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The Necessity of Medicaid Planning

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I. Introduction

Lawyers counseling clients on the legal means to reduce expenses by maximizing societal benefits is a venerated legal tradition. As Judge Learned Hand opined:

We agree with the . . . taxpayer that a transaction, otherwise within an exception of the tax law, does not lose its immunity, because it is actuated by a desire to avoid, or, if one choose, to evade, taxation. Any one may so arrange his affairs that his taxes shall be as low as possible; he is not bound to choose that pattern which will best pay the Treasury; there is not even a patriotic duty to increase one's taxes.¹

Yet the specific practice of lawyers advising elderly disabled clients of the benefits obtainable under the Medicaid Program is often attacked as a scurrilous perversion of the intent of the law to provide assistance only to the "truly needy."² The reality, however, is that the extraordinarily high cost of long term care, particularly in relation to a typical senior's income, makes qualification for the Medicaid program an inevitability.

As we enter the new millennium the picture of long term care in America can be painted in stark contrasts. The population of elderly is increasing with almost Malthusian precision. With that increase is a concomitant increase in demand for long term care services. The cost of long term care, however, can so severely diminish a lifetime of savings that Medicaid planning becomes a necessity for all but the very wealthy. This article will discuss the cost of long term care services and why private pay options may be insufficient to cover the expense of such care. This article will also explore how the practice of Medicaid planning provides an essential service to those individuals seeking to utilize the benefits provided under Medicaid law.

II. Background

In 1996 the population of persons aged 65 and older in the United States was estimated to be 33.9 million, or 12.8 percent of the total population.³ This figure represents an eight percent increase over previous estimates for this segment of the population.⁴ This dramatic rise in the elder population is traced to a number of factors, including the population explosion known as the post World War II "Baby Boom" and the significant advances in medicine that have resulted in an increase in the average life expectancy.⁵ The most rapid growth in the elder population is expected between the years 2010 and 2030 when it is projected that approximately 70 million persons, or 20 percent of the United States population, will be over the age of 65.⁶ This surge in the elder population will most certainly necessitate an increased demand for long term care services. Statistics show that in 1995 1.4 million or four percent of persons over the age of 65 were nursing

¹Helvering v. Gregory, 69 F.2d 809, 810 (1934).
³See id.
⁴See id. at 3. As of 1996, the average life expectancy for a female at age 65 is 19.2 years and 15.5 years for a male. See id.
⁵See id.
Today it is estimated that 43 percent of those 65 and older will require some form of nursing home care.\(^7\)

Not only will the number of people requiring nursing home care increase, but the age of the average nursing home resident will increase as well. The age of a resident is a significant factor in determining the resident’s economic status. For example, a nursing home resident who is over the age of 80 is likely to have been retired for at least 15 years.\(^9\) Any retirement income acquired during the resident’s lifetime would have suffered a substantial decrease and left the resident with severely depleted financial resources. As reported in the study entitled, The Economic Status of Elderly Nursing Home Users, Joshua M. Wiener\(^10\) found that:

Financial status declines precipitously between retirement age and first nursing home use. At the time of their first entry to a nursing home, 31 percent of nursing home admissions had less than half of their income and financial assets at age 67. About half had less than 70 percent of their initial retirement income and assets at the time of admission to a nursing home.\(^11\)

This study further suggests that, on average, nursing home residents are “fairly low-income” and have “relatively few assets, except for a house.”\(^12\)

These income statistics for the over 65 population are not encouraging when one considers the prospect of paying for long term care. In 1995 the median annual income for a male over 65 was $16,684 and only $9,626 for a female over 65.\(^13\) The Administration on Aging reports that “[f]or all older persons reporting income in 1996 (31.2 million), 40% reported less than $10,000. Only 18% reported $25,000 or more. The median income reported was $12,214.”\(^14\) Almost one-fifth of those over 65 was poor or near poor in 1996.\(^15\) Among the elderly population, persons who are unmarried or widowed, living alone, and chronically disabled, tend to have higher poverty rates.\(^16\) These traits “[a]lso describe the nursing home population.”\(^17\) Women, for example, constitute as much as 75 percent of the nursing home population.\(^18\) Based on the foregoing data, it is likely that the average nursing home patient is female, lives in poverty, and is totally incapable of paying for her long term care.

### III. The Cost Of Long Term Care Services – Current Options

Financing nursing home care is a nearly insurmountable problem. Of particular concern is the skyrocketing cost of services. In 1992 the annual cost of nursing home care ranged from $18,000 to $60,000\(^19\) with an average estimated cost of $37,000.\(^20\) Of these costs,

\(^7\)See id. at 4.

\(^8\)See Peter Kemper & Christopher M. Murtaugh, Lifetime Use of Nursing Home Care, 324 NEW ENG. J. MED. 595, 597 (Feb. 28, 1991); See also Joshua M. Wiener & Laurel Hixon Illston, How to Share the Burden: Long-term care reform in the 1990’s, 12 BROOKINGS REV. 17 (1994).


