs trust still accomplishes this goal. While the disabled individual is alive, the money cannot be used to pay for expenses that are not covered by Medicaid. The trustee may even distribute all of the funds in the trust for the beneficial enjoyment of the disabled person. It is only after the individual's death that the trust can be used to reimburse the State for the support of the beneficiary. By this time, the goals of the settlor have been accomplished, and the trust is no longer needed.

In addition to a supplemental needs trust, a trust that contains assets of a disabled individual of any age is exempt from Medicaid rules if it is established and managed by a non-profit association for the benefit of disabled persons.⁸⁹ The trustee of such a trust must maintain a separate account for each individual, but may pool the assets of the individuals for purposes of management and investment.⁹⁰ The fund may be established by a beneficiary, a parent, grandparent, or legal guardian of the beneficiary; or the court.⁹¹

Similar to the supplemental needs trust exempted in 42 U.S.C. § 1396p(d)(4)(A), the remainder of these trusts must be used to reimburse the State, or in the alternative, may be kept by the trust for the benefit of other disabled individuals.⁹² If the remainder is used to reimburse the State, any amount in excess of the State's Medicaid claim may be given to family members.

Finally, an income trust established by the State that is comprised only of pension, Social Security, and other income to the individual is exempt if the State receives reimbursement from the trust upon the beneficiary's death for the amount of Medicaid paid by the State.⁹³ This type of trust originated in *Miller v. Ibarra*.⁹⁴ *Miller* trusts are particularly useful in income cap states, where an applicant can often receive too much income to qualify for Medicaid, but not enough to pay for nursing home care. A court creates the trust by assigning the applicant's income to a trustee who then distributes the maximum amount of income that the individual may receive and still qualify for Medicaid. The distributed

income goes directly to the nursing home, and the excess remains in the trust. Medicaid pays that portion of the patient's nursing home bill that is in excess of the allowable income. When the patient dies, the income that was retained by the trust is paid to Medicaid as reimbursement for services.

Liens and Estate Recovery

Medicaid laws generally do not allow liens to be imposed against the property of a recipient before his or her death.⁹⁵ However, a recipient that is an inpatient in a nursing facility who is required, as a condition of receiving services, to spend all of his or her income, less a minimal personal needs allowance, for the cost of medical care, may be subject to a lien on his or her real property.⁹⁶ However, before the lien can be imposed, the recipient must be given notice and opportunity for a hearing. At the hearing, the State must find that the individual cannot reasonably be expected to be discharged from the nursing facility and return home.⁹⁷ The statute also provides that no lien can be imposed on the recipient's home when certain family members lawfully reside there: a spouse, a child under age twenty-one, a disabled child, or a sibling who has an equity interest in the home and has resided there for at least one year immediately before the recipient's admission to the nursing facility.⁹⁸ In addition, any lien that is imposed on the home of a Medicaid recipient dissolves if that person is discharged from the nursing facility and returns home.⁹⁹

If the home on which the State has placed a lien is sold, the State may recover for the amount of the lien at that time. If the family retains the home until the recipient's death, the State may recover against the estate of the individual for the amount of the lien.¹⁰⁰ The State may also recover funds from a recipient's estate even when there is no lien if the recipient received Medicaid when he or she was age fifty-five or older in the form of nursing facility services, home and community-based services, related hospital and prescription drug services, or any items or services under the State plan.¹⁰¹

Estate recovery is also limited by rules that protect family members of the recipient. Recovery may be made only after the death of the recipient's spouse, and at a time when he or she has no children who are blind, disabled, or under the age of twenty-one.¹⁰² In addition,

the State may not recover from a home subject to a lien if a sibling of the recipient who lived with the recipient for at least one year immediately before the individual's admission to the nursing home is living in the home and has lived there on a continuous basis since the individual was institutionalized.¹⁰³

The new rules under 42 U.S.C. § 1396 have broadened the definition of "estate," so that the State may recover nearly any asset that the recipient holds at his or her death. The statute provides that the "estate" shall include all real and personal property and other assets included in the recipient's probate estate.¹⁰⁴ In addition, each State may establish its own definition and include any other real and personal property and other assets in which the recipient had any legal title or interest.¹⁰⁵ This includes any assets conveyed to another person through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.¹⁰⁶