\(^10\)See Wiener, supra note 9.

\(^11\)Id., at Abstract.

\(^12\)Id. at 2.
at least one half were paid out of pocket by the elderly nursing home resident. In 1993 the out of pocket expense for an elderly nursing home resident represented 51 percent of the $54.7 billion dollars spent that year on nursing home services. 21 This figure, which does not take into account the subsidiary expenses associated with long term care, 22 is expected to increase 147 percent by the year 2018. 23 Given the astronomical cost of nursing home care, it is virtually impossible for an individual or a couple to privately finance the total cost of nursing home services out of income alone. Only the very wealthy, categorized as having an income of at least $5,000 per month, have resources that can sustain fifteen or more years of post retirement support.

Given the high cost of care, many of the elderly residents in nursing homes already are or will become impoverished as a result of their institutionalization. The House Select Committee on Aging estimated that in 1987 "over 600,000 elderly Americans were forced into poverty paying for their health care for themselves or for their loved ones." 24 It is also estimated that approximately half of those who privately pay for nursing home care must turn to public assistance within three to five years of institutionalization. 25 This problem is further compounded by the fact that the nursing home patient also suffers at least one disability. 26 When one considers that "56.9 percent of disabled elderly age 75 and older had less than $10,000 in financial assets [excluding home equity] ..." private pay is not a viable option. 27

A. Private Pay

Private pay of nursing home services at an average cost of $37,000 depletes an individual's savings and inevitably strains the resources of the individual or family member responsible for financing the nursing home care. In many cases, private pay only delays the inevitable resort to public assistance. With private pay rates substantially above medical assistance reimbursement rates, private pay presents a particular hardship to those individuals who are admitted for shorter stays. Once these residents return to the community, they must attempt to provide for their daily needs with little or no assets. As one commentator noted, "[i]f an individual has to exhaust most of the assets accumulated over a lifetime the first time a long-term care need arises, then both the individual and spouse will thereafter have to depend upon the faceless bureaucracy of the welfare system." 28 Faced with total impoverishment in the face of private pay rates far above income, many of the nation's elderly are searching for alternatives.

B. Family Contribution

Many times when an elderly relative requires nursing home care, the family will finance the cost of such care out of their own pockets. However, family contribution to the cost of nursing care is not a realistic alternative as it serves to reduce the ability of future generations to provide for their own long term care by diminishing the assets available for later generations. Thus, a strong economic argument exists against encouraging family members to take on the burden of financing an elderly family member's long term care needs. Moreover, "[o]ut of pocket expenditures also hobble the efforts of these caregivers to save for retirement while simultaneously caring for their elders, their children, and trying to put aside enough for their children's higher education." 29 In many cases, the financial contribution required from a family member who assumes

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21See id. at 19.

22Such costs include health insurance premiums, co-pays, and deductibles; items not covered by medical insurance such as hearing aids, eye glasses, and dentures, and items not covered by public assistance.

23See Rein, supra note 20.

24INFORMATION PLUS, INFORMATION SERIES ON CURRENT TOPICS: GROWING OLD IN AMERICA, 90 (1994).


26See Rein, supra note 18, at 248.

27Id.


29Rein, supra note 18, at 268.
the costs of paying for nursing home care could have catastrophic effects on future generations.

In addition to the financial drain on existing assets and resources, family caregivers suffer financial loss in the form of diminished income and earnings. Family members who assume responsibility for the care of family members may need to take time off from work, and in some instances outright departure from the workplace is necessary. The net effect of the financial and emotional strain placed on family caregivers is a reduction in the accumulation of wealth and private retirement pension benefits available to support these family members in their own retirement years. According to a study commissioned by the American Association of Retired Persons ("AARP"), "40.6 percent of caregivers incurred some expenses as part of their role . . . ." Further, "10.1 percent of caregivers were found to have spent 25-50% or more of their income on home care needs." Within this group, 6.8 percent exhausted more than half of their income. The net result is that care givers "pay the price" of long-term care needs of family members. Not only do family caregivers suffer the loss of financial security, but they also suffer the loss of time spent away from their own families and friends, loss of physical and mental well being, and a loss of recreation time.

C. Long Term Care Insurance

Long term care ("LTC") insurance is the often-cited panacea for the problem of financing long term care. However, LTC insurance imposes a major financial burden on those consumers who can and do purchase policies. Long term care insurance is privately funded insurance which provides coverage for costs that may result from care provided in a long term care facility such as a nursing home, assisted living facility, adult medical day care, respite care, or for individual services provided in the patient’s home. Generally, insurance carriers or Medicare pay expenses arising from hospitalization. The Medicare coverage may cease immediately upon discharge from the hospital or may continue for a short time if the patient is admitted to a nursing home and their medical condition justifies skilled medical care. When the health insurance coverage ends, the patient must pay privately for continuing long term care.

The premiums for a LTC policy are a significant expense. As the likelihood of requiring long term care increases with age, so do the premiums. In addition, a number of questions exist concerning the affordability, quality and reliability of available insurance products. Presently, LTC policies are not popular with consumers. A consumer study conducted by UNUM Life Insurance Company of America found that 37 percent of those polled "had not purchased long-term care insurance because they think they can’t afford it." Furthermore, between 40 percent to 85 percent of senior citizens cannot afford LTC insurance premiums.

Several problems exist which contribute to the significant expense of LTC insurance. The first problem is that LTC insurance is only desirable if one anticipates a

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need for long term care. As one study suggests, "[t]he dilemma is that when people's interest in purchasing long-term care is greatest - when they are elderly - the policies are unaffordable." Thus, the trend toward purchasing LTC insurance because of need directly affects its affordability.

Second, LTC insurers cannot offer affordable policies since the LTC market, unlike other insurance markets, cannot avoid adverse selection. That is, insurers cannot draw premiums from a large and varied pool of clients which contain a significant number or beneficiaries who will never require long term care. In addition, since "[c]alculation of risk and assignment of value are among the central precepts in the insurance industry," a primary problem in the LTC insurance market is that insurers are not able to spread the risk among purchasers. The inability to spread the risk also leads to the industry standard that involves disqualification of many potential elderly clients due to preexisting conditions. This is reflected in the limited coverage that many LTC insurance policies offer. It is estimated that 61 percent of people now in nursing homes would not have received any benefits from their LTC policies. One study found that:

Generally, long term care policies [will not] cover the following: health problems you had before you bought the insurance policy — called preexisting conditions; mental or nervous disorders or diseases other than Alzheimer's or related dementia; alcohol or drug addiction; illnesses caused by an act of war, self-inflicted injuries, attempted suicide, and any treatment already paid for by the government.

It is therefore evident that many elderly consumers will simply not qualify for a LTC policy, and would be unable to purchase private insurance to finance their long term care.

A third factor contributing to the high cost of LTC policies is that the majority of policies are sold individually to elderly clients. Compared to the private health insurance markets, where insurers are able to let employers absorb the administrative costs associated with marketing private health insurance policies, many elderly consumers individually pay higher administrative costs including marketing and advertising.

Presently, the high cost associated with LTC insurance makes the purchase of such policies appropriate only for select individuals. In order to consider purchasing LTC insurance, "[g]enerally, a married couple should have at least $100,000 in assets, excluding their home, and a single person should have at least $40,000 in assets." Thus, a "catch-22" dilemma arises: LTC insurance is only affordable to those persons with a minimum amount of assets; this in turn limits the number of persons available to purchase LTC insurance. If this trend continues, LTC insurance will remain unaffordable.

Another problem with the purchase of LTC insurance is that it is difficult to predict what kind of long term care benefits an individual will need. Advocates argue that LTC policies are most affordable when consumers are younger and healthier. For example, a LTC policy purchased at age 55 might only cost $500 a year. This same policy would cost at least double if the same person purchased...
this policy at age 65. Consumer Reports states that "[r]oughly two thirds of men now 65 will never enter a nursing home." Thus, purchasing policies at a younger age means paying thousands of dollars in premiums for over twenty years or more without ever receiving any benefits. Another danger lies in purchasing an inadequate policy at age 55, for example, which would not cover the actual long term care costs incurred due to the lack of realistic expectations at the time of purchase as to what kinds of benefits would be required 25 years later. In fact, many LTC policies are overly restrictive and will not pay benefits if you go to the wrong type of nursing facility. At present, LTC insurance is not a viable option for addressing the long term care needs of the growing elderly population.

IV. The Medicaid Program

The foregoing demonstrates that private pay, financial assistance by family members, and long term care insurance do not begin to solve the problem of financing long term care for those persons with limited assets and resources. Take, for example, a couple with assets valued at $100,000. Private pay for nursing home care at cost of $37,000 annually for just one spouse would deplete their total financial resources in less than three years and result in total impoverishment of the healthy spouse and the disabled spouse. Asking family members to help defray the cost of care proportionately reduces that family member’s ability to pay for their own long term care needs. Finally, long term care insurance is not an option for the couple in this example since their total assets are valued at $100,000 or less. While this hypothetical couple would not be considered "poor" in the strictest sense, they face the potential of total impoverishment in order to meet the costs of their long term care needs. Consumer Reports states that “[f]or the nonpoor elderly, the need for nursing-home care often spells the end of financial as well as physical independence." It is, therefore, no surprise that many elderly, once middle class, inevitably turn to the state medical assistance program to help defray the cost of long term care.