Moral and Ethical Concerns

Before any client begins to plan for nursing home care, he or she must deal with the moral issues that arise when one preserves assets at the cost of taxpayer dollars. The client must decide whether it is fair to give money away in order to qualify for Medicaid. The primary argument that Medicaid planning is improper is that Medicaid is a welfare program, not an insurance program like Medicare, into which all Americans have paid and from which all are entitled to benefits. Medicaid is a source of assistance to only the most needy citizens of the United States. This is precisely why the income and resource requirements are so strict.

Opponents of Medicaid planning also argue that it is wrong to make taxpayers foot the bill for nursing home care when many recipients are fully capable of paying. It is unfair that the family members of these recipients are reaping the benefits of their parent's life savings. With nursing home populations expected to double by 2030,¹⁰⁷ how will we keep up with the rising costs?

On the other hand, proponents of Medicaid planning claim that most of the people who use it are middle class and are not transferring hundreds of thousands of dollars to others simply to take advantage of Medicaid. Nor are they lifetime welfare benefits collectors who pay little or no taxes. These people have worked hard and paid taxes all of their lives; they think it only fair that

they should be able to pass their assets to their children.

Still other proponents argue that there are more practical reasons to preserve assets. Medicaid only permits a nursing home patient to have \$40 per month for personal expenditures. Meanwhile, Medicaid and Medicare fail to cover many of the necessities such as eyeglasses and dental work. If the client uses all of his or her funds to pay for nursing home expenses, there is nothing left to pay for pleasures such as flowers, hair styles, or entertainment. In addition, if a nursing home patient is transferred to a hospital, Medicaid will only pay to hold his or her bed at the nursing home for fifteen days.¹⁰⁸ After fifteen days, the patient's family must pay to hold the bed or the patient will lose it. If the patient loses the bed, it will be very difficult to find a new one when he or she is ready to return to the nursing home. This problem is compounded because the client is a Medicaid patient.¹⁰⁹ Therefore, it is important for the family to have some funds to use for the patient's benefit.

Attorneys also face many ethical issues when planning for elderly clients. Many of these issues arise because the elderly person may be unable to seek legal advice without the aid of family members. Quite often, family members will meet with an attorney on behalf of the person in need of planning. When this happens, the lawyer must make clear that he or she represents the Medicaid applicant. The attorney will have to determine whether the client is competent to make decisions regarding asset planning and whether this person really wants to use Medicaid as a source for the payment of his or her care.

Conclusion

At first blush, Medicaid planning appears unethical, even deceitful. Giving away one's assets so that the government will pay for medical expenses seems to go against the theory that welfare is only for the poorest members of our society. Many spectators may even ask whether a plan that involves the transfer of assets is legal. However, the most convincing argument for the use of Medicaid planning is that it is legal.

Congress has obviously pondered the impact of planning for medical care and the rising number of citizens in need of nursing home care. It made clear in the OBRA 1993 amendments¹¹⁰ to Medicaid law that it wanted to make eligibility tougher to attain. Congress

has taken an especially tough stance on the use of transfers of assets, extending the look-back period and creating an unlimited penalty period.

However, Congress only lengthened the look-back period to three years for transfers to individuals and five years for transfers to certain trusts. It could have made the look-back period ten years or more. It could have eliminated Medicaid planning altogether by making the look-back period unlimited or by prohibiting all transfers in anticipation of the need for long-term care. Therefore, it seems that even Congress sees some value to Medicaid planning.

When compared to similarly accepted practices in other areas of law, it is clear that Medicaid planning is not unethical. For example, a tax attorney spends his or her days finding ways to minimize a client's tax bill. This planning may require the attorney to find loopholes in the tax laws that permit the client to exclude income or take greater deductions. The attorney, in effect, takes money out of the hands of the government and places it in the hands of his or her client. Attorneys do not struggle with the ethics of these tax planning techniques because they are not illegal.