"Medical Assistance, or Medicaid, is a means-tested program that provides long-term care coverage to institutionalized persons who meet the technical, financial, and medical eligibility criteria established in federal and state law." The program, which was established under federal law, is the largest insurer of long term care. "Medical Assistance provides comprehensive medical insurance for long-term care, including nursing facility services, services that are equivalent to nursing facility services and are provided by any institution, and services provided under a home and community based waiver." Medicaid providers agree to accept the Medicaid reimbursement rate as payment in full and may not seek from a recipient the difference between the Medicaid payment and their private-pay rate.

Medicaid is a welfare program designed to assist those families or individuals with limited resources and income with their medical needs. The eligibility requirements are quite specific and state agencies must administer individual programs in compliance with federal statutory and regulatory requirements. The majority of states establish income and resource limits, using the

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52See Merline, supra note 48 at 16.

53Long Term Care Insurance Special Report: What to expect from Medicaid, supra note 40, at 40.


55See Long Term Care Insurance Special Report: What to expect from Medicaid, supra note 40, at 43.

56See Merline, supra note 48 at 16.

57Jason A. Frank, Elder Law in Maryland, 1996, at 394.


59Frank, supra note 57.


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Supplemental Security Income ("SSI") rules as the base. The Medicaid program allows states to offer benefits to persons who are either categorically needy or medically needy.

Categorically needy recipients are mandatory Medicaid coverage groups and include, for example, recipients of SSI. States may also include certain aged, blind, or disabled adults who have income above those requiring mandatory coverage but below the Federal poverty level, or institutionalized individuals with income and resources below specified limits.

The medically needy program permits states to extend Medicaid eligibility to additional qualified individuals who have too much income to qualify under the categorically needy groups. The medically needy option allows an individual to "spend down" their income and resources in order to qualify for Medicaid. Spending down is achieved by offsetting excess income by incurring medical or remedial care expenses. This offset results in a reduction of total income to a level below the eligibility maximum. One can also qualify as medically needy by paying monthly premiums to the state in an amount equal to the difference between family income and the income eligibility standard. The Health Care Financing Administration states that "low income is only one test for Medicaid eligibility; assets and resources are also tested against established thresholds." Medicaid eligibility is not entitlement, rather, it is a means tested program that requires one to meet the eligibility requirements in order to receive benefits.

Financial eligibility under Medicaid is determined by countable resources and the income of the applicant, or for married applicants, by the applicant and spouse. The financial eligibility requirements for Medicaid may be met if the individual's total countable resources do not exceed the medical assistance resource standard at any point during the month of application. For example, in the State of Maryland, the resource standard is $2,500 for an individual and $3,000 for a couple sharing a room. If a Medicaid recipient acquires resources that lead to excess resources, he or she must spend down to the applicable resource level within 30 days to maintain uninterrupted Medicaid benefits.

Resources are spent down by purchasing items for the recipient, paying debts, pre-paying for funeral expenses, or reimbursing the Medicaid program for expenditures made for the recipient's care. However, if the resources are not reduced below the resource standard within 30 days of when the resource is received, eligibility will terminate. The recipient must then pay privately for his or her care at the current private pay rate until he or she has again spent down to the resource level.

V. The Necessity Of Medicaid Planning

The complex structure of the eligibility requirements forces individuals to seek help in order to assess their potential eligibility and plan accordingly. Understanding Medicaid and its requirements, eligibility rules, income thresholds, resource tests, exceptions, exemptions and allowances necessitates careful evaluation and planning. Planning for Medicaid eligibility has evolved as a necessary part of receiving Medicaid benefits under any circumstances. Furthermore, the increasing complexity of the Medicaid rules and regulations has lead to more complex Medicaid planning.

61 See 42 U.S.C. § 1396r (1995). An exception to the SSI based requirement involves existing programs which were allowed to continue to exist under a grandfather provision (commonly referred to as 209b states).

62 See Medicaid Eligibility, supra note 58.

63 See id. See also 42 U.S.C. § 1396d(a) (1994).

64 See Medicaid Eligibility, supra note 58.

65 Id.


67 See Dept. of Health and Mental Hygiene, Maryland Medical Assistance Manual, Schedule MA-2 (1995). Note that a couple sharing a room for $3,000 a month applies for the first six months. After that, the couple must pay the individual rate of $2,500 each per month.
A. Medicaid De Facto Policies

The Medicaid program has a number of de facto policies that militate in favor of Medicaid planning. For example, the program policies and rules regarding asset transfers, calculation of penalties, and allowable exemptions all require planning in order to properly understand and make use of the program provisions that must be followed in order to qualify for benefits. It would be irrational to assume that the Medicaid program has adopted requirements which are meant to be ignored or that can only be met by chance. All statutory provisions that allow eligibility, given certain criteria, are intended to be available for those persons who can meet such criteria.

The Medicaid criteria governing asset transfers authorizes individuals to make such transfers without incurring a period of ineligibility for benefits under limited circumstances.68 These kinds of asset transfers are considered “exempt” asset transfers. An example includes Medicaid authorized transfers to a spouse or to a third party for the sole benefit of the spouse.69 The rules also allow asset transfers to certain disabled individuals or to certain kinds of trusts established for those individuals.70 A person who wishes to become eligible for Medicaid may, therefore, transfer assets to protect needy and disabled family members and still receive benefits. Even those asset transfers that are not expressly authorized by Medicaid (considered “non-exempt”) do not prohibit benefits altogether, but only limit an individual’s eligibility for Medicaid.

Non-exempt asset transfers are subject to the look-back period of the Medicaid program. This means that if a transfer of assets for less than fair market value is found within 36 months (or within 60 months for trusts)71 of an individual’s application for Medicaid, the state must withhold payment for various long term care services for a period of time referred to as the penalty period.72 Medicaid does not, however, prohibit eligibility altogether. It merely penalizes the asset transfer for a certain period of time.73 The fact that transfers are only looked at for 36 months prior to application clearly indicates that asset transfers prior to 36 months will not compromise an individual’s Medicaid eligibility. The adoption of the 36 month look back period is one de facto policy of the Medicaid program that promotes planning of asset transfers.

The calculation of the penalty period is another de facto policy of the Medicaid program that requires complex analysis in order to understand how the calculation operates. Effectively, the provision for a penalty calculation devised under the Medicaid program promotes the transfer of countable assets prior to an application for Medicaid benefits. The asset transfer penalty is determined by dividing the total uncompensated value of the asset transferred by the average private-pay cost of care in the state.74 For example, if the private-pay cost of care in state “A” is equal to $4,300, then state A will penalize an individual one month of ineligibility for every $4,300 transferred. The penalty begins the first day of the month in which the transfer is made. This means that an individual can give away $4,300 in each month that he or she does not ask Medicaid to pay for the nursing home care. Therefore, the total cost for each month not subsidized by Medicaid as a result of a period of ineligibility equals the difference between an individual’s income and the private-pay cost of care plus $4,300. Dividing the value of the individual’s total countable resource by this amount determines the maximum number of months an individual


69 See id.; see also Health Care Financing Administration, Transfers of Assets, (last modified Nov. 18, 1996) <http://www.hcfa.gov/medicaid/obs8.htm>.


71 See id.

72 See id.


can transfer resources while retaining sufficient funds to cover the cost of care during the transfer penalty period.\textsuperscript{75}

For individuals with increased assets, but insufficient income to pay their cost of care (e.g., individuals with assets of $250,000 to $400,000), the de facto policy is that they can protect any assets beyond what it costs to pay for their care for three years. As previously mentioned, the 36 month look back period requires that any transfer of assets must take place 36 months prior to an application for Medicaid.\textsuperscript{76} However, these individuals must retain enough assets to pay for their cost of care for three years. Therefore, as long as an individual can afford to pay privately for care during the three year look-back period, the Medicaid program allows asset transfers for an individual with increased assets. In order to understand whether an individual may transfer assets and what penalty, if any, will be imposed after an asset transfer, an individual must engage in a certain amount of evaluation and planning.\textsuperscript{77}

\textsuperscript{75}For example, if an individual has assets valued at $94,900, nursing home costs of $4,500 per month, and an income of $1,500 per month, the appropriate amount of assets that the individual should transfer would be calculated as follows: The difference between the cost of care ($4,500) and monthly income ($1,500) is the “deficit” ($3,000). The deficit is added to the state “A” penalty rate of $4,300 month. (i.e., $4500 - $1500 = $3,000) Dividing the total assets ($94,900) by $7,300 equals 13, which is the number of months an individual must be able to privately-pay the deficit. Therefore, the individual should retain $39,000 (13 x $3000) and transfer $55,900 ($55900 / $3000 = 13 months). This formula is a mathematical equation which has evolved as a result of the statutory penalty provision for asset transfers, known as the “half loaf” formula, because protecting half of the assets for the family is better than protecting none. It would be unreasonable to expect an individual to pay more than what is absolutely necessary or required. Medicaid in effect authorizes asset transfers after the fact through the imposition of the penalty period. The de facto policy for individuals is that they can protect half of their assets if they are willing to pay the other half for their care.

\textsuperscript{76}See 42 U.S.C. § 1396(c) (1991).

\textsuperscript{77}It is important to note, however, that assets transfers and the penalty calculation formula is only practical for those individuals with assets under $108,000. In a state with a $4,300 per month penalty, any transfer over $154,800 will result in an automatic penalty period of 36 months. Considering the fact that the average nursing home stay is three to four years for residents who require long term services, Medicaid eligibility is not a practical alternative for individuals with this level of assets. In fact, elderly individuals with substantial assets are more likely to receive their care at home or in a community based setting, rather than in a nursing home. Thus, Medicaid planning is not a tool for the very wealthy.