Likewise, criminal defense attorneys devote themselves to protecting the Constitutional rights of their clients by challenging the criminal justice system. Attorneys work to prevent their clients from being convicted when the system has violated these rights, even though the client may be guilty. The criminal defendant's attorney does not do anything unethical by using procedural rules to the client's advantage. In fact, the attorney would fail to provide effective assistance of counsel if he or she did not provide the best possible defense.

Similarly, an attorney practicing elder law protects his or her client from the financial perils of serious illness and institutionalization. No client wants to spend all of his or her money on nursing home care, leaving no funds to pay for the necessities and comforts Medicaid does not cover. An elder law attorney plans his or her client's future in accordance with the rules set forth by federal and state Medicaid laws. The attorney must create the most beneficial outcome available to the client under the existing rules.

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ENDNOTES:

¹ U.S. Dep't of Commerce, Economics and Statistical Administration, U.S. Census Bureau, Statistical Abstract of the United States, T. 114 (1994).

² *Id.*

³ 42 C.F.R. § 409.31(a)(1) (1994).

⁴ 42 C.F.R. § 409.31(a)(2) (1994).

⁵ 42 C.F.R. § 409.30(b) (1994).

⁶ 58 Fed. Reg. 58,553 (Nov. 2, 1993); 42 C.F.R. § 409.85 (1994).

⁷ *Id.*

⁸ In most cases, the patient will apply for benefits at some point after being admitted to a long-term care facility. Therefore, this paper will examine the eligibility requirements for an institutionalized individual.

⁹ 42 U.S.C. § 1396 (1988 & Supp. 1993).

¹⁰ *Id.*

¹¹ John J. Regan, *Tax, Estate & Financial Planning for the Elderly* § 10.07[2][b] (1994).

¹² COMAR 10.09.24.10D.

¹³ COMAR 10.09.24.10D(3).

¹⁴ COMAR 10.09.24.10D(2)(a)(i).

¹⁵ COMAR 10.09.24.10D(2)(c).

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ COMAR 10.09.24.10D(2)(d).

¹⁹ COMAR 10.09.24.10D(2)(b).

²⁰ COMAR 10.09.24.10-1C(1).

²¹ COMAR 10.09.24.08M (Schedule MA2).

²² COMAR 10.09.24.08G.

²³ COMAR 10.09.24.08G(1). Normally, full powers refers to the power to transfer the home and keep the proceeds.

²⁴ COMAR 10.09.24.08H(1).

²⁵ COMAR 10.09.24.08H(2).

²⁶ COMAR 10.09.24.08H(3)(a).

²⁷ COMAR 10.09.24.08H(3).