\textbf{B. Spousal Impoverishment}

In addition to these policies regarding non-exempt asset transfers, Medicaid policies also exist regarding exempt asset transfers that promote the need for Medicaid planning. One such policy arises from the provisions designed to protect against spousal impoverishment.\textsuperscript{78} The spousal impoverishment provisions apply where the member of a couple who is in a nursing facility or medical institution is expected to remain there for at least 30 days.\textsuperscript{79} When the couple applies for Medicaid, an assessment of their resources as of the first day of the month of institutionalization is conducted. The couple’s resources are combined and exemptions for the home, household goods, an automobile, and burial funds are deducted.\textsuperscript{80} The resultant figure is used by the state to determine the community spouse’s protected resource allowance.\textsuperscript{81}

The community spouse’s protected resource allowance is an amount equal to one-half of the couple’s combined countable resources as of the first day of the month of nursing home placement.\textsuperscript{82} However, this amount may not exceed the federal maximum resource standard nor may it be less than the federal minimum resource standard.\textsuperscript{83} Spend down of the unprotected resources can be made for the benefit of the community spouse depending on individual state medical assistance policy. At minimum, the use of annuities to spend down assets by purchasing an income stream for the community spouse allows medical assistance eligibility for institutionalized spouses in a matter of two or three months.

Another Medicaid provision that protects against spousal impoverishment concerns the income of the


\textsuperscript{79}See id.

\textsuperscript{80}See id.

\textsuperscript{81}See id.

\textsuperscript{82}See id.

\textsuperscript{83}See id.
community spouse. Income in the community spouse's name is not considered available to the spouse who is institutionalized. The state, therefore, uses income eligibility standards for one person rather than two. This policy encourages a community spouse to plan accordingly and to purchase annuities to boost his or her monthly income while having the nursing home spouse's care subsidized by Medicaid. These provisions compel a certain amount of planning for couples who face the prospect of one spouse requiring institutionalization. These guidelines, as with others, must be taken into consideration when an individual considers whether Medicaid will subsidize the cost of long term care.

Creation of a trust represents another type of exempt asset transfer under the Medicaid regulations. There are five types of trusts that are exempt from resource consideration for Medicaid eligibility purposes. These trusts include: (1) Miller trusts, (2) pooled asset trusts managed by non-profits, (3) trusts funded for disabled children or other disabled individuals under age 65, (4) supplemental needs trusts funded by third parties, and (5) any trust funded with the assets of a disabled person who is under the age of 65. In the case of an exempt trust, the trust funds are not counted as resources available to the Medicaid applicant. Transfers of assets into exempt trusts are not penalized; rather, federal Medicaid law and regulations sanction the practice.

VI. Income Tax Planning vs. Medicaid Planning: A Comparison

The types of asset transfers involved in Medicaid planning are not unlike those used for tax planning. Though the techniques involved in both practices are the same, the practice of tax planning is widely accepted in this country while the practice of Medicaid planning is often criticized. Federal tax law creates a number of options that allow taxpayers to defer or avoid paying income tax and to conserve family resources. Complete tax avoidance deprives the government of revenue. For example, the practice of investing in deferred income “tax shelters” converts the government from the role of “tax-gatherer” to that of investor. Some investments such as triple tax-free municipal bonds allow individuals to avoid paying taxes altogether. Arguably, the most common tax avoidance technique to reduce overall tax liability is the deductibility of mortgage interest. Other exemptions, such as those found in federal gift and estate tax law, allows an individual to give away up to $675,000 without incurring any tax liability. In addition, an individual may give away an unlimited amount of assets in increments of $10,000 or less in order to escape taxes. The tax avoidance techniques of gifting funds, retitling assets, and funding trusts are often the same tools used in Medicaid planning. Furthermore, it is often asserted that the federal government had the same goal in mind, that of conserving resources for families, when it developed the Medicaid and tax law.

As quoted above, Judge Learned Hand extolled the value of paying minimal income tax. This value is imbedded in the American way of life. Every taxpayer attempts to manipulate the tax laws in order to receive the maximum amount of deductions, exemptions, and other tax breaks. Each year millions of dollars in tax are not paid to the federal government due to the efforts of professional tax planners who use the allowances created under statutory guidelines. As Congressman William Green stated:

Taxes are always paid grudgingly and heavy taxes naturally meet with much opposition, however necessary they may be ... So much ingenuity has been used in inventing methods whereby less taxes would be paid that we have been obliged from time to time to change our revenue laws to meet these evasions ...

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5See 42 U.S.C. § 1396p(d)(4)(C) (1994). In the case of a d(4)(a) trust, medical assistance eligibility will not be compromised provided that, at the termination of the trust, the funds will be used to reimburse the state for Medicaid benefits paid to that applicant. See 42 U.S.C. § 1396(p)(d)(4)(a) (1994).