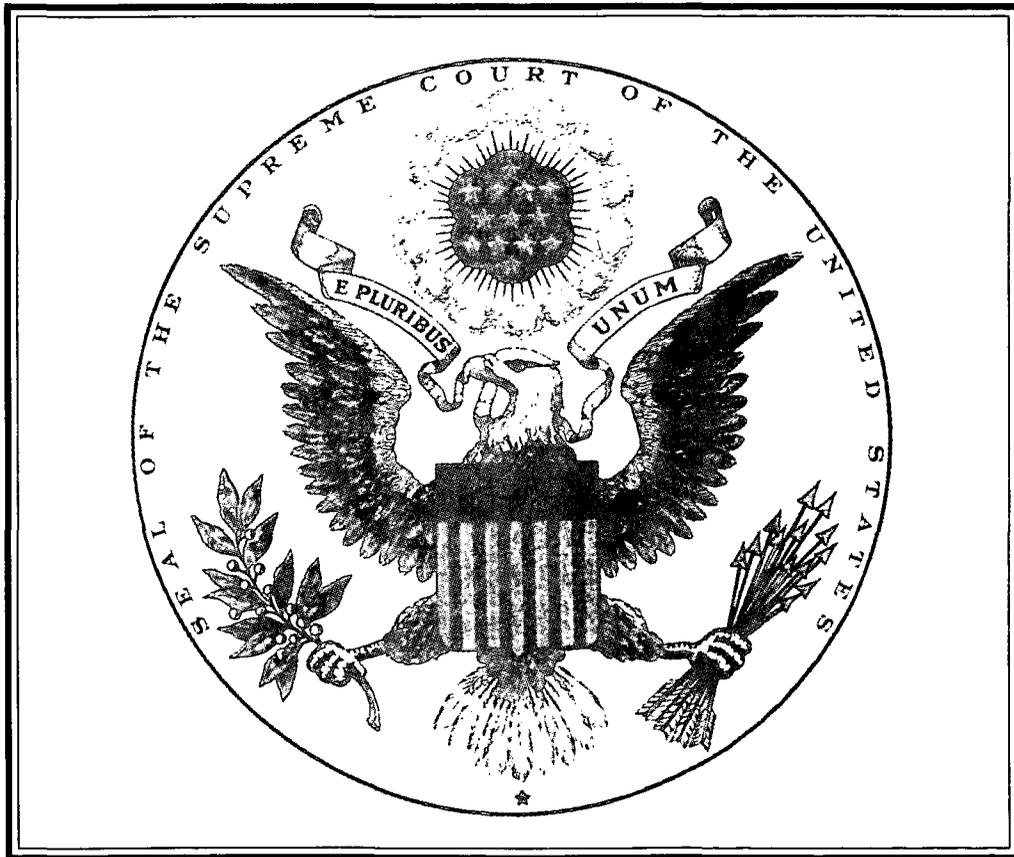
28 COMAR 10.09.24.08H(4).
29 COMAR 10.09.24.08H(6)(a).
30 *Id.*
31 COMAR 10.09.24.10-1D(1)(a)(i).
32 COMAR 10.09.24.10-1D(2).
33 Schedule MA-8, Release No.: MR-64.
34 COMAR 10.09.24.10-1E(1).
35 COMAR 10.09.24.08G(5).
36 *Id.*
37 COMAR 10.09.24.08G(5)(a).
38 COMAR 10.09.24.08G(5)(b).
39 42 U.S.C. § 1396p(c) (Supp. 1993).
40 42 U.S.C. § 1396p(e)(1)(B)(i) (Supp. 1993).
41 42 U.S.C. § 1396p(c)(1)(A) (1988).
42 Omnibus Budget and Reconciliation Act of 1993,
Pub. L. No. 103-66 (1993), codified at 42 U.S.C. §
1396 (Supp. 1993).
43 42 U.S.C. § 1396p(c)(1)(B) (Supp. 1993).
44 42 U.S.C. § 1396p(c)(1)(B)(i) (Supp. 1993); *see*
also 42 U.S.C. § 1396p(d)(3)(A)(iii) (Supp. 1993).
45 *See generally* 42 U.S.C. § 1396p (Supp. 1993).
46 42 U.S.C. § 1396p(c)(1)(E)(i) (Supp. 1993).
47 42 U.S.C. § 1396p(e)(1) (Supp. 1993).
48 *Id.*
49 *Id.*
50 Department of Health and Mental Hygiene, Nurs-
ing Home Transmittal No. 135, April 18, 1994.
51 *Id.* at 2.
52 *Id.* at 3.
53 *Id.*
54 *See* COMAR 10.09.24.08H(6).
55 42 U.S.C. § 1396p(c)(2)(A)(i) (1988 & Supp.
1993).
56 42 U.S.C. § 1396p(c)(2)(A)(ii) (1988).
57 42 U.S.C. § 1396p(c)(2)(A)(iv) (1988).
58 42 U.S.C. § 1396p(c)(2)(A)(iii) (1988).
59 42 U.S.C. § 1396p(c)(2)(B)(i)-(ii) (Supp. 1993).
60 Md. Code Ann., Trusts & Estates § 3-203.
61 Md. Code Ann., Trusts & Estates § 3-204.
62 42 U.S.C. § 1396p(c)(2)(C) (Supp. 1993).
63 42 U.S.C. § 1396p(c)(2)(D) (Supp. 1993).
64 I.R.C. § 213(a) (1995).
65 Regan, *supra* note 11.
66 Ron M. Landsman, *Paying for Long-term Care: Medicaid Eligibility* 80 (MICPEL 1994).
67 *Id.*
68 Remember that the Medicaid statute sets no maxi-
mum period of ineligibility for transfers made within the

look-back period. *See supra* note 34. However, if the applicant does not apply for Medicaid until after the look-back period has passed, the transfer will not be considered no matter how large its amount.