Generally, while the practice of tax planning is sanctioned and ethical considerations are not debated when speaking of not paying income tax, the practice of Medicaid planning is viewed with disdain. While tax attorneys are rarely criticized for counseling their clients to take advantage of the federal tax laws, some Medicaid attorneys are scorned for counseling their clients to take advantage of federal and state Medicaid law. The bottom line is that tax planning is a practice that sets out to deprive the federal government of revenue, while Medicaid planning allows individuals to receive much needed long term care at a time when they are most financially vulnerable. The distinction between practices that allow senior citizens with limited resources to receive government funded health care and allowing individuals of any age to conserve their personal wealth by avoiding payment of their share of income or gift and estate tax is an illusory one.

Although it is argued that Medicaid was originally intended for the “truly impoverished,” the legislative structure of Medicaid demonstrates otherwise. The “truly impoverished” do not need to worry about asset transfers, property exemptions, and other resource guidelines because the “truly impoverished” presumably do not have the kind of resources that these Medicaid provisions were designed to protect. It is, therefore, arguable as to whom Medicaid was intended to cover. What is clear, however, is that if an individual meets the eligibility criteria, he or she is entitled to receive benefits.

VII. Support For Medicaid Planning

An individual’s right to receive Medicaid benefits was confirmed by the recent focus of federal legislators on Medicaid planning. As discussed in the foregoing section, federal law allows certain transfers of assets up to 36 months prior to an application for Medicaid benefits and certain transfers to trusts up to 60 months. Such transfers result in a period of ineligibility for medical assistance. In 1996 Congress attempted to criminalize asset transfers under Medicaid. Section 217 of the Health Insurance Portability and Accountability Act of 1996 was signed into law on August 21, 1996. Section 217 applies to any individual who:

[K]nowingly and willfully disposes of assets . . . in order for an individual to become eligible for medical assistance under a state plan under title XIX, if disposing of the assets results in the imposition of ineligibility for such assistance under [42 U.S.C. § 1396p(c) . . . will be guilty of a misdemeanor if convicted and subject to fines up to $10,000 or imprisonment of up to 1 year or both.] 90

However, it was quickly realized that this provision could not criminalize lawful asset transfers.

In Peebler v. Reno, plaintiffs filed an action for declaratory relief seeking a judicial declaration that 42 U.S.C. § 1320a-7b(a)(6) was unconstitutional. The court found that an individual, who had “waited out” the ineligibility penalty period before filing a Medicaid application, even if the individual transferred assets during that period, did not trigger Section 217. 92 A person, therefore, who transfers assets and waits for three years or until the penalty period has expired to apply for Medicaid incurs no criminal liability.

Congress subsequently replaced Section 217 with Section 4734 which provided that whoever:

[F]or a fee and knowingly and willfully counsels or assists an individual to dispose of assets (including any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance . . . . 93

90 Id.
92 See id. at 31.
This modification attempted to criminalize counseling for the disposition of assets in order to qualify for Medicaid rather than the actual transfers themselves. However, the change was an unsuccessful attempt to curtail what had been thought of as the widespread use of Medicaid planning to qualify improperly for Medicaid. On March 11, 1998, Attorney General Janet Reno wrote to Congress refusing to enforce Section 4734. The Attorney General stated:

[T]his is to respectfully inform you that, after close and careful scrutiny of the matter, the Department of Justice will not defend that constitutionality of Section 1128B(a)(6) because the counseling prohibition in that provision is plainly unconstitutional under the First Amendment and because the assistance prohibition is not severable from the counseling prohibition."

The Attorney General’s letter further declared:

[T]he new Section 1128B(a)(6) of the Social Security Act would prohibit attorneys and other professional advisors from ‘counsel[ing]’ their clients to engage in an estate-planning strategy that itself is lawful. Under these unique circumstances, and in light of the fact that, pursuant to this provision, professional advisors such as attorneys would be prohibited from providing truthful, non-misleading advice to their clients about lawful behavior, we are unable to identify a governmental interest that would justify this restriction on protected speech."

Finally, the Attorney General informed Congress that the Department of Justice would not bring any criminal prosecutions under the current version of Section 4734.

In New York State Bar Association v. Reno, the New York State Bar Association challenged the constitutionality of section 4734 on the grounds that it violated the First and Fifth Amendments. The court issued a preliminary injunction preventing the federal government from enforcing the statute that made paid counseling of, or assistance to, an individual attempting to shift assets in order to qualify for Medicaid punishable by a fine or one year in prison.

Other courts have similarly upheld the legality of medical planning. In In re John XX, an elderly man suffered a stroke, was hospitalized, and then transferred to a nursing home. The man suffered significant and permanent cognitive dysfunction. The guardian petitioned the court for approval to transfer $640,000 of the disabled man’s assets to his children. The transfers were “intended as a Medicaid and estate planning device to shield the bulk of . . . assets from a potential Medicaid lien for the cost of the nursing facility services . . . ." The Supreme Court of New York found that “there being little question that, barring death, John will require continued nursing home care, the cost of which will exhaust his assets, it cannot be reasonably contended that a competent, reasonable individual in his position would not engage in the estate and Medicaid planning proposed in the petition.” The court also found that during the relevant period, federal law made no provision for the imposition of any penalty for transfers made prior to the look-back period.

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98See id. Specifically, the New York State Bar Association argued that section 4734 was unconstitutional because: (1) it unconstitutionally restricted free speech; (2) it was overly broad and violative of the First Amendment; and (3) it was vague and violative of the Fifth Amendment. See id at 713.
99See id. at 716.
101See id. at 81.
102See id.
103Id.
104Id. at 82-83.
The court stated that “the simple fact is that current law rewards prudent ‘Medicaid planning.”\textsuperscript{106}

Similarly, in \textit{In re Daniels},\textsuperscript{107} the New York Supreme Court recognized the value and reasonableness of asset transfers when it held that “a competent, reasonable individual . . . would prefer that his property pass to his child rather than serve as a source of payment for Medicaid and nursing home care bills where a choice is available.”\textsuperscript{108} This court also acknowledged the lawfulness of Medicaid planning when it stated that “[i]t appears that . . . the law provides a manner for her to preserve a portion of her estate for the benefit of her daughter and the issue of her other daughter.”\textsuperscript{109} The court’s opinion in \textit{Daniels} not only upheld the legality of Medicaid planning, it also recognized the significance of preserving personal wealth for future generations. In effect, this was also recognition of the value of inheritance.

Inheritance is another legislative process through which individuals and couples are able to plan how to dispose of property and other assets in the event of death. In \textit{Magoun v. Illinois Trust & Sav. Bank},\textsuperscript{110} the Supreme Court held “[t]he right to take property by devise or descent is the creature of the law . . .”\textsuperscript{111} The Court, in \textit{Keeney v. Comptroller of New York},\textsuperscript{112} later held that the power to regulate inheritance is within the domain of state power, and, “the State may confer particular rights of succession, but with them impose conditions, limitations, classifications, and impositions upon the right of each particular succession granted.”\textsuperscript{113} Thus, inheritance represents yet another legislative vehicle that may be used to convey property, subject to fees and limitations imposed by the federal government, with the primary objective of conserving wealth.

The practice of passing property on to future heirs through inheritance is solely a creature of law, and as such is accepted without question as a legitimate practice. In addition, the widespread ratification by state legislatures and courts of the inheritance process reflects the social value inherent in that process.\textsuperscript{114} As one author suggests, “[i]nheritance does seem to occupy a special place in the hearts of many Americans, even those who cannot realistically expect to inherit anything of significance.”\textsuperscript{115} This value is reflected in the fact that approximately $150 billion passes at death each year.\textsuperscript{116} This tradition of inherited wealth is firmly rooted in our historical customs.\textsuperscript{117} These historical customs have been embodied in legislative enactments and judicial holdings. The customs involved in Medicaid planning are similarly embodied in federal regulations and have, thus far, been upheld by the courts.

\section*{VIII. Conclusion}

The gross disparity between the average income of the disabled elderly and the cost of long-term care mandates that some public assistance program be available. Medicaid, the only such program currently available, predicates eligibility for assistance on meeting strict income and asset tests along with a number of carefully circumscribed exceptions. As the number of disabled elderly grows into the millions, and cures for the causes of institutionalization continue to elude medical science, both

\begin{itemize}
\item See id. at 83.
\item Id.
\item 618 N.Y.S.2d 499 (Sup. Ct 1994).
\item Id. at 504.
\item Id.
\item 170 U.S. 283 (1898).
\item Id. at 288.
\item 222 U.S. 525 (1911).
\item Id. at 529-30.
\item Id. at 75.
\item See id. at 72.
\item In his Commentaries, Blackstone stated that “[a] man’s children or nearest relations are usually about him on his death-bed, and are the earliest witnesses of his decease. They became, therefore, generally the next immediate occupants, till at length, in process of time, this frequent usage ripened into general law.” 2 William Blackstone, Commentaries *11-12.
\end{itemize}
the social and personal costs of long term care will continue to increase.

Those who advocate abandonment of long term care funding in favor of privately financed care, either through personal or family responsibility or private long term care insurance, are ignoring the realities of the costs of long term care. Family assets and hopes for better lives for children and grandchildren pass from the realm of possibility when a relative is institutionalized. The considerable cost of financing long term care results in depleted resources for both the institutionalized individual and, in many situations, a family member who assumes responsibility for such care. Additionally, long term care insurance, drawn from a pool of the healthy and wealthy, can never provide a comprehensive private alternative to a direct government role in financing long term care.

Until the need for Medicaid planning is eliminated, this service will remain an absolute necessity for the millions who face the financial devastation of paying for long term care. The perhaps all too human urge to get the most benefit at the least cost, such as tax avoidance, has resulted in a demand for lawyers whose practice includes a detailed knowledge of the Medicaid eligibility rules and how best to plan for eligibility.

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