69 I.R.C. § 1015 (1995).
70 I.R.C. § 1014 (1995).
71 42 U.S.C. § 1396 (Supp. 1993); *see supra* note 35.
72 Landsman, *supra* note 66, at 84.
73 42 U.S.C. § 1396p(d)(1) (Supp. 1993).
74 42 U.S.C. § 1396p(d)(2)(A)(i-iv) (Supp. 1993).
75 42 U.S.C. § 1396p(d)(2)(C)(i-iv) (Supp. 1993).
76 42 U.S.C. § 1396p(d)(3)(A)(iii); (3)(B)(ii) (Supp. 1993).
77 42 U.S.C. § 1396p(c)(1)(B) (Supp. 1993).
78 42 U.S.C. § 1396p(d)(3)(A)(i) (Supp. 1993).
79 42 U.S.C. § 1396p(d)(3)(A)(ii) (Supp. 1993).
80 42 U.S.C. § 1396p(d)(3)(A)(iii) (Supp. 1993).
81 42 U.S.C. § 1396p(d)(3)(B)(i) (Supp. 1993).
82 42 U.S.C. § 1396p(d)(3)(B)(I) (Supp. 1993).
83 42 U.S.C. § 1396p(d)(3)(B)(i)(II) (Supp. 1993).
84 42 U.S.C. § 1396p(d)(3)(B)(ii) (Supp. 1993).
85 *Id.*
86 42 U.S.C. § 1396p(d)(4)(A) (Supp. 1993).
87 *Id.*
88 *Id.*
89 42 U.S.C. § 1396p(d)(4)(C)(i) (Supp. 1993).
90 42 U.S.C. § 1396p(d)(4)(C)(ii) (Supp. 1993).
91 42 U.S.C. § 1396p(d)(4)(C) (Supp. 1993).
92 42 U.S.C. § 1396p(d)(4)(C)(iv) (Supp. 1993).
93 42 U.S.C. § 1396p(d)(4)(B)(i) and (ii) (Supp. 1993).
94 *Miller v. Ibarra*, 746 F. Supp. 19 (D. Colo. 1990).
95 42 U.S.C. § 1396p(a)(1) (1988).
96 42 U.S.C. § 1396p(a)(1)(B) (1988).
97 42 U.S.C. § 1396p(a)(1)(B)(ii) (1988).
98 42 U.S.C. § 1396p(a)(2) (1988).
99 42 U.S.C. § 1396p(a)(3) (1988).
100 42 U.S.C. § 1396p(b)(1)(A) (Supp. 1993).
101 42 U.S.C. § 1396p(b)(1)(B) (Supp. 1993).
102 42 U.S.C. § 1396p(b)(2)(A) (1988).
103 42 U.S.C. § 1396p(b)(2)(B) (Supp. 1993).
104 42 U.S.C. § 1396p(b)(4)(A) (Supp. 1993).
105 42 U.S.C. § 1396p(b)(4)(B) (Supp. 1993).
106 *Id.*
107 Ann Japenga, *The Hammocks: Three Brothers Must Decide Whether to Shelter Their Parents' Life Savings or Watch Their Mother's Nursing Home Costs Wipe Out Their Inheritance*, Health, Oct. 1993, at 86.
108 COMAR 10.09.10.04D.

¹⁰⁹ See *supra* text accompanying note 9.

¹¹⁰ See *supra* note 35.



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The Maryland State flag is a quartered design with two sections each for the arms of the Calvert and Crossland families. The Calverts, the family name of the Lords Baltimore, used colors of gold and black which appear in the first and fourth quarters of the flag. The Crosslands, the family of the mother of George Calvert, first Lord Baltimore, used the colors red and white with a Greek cross stretching across the length of a square. The flag was officially adopted as the State flag in 1904 (Chapter 48, Acts of 1904).

